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: H4407
Audit ID: 361
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PC02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/23/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found that they do not include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H4407
Audit ID: 361
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/23/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and they do not include the following provisions: - to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to 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, and - to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring does not meet the CMS compliance standard because 1 out of the 10 cases provided for beneficiaries affected by a formulary maintenance change from a universe of 2,445 were misclassified and, to account for this, the auditor reduced the sample size by 1 and made the sample size 9. CMS reviewed the 9 cases and found 5 cases were lacking an effective date of change on the EOB provided to the beneficiary.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include the following provisions: - to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to 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, and - to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring 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. HealthSpring must include an effective date of change on every EOB in order to meet CMS requirements.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
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Element Accepted Date: 11/8/2007
Element Release Date: 11/8/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's Notice of Formulary Changes policies and procedures and found they do not contain the following: - a provision for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, - a provision with a description of the procedures for providing a notice of "maintenance" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing a notice of "other" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements.

Corrective Action Required:

HealthSpring must revise its policies and procedures to contain the following provisions: - a provision for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, - a provision with a description of the procedures for providing a notice of "maintenance" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing a notice of "other" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

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: 4/27/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS has reviewed HealthSpring's policies and procedures and they do not include the following: - requirements for addressing the immediate needs of 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, HealthSpring did not submit system reports regarding its transition process utilization for LTC residents to verify that HealthSpring correctly implements the transition process for LTC residents, as described in its policies and procedures and consistent with its contractual requirements. HealthSpring also did not submit system reports regarding its transition process utilization for LTC residents to verify that HealthSpring has and implements a transition process that covers an emergency supply or "first-fill" of non-formulary Part D drugs.

Corrective Action Required:

HealthSpring must revise its Transition Process policies and procedures to include requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and to include a provision to abide by extensions to the transition period in accordance with CMS policy. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must develop a system to track and provide reports regarding HealthSpring's transition process utilization for LTC residents. This documentation must demonstrate to CMS that HealthSpring correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements, as well as the ability to document that HealthSpring has and implements a transition process that covers an emergency supply or "first fill" of non-formulary Part D drugs.

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

Findings: Not Met
Audit ID: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. HealthSpring was unable to produce documentation demonstrating that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. HealthSpring provided a memo from its PBM (Argus), which stated, "During 2006, on-site audits did not include the review of posting of certain notices."

Corrective Action Required:

HealthSpring must revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. HealthSpring must demonstrate 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. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
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Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations (CD02PP) and found they do not include the following: - provisions for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing, and -a provision stating that individuals who can request a standard or expedited coverage determination are (1) the enrollee, (2) the enrollee¿s appointed representative, on behalf of the enrollee, and (3) the prescribing physician, on behalf of the enrollee.

Corrective Action Required:

HealthSpring must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations to include a provision for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. HealthSpring also must revise its policies and procedures to include a provision stating that individuals who can request a standard or expedited coverage determination are (1) the enrollee, (2) the enrollee's appointed representative, on behalf of the enrollee, and (3) the prescribing physician, on behalf of the enrollee. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
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Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 9/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not contain a provision stating that HealthSpring 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.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include a provision stating that the 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. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 11/8/2007
Element Release Date: 11/8/2007
Element Projected Completion Date: 11/6/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS requested HealthSpring's policies and procedures regarding coverage determinations concerning payment, and HealthSpring was unable to provide these policies and procedures. CMS reviewed 10 requests for standard coverage determinations concerning payments cases from a universe of 46 and found 10 cases that did not contain evidence that the enrollee was ever notified, either orally or in writing, of the disposition of the coverage determination request, or that the case was forwarded to the IRE and the enrollee was notified of the forwarding.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include provisions that address the following requirements regarding coverage determinations concerning payment: (1) HealthSpring 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, (2) HealthSpring 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, (3) and HealthSpring 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. HealthSpring must ensure that all enrollees are provided with written notification of its decision regarding standard coverage determinations concerning payment within the CMS approved timeframe. If HealthSpring fails to make the coverage determination within the CMS-approved timeframe, it must ensure that it forwards the request to the IRE within the CMS-approved timeframe and timely notifies the enrollee that his or her request has been forwarded. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

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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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or other applicable party). CMS reviewed 5 requests for standard coverage determinations concerning drug benefits samples out of a universe of 3610 and found that 5 cases were deficient because the written notice provided to the enrollee did not contain a CMS approval number. CMS reviewed 4 requests for standard coverage determinations concerning payments samples out of a universe of 24 and found that 2 cases did not demonstrate that oral or written notice was provided to enrollee, and 2 cases did not include any supporting documentation.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or other applicable party). HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring 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 the audit. HealthSpring must ensure that enrollees are provided with a denial notice, when appropriate, and that this is documented. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

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

Findings: Not Met
Audit ID: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
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CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found that they do not: - discuss means for issuing prompt decisions on expediting determinations in accordance with CMS requirements. HealthSpring must grant a request for an expedited 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. - include the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations, and - discuss means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours.

