CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PC02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.

Reference:

42 CFR § 423.120(b)(5)(i); § 423.120(b)(5)(iii); § 423.578(d); Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

CMS reviewed AAHP's policy and procedure (M5100.04)to determine compliance with this requirement and found that it does not include a provision to provide retrospective notice of formulary changes to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Refer to 42 CFR 423.120(b)(5)(iii).

Corrective Action Required:

AAHP must revise its policies and procedures to include the provision noted above.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/23/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.

Reference:

Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

CMS reviewed plan policies and procedures, plan documentation demonstrating that the plan conducts ongoing monitoring, and a sample review of contracts and/or compensation structures with sales representatives to determine compliance with the requirements for this element. AAHP's marketing policy and procedure (M8000.06) is missing a provision that requiring all persons marketing on behalf of the plan be state-licensed, certified or registered individuals.

Corrective Action Required:

AAHP must revise its policy and procedure to include the missing requirement noted above and submit a copy of the revised policy and procedure to CMS.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.

Reference:

42 CFR § 423.120(b)(5)(i-iii); § 423.120(b)(7); § 423.578(d); Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

CMS reviewed plan policies and procedures to determine compliance with requirements for this element. AAHP's policiy and procedure (M5100.04) does not include a provision to provide retrospective notice to affected enrollees when it removes a covered Part D drug immediately from the fomulary because it is deemed unsafe by the FDA or the manufacturer removes the covered drug from the market.

Corrective Action Required:

AAHP must revise its policies and procedures to include the provision noted above and resubmit the revised version to CMS as part of its CAP.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PH03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.

Reference:

42 CFR § 423.120(a)(5); MA-PD Solicitation; Long Term Care Guidance

Deficiencies:

CMS reviewed policies and procedures and AAHP's Long Term Care (LTC)Pharmacy to Nursing Bed Ratio Analysis to determine compliance with this review element. Although AAHP's nursing bed ratio analysis it had adequate bed access, neither it nor its two contracted PBMs (Rx America until 12/31/06 and ESI 1/1/07 onward) had policies and procedures stating that they must offer standard contracting terms and conditions, including performance and service criteria for LTC pharmacies that CMS specifies, to any LTC pharmacy in its service area that requests the contract.

Corrective Action Required:

AAHP must develop a policy and procedure for contracting with LTC pharmacies that includes the missing provision noted in the finding above. Since its PBM, ESI, actually does the LTC contracting on the plan's behalf, AAHP must also ensure that its current PBM has policies and procedures that include this provision, and also describe how it is or will monitor ongoing compliance with the contracting requirement.

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Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.

Reference:

42 CFR § 423.120(b)(5)(i); § 423.120(b)(5)(iii); § 423.578(d); Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

CMS reviewed plan policies and procedures to determine compliance with requirements in this element and found that they did not include provisions describing its procedures for providing a notice of "maintenance" formulary and "other" formulary changes to CMS, SPAPs (if appropriate) and entities providing other prescription drug coverage in accordance with CMS requirements at 42 CFR 423.120(b)(5)(i), 423.120(b)(5)(iii) and 423.578(d).

Corrective Action Required:

AAHP must revise its polices and procedures to include the provisions noted above and submit them to CMS as part of its CAP.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 4/4/2008
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.

Reference:

42 CFR § 423.562(a)(3); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed policies and procedures, a template contract between the part D sponser/PBM and each network pharmacy type, and other documentation to determine compliance with requirements in this element. CMS determined that the Part D sponsor is missing documentation demonstrating that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception.

Corrective Action Required:

AAHP must either submit documentation showing the number and percentage of network pharmacies it has audited to ensure that pharmacies are posting or distributing notices describing how members may obtain coverage determinations or request exceptions, or it may develop a monitoring process and submit it along with a schedule.

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Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 11/5/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.

