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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 8/27/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

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

Reference:

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing and found that they do not include the following provisions: - to conduct ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines, and - a requirement that all persons marketing on behalf of the Part D sponsor be state licensed, certified or registered individuals. CMS requested documentation demonstrating that MemberHealth conducts ongoing monitoring of the marketing activities of internal and external marketing representatives. MemberHealth was unable to demonstrate that its marketing representatives are providing the required written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. CMS reviewed 10 samples of individuals who perform marketing from a universe of 7052 and found that 1 sample provided was misclassified. To account for this, the auditors reduced the sample size by 1 and made the sample size 9. Nine out of the nine samples did not contain the following provisions in their contracts: (1) a provision prohibiting payment by the person performing marketing to beneficiaries, (2) a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short time frame, (3) a provision requiring any person directly employed or contracted to market on behalf of MemberHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with MemberHealth. The person may be compensated based on your enrollment in a plan,' and (4) a provision for coordinated marketing. Also, one case lacked a signature from CCOS on the contract and therefore did not demonstrate that a contractual relationship exists with the agent.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include the following provisions: - to conduct ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines, and -a requirement that all persons marketing on behalf of the Part D sponsor be state licensed, certified or registered individuals. MemberHealth 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. MemberHealth must provide CMS with documentation that its marketing program monitoring activities confirm that MemberHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. MemberHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following provisions: (1) a provision prohibiting payment by the person performing marketing to beneficiaries, (2) a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short time frame, (3) a provision requiring any person directly employed or contracted to market on behalf of MemberHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with MemberHealth. The person may be compensated based on your enrollment in a plan,' and (4) a provision for coordinated marketing. It must also ensure that all contracts are signed by all appropriate parties. Member Health must provide a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.

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:** 501

Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 9/13/2007
Element Release Date: 1/11/2008
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

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

Reference:

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed the 10 samples of beneficiaries affected by a formulary maintenance change from a universe of 93,562 and found that in 3 samples MemberHealth did not provide notice of formulary change to the affected enrollee within 60 days of the effective date of change.

Corrective Action Required:

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, MemberHealth must ensure that it provides a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. MemberHealth must provide documentation to CMS demonstrating that it provides written notice to affected enrollees within 60 days prior to the change, or provides an affected enrollee with a 60-day supply of the drug under the same terms as well as written notice of the formulary change at the time a refill of the drug is requested.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: PH03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 8/30/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits.

Reference:

42 CFR § 423.120(a)(5); PDP Solicitation; Long Term Care Guidance

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures regarding access to long-term care pharmacies and found that they do not include a provision that states that MemberHealth must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to any long-term care pharmacy in its service area that requests the contract.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision that states that it must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to any long-term care pharmacy in its service area that requests the contract. MemberHealth must conduct training of its staff responsible for long-term care network contracting and any other 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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 8/30/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures for providing notification of formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage and found that they do not include: - a provision with a description of the procedures for providing a notice of 'maintenance' formulary changes to SPAPs and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing a notice of 'other' formulary changes to SPAPs and entities providing other prescription drug coverage, in accordance with CMS requirements.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision with a description of the procedures for providing a notice of 'maintenance' formulary changes to SPAPs and entities providing other prescription drug coverage, in accordance with CMS requirements. MemberHealth must revise its policies and procedures to include a provision with a description of the procedures for providing a notice of 'other' formulary changes to SPAPs and entities providing other prescription drug coverage, in accordance with CMS requirements. MemberHealth 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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: TP02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 1/8/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.

Reference:

42 CFR § 423.120(b)(3); PDP Solicitation; Information for Part D Sponsors on Requirements for a Transition Process

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures regarding the transition process for residents of long-term care facilities and found that they do not include a provision to abide by extensions to the transition period in accordance with CMS policy. In addition, CMS requested system reports regarding the Part D sponsor's transition process utilization for LTC residents. MemberHealth was unable to demonstrate that it implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements. MemberHealth was also unable to demonstrate that it has and implements a transition process that covers an emergency supply or 'first-fill' of non-formulary Part D drugs.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision to abide by extensions to the transition period in accordance with CMS policy. MemberHealth 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. MemberHealth must submit system reports regarding its transition process utilization for LTC residents to demonstrate that: - It correctly implements the transition process for LTC residents as described in its policies and procedures and that is consistent with its contractual requirements, and - It has and implements a transition process that covers an emergency supply or 'first-fill' of non-formulary Part D drugs.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CN05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 8/30/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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.