Corrective Action Required:

HealthSpring must revise its policies and procedures to develop a process for issuing prompt decisions on expedited determinations in accordance with CMS requirements. The policy should state that HealthSpring must grant a request for an expedited 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. HealthSpring must revise its policies and procedures to include the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations. HealthSpring must revise its policies and procedures to include a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

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: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 9/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not include a provision for timeliness of expedited coverage determination denial notification in accordance with CMS requirements, including: automatically transferring the request to the standard coverage determination process and giving the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently delivering (i.e., mailing) to the enrollee, within 3 calendar days, written notice.

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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

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: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 11/8/2007
Element Release Date: 11/8/2007
Element Projected Completion Date: 11/6/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not include the following provisions: - oral and written notice must provide an explanation that HealthSpring must process the request using the 72 hour timeframe for standard determinations, - oral and written notice must inform the enrollee of the right to file an expedited grievance, - oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and -oral and written notice must provide instructions about HealthSpring's grievance process and its timeframes

Corrective Action Required:

HealthSpring must revise its policies and procedures to include the following provisions: oral and written notice must provide an explanation that HealthSpring must process the request using the 72 hour timeframe for standard determinations, oral and written notice must inform the enrollee of the right to file an expedited grievance, oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and oral and written notice must provide instructions about HealthSpring's grievance process and its timeframes. HealthSpring must provide CMS with a CMS-approved notice, Notice of Right to an Expedited Grievance. If HealthSpring 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. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 9/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not include the following provisions: - stating that if a decision is adverse and HealthSpring first notifies the enrollee of the determination orally, HealthSpring must mail written confirmation to the enrollee within 3 calendar days of the oral notification, and - to inform the enrollee, within 24 hours, when his or her case is forwarded to the IRE.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include a provision stating that if a decision is adverse and HealthSpring first notifies the enrollee of the determination orally, HealthSpring must mail written confirmation to the enrollee within 3 calendar days of the oral notification. HealthSpring must revise its policies and procedures to include a provision to inform the enrollee, within 24 hours, when his or her case is forwarded to the IRE. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 9/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures found they do not include the following provisions: - stating that if the decision is adverse, then HealthSpring must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and -stating that if oral notice is provided for adverse decision, the notice must satisfy the following requirements: (1) states the specific reason for the denial and takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, (2) provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and (3) provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. One out of the 10 cases provided from a universe of 392 was misclassified and, to account for this, the auditor reduced the sample size by 1 and made the sample size 9. CMS reviewed the 9 cases and found that 2 cases did not demonstrate that HealthSpring uses a notice that is CMS approved.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. HealthSpring must revise its policies and procedures to include a provision stating that if oral notice is provided for the adverse decision, the notice must satisfy the following requirements: (1) states the specific reason for the denial and takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, (2) provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and (3) provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring 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. HealthSpring 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. HealthSpring must demonstrate to CMS that it uses the correct notice when an enrollee¿s request is denied.

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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

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: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 9/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not include the following provisions for processing requests for exceptions to its tiered cost-sharing structure: - stating that an enrollee, an enrollee's appointed representative, or an enrollee¿s prescribing physician is permitted to file a request for a tiering exception, - stating if it requires a written statement from the enrollee's prescribing physician, it must make this request immediately, - stating that the prescribing physician's statement must indicate that the preferred drug wouldn't be as effective as the drug requested and/or would have adverse effects on the enrollee, - stating that the prescribing physician must demonstrate in the physician's written statement that either the preferred drug wouldn't be as effective as the requested drug OR that the preferred drug would have adverse effects, - requiring HealthSpring to clearly identify the types of additional documentation it is requesting if it does make a request for additional medical documentation, - requiring HealthSpring to wait at least 96 hours after receiving a standard request and 48 hours after receiving an expedited request for a physician's supporting statement before HealthSpring issues its determination on the tiering exception, - stating that HealthSpring will grant a tiering exception when it finds that the preferred drug would not be as effective at treating the enrollee's condition as the requested drug and/or would have adverse effects, - stating that HealthSpring must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and -stating that HealthSpring does not restrict the number of exception requests submitted per enrollee.

