CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5433
Audit ID: 441
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/10/2007
Element Release Date: 10/10/2007
Element Projected Completion Date: 10/4/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement. CMS reviewed policies and procedures and personnel documents associated with marketing representatives and the following deficiencies were identified for this element. 1. There is no policy and procedure for monitoring sales and marketing activities of sales reps. (As of the date of the site visit, OneCare is only using internal sales representatives.) In a crosswalk document prepared for CMS as part of the monitoring audit, the plan indicates that it evaluates sales reps on a monthly basis for the first six months of employment and then quarterly thereafter. However, this process was not documented in the plan¿s internal policies and procedures. 2. It is not documented that the plan has designated an individual to be responsible for overseeing the activities of sales reps. 3. It was not documented anywhere that sales reps provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment that states the following: ¿The person who is discussing plan options with you is either employed by or contracted with CalOptima. The person may be compensated based on your enrollment in the plan.¿ 4. There was no documentation confirming that sales reps are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. 5. Of the plan¿s six internal sales reps, there was no documentation confirming a contractual arrangement between the health plan and the marketing representative, nor was there a compensation structure for five of them. The plan explained that they were hired into the sales position from a previous position within the company, and the compensation arrangement was provided verbally. Of the one sales rep who was given a contract or employment agreement, it was not provided to CMS for review, despite several requests for it. 6. The individual sales reps¿ files did not include adequate documentation of training, oversight, and performance data. For example, for all six sales reps, the only documentation of training was a sign-in sheet for one training session held in late August 2006, and a signed letter of receipt stating that the sales rep received a copy of the Medicare Marketing Guidelines and will abide by them. However, for the latter all letters of receipt were signed and dated in late March 2007, just prior to the site visit, even though all sales reps had been hired in previous months. Also, despite the fact that the crosswalk of sales oversight activities (see #1 above) indicates that sales reps will be evaluated monthly for the first six months of employment and then quarterly thereafter, most sales rep files did not include documentation of all of those reviews.

Corrective Action Required:

1. CalOptima must develop and implement a policy and procedure (P and P) that defines the oversight and monitoring process of sales and marketing activities of sales reps. The P and P should address how sales reps will be trained, both initially and on an ongoing basis, how their sales activities will be monitored, by whom, and at what frequency, what performance data will be collected, by whom, how frequently, and how that data will be used and communicated to the sales rep, and what actions will be implemented for perceived sales and marketing abuses. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. 2. Indicate in the P and P for overseeing sales reps who is responsible for those oversight activities. 3. Include in the P and P for overseeing sales reps that they must provide the required written disclosure to members. 4. Develop and implement a P and P that ensures sales reps are providing potential enrollees with the required written disclosure statement. 5. Develop a contract with a compensation structure for all sales reps that indicates the following: ¿ A contractual relationship exists between the Medicare Advantage plan and the sales rep. ¿ That the compensation is in line with industry standards. ¿ That the incentive structure is in compliance with CMS requirements. ¿ That sales reps are prohibited from offering payment as a condition of enrollment. ¿ That there is a provision for withholding pay for rapid disenrollment (i.e., chargebacks). ¿ That there is a provision for the required written disclosure statement to be provided to potential enrollees. 6. Develop a process to ensure that sales reps files contain documentation of all training, oversight, and monitoring activities. 7. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/15/2007
Element Release Date: 10/15/2007
Element Projected Completion Date: 10/4/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because CMS reviewed nine cases from a universe of nine and found nine cases where the notice of formulary change, an Explanation of Benefits, did not indicate the effective date of the formulary change(s). Because the date of formulary change was not indicated in the notice, it was not possible to determine whether the notices were sent timely to members, nor would members know when the formulary change would become effective. Also, for one of the nine cases, no notice (EOB) was sent to the member. EOBs are sent on a monthly basis for members who receive prescription drugs that month. However, one member in the sample did not receive any drugs during the month in which the EOB included notification of a formulary change, so that member did not receive any notification from the plan of the change.