Reference:

42 CFR § 423.120(a)(5); PDP Solicitation; Long Term Care Guidance

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed a sample of five executed network long -term care pharmacy contracts from a universe of 1,141 and found that all five samples did not include a provision to require the pharmacy to provide price differential information to Part D plans for inclusion in the written Explanation of Benefits.

Corrective Action Required:

MemberHealth must amend its long-term contract addenda to include a provision to require the pharmacy to provide price differential information to Part D plans for inclusion in the written Explanation of Benefits. MemberHealth must provide a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 7/20/2007
Element Release Date: 8/30/2007
Element Projected Completion Date: 7/5/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS requested MemberHealth's CMS-issued notice template for `Medicare Prescription Drug Coverage and Your Rights,' and MemberHealth was unable to provide this notice template.

Corrective Action Required:

MemberHealth must provide CMS with a notice consistent with CMS-issued model notice for `Medicare Prescription Drug Coverage and Your Rights.' If MemberHealth 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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

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

Reference:

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found that they do not include provisions for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. MemberHealth's policies and procedures do not define coverage determination in accordance with §423.566(b)(1-5). Under §423.566(b)(1-5) the following actions by a Sponsor are considered coverage determinations: - A decision not to provide or pay for a Part D drug (including a decision not to pay because the drug is not on the Part D sponsor's formulary, because the drug is determined not to be medically necessary, because the drug is furnished by an out-of-network pharmacy, or because the Part D sponsor determines that the drug is otherwise excludable) that the enrollee believes may be covered by the plan. - Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the enrollee. - A decision concerning an exceptions request regarding a plan's tiered cost-sharing structure. - A decision concerning an exceptions request regarding a non-formulary drug. MemberHealth's policies and procedures do not include a provision for quarterly reporting of all data requested in Reporting Requirements Section VII: Appeals. CMS requested documentation demonstrating MemberHealth's ability to track and address in a timely manner enrollees' oral and written requests for exceptions, coverage determinations, and redeterminations and, more specifically, that MemberHealth has systems to track at a minimum the date of receipt, date of notification, disposition of request and date of disposition, and MemberHealth was unable to provide this documentation.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. MemberHealth must revise its policies and procedures to define coverage determinations in accordance with §423.566(b) (1-5). MemberHealth's policies and procedures must include a provision for quarterly reporting of all data requested in Reporting Requirements Section VII: Appeals. MemberHealth must provide documentation to CMS demonstrating that it has developed and implemented systems to track and address in a timely manner enrollees' oral and written requests for exceptions, coverage determinations, and redeterminations and more specifically systems to track at a minimum the date of receipt, date of notification, disposition of request and date of disposition. MemberHealth must conduct training of appropriate staff on these policies, procedures, and systems 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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
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Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found that they do not include a provision stating that MemberHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its decision regarding a coverage determination concerning drug benefit 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. CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefits from a universe of 53,066 and found 1 sample was misclassified. To account for this, the auditor reduced the sample size by one and made the sample size 9. One out of 9 cases did not demonstrate compliance with notifying enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions stating that MemberHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but not later than 72 hours after receipt of the request, or for an exceptions request, the physician's supporting statement. MemberHealth 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. MemberHealth must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of 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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found that they do not contain provisions that specifically address the requirements for coverage determinations concerning payment. Specifically, MemberHealth's policies and procedures do not include provisions stating: - MemberHealth must notify the enrollee of its coverage determination regarding payment decision no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - for favorable coverage determinations concerning payment, MemberHealth 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 - for favorable coverage determinations concerning payment, MemberHealth 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. Additionally, MemberHealth indicated during Staff Discussions that enrollees are notified of favorable coverage determination decisions concerning payment 7-14 days after receipt of the payment request, via the EOB and payment check. However, policies and procedures must be updated to reflect the above CMS requirements. Over 30% of samples provided for WS-CD2_D, Standard Coverage Determination Concerning Payment, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to address the requirements for coverage determinations concerning payment. Specifically, these policies and procedures must include provisions stating: - MemberHealth must notify the enrollee of its coverage determination regarding payment decision no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - for favorable coverage determinations concerning payment, MemberHealth 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 - for favorable coverage determinations concerning payment, MemberHealth must make payment within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
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Element Release Date: 5/8/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.

