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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PC02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC does not meet the CMS compliance standard because CMS reviewed AHC's policies and procedures (2711.pdf) and found that they do not include a provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes at least 60 days prior to the date the change becomes effective. AHC¿s policies and procedures also do not include a description of the method(s) used to provide notification of formulary changes. Notification method(s) must include, at a minimum, posting formulary changes on each affected plan's Internet website.

Corrective Action Required:

AHC must revise its policies and procedures to include the following: - a provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes, which are defined as assigning a higher cost sharing to a drug, removing a drug from the sponsor's formulary, or adding utilization tools to a drug, at least 60 days prior to the date the change becomes effective, and - a description of the method(s) used to provide notification of formulary changes. Notificiation method(s) must include, at a minimum, posting formulary changes on each affected plan's Internet website. AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
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Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, contracts, and compensation documents associated with marketing representatives and found that AHC does not meet the CMS compliance standard. AHC's Policies do not include a requirement that any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Documentation that AHC submitted does not confirm that AHC's marketing representatives are providing the written disclosure statement to all potential enrollees prior to or at the time of enrollment. AHC indicated during staff discussions that marketing representatives do not include a disclosure statement to potential enrollees. AHC's policies and procedures do not include a requirement that all persons marketing on behalf of AHC be state licensed, certified or registered individuals. One of the ten marketing agents included in the sample cases does not appear to have a compliant certification status. Nine of the ten sample cases included sales compensation documents that were signed in 2004, and one case did not have any documentation that was signed by the marketing representative. None of the compensation schedules or other contractual documentation included a provision requiring the marketing representative disclose to a potential beneficiary that the representative may be compensated based on the potential enrollee's enrollment in a plan. None of the compensation documentation included a provision prohibiting payment by a marketing representative to beneficiaries. One of the ten marketing agents included in the sample cases does not appear to have a compliant certification status. Nine of the ten sample cases included sales compensation documents that were signed in 2004, and one case did not have any documentation that was signed by the marketing representative. None of the compensation schedules or other contractual documentation included a provision requiring the marketing representative disclose to a potential beneficiary that the representative may be compensated based on the potential enrollee's enrollment in a plan. None of the compensation documentation included a provision prohibiting payment by a marketing representative to beneficiaries.

Corrective Action Required:

AHC must revise its policies and procedures to include the following: - a requirement that any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, - a requirement that all persons marketing on behalf of the sponsor be state licensed, certified or registered individuals, and - a requirement that all persons marketing on behalf of the Part D sponsor be state licensed, certified or registered individuals. AHC must provide CMS with evidence that its marketing program monitoring activities confirm that AHC's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. AHC must also provide CMS with evidence that it has a current compensation structure in effect that includes the following: 1) a provision requiring the marketing representative to disclose to a potential beneficiary that the representative may be compensated based on the potential enrollee's enrollment in a plan, and 2) a provision prohibiting payment by a marketing representative to beneficiaries.

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Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Desk Review
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Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement. No formulary changes had taken place during the review period. Therefore, CMS reviewed policies and procedures to determine whether AHC had processes in place to meet this requirement. The auditor determined that AHC's policies and procedures do not include a requirement to provide direct written notice to affected enrollees at least 60 days prior to the date the formulary change becomes effective. The revised policies also do not include a provision that if no prior notice is given, AHC will ensure that affected enrollees are provided with a 60-day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and are provided written notice of the formulary change.

Corrective Action Required:

AHC must revise its policies and procedures to include the required provisions. AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PH03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
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Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC does not meet this requirement. CMS reviewed AHC's policies and procedures regarding access to long-term care pharmacies and determined that they do not include a provision stating that AHC will 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:

AHC must revise its policies and procedures to include a provision which reflects that it meets this requirement. AHC 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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Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
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Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed policies and procedures and found that they do not include procedures for the following: - providing a notice of "maintenance" formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, - providing a notice of "other" formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, and - providing notification of formulary changes. Notification must include, at a minimum, posting formulary changes on each affected plan's internet website.