Corrective Action Required:

CalOptima must develop a process to ensure that EOBs clearly indicate the effective date of the formulary change. Also, an alternate process must be developed to inform members of a formulary change when no EOB will be sent to such members in a given month because they have not received prescription drugs that month. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.

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

Findings: Not Met
Audit ID: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
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Element Accepted Date: 12/12/2007
Element Release Date: 12/12/2007
Element Projected Completion Date: 11/8/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because it did not provide evidence that it has arranged 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. The pharmacy benefit management services agreement does not contain a provision specifying this. Also, we could not determine whether CalOptima¿s network pharmacies meet this requirement because the audits of the contracted pharmacies, which are outsourced by the plan, did not contain a provision to check for this requirement.

Corrective Action Required:

Submit documentation that demonstrates that network pharmacies are responsible for posting or distributing 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. Also provide evidence that network pharmacies are aware of this requirement. Finally, revise the contract with your pharmacy audit contractor to ensure this provision is included in the audit protocol.

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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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
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Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because neither P and P MA.6101 nor MA.6102 indicate that the plan tracks requests for coverage determinations. Although the plan did provide a Part D grievance log, it was verbally explained to me that this log included appeals and grievances. It does not include coverage determinations or requests for exceptions.

Corrective Action Required:

Develop policies and procedures that track requests, both oral and written, for Part D coverage determinations. The process should track, at a minimum, the date of receipt, the date of notification, the disposition of the request, and the date the disposition was made. Conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.

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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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement. CMS reviewed ten cases from a universe of 2362, but one of the ten cases was misclassified. Of the nine Part D benefit coverage determination cases correctly classified, CalOptima decided favorably for all of them, thus requiring only oral notification to the member. The health plan did not document, however, the date and time the member was notified orally of the Part D coverage determination and therefore it cannot be determined whether members were notified timely of the decision. Policy and Procedure MA.6101 does not indicate that if the request was denied and initial notification was made orally, then the plan is required to send written notification within 3 calendar days of the oral notification. Policy and Procedure MA.6101 does not indicate that if the health plan fails to provide notification within 72 hours of receipt of the request, it constitutes an adverse coverage determination that must be forwarded to the Independent Review Entity within 24 hours of the expiration of the adjudication timeframe.

Corrective Action Required:

Modify your Part D coverage determination process to include: ¿ documentation of the date and time the member was verbally notified of a favorable decision. ¿ documentation of the date and time of verbal and written notification of an adverse decision. ¿ a process for forwarding the case to the Independent Review Entity within 24 hours after the expiration of the adjudication timeframe, when the health plan fails to provide notification within 72 hours of receipt of the request. Conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because CMS reviewed CalOptima¿s policies and procedure (MA.6101) and found it does not include provisions stating: ¿ that the health plan 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. ¿ that the health plan must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician¿s supporting statement. ¿ that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the health plan to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. In addition, CalOptima does not meet this requirement because CMS reviewed 10 cases, from a universe of 12 cases, and the following deficiencies were found: ¿ Of the 10 cases reviewed, in 7 cases the enrollee was notified by the plan of their determination more than 72 hours after receipt of the enrollee¿s request for payment. ¿ Of the 10 cases reviewed, two of the cases resulted in a partially adverse decision. In one case, the member was requesting reimbursement of the $590.23 she paid out of pocket for her prescriptions. The plan submitted documentation that she was reimbursed only $406.75 Even with the deduction of the enrollee¿s copayments, this was a partial adverse determination because she should have been reimbursed a higher amount. In another case, the enrollee was requesting reimbursement for two prescriptions she paid out of pocket. The plan¿s contracting pharmacy paid for one, but denied the other one as the member had received a refill on that prescription four days prior. In neither of these two denied requests did the plan follow up the oral notification with a written notice to the enrollee informing him/her of the denial. ¿ If the health plan fails to notify the enrollee within 72 hours after receipt of the enrollee¿s request, it constitutes an adverse coverage determination requiring the health plan to forward the case to the IRE. The health plan did not forward any of the 7 cases in which no decision had been made within 72 hours of receipt of the request to the IRE. ¿ Because none of the 7 cases that should have been forwarded to the IRE were forwarded, the plan did not notify those enrollees that their request had been forwarded to the IRE.