Reference:

42 CFR § 423.568(c-d); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and /or other applicable party). CMS requested MemberHealth's notice template for notifying enrollees of an adverse coverage determination, whether in part or whole, and MemberHealth provided a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. However, this notice did not contain an OMB control number. Over thirty percent of samples provided for WS-CD2_D, Requests for Coverage Determination Concerning Payment, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or applicable party). MemberHealth 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. MemberHealth must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. The OMB control number must be displayed in the upper right hand corner of the notice, as required by CMS. MemberHealth must conduct training of appropriate staff on the use of the appropriate notice 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not discuss a means for making expedited coverage determination decisions within the appropriate timeframe for requests received outside of normal business hours. Over thirty percent of samples provided for WS-CD3_D, Requests for Expedited Coverage Determinations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions discussing a means for making expedited coverage determination decisions within the appropriate timeframe for requests received outside of normal business hours. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

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

Reference:

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include a provision for timeliness of expedited coverage determination denial notification in accordance with CMS requirements. More specifically, CMS requires that if a request to expedite a coverage determination is denied, MemberHealth must automatically transfer the request to the standard coverage determination process, give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e. mail) to the enrollee, within 3 calendar days, written notice. Over thirty percent of samples provided for WS-CD3_D, Requests for Expedited Coverage Determinations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision for timeliness of expedited coverage determination denial notification in accordance with CMS requirements. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

CMS Part D Audit Report

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Date Report Generated: 9/30/2008

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

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Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD08
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

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

Reference:

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures regarding enrollee notification following a decision to deny a request for expedited coverage determination, and found they lack the following provisions: - oral and written notice must provide an explanation that MemberHealth must process the request using the 72 hour timeframe for standard determinations, - oral and written notice must inform the enrollee of the right to file an expedited grievance, - 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, and - oral and written notice must provide instructions about MemberHealth's grievance process and its timeframes. Additionally, MemberHealth was unable to provide a notice consistent with the CMS-issued model notice, Notice of Right to an Expedited Grievance, for notifying beneficiaries when MemberHealth denies an expedited coverage determination. CMS requested MemberHealth's notice template for notifying enrollees of the right to an expedited grievance, and MemberHealth did not provide a notice that is CMS-approved. Over thirty percent of samples provided for WS-CD3_D, Requests for Expedited Coverage Determinations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance

Corrective Action Required:

MemberHealth must revise its policies and procedures for enrollee notification following a decision to deny a request for an expedited coverage determination to include the following provisions: - _____ oral and written notice must provide an explanation that MemberHealth must process the request using the 72 hour timeframe for standard determinations, - _____ oral and written notice must inform the enrollee of the right to file an expedited grievance, - 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, and - _____ oral and written notice must provide instructions about MemberHealth¿s grievance process and its timeframes. MemberHealth 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. MemberHealth must provide CMS with a CMS-approved notice template that is consistent with CMS-issued Notice of Right to an Expedited Grievance. If MemberHealth 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. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