Corrective Action Required:

AHC must revise its policies and procedures to include the following, in accordance with CMS requirements: - Procedures for providing a notice of "maintenance" formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, - Procedures for providing a notice of "other" formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, and - a description of the method used to provide notification of formulary changes. Notification must include, at a minimum, posting formulary changes on each affected plan's internet website. AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: TP02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
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Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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); MA-PD Solicitation; Information for Part D Sponsors on Requirements for a Transition Process; Transition Process Requirements for Part D Sponsors

Deficiencies:

AHC does not meet this requirement because CMS reviewed AHC's policies and found that they do not include the following: - a requirement for addressing the immediate needs of long-term care (LTC) beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and - a provision to abide by extensions to the transition period in accordance with CMS policy. In addition, AHC did not submit system reports regarding its transition process utilization for LTC residents to verify that AHC correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements.

Corrective Action Required:

AHC must revise its policies and procedures to include the required provisions. America's Health Choice must provide CMS with system reports regarding its transition process utilization for LTC residents to verify that AHC correctly implements the transition process for LTC residents as described in its SOP and consistent with its contractual requirements.

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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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Desk Review
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Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because it is unable to provide documentation demonstrating that it conducts ongoing monitoring of its network pharmacies to ensure that they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. In addition, AHC indicated in staff discussions that it does not conduct any ongoing monitoring of its pharmacies to ensure that they are meeting this requirement.

Corrective Action Required:

AHC must provide CMS with documentation that demonstrates that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.

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

Findings: Not Met
Audit ID: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Desk Review
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Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC does not meet this requirement because CMS reviewed policies and procedures for tracking and addressing requests for redeterminations and found that they are inadequate. CMS also reviewed documentation showing the systems that AHC uses to track and address enrollees' oral and written requests for exceptions, coverage determinations, and redeterminations. The auditor found that although AHC's system documentation and policies and procedures show that requests are logged, there is nothing to show that AHC actually addresses requests or that AHC ensures that it responds to requests for redeterminations in a timely manner.

Corrective Action Required:

AHC must revise its policies and procedures for tracking and addressing redeterminations to include provisions for ensuring that it addresses requests for redeterminations and responds to them in a timely manner. AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
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Element Release Date: 9/26/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed policies and procedures, and requested AHC's notice template for enrollee notification when a request is forwarded to the IRE. AHC is unable to provide a CMS-approved notice template. In addition, CMS reviewed ten sample cases and found that in six cases, AHC did not send timely notices of coverage determination concerning the drug benefit.

Corrective Action Required:

AHC must provide CMS with a CMS-approved notice template for enrollee notification when a request for coverage determination concerning drug benefit is forwarded to the IRE. If AHC 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.

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Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Desk Review
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Estimated Visit Start Date: 1/29/2007
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Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC does not meet this requirement. CMS reviewed policies and procedures and requested AHC's notice template for enrollee notification when a request is forwarded to the IRE. AHC is unable to provide a CMS-approved notice template. In addition, CMS reviewed eight sample cases and found that eight did not contain the date on which AHC notified the enrollee of its determination.

Corrective Action Required:

AHC must provide CMS with a CMS-approved notice template for enrollee notification when it forwards a request for coverage determination concerning payment to the IRE. If AHC 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. AHC must revise its policies and procedures to include provisions for ensuring that it notifies enrollees of coverage determinations in a timely manner, and that it documents the dates on which it makes those notifications. AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD05
Audit Type: Routine
Audit Location: Desk Review
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CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed policies and procedures, the notice template for notifying enrollees of an adverse coverage determination, and sample cases and found that AHC is unable to provide a CMS-approved notice template. In addition, CMS found that five of ten sample cases reviewed did not contain compliant notifications.

