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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PC02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 12/7/2007
Element Release Date: 12/20/2007
Element Projected Completion Date: 1/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed a copy of CareOregon's website formulary change page and a "formulary change announcement" document that CareOregon chose to submit to the Audit Team for this element and found evidence of noncompliance. This documentation indicated that CareOregon did not provide 60-day prior notice to all authorized prescribers, network pharmacies, and pharmacists of a pending negative formulary change. Specifically, the documentation showed that CareOregon intended to remove the drug Ditropan XL from its formulary effective 4/15/07, and that it posted this formulary change notice on its website on 3/27/07. In response to a question in follow up to staff discussions, CareOregon indicated that this formulary change (Ditropan XL) did not actually become effective until 6/1/07 because of a technical error in its initial negative change request that caused CareOregon to have to re-submit the change to CMS. Therefore, while this makes a 3/27 notification consistent with the 60-day prior notice requirement, CareOregon's response indicates that it intended to ignore the 60-day notice requirement and effectuate the negative formulary change on 4/15, with provider notification on 3/27.

Corrective Action Required:

For all future plan year 2007 negative formulary changes that become effective on or after 6/1/07, CareOregon must provide CMS with documentation that demonstrates 1) the effective date of the negative formulary change and 2) the date that notification of the negative change was posted to CareOregon¿s provider website formulary change page. This documentation must show that CareOregon is providing the required 60 day prior notification to all authorized prescribers, network pharmacies, and pharmacists.

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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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures for formulary change notification and found that they make no mention of the requirement to notify entities providing other prescription drug coverage of negative formulary changes. Although CareOregon indicated in staff discussions that is does not believe that this requirement applies to it, CMS does require the inclusion of a provision that addresses this requirement in CareOregon's policies and procedures. In addition, the Audit Team determined that there may, in fact, be entities providing other prescription drug coverage that may be interested in CareOregon's formulary. Therefore, the notification of "entities providing other prescription drug coverage" must be addressed in CareOregon's policies and procedures.

Corrective Action Required:

CareOregon must revise its policies and procedures (P and T Committee and Formulary Management.doc) to address the requirement to provide notification of negative formulary changes to entities providing other prescription drug coverage. Specifically, CareOregon's policies and procedures must address 60-day prior notification of entities providing other prescription drug coverage for "maintenance" formulary changes and "other" formulary changes, and the provision of retrospective notice to entities providing other prescription drug coverage 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. CareOregon 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. For a definition of "formulary maintenance changes" and "other formulary changes," please refer to Chapter 6 of the Prescription Drug Benefit Manual, Section 30.3. CMS has not issued any specific guidance on appropriate notification methods Part D sponsors must use to meet this requirement. Notification method(s) must include, at a minimum, posting formulary changes on CareOregon's Internet website.

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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CN05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/26/2007
Element Release Date: 12/20/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

Requirement:

Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) 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:

CareOregon does not meet this requirement. CMS reviewed a sample of five network long-term care pharmacy contracts from a universe of ten and found that one contract was misclassified because the contract was not effective during the audit period. The auditor reduced the sample size by one and made the sample size four. CMS reviewed the four cases and found that one was non-compliant because CareOregon did not provide a signed long-term care pharmacy addendum, and another case was not compliant because auditors could not determine an effective date for the contract.

Corrective Action Required:

CareOregon must provide CMS with a copy of the signed long-term care pharmacy addendum for its pharmacy with the code 905. CareOregon must also provide CMS with a contract for its pharmacy with the code 307 that includes the appropriate effective dates.

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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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed the submitted policies and procedures and found they do not include the following provisions: - a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the long-term care (LTC) facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices, and - a provision for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice 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. CareOregon was unable to produce documentation demonstrating that, during the audit period, it conducted 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:

CareOregon must revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. CareOregon must also revises its policies and procedures to include a provision for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice 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. CareOregon 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. CareOregon must demonstrate that its network pharmacies are posting or distributing the "Medicare Prescription Drug Coverage and Your Rights" notice. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.

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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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not contain a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination that requires 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. Specifically, the documentation CareOregon submitted did not state that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination. CareOregon also incorrectly stated that failure to notify the enrollee within the timeframe requires the request be forwarded [from RxAmerica] to CareOregon Advantage AND/OR the Independent Review Entity (IRE) within 24 hours of the expiration of the timeframe. Forwarding cases to the IRE is not optional, as it is implied by CareOregon, when CareOregon fails to notify the enrollee within the 72 hour timeframe. CareOregon does not meet the CMS compliance standard. CMS reviewed a sample of 10 requests for standard coverage determinations concerning benefit from a universe of 1208 and found that 1 sample was misclassified because it was not related to the Part D benefit. The auditor reduced the sample size by 1 and made the sample size 9. CMS reviewed the 9 cases and found that 4 cases failed to demonstrate that CareOregon forwarded coverage determination requests to the IRE when the decision was not made timely.