Corrective Action Required:

CalOptima must revise its policies and procedures to include provisions stating: ¿ that the health plan 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. ¿ that the health plan must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician¿s supporting statement. ¿ that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the health plan to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.

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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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD05
Audit Type: Routine
Audit Location: Onsite
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Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet the CMS compliance standard because CMS reviewed 10 cases of coverage determination requests for payment from a universe of 12, and found 2 cases where CalOptima made an adverse coverage determination regarding payment and failed to provide written notice to the enrollee.

Corrective Action Required:

CalOptima must notify enrollees of an adverse coverage determination decision using a CMS-approved notice, and provide documentation of this to CMS.

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Date Report Generated: 9/30/2008

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

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Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
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Element Accepted Date: 10/10/2007
Element Release Date: 10/10/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because CMS reviewed their policies and procedures and found that MA.6101 indicates that requests for expedited coverage determinations should be submitted orally or in writing to the OneCare Customer Service Department, but does not include a phone or fax number. Also, MA.6101 does not address means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours.

Corrective Action Required:

Revise MA.6101 to include a phone and fax number for submission of expedited coverage determination requests.

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

Findings: Not Met
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Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
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Audit Type: Routine
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because the notice provided to us with the expedited organization determination policy and procedure is for a request for an expedited reconsideration, not an expedited organization determination. No notice was provided for an expedited organization determination.

Corrective Action Required:

Submit for review a notice that notifies the enrollee that a request for an expedited coverage determination is denied. It should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).

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

Findings: Not Met
Audit ID: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 9/6/2007
Element Release Date: 9/6/2007
Element Projected Completion Date: 7/30/2007

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CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement. CMS reviewed 10 cases out of a universe of 907, and found two cases were misclassified, leaving a sample size of eight. Of the eight correctly categorized cases, none of them met this requirement. CalOptima was unable to provide documentation of when and how the member was notified of the expedited coverage determination. Therefore, it cannot be determined that any of the cases were processed timely (i.e., the member was notified no later than 24 hours after their request was received). Because the reviewer could not determine whether the members were notified within 24 hours of receipt of their request, it is possible that some or all of the eight members whose cases were reviewed were notified more than 24 hours after their request was received. In this case, the plan should have considered these adverse determinations and should have forwarded them to the IRE within 24 hours of the expiration of the adjudication timeframe (i.e., within 48 hours of receipt of the request). In addition, if any of the cases fell into this category, the plan should have notified those members that their request was being forwarded to the IRE.

Corrective Action Required:

Revise MA.6101 to include the following: ¿ a process to ensure that the date and time the member is notified of your decision is documented. ¿ a process to ensure that a decision is made and communicated to the member within 24 hours of receipt of the member¿s request. ¿ a process to ensure that if the decision is adverse and the member is notified orally within 24 hours of receipt of the request, the oral notification is followed by a written notification to the member within 3 calendar days of the oral notification. ¿ a process to ensure that if no decision is made and communicated to the member within 24 hours of receipt of their request, the request is forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe (i.e., within 48 hours of receipt of the request). ¿ a process to ensure that if the case is forwarded to the IRE, the member is notified of this action within 24 hours of the expiration of the adjudication timeframe (i.e., within 48 hours of receipt of the request). Also, conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/10/2007
Element Release Date: 10/10/2007
Element Projected Completion Date: 10/4/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because CMS reviewed CalOptima¿s policies and procedures and found they do not include a provision clearly stating that: ¿ the prescribing physician¿s statement must indicate that the preferred drug for the treatment of the enrollee¿s condition (1) would not be effective as the requested drug and/or (2) would have adverse effects. ¿ the prescribing physician is required to demonstrate in its written statement one of the two factors discussed in the bullet point above. ¿ if the Sponsor makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted (i.e., (1) or (2) above). ¿ the Sponsor must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. ¿ if the Sponsor is waiting on a physician¿s statement in support of a tiering exception request, the Sponsor 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. ¿ a Part D sponsor 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. ¿ the Sponsor does not restrict the number of exception requests submitted per enrollee. In addition, CalOptima does not have a notice consistent with the CMS-issued standard notice, Request for Additional Information. It has what appears to be a fax cover sheet that gives the ¿PATH ID#¿ , the patient name, the patient OneCare ID#, and says ¿Additional Information Needed: Deferred by OneCare for Medical Justification Supporting Statement.¿