Reference:

42 CFR § 423.566(a); § 423.566(b); § 423.566(c); § 423.570(c)(1-2); MA-PD Solicitation; Reporting Requirements Section VII: Appeals Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

Deficiencies:

CMS determined that provisions are missing from the plan's submitted policy and procedure. The list of those who may request standard or expedited coverage determinations does not include the prescribing physician on behalf of an enrollee and does not define the 5 types of coverage determinations that may be requested.

Corrective Action Required:

AAHP must correct its policies and procedures to include the above noted deficiencies. Refer to 42 CFR sections 423.566(b)(1-5) and 423.566 c) to obtain the information.

CMS Part D Audit Report

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Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 11/5/2007
Element Release Date: 11/5/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.

Reference:

42 CFR § 423.568(b); § 423.568(e); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures, a notice, and the sample for WSCD_2 to determine compliance with requirements in this element and found that (1) Policies and procedures are missing a provision stating that plans mail payment to members within 30 calendar days of receiving requests, as well as a provision addressing the need for the plan to forward an enrollee's case to the independent review entity (IRE) within 24 hours if it misses the adjudication timeframe. (2) CMS audited 3 cases from a universe of 3 and found processing deficiencies in all of them. AAHP made favorable determinations in two cases. In the first, AAHP took more than 60 days to make its determination. It should have forwarded the case to the IRE within 24 hours after the expiration of the 72 hour period if it could not make a determination. In the second case, file documentation did not show when the plan notified the member orally or in writing of its decision and it took more than 30 days from the request date to issue a check, and there was no documentation that a supporting statement from a physician was needed. In the third case, the plan denied the reimbursement request and notified the member in writing 8 days after the request was received. The file documentation does not include the date and time the plan notified the member orally of its decision.

Corrective Action Required:

(1) AAHP must revise its policies and procedures to incorporate the missing provisions noted above. Refer to Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, Section 130.2.3 and 42 CFR 423.568 (e). (2) AAHP must describe the measures it is taking to correct the processing deficiencies noted in (3) above to ensure timely payment decisions and member notification, and appropriate transfer of cases to the IRE if it does not make a determination within the prescribed time-frames. It should also describe how it will monitor performance to ensure compliance.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.

Reference:

42 CFR § 423.570(c)(3); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed policies and procedures as well as samples to determine compliance with requirements for this element. The plan's policy and procedure for coverage determinations (desk procedure) does not describe the means for issuing prompt decisions on expediting requests for expedited coverage determinations. It also does not address the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Other policies and procedures that AAHP submitted to demonstrate compliance with this requirement included the provisions but were specifically for the prior authorization process, which is only one type of coverage determination.

Corrective Action Required:

AAHP must either expand and update its current policy and procedure (desk procedure) or develop a comprehensive coverage determination policy and procedure that includes the above noted deficiencies. Refer to CFR 42 section 423.570 (c)(3) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, section 50.4.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD07
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.

Reference:

42 CFR § 423.570(d); § 423.572(a); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed policies and procedures as well as samples to determine compliance with requirements in this element. The plan's policy and procedure for coverage determinations (desk procedure) did not include a provision for timeliness of expedited coverage determination denial notification in accordance with CMS requirements. The other policy and procedure AAHP submitted to demonstrate compliance with this requirement included these provisions but were specifically for prior authorization requests which are only one type of coverage determination.

Corrective Action Required:

AAHP must either expand and update its current policy and procedure (desk procedure) or develop a comprehensive coverage determination policy and procedure that includes the above noted deficiencies. Refer to CFR 42 section 423.570 (d) and section 42.572(a) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, section 50.3.

CMS Part D Audit Report

Auditing Results (Public Website Version)

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Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD08
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.

Reference:

42 CFR § 423.570(d)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed policies and procedures, a notice template, and samples to determine compliance with requirements for this element. The plan's policy and procedure for coverage determinations (desk procedure) did not include a provision describing what must be included in oral and written notice to members following the plan's decision to deny a request to expedite a coverage determination. Oral and written notice must state that the plan must process requests using the 72 hour timeframe for standard determinations, that enrollees have a right to file an expedited grievance if they disagree with the decision, that enrollees have the right to resubmit requests for expedited determinations with the prescribing physician's support, and must include instructions about use of the plan's grievance process and timeframes.