Corrective Action Required:

AHC must provide CMS with a CMS-approved notice template for notifying enrollees of an adverse coverage determination. If AHC 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. AHC must conduct training of appropriate staff on providing the notice to enrollees 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed AHC's policies and procedures for Expedited Coverage Determination and Notice Requirement Timeframes (3024.pdf) and found that they do not include the following: - Identification of a designated office and/or department to receive both oral and written requests for expedited coverage determinations, and - A provision that states that all oral requests for expedited coverage determinations must be documented in writing and that documentation of the request must be maintained in a case file. In addition, CMS reviewed three sample cases from worksheet WS-CD3_D and found that in one case, AHC made an incorrect decision to not expedite a request.

Corrective Action Required:

AHC must revise its policies and procedures to include the required provisions. AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed three sample cases and found that one case did not contain documentation showing that AHC orally notified the enrollee in a timely manner. In addition, the case did not contain evidence that AHC transferred the case to the standard coverage determination process after 24 hours.

Corrective Action Required:

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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD08
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS requested a CMS-approved notice template for notifying beneficiaries when it denies an expedited coverage determination. However, AHC is unable to provide this notice. In addition, CMS reviewed three sample cases from worksheet WS-CD3_D and found that one case did not contain a notice that was compliant with the CMS Model Notice of Right to an Expedited Grievance.

Corrective Action Required:

AHC must provide CMS with a CMS-approved notice template for notifying enrollees when it denies an expedited coverage determination. If AHC 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
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Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed policies and procedures, sample cases, and requested AHC's notice template for enrollee notification when an expedited coverage determination is forwarded to the IRE, and found the following: - AHC's policies do not include a provision to inform the enrollee, within 24 hours, when his/her expedited coverage determination case is forwarded to the IRE due to AHC's failure to notify the enrollee of a decision within the required timeframe, - One of three sample cases reviewed for worksheet WS-CD3_D did not show that AHC was compliant with timely notification of expedited coverage determinations, and - AHC is unable to provide a CMS-approved notice template.

Corrective Action Required:

AHC must revise its policies and procedures for Expedited Coverage Determination and Notice Requirement Timeframes (3024.pdf) to include the required provision and to ensure that it documents notification dates. AHC 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. AHC must provide CMS with a CMS-approved notice template for enrollee notification when an expedited coverage determination is forwarded to the IRE. If AHC 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)

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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: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed its policies and procedures and found that they do not include the following provisions: - If AHC makes an adverse expedited coverage determination decision, then it must notify the enrollee in writing using a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, - If AHC provides oral notice regarding an adverse expedited coverage determination decision, then the notice must: a) State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, b) Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and c) 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. (Note that AHC's policies and procedures for Expedited Coverage Determination and Notice Requirement Timeframes (3024.pdf) state these requirements only as they pertain to written notice.) In addition, CMS requested AHC¿s CMS-approved notice template for notifying enrollees of an adverse expedited coverage determination. However, AHC is unable to provide the notice template.

Corrective Action Required:

AHC must revise its policies and procedures for Expedited Coverage Determination and Notice Requirement Timeframes (3024.pdf) to include all of the required provisions. AHC 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. In addition, AHC must provide CMS with a CMS-approved notice template for notifying enrollees of an adverse expedited coverage determination. If AHC 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)

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

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Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC does not meet this requirement because CMS reviewed AHC¿s policies and procedures and found that they do not include the following provisions: - If AHC requires a written statement from the enrollee's prescribing physician in support of a request for an exception to its tiered cost-sharing structure, it must do so immediately, - AHC must not keep the exceptions request open indefinitely when a physician does not submit a statement in support of a request for an exception to its tiered cost-sharing structure, - If AHC is waiting on a physician's statement in support of a tiering exception request, it must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception, and - AHC 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. In staff discussions, AHC indicated that it allows 72 hours for receipt of a physician's supporting statement rather than the required minimum of 96 or 48 hours. CMS also requested AHC¿s CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. However, AHC is unable to provide the notice template.