CMS Part D Audit Report

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

Findings: Not Met **Audit ID:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
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Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include provisions stating that: - MemberHealth must make an expedited coverage determination decision and notify the enrollee (and/or other applicable party) 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 an expedited coverage determination decision is adverse and MemberHealth first notifies the enrollee of the determination orally, MemberHealth must mail written confirmation to the enrollee within 3 calendar days of the oral notification, and - MemberHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Over thirty percent of samples provided for WS-CD3_D, Requests for Expedited Coverage Determinations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions stating that: -MemberHealth must make an expedited coverage determination and notify the enrollee (and/or other applicable party) 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 a expedited coverage determination decision is adverse and MemberHealth first notifies the enrollee of the determination orally, MemberHealth must mail written confirmation to the enrollee within 3 calendar days of the oral notification, and -MemberHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

CMS Part D Audit Report
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Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
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Audit Type: Routine
Audit Location: Desk Review
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Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include provisions stating that: - if the expedited coverage determination decision is adverse, MemberHealth must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and - if oral notice is provided for adverse decision, the notice must satisfy the following requirements: - state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. CMS requested MemberHealth's notice template for notifying enrollees of an adverse coverage determination, whether in part or whole, and MemberHealth provided a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. However, this notice did not contain the OMB control number. Over thirty percent of samples provided for WS-CD3_D, Requests for Expedited Coverage Determinations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision stating that if the decision on an expedited coverage determination is adverse, MemberHealth must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. Policies and procedures must also include a provision stating that if oral notice is provided for adverse decision, the notice must satisfy the following requirements: -state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. MemberHealth 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. MemberHealth must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. The OMB control number must be displayed in the upper right hand corner of the notice, as required by CMS. MemberHealth must conduct training of appropriate staff on the use of the appropriate notice 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

CMS Part D Audit Report

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Date Report Generated: 9/30/2008

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

Findings: Not Met **Audit ID:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

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

Reference:

42 CFR § 423.578(a)(1-2); § 423.578(a)(4); 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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's exceptions policies and procedures and found they do not include provisions stating that: - if MemberHealth requires a written statement from the enrollee's prescribing physician, it must do so immediately, - the prescribing physician's statement must indicate that the preferred drug for the treatment of the enrollee's condition (1) would not be effective as the requested drug and/or (2) would have adverse effects, - the prescribing physician is required to demonstrate in its written statement one of the following two factors: that a preferred drug for the treatment of an enrollee's condition (1) would not be effective as the requested drug and/or (2) would have adverse effects, - if MemberHealth makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, and -MemberHealth 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.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions stating that: - if MemberHealth requires a written statement from the enrollee's prescribing physician, it must do so immediately, - the prescribing physician's statement must indicate that the preferred drug for the treatment of the enrollee's condition (1) would not be effective as the requested drug and/or (2) would have adverse effects, - the prescribing physician is required to demonstrate in its written statement one of the following two factors: that a preferred drug for the treatment of an enrollee's condition (1) would not be effective as the requested drug and/or (2) would have adverse effects, - if MemberHealth makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, and - MemberHealth 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. MemberHealth 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:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Desk Review
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Element Accepted Date: 8/1/2007
Element Release Date: 8/30/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include provisions 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 MemberHealth's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, or (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. Additionally, MemberHealth's policies and procedures do not include provisions stating that: - MemberHealth 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, and - if MemberHealth makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions 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 MemberHealth's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, or (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. Additionally, MemberHealth must revise its policies and procedures to state that: - MemberHealth 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, and - if MemberHealth makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. MemberHealth 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:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
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Element Release Date: 9/13/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found that they do not include provisions stating that: - coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, - enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and - all approved non-formulary drugs must be placed in existing cost-sharing tier(s). Over 30% of samples provided for WS-CD2_D, Standard Coverage Determination Concerning Payment, were misclassified. Therefore auditors were unable to use these samples to assess whether MemberHealth places all approved non-formulary drugs in existing cost-sharing tiers or that MemberHealth provides coverage for approved tiering exceptions at the same cost-sharing tier as preferred drugs. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions stating that: - coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, - enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and - all approved non-formulary drugs must be placed in existing cost-sharing tier(s). MemberHealth 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. MemberHealth must provide documentation to CMS demonstrating that it places all approved non-formulary drugs in existing cost-sharing tiers and provide coverage for approved tiering exceptions at the same cost-sharing tier as preferred drugs. Additionally, MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Desk Review
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Element Release Date: 9/5/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found that they do not include provisions for promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals. During Staff Discussions when MemberHealth was questioned as to how enrollees are notified whether their complaints are subject to grievance or coverage determination procedures, it was stated by MemberHealth staff that every complaint is treated as a grievance, demonstrating that MemberHealth does not correctly distinguish between grievances and coverage determinations. In addition, CMS requested documentation that demonstrates that MemberHealth has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures, and MemberHealth was unable to provide this documentation. CMS reviewed a sample of 15 standard grievances from a universe of 1320 and found that 15 did not demonstrate MemberHealth was compliant with the case categorization procedure. Specifically, 15 out of 15 cases did not demonstrate the enrollee was informed whether the complaint was subject to grievance procedures or coverage determination procedures. Over 30% of samples provided for WS-CD2_D, Standard Coverage Determinations Concerning Payments, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance. Over 30% of samples provided for WS-CD3_D, Expedited Coverage Determinations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions for promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals. MemberHealth must conduct training of its Customer Service staff, Grievance staff, and any other 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. MemberHealth must provide documentation to CMS demonstrating its communication methods for informing enrollees of complaint categorization. MemberHealth must provide documentation to CMS demonstrating that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. MemberHealth must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payments, and WS-CD3_D, Expedited Coverage Determinations, contain misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
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Element Accepted Date: 9/13/2007
Element Release Date: 9/13/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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); PDP Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Reporting Requirements for Section V: Grievances