Corrective Action Required:

CalOptima must develop and implement policies and procedures that include the provisions described above. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained. CalOptima must develop a notice consistent with the CMS-issued standard notice, Request for Additional Information. It should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/10/2007
Element Release Date: 10/10/2007
Element Projected Completion Date: 7/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because CMS reviewed CalOptima¿s policies and procedures and found that they do not include provisions stating that: ¿ the prescribing physician¿s statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects. (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee¿s disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug¿s effectiveness or patient compliance, or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee¿s disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug¿s effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. Instead, CalOptima¿s current policy and procedure lists the following as criteria used to grant non-formulary exceptions: safety, efficacy, essential need, misuse potential, and cost. ¿ if the Sponsor makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. ¿ the Sponsor must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. ¿ if the Sponsor is waiting on a physician¿s statement in support of a formulary exception request, the Sponsor must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. ¿ the Part D sponsor must grant a formulary exception when it determines that one of the three factors discussed in Step 1B has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug.

Corrective Action Required:

CalOptima must develop and implement policies and procedures that include the provisions described above. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 12/12/2007
Element Release Date: 12/12/2007
Element Projected Completion Date: 11/8/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CalOptima does not meet the CMS compliance standard because CMS audited seven cases from a universe of seven and for all seven cases, the member was not informed whether the complaint is subject to the grievance or coverage determination procedures. Also, neither the plan¿s policy and procedure, MA.6102, nor the template grievance notices indicated to the member which category their complaint fell into.

Corrective Action Required:

CalOptima must revise its policies and procedures and its template grievance notice to inform members of which category¿grievance or coverage determination¿their complaint falls into. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 9/7/2007
Element Release Date: 9/7/2007
Element Projected Completion Date: 7/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement. CalOptima¿s P and P MA.6102, the Part D grievance and coverage determination policy and procedure, does not include a provision for accepting information or evidence concerning the grievance. It does not contain a requirement for transmitting grievances to appropriate decision-making levels when appropriate and in a timely fashion. It also does not include a provision for quarterly reporting of all data requested in Reporting Requirements, Section V: Grievances.

Corrective Action Required:

Revise P and P MA.6102 to include the missing requirements described in the finding for GV02. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/29/2007
Element Release Date: 10/29/2007
Element Projected Completion Date: 10/29/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because they did not provide a template notice consistent with the CMS-issued model notice, Notice of Plan¿s Decision to Extend the Deadline for Making a Decision Regarding a Grievance.

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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/15/2007
Element Release Date: 10/15/2007
Element Projected Completion Date: 10/4/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because their grievance resolution letter is missing the required description of the enrollee¿s right to file a written complaint with the QIO.

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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 9/10/2007
Element Release Date: 9/10/2007
Element Projected Completion Date: 7/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because CMS reviewed CalOptima¿s policies and procedures and found that they do not include provisions for: ¿ maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. Instead, MA.6102 states ¿CalOptima shall establish an efficient and convenient means for individuals to submit oral and written requests, document all oral requests in writing, and maintain the documentation in the case file.¿ It does not describe what this process actually is. ¿ naming a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals. P and P MA.6102 does not include telephone or fax numbers.

Corrective Action Required:

CalOptima must revise its policies and procedures to include the provisions described above. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/17/2007
Element Release Date: 10/17/2007
Element Projected Completion Date: 10/4/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because CMS reviewed CalOptima¿s policies and procedures and found that they do not include provisions stating that the health plan must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Also, CalOptima did not provide us with a template notice consistent with the CMS-issued model notice, Request for Reconsideration.