Corrective Action Required:

AHC must revise its policies and procedures entitled Requesting Additional Information Timeframes (3027.pdf), Tiering Exceptions (3036.pdf), and Exceptions Process General (3038.pdf) to include required provisions. AHC must include the provisions in all three of these policies, with one exception. AHC does not need to include the provision to grant a tiering exception when the preferred drug would not be as effective as the requested drug and/or would have adverse effects in the policy Requesting Additional Information Timeframes (3027.pdf). AHC 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. In addition, AHC must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If AHC 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)

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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: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
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Element Release Date: 9/26/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC has not demonstrated that it has policies and procedures in place to ensure that it has established and maintains exceptions procedures for receipt of an off-formulary drug. AHC does not meet this requirement because CMS reviewed AHC¿s policies and procedures and found that they do not include the following provisions: - AHC must not keep the exceptions request open indefinitely when a physician does not submit a statement in support of a request for an exception for a non-formulary Part D drug, and - If AHC is waiting on a physician's statement in support of a request for an exception for a non-formulary Part D drug, it must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the non-formulary exception. In staff discussions, AHC indicated that it allows 72 hours for receipt of a physician's supporting statement rather than the required minimum of 96 or 48 hours. CMS also requested AHC's CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. However, AHC was unable to provide the notice template.

Corrective Action Required:

AHC must revise its policies and procedures entitled Requesting Additional Information Timeframes (3027.pdf), Exceptions Process (Non-formulary drug) (3026.pdf), and Exceptions Process General (3038.pdf) to include the required provisions. AHC 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. In addition, AHC provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
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Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed AHC¿s policies and procedures regarding determining cost-sharing for approved exceptions and found that they do not include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Its policies and procedures entitled Tiering Exceptions (3036.pdf) state that in no cases shall it grant a tiering exception for a brand name drug to a generic cost-sharing tier. AHC stated during staff discussions that it denies brand name drug tiering exceptions only when there is no generic available for that brand.

Corrective Action Required:

AHC must revise its policies and procedures entitled Tiering Exceptions (3036.pdf) to clarify its policies for granting tiering exceptions for brand name drugs in accordance with CMS requirements and statements made during staff discussions. AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
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: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
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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:

AHC does not meet this requirement because CMS reviewed AHC's grievance policies and procedures and found that they do not include provisions for promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals. In addition, CMS requested documentation that demonstrates that AHC has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. CMS requested AHC's CMS-approved notice template for informing enrollees about inquiries involving excluded drugs. However, AHC is unable to provide this documentation. CMS also reviewed sample cases from worksheet WS-GV1_D and found that fourteen of fifteen cases are noncompliant because cases were incorrectly categorized as grievances. - In nine cases, AHC incorrectly categorized the issues as grievances, and - In eight cases, AHC did not inform the enrollee about how they categorized the issue.

Corrective Action Required:

AHC must revise its grievance policies and procedures to include the following provisions: - Promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals, and - Informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures and demonstrating that it has a means for informing enrollees of complaint categorization (e.g., phone script and notice template). AHC 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. AHC must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs. If AHC 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

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Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

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Auditing Element: GV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
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Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC does not meet this requirement because CMS reviewed AHC's policies and procedures entitled Grievance Data Collection and Reporting (GRV-0004) and found that they do not reflect the Part D reporting requirements. In addition, AHC did not provide sufficient system documentation to demonstrate that it tracks and addresses the timely resolution of grievances. AHC also did not provide sufficient documentation to demonstrate that it has a system for logging enrollee grievances in a centralized location and for tracking, at a minimum, the following information: - Receipt date, - Mode of receipt (e.g., fax, telephone, letter, etc.), - Person or entity that filed the grievance, - Grievance subject, - Disposition, and - Date AHC notified the enrollee of the disposition.

Corrective Action Required:

AHC must revise its policies and procedures entitled Grievance Data Collection and Reporting (GRV-0004) to include the Part D reporting requirements. AHC 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. AHC must update its grievance tracking system to ensure that it tracks and addresses the timely resolution of grievances, and to ensure that it tracks the minimum information required.

