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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 7/28/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

Requirement:

Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, 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. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage 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 § 423.568(a); § 423.568(e); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) and did not find a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Additionally, WellCare's policies and procedure did not contain a provision stating that WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. On October 30, 2007 WellCare submitted the following statement: 'Every coverage determination made by WellCare takes into consideration the enrollee's health although not specifically stated in our P and Ps.' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefit from a universe of 158,855 and found 1 sample was misclassified, as WellCare noted in the file that it should have been treated as an expedited request. To account for this the auditor reduced the sample size by one and reviewed the nine samples. Nine out of the nine samples were not compliant, as they did not demonstrate that WellCare provided notification of the coverage determination decision to the enrollee. Failure to notify the enrollee of WellCare's decision within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the IRE within 24 hours of the adjudication timeframe. WellCare did not demonstrate that any of the 9 sample cases were forwarded to the IRE.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this 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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 2/15/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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

Deficiencies:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification of coverage determinations concerning payment (C7RX-041, C7RX-039, and C7RX-040) and found they did not include the following: - a provision stating that WellCare 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, - a provision stating that WellCare 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, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: - a provision stating that WellCare 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, - a provision stating that WellCare 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, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 2/15/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) and found this policy did not: - State that all oral requests must be documented in writing and that documentation of the request must be maintained in case file, and - Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. CMS reviewed a sample of 10 requests for expedited coverage determinations from a universe of 11,911 and found one sample was not compliant. As the request was marked 'urgent' by a physician. Internal screen shots demonstrate that WellCare marked the case as 'standard' and not 'expedited'.

Corrective Action Required:

WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: - State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and - Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must be able to identify all requests for expedited coverage determinations. A request to expedite a coverage determination decision must be granted if the expedited request was made or supported by a physician, and the physician indicates either orally or in writing that applying the standard timeframes could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Additionally, WellCare must implement systems to address technician error that could lead to mislabeling of expedited coverage determination requests as standard requests. WellCare must provide documentation demonstrating this 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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 2/13/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed a sample of 10 requests for expedited coverage determinations from a universe of 11,911 and found one sample was not compliant. In 1 out of the 10 samples the case was not correctly categorized as it was an expedited request that was marked 'standard' within WellCare's screen shots. WellCare did not demonstrate that the enrollee was notified the request to expedite was denied.

Corrective Action Required:

WellCare must notify enrollees when a request to expedite a coverage determination is denied. Additionally, WellCare must implement systems to address technician error that could lead to mislabeling of expedited coverage determination requests as standard requests. WellCare must provide documentation demonstrating this 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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD08
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 2/13/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification following the decision to deny a request for an expedited coverage determination (C7RX-039) and found it did not include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support. WellCare does not meet this requirement because CMS reviewed a sample of 10 requests for expedited coverage determinations from a universe of 11,911 and found one sample was not compliant. In 1 out of the 10 samples the case was not correctly categorized as it was an expedited request that was marked 'standard' within WellCare's screen shots. WellCare did not demonstrate that the enrollee was notified of the decision to not expedite the request and, therefore, WellCare did not demonstrate the use of a CMS compliant notice consistent with Notice of Right to an Expedited Grievance.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees when a request to expedite a coverage determination is denied using a CMS compliant notice, consistent with Notice of Right to an Expedited Grievance. Additionally, WellCare must implement systems to address technician error that could lead to mislabeling of expedited coverage determination requests as standard requests. WellCare must provide documentation demonstrating this 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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 2/13/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification following the decision on an expedited coverage determination (C7RX-039) and found it did not include: - a provision stating that WellCare must inform the enrollee, 'within 24 hours', when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe 'constitutes an adverse determination' requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks is missing. CMS reviewed a sample of 10 requests for expedited coverage determinations from a universe of 11,911. One sample that was incorrectly categorized was not applicable, as screen shots demonstrate that WellCare treated the sample as a standard coverage determination. CMS reviewed the nine samples and found that seven out of the nine samples were noncompliant. Specifically, WellCare was unable to demonstrate that the enrollee was notified of the expedited coverage determination decision in a timeframe consistent with CMS requirements. Additionally, failure to notify an enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the case file to the IRE for review. WellCare did not demonstrate that these seven sample cases were forwarded to the IRE.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of all expedited coverage determination decisions and do so within CMS compliant timeframes. WellCare must provide documentation demonstrating this to CMS. Additionally, WellCare must forward the case file to the IRE in all instances that an enrollee is not notified of its expedited coverage determination decision within the required timeframe and provide documentation demonstrating this 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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 2/13/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification following the decision on an expedited coverage determination (C7RX-039) and found it did not include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provides 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.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provides 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. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 2/13/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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); PDP 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 ¿