Corrective Action Required:

AAHP must either expand and update its current policy and procedure (desk procedure) or develop a comprehensive coverage determination policy and procedure that includes the above noted deficiencies. Refer to CFR 42 section 423.570 (d)(2) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, section 50.3.

CMS Part D Audit Report

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Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.570(e); § 423.572(a-b); § 423.572(d); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed policies and procedures as well as samples to determine compliance with requirements for this element. AAHP does not meet the CMS 95% compliance standard for the sample review. CMS audited 10 cases from an initial universe of 104 and found 2 not processed timely. In one, the plan had no documentation to show that it notified the member either orally or in writing of the decision. In the second, AAHP requested supporting documentation for its decision, but failed to forward the case to the IRE on a timely basis, when the requested information was not received.

Corrective Action Required:

AAHP must describe the measures it is taking to ensure that it makes expedited determinations and notifies members within required timeframes.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.

Reference:

42 CFR § 423.572(c); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures, a notice template for advising enrollees of adverse expedited coverage determinations, and samples to determine compliance with requirements for this element. Plan policies and procedures do not include a provision stating that if the plan's decision is adverse, it must use a notice consistent with the CMS-issued stand notice, Notice of Denial of Medicare Prescription Drug Coverage. They also do not include a provision stating that oral adverse decision notices must (1) state the specific reason for the denial and take into account the the member's presenting medical condition, disabilities, and special language requirements, if any, (2)provide information regarding the right to appoint a representative to file and appeal on the enrollee's behalf, and (3) provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. AAHP also did not meet the CMS 95% compliance standard for the sample. CMS reviewed 10 cases from an initial universe of 104 expedited coverage determinations and found 5 non-compliant because the plan had not notified beneficiaries of its decisions either orally or in writing within the required timeframe. All were favorable expedited decisions.

Corrective Action Required:

AAHP Health Plan must update its policies and procedures to include the above noted deficiencies. Refer to 42 CFR sections 423.572 (b-c). AAHP must describe the steps it is taking to ensure compliance with notification requirements for expedited determinations, including ongoing monitoring for compliance.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 11/7/2007
Element Release Date: 11/7/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.

Reference:

42 CFR § 423.578(a)(1-2); § 423.578(a)(4); MA-PD Solicitation and EP Attestation Addendum; Reporting Requirements for Section VI: Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

Deficiencies:

CMS reviewed plan policies and procedures and a notice template used to request additional information from members' physicians in order to determine compliance with requirements for this element. CMS determined that policies and procedures are missing provisions stating that (1) an enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician is permitted to file a request for a tiering exception, (2) if the plan requires a written statement from the enrollee's prescribing physician, it must request it immediately, (3) the prescribing physician's statement must indicate that the preferred drug for the treatment of the enrollee's condition would not be as effective as the requested drug and/or would have adverse effects, (4) the prescribing physician is required to demonstrate in his written statement one of the two factors in (3) above, (5) if the plan makes a request for additional supporting medical documention, it identifies the type of information that must be submitted, (6) the plan must not keep exception requests open indefinitely when physicians do not submit requested supporting statements, (7) if the plan is waiting on a physician's statement in support of a tiering exception request, it must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception, (8) the plan must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects,and, (9) the plan does not restrict the number of exception requests submitted per enrollee. The notice AAHP sends to members' prescribing physicians to request additional information before it can make a decision on exception requests includes a bold header "Pharmacy Prior Authorization." The header is misleading and should be removed since there are different types of coverage determinations, only one of which is for drugs listed on the plan's formularies requiring prior authorization. The form may be returned to the prior authorization department. We suggest that the notice have check blocks to indicate the type of exception request being processed, i.e., for a non-formulary drug, for a drug requiring prior authorization on the formulary, for a drug with step therapy requirements, etc.