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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

MA-PD Solicitation

Deficiencies:

AHC does not meet this requirement because CMS requested a description of AHC¿s grievance training program, however, the documentation that AHC provided does not demonstrate that AHC has a grievance training program. AHC submitted policies which state that it will conduct training bi-annually in January and July, an agenda and sign-in sheet for web-based training that CMS hosted, and documents entitled ¿Grievance Rounds Topics for Training¿ that were little more than bullet points. AHC also submitted a schedule and attendance logs for training about the plan benefit package, which is not applicable to this requirement.

Corrective Action Required:

AHC must provide CMS with documentation which demonstrates that it has the formal bi-annual training program described in its grievance policies and procedures. Documentation should include the materials used in the training program, the individuals who conduct the training, and the staff who are 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC does not meet this requirement because CMS reviewed AHC's policies and procedures and found that they do not address situations in which the enrollee or AHC requests to extend the 30-day timeframe for grievance resolution. CMS also requested AHC¿s CMS-approved notice template for informing enrollees of grievance deadline extension. However, AHC is unable to provide it. In addition, 30 percent or more of the sample cases provided for worksheet WS-GV1_D were misclassified. This universe is not representative of cases that CMS requested, and is therefore inadequate for determining compliance. - Cases 6, 10, and 11 were requests for coverage determinations (request for an early-refill edit override, request for a prior authorization edit override, and request for payment for drugs paid for out-of-pocket), and - Cases 9 and 11 were inquiries (a billing inquiry and an inquiry regarding the coverage gap).

Corrective Action Required:

AHC must revise its policies and procedures to include the following provisions: - Extending the grievance resolution timeframe by 14 days or less if the enrollee requests the extension or if the AHC justifies a need for additional information and documents how the delay is in the interest of the enrollee, - Notifying the enrollee immediately in writing when AHC extends the deadline for grievance resolution, - Recording the date that AHC notified the enrollee of the grievance disposition, and - Notifying all concerned parties 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 the Sponsor receives the grievance. AHC 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. AHC must provide CMS with a CMS-approved notice to inform enrollees in all cases where the Sponsor extends the grievance deadline. If AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC does not meet this requirement because CMS reviewed AHC's policies and procedures and found that they do not include provisions for responding in writing whenever the enrollee requests a written response. In addition, CMS requested AHC¿s CMS-approved notice template for notification of grievance disposition. However, AHC is unable to provide this notice template. Thirty percent or more f sample cases provided for WS-GV1_D were misclassified. This universe is not representative of cases that CMS requested, and is therefore inadequate for determining compliance. - Cases 6, 10, and 11 were requests for coverage determinations (request for an early-refill edit override, request for a prior authorization edit override, and request for payment for drugs paid for out-of-pocket), and - Cases 9 and 11 were inquiries (a billing inquiry and an inquiry regarding the coverage gap).

Corrective Action Required:

AHC must revise its grievance policies and procedures to include provisions for the following: - Responding in writing to all grievances that are submitted in writing and whenever the enrollee requests a written response, and - Recording the method of member notification of the grievance disposition. AHC 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. AHC must provide CMS with a CMS-approved notice to inform enrollees of grievance disposition when written notice is required. If AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed AHC¿s policies and procedures and found that they do not include provisions for responding in writing to grievances related to quality of care when required. CMS also requested AHC¿s CMS-approved notice template for notification of grievance disposition. However, AHC is unable to provide this notice template.

Corrective Action Required:

AHC must revise its policies and procedures to include provisions for responding in writing to all grievances that are related to quality of care, regardless of how the grievance is filed. AHC 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. AHC must also provide CMS with a CMS-approved notice to inform enrollees of grievance disposition when written notice is required. If AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed AHC¿s policies and procedures entitled Request for Urgent Grievance Review (GA25-0004) and found that they are not compliant with CMS requirements for timeliness of response to expedited grievances. Specifically, they do not include provisions for allowing a 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by AHC to grant a 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. Other AHC grievance policies and procedures (grievance.pdf) do contain provisions for responding to expedited grievances. However, these policies have not been updated for Part D, and contain only the Part C terms "organization determination" and "reconsideration" instead of "coverage determination" and "redetermination."