Corrective Action Required:

CareOregon must revise its policies and procedures to include a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination that requires 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. CareOregon 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. CareOregon must provide documentation to CMS that demonstrates it forwards coverage determinations to the IRE within 24 hours of the expiration of the adjudication timeframe when they were not determined timely.

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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures regarding coverage determinations and discovered that CareOregon did not have any policies and procedures for coverage determinations concerning payment.

Corrective Action Required:

CareOregon must revise its policies and procedures to include provisions that address the following requirements regarding coverage determinations concerning payment: (1) CareOregon 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, (2) CareOregon must 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, and (3) failure to notify the enrollee within the timeframe constitutes an adverse coverage determination that requires CareOregon to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CareOregon must conduct training of appropriate staff on each of 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations and found that they do not include a telephone number for receipt of oral requests by the designated office and/or department that receives both oral and written requests. In addition, policies and procedures do not include a provision stating that all oral requests-- of formulary exceptions as well as prior authorizations-- must be documented in writing and that documentation of each request must be maintained in a case file.

Corrective Action Required:

CareOregon must revise its policies and procedures to include a telephone number of the designated office and/or department that receives both oral and written requests. CareOregon must also revise its policies and procedures to include a provision stating that all oral requests must be documented in writing and that documentation of each request must be maintained in a case file. CareOregon must conduct training of appropriate staff on each of 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed the submitted policies and procedures and found that they are incomplete for the following reasons: - policies and procedures do not clearly state that CareOregon will notify the enrollee of its decision on an expedited coverage determination as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, after receipt of the physician's supporting statement, - the policies and procedures do not clearly state that if the expedited coverage determination decision is adverse and CareOregon first notifies the enrollee of the determination orally, CareOregon must mail written confirmation to the enrollee within 3 calendar days of the oral notification, - the policies and procedures do not clearly state that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring CareOregon to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - the policies and procedures do not include a provision stating that CareOregon must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. CMS reviewed a sample of 10 requests for expedited coverage determination cases from a universe of 139 and found that 1 sample was misclassified because it was a standard coverage determination case. The auditor reduced the sample size by 1 and made the sample size 9. CMS reviewed the 9 cases and found that 6 cases are non-compliant because CareOregon did not demonstrate that it notified members within the 24-hour timeframe required by CMS.

Corrective Action Required:

CareOregon must revise its policies and procedures to include the following: (1) a provision stating that CareOregon will notify the enrollee of its decision on an expedited coverage determination as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, after receipt of the physician's supporting statement, (2) a provision stating that if a decision is adverse and CareOregon first notifies the enrollee of the determination orally, CareOregon must mail written confirmation to the enrollee within 3 calendar days of the oral notification, (3) a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring CareOregon to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and (4) a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. CareOregon 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. CareOregon must provide documentation to CMS demonstrating that it informs enrollees, within 24 hours, when their cases are forwarded to the IRE.

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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
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Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed submitted policies and procedures and found they do not include a provision stating that if the decision is adverse, then CareOregon must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage.

Corrective Action Required:

CareOregon must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. CareOregon must conduct training of appropriate staff on the use of this notice template 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

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Findings: Not Met
Audit ID: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
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Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include a provision stating that if CareOregon makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. CMS requested CareOregon's notice for requesting additional information from the enrollee¿s prescribing physician and CareOregon was unable to provide a notice consistent with the CMS-issued notice template, Request for Additional Information.

Corrective Action Required:

CareOregon must revise its policies and procedures to include a provision stating that if CareOregon makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. CareOregon 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. CareOregon must provide CMS with a CMS-approved notice template that is consistent with the CMS-issued Request for Additional Information. If CareOregon does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.

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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include 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:

CareOregon must revise its policies and procedures 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. CareOregon 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 10/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CareOregon did not provide sufficient documentation (e.g., phone scripts) to demonstrate that it has a means for informing enrollees whether their complaints are subject to grievance or coverage determination procedures. In addition, CMS reviewed the sample standard grievance case provided from a universe of one and that found the case did not demonstrate that the enrollee was notified of whether the complaint was subject to grievance or coverage determination procedures. CMS requested CareOregon's CMS-issued notice template, Notice of Inquiry Regarding an Excluded Drug, and CareOregon was unable to provide this notice template.