Corrective Action Required:

AAHP must either expand its current policy to include the provisions noted above in the finding, or develop a new comprehensive one for tiered cost-sharing exceptions. Refer to 42 CFR sections 423.578(a)(1-2), 423.578(a)(4) and Chapter 18 Part D Enrollee Grivances, Coverage Determinations, and Appeals, section 30.2.1. Additionally, AAHP needs to revise its member notice for missing information as indicated in the finding above. Refer to Appendix 11 in Chapter 18 of the Prescription Drug Manual.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.

Reference:

42 CFR § 423.578(b); § 423.578(b)(1); § 423.578(b)(2); § 423.578(b)(5); MA-PD Solicitation and EP Attestation Addendum; Reporting Requirements for Section VI: Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

Deficiencies:

CMS reviewed plan policies/procedures and a notice template the plan uses to request additional information from members'physicians to determine compliance with the requirements for this element. CMS found that the plan's policy and procedure for processing non-formulary drug exception requests did not include provisions stating that (1) an enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician is permitted to file a request for a non-formulary exception, (2) that prescribing physician statements must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because (a) all covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, (b) the number of doses available under a dose restriction for the prescription drug (has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (c) prescription drug alternatives listed on the formulary or required to be used in accordance with step therapy requirements have been (i) ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (ii) has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee., (3) if the plan makes a request for additional supporting medical documentation, it must clearly identify the type of information that must be submitted, (4) the plan must not keep the exception requests open indefinitely when physicians do not submit supporting statements, (5) if the plan is waiting on physician statements in support of formulary exception requests, it must wait a minimum of 96 hours after receiving standard requests or a minimum of 48 hours after receiving expedited requests before issuing its determinations on formulary exceptions, (6) the plan must grant a formulary exception when it determines that one of the three factors discussed in (2) above has been demonstrated, and the drugs would be covered but for the fact that they are off-formulary drugs. AAHP's notice to the enrollees prescribing physician for more information needs revision. Refer to the finding for CE01 above.

Corrective Action Required:

AAHP must either expand its current policies and procedures to incorporate the above noted provisions or develop a comprehensive non-formulary drug exception policy and procedure. Refer to 42 CFR sections 423.578(b), 423.578(b)(2), 423.578(b)(5) and to Chapter 18 Enrollee Grivances, Coverage Determinations, and Appeals,section 30.2.2.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.

Reference:

42 CFR § 423.564(b); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed policies and procedures as well as samples to determine compliance with requirements in this element. AAHP does not meet the CMS 95% compliance standard for the sampled grievances. CMS audited 15 cases from a universe of 38 and 8 cases were mis-classified. When 30% or more of sampled cases are misclassified, any element on which the sample is based must be considered NOT MET. The 8 misclassified grievances dealt with Part C issues rather than Part D.

Corrective Action Required:

AAHP must correct its internal coding to make sure that cases are correctly coded and resubmit a corrected universe WSGV1_D for the same review period, 9/1/06 through 2/28/07.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.

Reference:

42 CFR § 423.562(a)(1)(i); § 423.564(a-b); § 423.564(g); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Reporting Requirements for Section V: Grievances

Deficiencies:

CMS determined that the Part D sponsor's policies and procedures lack a provision for quarterly reporting of all data requested in the 2007 Reporting Requirements, Section IV: Grievances. (For 2006, Section V.)

Corrective Action Required:

AAHP must update its Policy and Procedures to correct the above noted deficiency. Refer to the Medicare Part D Reporting Requirements Contract Year 2007, section IV to obtain this information.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.

Reference:

42 CFR § 423.564(e)(1-2); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Refer to finding for GV01.

Corrective Action Required:

Refer to CAR for GV01_D.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Contract Number: H5985
Audit ID: 561
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007
3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.