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's grievance policies and procedures and found that they do not include a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary.

Corrective Action Required:

MemberHealth must revise its grievance policies and procedures to include a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary. MemberHealth 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)

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

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Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
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Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found that they do not include provisions 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, but not later than 30 days after MemberHealth receives the oral or written grievance, and - the enrollee must immediately be notified in writing when MemberHealth extends the deadline. Additionally, MemberHealth's policies and procedures do not state that the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if MemberHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee. During Staff Discussions when MemberHealth was asked to identify their grievance extension timeframes, staff stated that MemberHealth uses a 14-30 day extension timeframe rather than 14 days or less, per CMS requirements. CMS reviewed a sample of 15 standard grievances from a universe of 1,320 and found that 11 did not demonstrate compliance with grievance adjudication as a result of documentation not demonstrating that enrollees were notified of grievance resolution within the CMS-approved timeframes.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions 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, but not later than 30 days after MemberHealth receives the oral or written grievance, - the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if MemberHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and - the enrollee must immediately be notified in writing when MemberHealth extends the deadline. MemberHealth must conduct training of Customer Service, Grievance, and any other 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. MemberHealth must submit documentation to CMS demonstrating that it notifies enrollees of grievance resolutions within the CMS-approved timeframes.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met **Audit ID:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Desk Review
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found that they do not: - include a provision stating that all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing, and - state MemberHealth's commitment to cooperating with the QIO in resolving grievance cases.

Corrective Action Required:

MemberHealth must revise its policies and procedures and found they do not include provisions stating: - all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing, and - MemberHealth's commitment to cooperating with the QIO in resolving grievance cases. MemberHealth 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

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

Findings: Not Met
Audit ID: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
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Element Accepted Date: 8/1/2007
Element Release Date: 8/30/2007
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because, although MemberHealth's policies and procedures appropriately identified expedited grievance timeframes, during Staff Discussions MemberHealth staff could not identify expedited grievance timeframes. Additionally, staff responses indicated that MemberHealth does not distinguish between expedited grievances and expedited coverage determinations.