Deficiencies:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) and found it did not include provisions stating: - if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, and - WellCare 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. Additionally WellCare's policies and procedures do not include a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. On October 30, 2007 WellCare submitted the following statement: 'Although WellCare does not have a P and P that states that request cannot be left open indefinitely, WellCare follows the CMS guidelines in regard to exception processing requirements. No requests are kept open indefinitely. This can be confirmed in the universe supplied, as there are no open cases in the universe, indicating cases are not left open indefinitely.' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. Furthermore WellCare's policies and procedures do not include a provision stating that if WellCare is waiting on a physician¿s statement in support of a tiering exception request, WellCare 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. On October 30, 2007 WellCare submitted the following statement: 'WellCare did not have a policy on waiting 96 hours at the time of the audit review period. However, not withstanding, WellCare did operationally meet the CMS requirement timeframes. WellCare reaches out to the physician to obtain the necessary supporting documentation in order to meet the expedited or standard request timeframes.' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures.

Corrective Action Required:

WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost -sharing structure (C7RX-038) to include provisions stating: - if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, - WellCare 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, - WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare 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. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 2/13/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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); PDP Solicitation and EP Attestation Addendum; Reporting Requirements for Section VI: Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions; Prescription Drug

Deficiencies:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) and found it did not include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1)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, (2)The number of doses available under a dose restriction for the prescription drug: (a)Has been ineffective in the treatment of the enrollee's disease or medical condition or,(b) 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 (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) 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 (b) 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. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. Additionally WellCare's policies and procedures do not include a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. On October 30, 2007 WellCare submitted the following statement: 'Although WellCare does not have a P and P that states that request cannot be left open indefinitely, WellCare follows the CMS guidelines in regard to exception processing requirements. No requests are kept open indefinitely. This can be confirmed in the universe supplied, as there are no open cases in the universe, indicating cases are not left open indefinitely.' Furthermore WellCare's policies and procedures do not include a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare 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 formulary exception. On October 30, 2007 WellCare submitted the following statement: 'WellCare did not have a policy on waiting 96 hours at the time of the audit review period. However, not withstanding, WellCare did operationally meet the CMS requirement timeframes. WellCare reaches out to the physician to obtain the necessary supporting documentation in order to meet the expedited or standard request timeframes.' In order to demonstrate compliance with CMS requirements these provisions must be included in written policies and procedures.

Corrective Action Required:

WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) 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, (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or,(b) 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 (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) 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 (b) 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. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare 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 formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/13/2008
Element Release Date: 2/13/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

Requirement:

Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.

Reference:

42 CFR § 423.578(c)(3); § 423.578(c)(4)(i-ii); EP Attestation Addendum; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) and did not find a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year.

Corrective Action Required:

WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 7/29/2008
Element Release Date: 7/29/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement. CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefits from a universe of 158,855. One case was misclassified, and to account for this the auditors reduced the sample size by one. CMS reviewed the nine requests for standard coverage determinations concerning drug benefits and found that 2 were noncompliant. Specifically, in two samples the cases were incorrectly categorized. One request was for a Part B covered drug, and the second request was for a long term care resident's first fill. Neither of these are Part D coverage determination requests. CMS reviewed a sample of 10 requests for expedited coverage determinations from a universe of 11,911 and found that two cases were noncompliant. Specifically, two cases were incorrectly categorized. One sample was not requested to be expedited. A second sample was requested as 'urgent', yet screen shots demonstrate that WellCare treated this request as a standard request.

Corrective Action Required:

WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this 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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (C7RX-036) and found it does not include provisions: - for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and - stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. During Staff Discussions, WellCare stated that it informs the enrollee within 24 hours when the case is forwarded to the IRE. Additionally, on October 30, 2007 WellCare submitted the following statement: "Although this process is not documented in the P and P, the approved letter that WellCare sends to members is attached as an addendum. The Notice of Case Status letter states 'The law requires us to forward your case file to an independent review organization within 24 hours if the plan does not provide you with an answer within the required time frame.'" In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. Over 30% of samples provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: - for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and - stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) and found it did not include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. During Staff Discussions, WellCare stated that it informs the enrollee within 24 hours when the case is forwarded to the IRE. Additionally, on October 30, 2007 WellCare submitted the following statement: "Although this process is not documented in the P and P, the approved letter that WellCare sends to members is attached as an addendum. The Notice of Case Status letter states 'The law requires us to forward your case file to an independent review organization within 24 hours if the plan does not provide you with an answer within the required time frame.'' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. CMS reviewed a sample of 10 standard redeterminations requests concerning payment from a universe of 85 and found that 7 out of the 10 samples were not compliant. In one sample the enrollee was not notified of the adverse decision in a timeframe consistent with CMS requirements, and the enrollee was not provided with a Request for Reconsideration notice. Additionally, WellCare did not demonstrate that the case file was forwarded to the IRE, which is required when the decision timeframe is exceeded. In two samples demonstrating adverse decisions, the notices provided were not CMS approved notices. In two samples demonstrating adverse decisions, a Request for Reconsideration notice was not provided. Two samples did not demonstrate that payment was provided in a timeframe consistent with CMS requirements.

Corrective Action Required:

WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this 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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) and found it did not include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. During Staff Discussions, WellCare stated that it informs the enrollee within 24 hours when the case is forwarded to the IRE. Additionally, on October 30, 2007 WellCare submitted the following statement: 'Although this process is not documented in the P and P, the approved letter that WellCare sends to members is attached as an addendum. The Notice of Case Status letter states 'The law requires us to forward your case file to an independent review organization within 24 hours if the plan does not provide you with an answer within the required time frame.'' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

Requirement:

Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.

Reference:

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

Deficiencies:

WellCare does not meet this requirement. Over 30% of samples provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

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:

WellCare does not meet this requirement. Over 30% of samples provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance. Additionally, CMS reviewed 10 requests for expedited redeterminations from a universe of 1674 and found that one was misclassified and, to account for this, the auditor reduced the sample size by one and made the sample size nine. CMS reviewed the nine requests for expedited redeterminations concerning drug benefits and found that in 2 out of 3 cases in which an expedited redetermination decision was adverse and the enrollee requested a reconsideration, WellCare was unable to demonstrate that the file was forwarded to the IRE in a timely manner.

Corrective Action Required:

When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

Requirement:

Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor 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 it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

42 CFR § 423.636(b)(1); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

WellCare does not meet this requirement because CMS reviewed internal data provided by Maximus to CMS on WellCare's compliance with reconsideration decisions where WellCare's determination was fully or partially reversed, and found evidence of noncompliance in 30 of 100 reconsideration cases for drug benefit (standard priority). Specifically, in 3 cases WellCare did not effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 72 hours after the date it received notice reversing the determination, and in 27 cases WellCare did not provide a notice to the IRE that it effectuated a reversal decision. On October 30, 2007 WellCare submitted the following statement: 'WellCare has developed a QA process and re-training program to ensure IRE effectuation and compliance. Quarterly and on an ad hoc basis, meetings are scheduled with Maximus to address such issues as timely effectuation of IRE decisions.' WellCare's QA process has been documented, however data provided from Maximus to CMS for the audit period of January 1, 2007 to June 30, 2007 does not demonstrate compliance. Over 30% of samples provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

WellCare must demonstrate to CMS that it effectuates third party reversals for standard drug benefit cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision and provide documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.

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: 3181
Contract Number: S5967
Part D Sponsor Name: WELLCARE PRESCRIPTION INSURANCE, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date: 7/29/2008
CAP Accepted Date:

Requirement:

Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

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

Deficiencies:

WellCare does not meet this requirement because CMS reviewed internal data provided by Maximus to CMS on WellCare's compliance with reconsideration decisions where WellCare's determination was fully or partially reversed, and found evidence of noncompliance in 14 of 37 reconsideration cases for drug benefit (expedited priority). Specifically, in 10 cases WellCare did not effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 24 hours after the date it received notice reversing the determination, and in 4 cases WellCare did not provide a notice to the IRE that it effectuated a reversal decision. On October 30, 2007 WellCare submitted the following statement: 'WellCare has developed a QA process and re-training program to ensure IRE effectuation and compliance. Quarterly and on an ad hoc basis, meetings are scheduled with Maximus to address such issues as timely effectuation of IRE decisions.' WellCare's QA process has been documented, however data provided from Maximus to CMS for the audit period of January 1, 2007 to June 30, 2007 does not demonstrate compliance.

Corrective Action Required:

WellCare must demonstrate to CMS that it effectuates third party reversals for expedited drug benefit cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.