

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Center for Medicare  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850



**MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP**

---

**AD HOC CORRECTIVE ACTION PLAN**

December 9, 2014

Contract Number: H9302

Ms. Sheila Nishimoto  
Catholic Health Initiatives  
32129 Weyerhaeuser Way S.,  
Suite 100  
Federal Way, WA 98001

VIA EMAIL: [s.nishimoto@soundpathhealth.com](mailto:s.nishimoto@soundpathhealth.com)

RE: CY 2014 INACCURATE ANNUAL NOTICE OF CHANGE/EVIDENCE OF  
COVERAGE (ANOC/EOC)

Dear Ms. Nishimoto:

The Centers for Medicare & Medicaid Services (CMS) is issuing this determination for a Corrective Action Plan (CAP) to your organization based on the issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to your Medicare enrollees for the Contract Year 2014.

Federal regulations at 42 C.F.R. §422.111(a) and 42 C.F.R. §423.128(a) require Medicare Advantage Organizations and Prescription Drug Plan Sponsors (organizations) to disclose plan descriptions in a clear, accurate, and standardized form. Your organization failed to accurately describe benefits and/or cost sharing information in your ANOC/EOC documents; this determination was based on our review of your errata sheets. Failure to provide correct information prevents beneficiaries from making a fully informed health care choice. Therefore, your organization is out of compliance with CMS requirements.

CMS requests that your organization implement a detailed CAP to ensure ANOC/EOC documents are accurate prior to mailing. Please send the CAP to Samantha Nebolsine, Account Manager at [samantha.nebolsine@cms.hhs.gov](mailto:samantha.nebolsine@cms.hhs.gov) no later than 30 days from the date of this letter.

CMS is issuing this compliance notice pursuant to 42 C.F.R. §422.510(c) and 42 C.F.R. §423.509(c), which require CMS to afford an organization at least 30 days to develop and implement a corrective action plan to correct deficiencies before taking steps to terminate an organization's Medicare contract. While CMS is not obligated to grant a greater than 30-day cure period, we acknowledge that an extended period may be appropriate, depending on the nature of

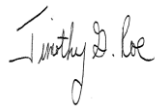
the correction required. CMS advises that, for any part of its timeline scheduled to be completed in more than 30 days, your organization provide a justification of the need for that additional time. CMS expects that the correction timeline will be no longer than absolutely necessary and will reflect an appropriate level of urgency in resolving this matter.

CMS has the authority to impose sanctions, penalties, and other enforcement actions as described in Federal regulations at 42 C.F.R. 422 and 423 Subpart O. Should your organization fail to develop, implement, or complete its CAP, CMS may consider the imposition of intermediate sanctions, (e.g., suspension of marketing and enrollment activities), or civil money penalties.

Please be aware that this letter will be included in the record of your organization's past Medicare contract performance, which CMS will consider as part of our review of any application for new or expanded Medicare contracts your organization may submit. This letter is considered a Part C and D issue with beneficiary impact for past performance purposes.

If you have any questions, please contact Marie Gutierrez at [marie.gutierrez1@cms.hhs.gov](mailto:marie.gutierrez1@cms.hhs.gov) and copy your Regional Office account manager.

Sincerely,

A handwritten signature in black ink that reads "Timothy G. Roe". The signature is written in a cursive style with a large initial 'T' and 'R'.

Timothy G. Roe, Acting Director  
Division of Surveillance, Compliance and Marketing

cc via email: Christine Reinhard, Part C Compliance Lead  
Scott Nelson, Part D Compliance Lead  
Marie Gutierrez, Part C Compliance Project Lead  
Samantha Nebolsine, Account Manager