Reference:

42 CFR § 423.564(e)(3)(i-ii); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Refer to finding for GV01_D.

Corrective Action Required:

Refer to CAR for GV01_D.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.

Reference:

42 CFR § 423.582(a-b); § 423.586; MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies/procedures and documentation to determine compliance with requirements for this element and determined that the plan's policy and procedure for standard redeterminations does not include provisions for (1) accepting written requests filed by enrollees within 60 calendar days of the notice of the coverage determination, and (2) providing a reasonable opportunity for members or their prescribing physicians to submit evidence and allegations of law and fact, in person or in writing, related to the disputed issue. The materials provided by AAHP to illustrate its redeterminations policy and procedure do not provide a comprehensive understanding of the requirements for Part D redeterminations.

Corrective Action Required:

AAHP must either expand its current redetermination policy and procedure or develop a new comprehensive one that includes the above noted provisions. Refer to 42 CFR sections 423.582 (a-b) and 423.586.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. Since the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.

Reference:

42 CFR § 423.584(c)(1); § 423.586; MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies/procedures and other plan-submitted documentation to determine compliance with requirements for this provision. CMS found the the plan's policy and procedure for expedited redeterminations did not include (1) provisions for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, (2) the name of the designated office and/or department that receives both oral or written requests, the telephone number for oral requests, and a facsimile number to facilitate receipt of requests for expedited appeals, (3) provision for documenting all oral requests in writing, (4) provisions for maintaining documentation of expedited redetermination requests in case files. The materials provided by AAHP to illustrate its redeterminations policy and procedure do not provide a comprehensive description of the requirements for Part D redeterminations.

Corrective Action Required:

AAHP must either expand its current redetermination policy and procedure or develop a new comprehensive one that includes the above noted provisions. Refer to 42 CFR sections 423.584 (c)(1) and 423.586.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.

Reference:

42 CFR § 423.584(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed the plan's policy and procedure, Member Pharmacy Redeterminations, to determine compliance with the requirement to accept or deny requests for expedited redeterminations, and found it does not provide a comprehensive description of Part D redetermination requirements. It did not include provisions stating that (1) the plan's decision to accept or deny a request to expedite a redetermination is based on enrollee's request indicating that applying the standard timeframe for making a redetermination may seriously jeopardize his/her life, health, or ability to regain maximum function, (2) the plan automatically expedites a request when the enrollee's physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, (3) any additional medical information the Part D sponsor requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination.

Corrective Action Required:

AAHP must either expand its current redetermine policy and procedure or develop a new comprehensive one that includes the above noted provisions. Refer to 42 CFR section 423.584 (c)(2).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.

Reference:

42 CFR § 423.584(d-e); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed the plan's policy and procedure (Member Pharmacy Redeterminations)and plan notice telling members their requests to expedite a redetermination had been denied. CMS determined that the plan's policy and procedure is deficient because it does not include provisions stating that the plan must provide prompt oral notice to the enrollee and follow that up with an equivalent written notice within 3 calendar days of issuing the oral notice.

Corrective Action Required:

AAHP must either expand its current policy and procedure or develop a new comprehensive one that includes the provisions noted above. Refer to 42 CFR section 423.584(d)(2).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.590(a)(1-2); § 423.590(c); § 423.590(g)(1-4); § 423.636(a)(1); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies/procedures, plan notices advising members of an adverse redetermination and how to request a reconsideration, as well as sample cases to determine compliance with the requirements for this element. CMS determined the plan's policy and procedure for timely notification and effectuation of standard redeterminations does not include a provision stating that the plan must inform enrollees within 24 hours of forwarding cases to the IRE when it is unable to make a timely determination.