Corrective Action Required:

AHC must revise its policies and procedures entitled Grievance Procedures (Grievance.pdf) and Request for Urgent Grievance Review (GA25-0004) to include Part D terminology and CMS requirements for timely response to expedited grievances. Specifically, policies and procedures must contain provisions for allowing a 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by AHC to grant a 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. AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

Requirement:

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

Reference:

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

Deficiencies:

AHC does not meet this requirement. CMS reviewed AHC¿s policies and procedures and documentation demonstrating AHC's system for accepting oral and written requests for expedited redeterminations. The auditor found that AHC¿s policies and procedures for accepting and addressing requests for expedited redeterminations are inconsistent. Its policies and procedures entitled Expedited Redeterminations (3003.pdf) are correct and contain a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. However, two other policy and procedure documents (Coverage Determinations (3022.pdf) and Tiering Exceptions (3036.pdf)) state that requests for expedited redeterminations must be in written format. In addition, AHC's policies and procedures do not include a provision that states the name of a designated office and/or department to receive both oral or written requests for expedited redeterminations and a telephone number for oral requests.

Corrective Action Required:

AHC must revise its policies and procedures entitled Coverage Determinations (3022.pdf) to include a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. AHC must also update its policies and procedures for tiering exceptions (3036.pdf) to include a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. In lieu of making these updates to these two documents, AHC may remove the discussion of expedited redeterminations from both of them, as it is outside of their title scope. CMS expects AHC to have one complete policy and procedure document for accepting requests for expedited redeterminations that its staff can reference. AHC must also revise its policies and procedures entitled Expedited Redeterminations (3003.pdf) to include the following: - The name of a designated office and/or department to receive both oral and written requests for expedited redeterminations, including a telephone number for oral requests. These policies and procedures may also include a facsimile number to facilitate receipt of requests for expedited redeterminations. - A provision for maintaining documentation of each expedited redetermination request in a case file. AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE04
Audit Type: Routine
Audit Location: Desk Review
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Element Accepted Date: 9/26/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed AHC¿s policies and procedures and found that AHC¿s policies do not include the following provisions addressing situations when AHC denies a request for an expedited redetermination: - Transfering the denied request to the standard redetermination timeframe, and - Providing prompt oral notice to the enrollee and written notice within three calendar days of the oral notice. CMS found two policy and procedure documents (Coverage Determinations (3022.pdf) and Tiering Exceptions (3036.pdf)) that do include these provisions. However, both of these documents use the Part C term "reconsideration" instead of "redetermination," and the process for handling expedited redeterminations is outside the title scope of these documents. In addition, CMS requested AHC¿s CMS-approved notice template for notifying an enrollee that a request for an expedited redetermination is denied. However, AHC is unable to provide this notice template.

Corrective Action Required:

AHC must revise its policies and procedures entitled Expedited Redeterminations (3003.pdf) to include the required provisions. AHC 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. In addition, AHC must provide CMS with a CMS-approved notice template for notifying an enrollee that a request for an expedited redetermination is denied. If AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed AHC's policies and procedures and found that they do not include a provision to inform the enrollee, within 24 hours, when his/her standard redetermination concerning a drug benefit is forwarded to the IRE due to AHC's failure to notify the enrollee of a decision within the required timeframe. CMS requested the following CMS-approved notice templates: - Notice of an adverse standard redetermination concerning the drug benefit, - Notice requesting a Reconsideration of Medicare Prescription Drug Denial, and - Notice that a request for standard redetermination concerning the drug benefit case is forwarded to the IRE. However, AHC is unable to provide these notice templates. CMS also reviewed three sample cases from worksheet WS-RE1_D and found that in two cases, AHC did not effectuate the decision and notify the member in a timely manner.