Corrective Action Required:

CareOregon must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. If CareOregon does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. CareOregon must conduct training of appropriate staff on the use of this notice template 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. CareOregon must provide documentation to CMS that demonstrates it has a means for informing enrollees whether their complaints are subject to grievance or coverage determination procedures. CareOregon must provide documentation to CMS that demonstrates it notifies enrollees whether their complaints are subject to grievance or coverage determination procedures, per CMS requirements.

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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 10/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found that the following provisions are not fully addressed: - a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary, - a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition, and - a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances

Corrective Action Required:

CareOregon must revise its policies and procedures to ensure they include a provision requiring prompt and appropriate action regarding a grievance. Policies and procedures must also include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. Lastly, policies and procedures must be revised to include a provision for quarterly reporting all data requested in the CMS Reporting Requirements Section V: Grievances. CareOregon 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 10/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

Requirement:

Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.

Reference:

MA-PD Solicitation

Deficiencies:

CareOregon did not meet this requirement because it did not have policies and procedures regarding grievance process training in place during the audit period. CareOregon could not provide documentation demonstrating that it implemented training on grievance policies and procedures during the audit period.

Corrective Action Required:

CareOregon must develop policies and procedures regarding grievance process training that contain a provision for training relevant staff and contractors on grievance policies and procedures. CareOregon must conduct training of appropriate staff and contractors (if applicable) 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. CareOregon must provide documentation demonstrating that it has and implements training on grievance policies and procedures for staff and contractors (if applicable).

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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 10/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS has reviewed CareOregon's policies and procedures and found the following provisions are missing: - a provision stating that all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status. CareOregon's policies and procedures only state that all concerned parties are notified of the grievance disposition within 30 days after the Sponsor receives the oral or written grievance, - a provision stating that the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if the Part D sponsor justifies a need for additional information and documents how the delay is in the interest of the enrollee, and - a provision stating that the enrollee must immediately be notified in writing when the Part D sponsor extends the deadline. In addition, CMS reviewed one sample standard grievance from a universe of one and found that the case did not demonstrate that CareOregon addressed the grievance fully and in a timely manner.

Corrective Action Required:

CareOregon must revise its policies and procedures to ensure they include a provision stating that all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status. Policies and procedures must also include a provision stating that the 30 -day timeframe may be extended by 14 days or less if the enrollee requests the extension or if the Part D sponsor justifies a need for additional information and documents how the delay is in the interest of the enrollee, as well as a provision stating that the enrollee must immediately be notified in writing when the Part D sponsor extends the deadline. CareOregon 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. CareOregon must provide documentation to CMS that demonstrates it addresses enrollee grievances fully and within the timeframes required by 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 10/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CMS reviewed one sample standard grievance from a universe of one and found that the sample did not demonstrate that CareOregon's method of response to enrollees concerning the grievance was correct. Specifically, CareOregon did not demonstrate that it responds to an enrollee's oral grievance in writing if the enrollee specifically requests a written response.

Corrective Action Required:

CareOregon must provide documentation to CMS that demonstrates it responds to enrollee grievances in accordance with CMS requirements.

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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 10/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

Requirement:

Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.

Reference:

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

Deficiencies:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found that they lack a provision clearly stating CareOregon's commitment to cooperating with the QIO in resolving grievance cases. CareOregon's policies and procedures state that the AGC (Appeals Grievance Counselor) recognizes the authority of the QIO. However, in discussions with CareOregon's staff, CareOregon confirmed that the role of the AGC is to support the appeals process and not the grievance process.

Corrective Action Required:

CareOregon must update its policies and procedures to remove reference to the AGC when describing its commitment to cooperating with the QIO in resolving grievance cases. CareOregon 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 10/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

Requirement:

Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.

Reference:

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

Deficiencies:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found that they include a provision that is inconsistent with CMS requirements. In its policies and procedures, Part D Grievance Policy and Procedure - original.doc, CareOregon states, "All grievances will be resolved within 30 calendar days with the exception of the expedited grievance which are resolved within 24 or 72 hours." This provision is deficient because CareOregon must not exceed 24 hours from the time it receives the expedited grievance when responding to an enrollee.

Corrective Action Required:

CareOregon must update its policies and procedures to ensure they include a provision stating that CareOregon must respond within 24 hours to the enrollee's expedited grievance if the complaint involves a refusal by CareOregon to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased the drug that is in dispute. CareOregon 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include a provision containing a telephone number for receiving oral requests for expedited redeterminations.