Corrective Action Required:

MemberHealth must conduct training of appropriate staff on policies and procedures for expedited grievances 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

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

Findings: Not Met
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Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
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Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

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

Reference:

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. CMS requested documentation from MemberHealth demonstrating its system for accepting requests for standard redeterminations, and MemberHealth was unable to demonstrate it has a system in place to accept written requests from the enrollee for a redetermination within the 60 calendar day timeframe. Over 30% of the samples provided for worksheet WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefit, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance. Over 30% of the samples provided for worksheet WS-RE2_D, Requests for Standard Redeterminations Concerning Payments, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. MemberHealth 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. MemberHealth must provide documentation to CMS demonstrating that it has developed and implemented a system to accept written requests from the enrollee for a redetermination within the 60 calendar day timeframe in order to meet the CMS compliance standards for RE01. MemberHealth must conduct training of appropriate staff on these policies and procedures and this system 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. Additionally, MemberHealth must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D and WS-RE2_D contained misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

CMS Part D Audit Report

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Date Report Generated: 9/30/2008

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

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Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
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Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's documentation and found that, although MemberHealth did provide documentation demonstrating MemberHealth has a system for accepting requests for expedited redeterminations and documents all oral requests in writing, MemberHealth was unable to demonstrate it maintains documentation of expedited redetermination requests in case files. Over thirty percent of samples provided for WS-RE3_D, Requests for Expedited Redeterminations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining whether MemberHealth has a system for maintaining documentation of expedited redetermination requests in case files in addition to accepting requests for expedited redeterminations and documenting all oral requests in writing.

Corrective Action Required:

MemberHealth must provide documentation to CMS demonstrating that it has implemented a system for accepting oral and written requests for expedited redeterminations that maintains documentation of expedited redetermination requests in case files. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

CMS Part D Audit Report

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Date Report Generated: 9/30/2008

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

Findings: Not Met **Audit ID:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
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Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include provisions stating that: - MemberHealth automatically expedites a request when the enrollee's physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, and - any additional medical information MemberHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. Over thirty percent of samples provided for WS-RE3_D, Requests for Expedited Redeterminations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions stating that: -MemberHealth automatically expedites a request when the enrollee's physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, and - any additional medical information MemberHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include provisions stating that: - MemberHealth must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - MemberHealth must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. CMS requested MemberHealth's notice template for notifying enrollees that a request for an expedited redetermination is denied and MemberHealth did not provide a notice that is CMS-approved. Over thirty percent of samples provided for WS-RE3_D, Requests for Expedited Redeterminations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions stating that: -MemberHealth must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - MemberHealth must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. MemberHealth 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. MemberHealth must provide CMS with a CMS-approved notice template that is consistent with the CMS-issued Notice of Right to an Expedited Grievance. If MemberHealth 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. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth¿s policies and procedures and found they do not include a provision for effectuating the favorable redetermination (concerning drug benefit) 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. Additionally, MemberHealth policies and procedures do not include a provision to inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Over 30% of the samples provided for worksheet WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefit, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision 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. MemberHealth must also revise its policies and procedures to include a provision stating that MemberHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. MemberHealth 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. Additionally, MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contained misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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:** 501

Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include a provision stating that for favorable redeterminations to the enrollee (concerning payment), MemberHealth 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. MemberHealth¿s policies and procedures do not include a provision to inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Over thirty percent of samples provided for WS-RE2_D, Requests for Standard Redeterminations Concerning Payments, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision stating that for favorable redeterminations to the enrollee, MemberHealth 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. MemberHealth must also revise its policies and procedures to include a provision stating that MemberHealth must inform the enrollee, within 24 hours, when their case is forwarded to the IRE. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/27/2007
Element Release Date: 8/30/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include provisions: - indicating that notification of a favorable decision may be made orally or in writing, - indicating that the initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, - stating that medical information must be requested within 24 hours of the enrollee¿s initial request, and - stating that MemberHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Over thirty percent of samples provided for WS-RE3_D, Requests for Expedited Redeterminations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing, - indicating that the initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, - stating that medical information must be requested within 24 hours of the enrollee's initial request, and - stating that MemberHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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:** 501
Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE08
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 7/24/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

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

Reference:

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

Deficiencies:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's documentation and found that it did not demonstrate it has a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination. Over thirty percent of samples provided for WS-RE3_D, Requests for Expedited Redeterminations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 7/24/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet the CMS compliance standard because over 30% of samples provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefit, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance. Over 30% of samples provided for WS-RE2_D, Requests for Standard Redeterminations Concerning Payments, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance. Over 30% of samples provided for WS-RE3_D, Requests for Expedited Redeterminations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, WS-RE2_D, and WS-RE3_D contain misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. MemberHealth must provide documentation to CMS demonstrating that it uses appropriate personnel to conduct redeterminations.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 7/24/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

Requirement:

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

Reference:

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

Deficiencies:

MemberHealth does not meet the CMS compliance standard because over 30% of samples provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefit, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance. Over 30% of samples provided for WS-RE2_D, Requests for Standard Redeterminations Concerning Payments, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance. Over 30% of samples provided for WS-RE3_D, Requests for Expedited Redeterminations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, WS-RE2_D, and WS-RE3_D contain misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 7/24/2007
Element Release Date: 1/11/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed internal data on MemberHealth's compliance with standard reconsideration decisions and found that 21 out of 87 appeal cases were noncompliant. Specifically, in 7 out of 87 appeal cases MemberHealth did not provide a notice to the IRE that it effectuated a reversal decision, and in 13 of 87 appeal cases it did not effectuate the IRE's decision in a timely manner. Over 30% of samples provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefit, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must demonstrate to CMS that it effectuates a standard reconsideration decision that has been reversed by the IRE for appeal cases concerning drug benefit within the timeframes required by CMS and must notify the IRE of the effectuation of any reconsideration decision that fully or partially reverses MemberHealth's redetermination decision. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contained misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: 501
Contract Number: S5803
Part D Sponsor Name: PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 8/1/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth does not meet this requirement because CMS reviewed MemberHealth's policies and procedures and found they do not include a provision stating that payment must be made no later than 30 days from the date MemberHealth receives notice reversing the decision. Over thirty percent of samples provided for WS-RE2_D, Requests for Standard Redeterminations Concerning Payments, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise its policies and procedures to include a provision stating that payment must be made no later than 30 days from the date MemberHealth receives notice reversing the decision. MemberHealth 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. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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:** 501

Contract Number: S5803 **Part D Sponsor Name:** PENN LIFE INS CO AND AMER PROG LIFE AND HTH INS CO

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/25/2007
Date Report Due: 7/9/2007
Element Accepted Date: 7/24/2007
Element Release Date: 5/9/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/19/2007
Estimated Visit Start Date: 3/23/2007
Actual Visit Start Date: 3/19/2007
Actual Visit End Date: 3/23/2007
Part D Sponsor Response Received Date: 7/10/2007
Part D Sponsor Response Due Date: 7/9/2007
CAP Release Date: 5/9/2008
CAP Accepted Date: 9/14/2007

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:

MemberHealth did not meet this requirement because CMS reviewed MemberHealth's policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit and found that they do not contain a provision stating 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. Additionally, during Staff Discussions, MemberHealth staff stated that MemberHealth processes the effectuation of third party reversals for expedited requests within a 72 hour timeframe. MemberHealth does not meet this requirement because CMS reviewed internal data on MemberHealth's compliance with expedited reconsideration decisions and found that 14 out of 21 appeal cases were noncompliant. Specifically, in 3 out of 21 appeal cases MemberHealth did not provide a notice to the IRE that it effectuated a reversal decision, and in 11 of 21 appeal cases it did not effectuate the IRE's decision in a timely manner. Over 30% of samples provided for WS-RE3_D, Requests for Expedited Redeterminations, were misclassified. The universe provided by MemberHealth is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

MemberHealth must revise policies and procedures to include a provision stating 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. MemberHealth must conduct training of appropriate staff on effectuation of third party reversals 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. MemberHealth must demonstrate to CMS that it effectuates an expedited reconsideration decision that has been reversed by the IRE for appeal cases concerning drug benefit within the timeframes required by CMS and must notify the IRE of the effectuation of any reconsideration decision that fully or partially reverses MemberHealth's redetermination decision. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.