Corrective Action Required:

CalOptima must revise its policies and procedures to include a process for the health plan to inform the enrollee within 24 hours that their reconsideration request has been forwarded to the IRE. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained. CalOptima must develop a notice consistent with the CMS-issued standard notice, Request for Reconsideration. It should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/17/2007
Element Release Date: 10/17/2007
Element Projected Completion Date: 10/4/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because CMS reviewed CalOptima¿s policies and procedures and found that they do not state that for redeterminations favorable to the enrollee, the Part D sponsor must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. MA.6102 says that it will issue a redetermination of a request for payment no later than 7 calendar days from the date of receipt of the request. It does not say it authorizes payment within 7 calendar days, and it doesn¿t say it will actually make payment within 30 days. CMS also found that the policies and procedures do not include a provision that states that CalOptima must inform the enrollee, within 24 hours, when the case is forwarded to the IRE.

Corrective Action Required:

CalOptima must revise its policies and procedures to address the deficiencies described above. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/17/2007
Element Release Date: 10/17/2007
Element Projected Completion Date: 10/4/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement. CMS reviewed three cases out of a universe of three (the universe originally provided by CalOptima was two, but in the course of the review, CMS found that one expedited request had been misclassified in the standard redetermination universe). The health plan determined that the third case did not meet the criteria to be handled as an expedited case and transferred the case to the standard redetermination process. Of the two remaining cases, one was non-compliant. Although the redetermination decision was favorable to the member, it was made five days after the request was received. Because CalOptima failed to notify the member of its decision within 72 hours of receipt of the request, it should have forwarded the case to the IRE, but it did not. CMS reviewed CalOptima¿s policies and procedures and found that they do not include provisions indicating that: ¿ notification of a favorable decision may be made orally or in writing. ¿ initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification. ¿ medical information must be requested within 24 hours of the enrollee¿s initial request. ¿ the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE.

Corrective Action Required:

CalOptima must revise its policies and procedures to address the deficiencies described above, both those discovered through the sample case review as well as review of the policies and procedures. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE08
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 10/17/2007
Element Release Date: 10/17/2007
Element Projected Completion Date: 10/4/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CalOptima does not meet this requirement. CMS reviewed three cases out of a universe of three (the same universe as for RE07). Of the two cases processed as expedited cases, one of them was not processed timely. CalOptima did not provide the requested drug until five days after receipt of the enrollee¿s request.

Corrective Action Required:

CalOptima must develop a process to ensure that when it reverses, in whole or in part, its coverage determination based on an expedited request for Part D benefits, it authorizes or provides the benefit as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date it receives the enrollee¿s request.

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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 9/10/2007
Element Release Date: 9/10/2007
Element Projected Completion Date: 7/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CalOptima does not meet this requirement because CMS reviewed CalOptima¿s policies and procedures and found that they do not state that case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file.

Corrective Action Required:

CalOptima must revise its policies and procedures to state that case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office 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: 441
Contract Number: H5433
Part D Sponsor Name: ORANGE COUNTY HEALTH AUTHORITY

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 6/21/2007
Date Report Due: 8/5/2007
Element Accepted Date: 9/10/2007
Element Release Date: 9/10/2007
Element Projected Completion Date: 7/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 5/7/2007
Actual Visit End Date: 5/8/2007
Part D Sponsor Response Received Date: 11/14/2007
Part D Sponsor Response Due Date: 8/5/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

CalOptima does not meet this requirement because CMS reviewed CalOptima¿s policies and procedures and found that they do not require a notice to be sent informing the IRE of effectuation of the decision. MA.6102 states that CalOptima will ¿inform¿ the IRE that they¿ve effectuated the decision, but it is not clear that the plan provides an actual notice. It could imply verbal notification.

Corrective Action Required:

CalOptima must revise its policies and procedures to require that an actual notice is sent to the IRE informing them of the effectuation of the IRE¿s decision. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.