Corrective Action Required:

AHC must revise its policies and procedures entitled Failure to Meet Timeframes (Standard and Expedited Redeterminations) (3006.pdf) to include the required provision. AHC 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. AHC must also provide the required CMS-approved notice templates. If AHC does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. AHC must conduct training of appropriate staff on the timely notification and effectuation of standard redeterminations concerning covered drug benefits (e.g., as expeditiously as as the enrollee's health condition requires, but no later than 7 calendar days from the date it received the request). AHC must 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 may later request that AHC resubmit case files that demonstrate that it is in compliance with this requirement.

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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
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Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed AHC¿s policies and procedures and found that they do not include a provision to inform the enrollee, within 24 hours, when his/her standard redetermination concerning payment is forwarded to the IRE due to AHC's failure to notify the enrollee of a decision within the required timeframe. CMS also requested the following CMS-approved notice templates: - Notice of an adverse standard redetermination concerning payment, - Request for a Reconsideration of Medicare Prescription Drug Denial, and - Notice that a request for standard redetermination concerning payment is forwarded to the IRE. However, AHC is unable to provide these notice templates.

Corrective Action Required:

AHC must revise its policies and procedures entitled Failure to Meet Timeframes (Standard and Expedited Redeterminations) (3006.pdf) to include the required provision. AHC 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. AHC must provide CMS the required CMS-approved notice templates. If AHC does not have notice templates that have been approved by CMS, then it must submit them 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed AHC's policies and procedures and found that they do not include a provision to inform the enrollee, within 24 hours, when his/her expedited redetermination case is forwarded to the IRE due to AHC's failure to notify the enrollee of a decision within the required timeframe. CMS also requested the following CMS-approved notice templates: - Notice of an adverse expedited redetermination, - Request for a Reconsideration of Medicare Prescription Drug Denial, and - Notice that an expedited redetermination case is forwarded to the IRE. However, AHC is unable to provide the notice templates.

Corrective Action Required:

AHC must revise its policies and procedures entitled Failure to Meet Timeframes (Standard and Expedited Redeterminations) (3006.pdf) to state that it must inform the enrollee, within 24 hours, when his/her expedited redetermination case is forwarded to the IRE due to AHC's failure to notify the enrollee of a decision within the required timeframe. AHC 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. AHC must also provide the required CMS-approved notice templates. If AHC does not have notice templates that have been approved by CMS, then it must submit them 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS reviewed one sample cases from worksheet WS-RE1_D and found that it did not contain the names of individuals involved in making the determination and redetermination decision.

Corrective Action Required:

AHC must provide documentation that demonstrates that it uses appropriate personnel to conduct redeterminations. AHC 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, AHC must ensure that 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. CMS may request additional sample cases to determine that AHC is in compliance with this requirement.

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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS requested its CMS-approved notice template for notifying the IRE of its effectuation of a decision reversing a determination on a request for drug benefit, but AHC us unable to provide it.

Corrective Action Required:

AHC must provide CMS with the required CMS-approved notice template. If AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS requested a CMS-approved notice template for notifying the IRE of its effectuation of a decision reversing a determination on a request for payment, but AHC is unable to provide it.

Corrective Action Required:

AHC must provide CMS with the required CMS-approved notice template. If AHC 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: 81
Contract Number: H1034
Part D Sponsor Name: AMERICA'S HEALTH CHOICE MEDICAL PLAN

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/13/2007
Date Report Due: 4/27/2007
Element Accepted Date: 9/26/2007
Element Release Date: 9/26/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/29/2007
Estimated Visit Start Date: 2/2/2007
Actual Visit Start Date: 1/29/2007
Actual Visit End Date: 2/2/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/27/2007
CAP Release Date: 9/26/2007
CAP Accepted Date: 9/26/2007

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:

AHC does not meet this requirement because CMS requested a CMS-approved notice template for notifying the IRE of its effectuation of a decision reversing an expedited determination or expedited redetermination for drug benefit. However, AHC is unable to provide this notice.

Corrective Action Required:

AHC stated that it did not have any third party reversals of cases of expedited determination or expedited redetermination for benefits during the audit period. Therefore, there are no cases for worksheet WS-RE3_D that apply to this element.