Corrective Action Required:

AAHP must either expand its current policy and procedure or develop a new comprehensive one covering redeterminations that include the above-noted provision. Refer to Chapter 18, Part D Enrollee and Grievances, Coverage Determinations, and Appeals, section 70.10.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.590(b-c); § 423.590(g)(1-4); § 423.636(a)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed the plan's policy and procedure for timely notification and effectuation of standard redetermination concerning payment, plan notices for informing enrolles of adverse standard redeterminations and for requesting a reconsideration. CMS determined the policy and procedure did not include a provisions that state that (1) for redeterminations favorable to enrollees, the plan must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, (2) the plan must inform enrollees within 24 hours when it forwards cases to the IRE.

Corrective Action Required:

AAHP must either expand it current policy and procedure or develop a new comprehensive one for redeterminations that includes the above noted provisions. Refer to 42 CFR section 423.590 (b) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations and Appeals, section 70.10.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.584(e); § 423.590(d-e); § 423.638(a); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures, notices advising members of adverse expedited determinations and for requesting reconsideration, as well as sample cases. CMS determined that the plan's policy and procedure (Effectuation of Part D Redeterminations) did not include required provisions stating that (1) the plan must notify the enrollee (and the prescribing physician involved, as appropriate) of its redetermination decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after it received the expedited request, (2) notification of a favorable decision may be made orally or in writing, (3) initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, (4) medical information must be requested within 24 hours of the enrollee's initial request, (5) failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the request to the IRE within 24 hours of the expiration of the adjudication timeframe, (6) the plan must inform the enrollee, within 24 hours, when it forwards the case to the IRE.

Corrective Action Required:

AAHP must either expand its current policy to include the provisions cited in the finding above, or develop a new comprehensive redetermination policy and procedure. Refer to 42 CFR sections 423.590 (d-e) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, section 70.10.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE08
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.

Reference:

42 CFR § 423.638(a); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed the plan policies and procedures, plan submitted documentation, and sample cases to determine compliance with requirements for this element and had the following findings: (1) The plan's policy and procedure for expedited coverage redeterminaiton reversals does not include a provision for authorizing or providing the benefits in dispute within the 72-hour required timeframe. Documentation submitted by did not establish that it had a system in place for authorizing or providing a benefit under disipute within 72 hours of receiving the redetermination request. (2) AAHP also does not meet the CMS 95% compliance standard for the sample review. CMS reviewed 2 cases from a universe of 2 and found that the plan did not authorize or provide the benefit within the required timeframe.

Corrective Action Required:

AAHP must (1) either revise its current policy or develop a new comprehensive redetermination policy and procedure that includes the above noted provisions. It must submit the revised/new policy and procedure to CMS with its CAP. Refer to 42 CFR section 423.638 (a). (2) describe in its CAP the steps that it is taking to ensure ongoing compliance with the requirements in this element.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 561
Contract Number: H5985
Part D Sponsor Name: ABRAZO ADVANTAGE HEALTH PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/25/2007
Date Report Due: 8/9/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/10/2007
Estimated Visit Start Date: 5/11/2007
Actual Visit Start Date: 5/10/2007
Actual Visit End Date: 5/11/2007
Part D Sponsor Response Received Date: 8/9/2007
Part D Sponsor Response Due Date: 8/9/2007
CAP Release Date: 4/4/2008
CAP Accepted Date: 11/7/2007

Requirement:

Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.

Reference:

Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed the plan's policy and procedure, as well as sample cases to determine compliance with the requirements for this element. CMS determined that the plan's policy and procedure (Member Pharmacy Redeterminations) did not include provisions stating that (1) the plan must transfer files to the IRE within 24 hours (for expedited requests) or 48 hours (for standard requests) from the time it receives the IRE requests for case files, (2) that the plan must sent hard copies of the case files to the IRE by overnight delivery at the IRE's designated address, or fax them to the IRE's designated fax number.

Corrective Action Required:

AAHP must either expand its current policy and procedure to incude the above-noted provisions or develop a new comprehensive policy and procedure for redeterminations. It must submit the revised/new policy and procedure to CMS with its CAP. Refer to Chapter 18 Part D Enrollee Grievances, Coverage Determinations and Appeals, section 70.20.