Corrective Action Required:

CareOregon must revise its policies and procedures to include a telephone number for receiving oral requests for redeterminations. CareOregon 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include provisions stating that: - The decision to accept or deny an expedited redetermination request is based on the enrollee's request indicating that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, and - Any additional medical information CareOregon requires must be requested within 24 hours of receiving the initial request for an expedited redetermination.

Corrective Action Required:

CareOregon must revise its policies and procedures to include provisions stating that: - The decision to accept or deny an expedited redetermination request is based on the enrollee's request indicating that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, and - Any additional medical information CareOregon requires must be requested within 24 hours of receiving the initial request for an expedited redetermination. CareOregon 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include provisions stating that: - CareOregon must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - CareOregon must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. CMS requested CareOregon's notice for notifying an enrollee that a request for an expedited redetermination is denied and CareOregon was unable to provide a notice consistent with the CMS-issued notice template, Notice of Right to an Expedited Grievance for this element.

Corrective Action Required:

CareOregon must revise its policies and procedures to include provisions stating that: - CareOregon must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - CareOregon must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. CareOregon 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. CareOregon must provide CMS with a CMS-approved notice template that is consistent with the CMS-issued Notice of Right to an Expedited Grievance. If CareOregon does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.

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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination. CMS reviewed a sample of 10 requests for standard redeterminations concerning drug benefit from a universe of 42 and found that 1 sample was misclassified because it is not a valid redetermination request. The auditor reduced the sample size by 1 and made the sample size 9. CMS reviewed the 9 cases and found that 5 cases are non-compliant because CareOregon did not demonstrate that it provides enrollees with the notice, Request for Reconsideration, for denied redeterminations concerning drug benefit.

Corrective Action Required:

CareOregon must revise its policies and procedures to include a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination. CareOregon must conduct training of its 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. CareOregon must provide CMS with documentation demonstrating that CareOregon provides enrollees with the notice, Request for Reconsideration, for denied redeterminations concerning drug benefit.

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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include provisions stating that: - For favorable redeterminations to the enrollee (concerning payment), CareOregon 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. - Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring CareOregon to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe.

Corrective Action Required:

CareOregon must revise its policies and procedures to include provision stating that: - For favorable redeterminations to the enrollee (concerning payment), CareOregon 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. - Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring CareOregon to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CareOregon must conduct training of its 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include provisions stating that: - Medical information must be requested within 24 hours of the enrollee's initial request, - Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring CareOregon to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - CareOregon must inform the enrollee, within 24 hours, when the case is forwarded to the IRE.

Corrective Action Required:

CareOregon must revise its policies and procedures to include provisions stating that: - Medical information must be requested within 24 hours of the enrollee's initial request, - Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring CareOregon to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - CareOregon must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. CareOregon must conduct training of its 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

Requirement:

Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, 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 the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

42 CFR § 423.636(b)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include provisions stating that: - Payment must be authorized within 72 hours from the date CareOregon receives notice reversing the decision, and - Payment must be made no later than 30 days from the date CareOregon receives notice reversing the decision.

Corrective Action Required:

CareOregon must revise its policies and procedures to include a provision stating that: - Payment must be authorized within 72 hours from the date CareOregon receives notice reversing the decision, and - Payment must be made no later than 30 days from the date CareOregon receives notice reversing the decision. CareOregon must conduct training of its 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: 1181
Contract Number: H5859
Part D Sponsor Name: HEALTH PLAN OF CAREOREGON, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 7/31/2007
Date Report Due: 9/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
Element Projected Completion Date: 9/14/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 6/14/2007
Estimated Visit Start Date: 6/18/2007
Actual Visit Start Date: 6/14/2007
Actual Visit End Date: 6/18/2007
Part D Sponsor Response Received Date: 10/26/2007
Part D Sponsor Response Due Date: 9/14/2007
CAP Release Date: 4/9/2008
CAP Accepted Date: 12/21/2007

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:

CareOregon does not meet this requirement because CMS reviewed CareOregon's policies and procedures and found they do not include a provision for authorizing or providing a benefit as expeditiously as the enrollee's health requires. Currently, policies and procedures only state, "The PT effectuates the decision within 72 hours for standard requests and 24 hours for expedited requests of receipt of the Maximus CHDR decision" (COA Policy - Part D Appeals.doc).

Corrective Action Required:

CareOregon must update its policies and procedures to include a provision that states that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. CareOregon must conduct training of its 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.