Corrective Action Required:

HealthSpring must develop policies and procedures regarding processing requests to its tiered cost-sharing structure that contain the required provisions. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 9/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not include the following provisions: - stating that an enrollee, an enrollee's appointment representative, or an enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception, - 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 HealthSpring'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 either 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 (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 - stating that if it makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - stating that if HealthSpring is waiting on a physician's statement in support of a formulary exception request, it must wait at least 96 hours after receiving a standard request or at least 48 hours after receiving an expedited request before issuing the determination on the formulary exception, - stating that HealthSpring must grant a formulary exception when it determines that one of the three factors discussed in the preceding paragraph has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, and - stating that HealthSpring must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - stating that HealthSpring does not restrict the number of exception requests submitted per enrollee.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include the required provisions regarding processing requests for exceptions for non-formulary drugs. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date: 9/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not include the following provisions: - stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, - stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and - stating that all approved non-formulary drugs must be placed in existing cost-sharing tier(s). CMS reviewed HealthSpring sample documentation. For five out of five samples that were approvals for a non-formulary drug, documentation provided did not demonstrate that, when HealthSpring approves non-formulary drug exceptions, it places the drug in an existing cost-sharing tier.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include provisions stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and all approved non-formulary drugs must be placed in existing cost-sharing tier(s). HealthSpring must provide documentation to CMS that it places all approved non-formulary drugs in existing cost-sharing tiers, in order to demonstrate compliance with this CMS-requirement. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 9/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS requested HealthSpring's CMS-issued notice template, Notice of Inquiry Regarding an Excluded Drug, and HealthSpring was unable to provide this notice template. One out of the 15 standard grievances cases provided from a universe of 988 was misclassified and, to account for this, the auditor reduced the sample size by 1 and made the sample size 14. CMS reviewed the 14 cases and found 14 cases did not demonstrate that enrollees were notified of whether their complaint was subject to grievance or coverage determination procedures. As a result, HealthSpring did not demonstrate compliance with the case categorization process.

Corrective Action Required:

HealthSpring must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. If HealthSpring 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. HealthSpring must document and notify enrollees of whether their complaint is subject to grievance or coverage determination processes, per CMS requirements. HealthSpring 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.

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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 9/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS has reviewed HealthSpring's policies and procedures and found they do not include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. HealthSpring did not provide sufficient documentation to demonstrate that it has a system for logging enrollee's grievances in a centralized location and for tracking, at a minimum, the following information: date of receipt of the grievance, mode of receipt of grievance (i.e. fax, telephone, letter, etc.), person or entity that filed the grievance, subject of the grievance, disposition of the grievance, and the date the enrollee was notified of the disposition.

Corrective Action Required:

HealthSpring must revise its policies and procedures to ensure they include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. HealthSpring must revise its grievance tracking system to ensure that it captures and maintains the minimum information required: date of receipt of the grievance, mode of receipt of grievance, person or entity that filed the grievance, subject of the grievance, disposition of the grievance, and the date the enrollee was notified of the disposition, and provide CMS with documentation to demonstrate this. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 11/14/2007
Element Release Date: 2/20/2008
Element Projected Completion Date: 11/6/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement. One out of the 15 standard grievances cases provided from a universe of 988 was misclassified and, to account for this, the auditor reduced the sample size by 1 and made the sample size 14. CMS reviewed the 14 cases and found 8 cases did not demonstrate that the issue was resolved and 6 cases did not demonstrate that enrollees were notified timely of grievance resolution.

Corrective Action Required:

HealthSpring must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances. HealthSpring must resolve enrollee grievances and do so within the timeframes specified by CMS.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 11/14/2007
Element Release Date: 2/20/2008
Element Projected Completion Date: 11/6/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement. One out of the 15 standard grievances cases provided from a universe of 988 was misclassified and, to account for this, the auditor reduced the sample size by 1 and made the sample size 14. CMS reviewed the 14 cases and found 4 cases did not demonstrate that the method of response to enrollees was correct.

Corrective Action Required:

HealthSpring must ensure it responds to enrollee grievances in accordance with CMS requirements and provide documentation of this to CMS.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 7/13/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring¿s policies and procedures and found they do not include the following provisions: - 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, and - the name of 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.

Corrective Action Required:

HealthSpring must revise its policies and procedures to 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, and the name of 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. HealthSpring 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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/23/2007
Element Release Date: 9/21/2007
Element Projected Completion Date: 7/13/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement. Two out of the 10 requests for standard redeterminations concerning drug benefits cases provided from a universe of 148 were misclassified and, to account for this, the auditor reduced the sample size by 2 and made the sample size 8. CMS reviewed the 8 cases and found that 2 cases did not demonstrate that HealthSpring uses the correct notices when an enrollee's request is denied.

Corrective Action Required:

HealthSpring must demonstrate that it uses the correct notices when an enrollee's request is denied.

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: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 8/29/2007
Element Release Date: 10/18/2007
Element Projected Completion Date: 7/13/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed HealthSpring's policies and procedures and found they do not include a provision indicating that notification of a favorable decision may be made orally or in writing.

Corrective Action Required:

HealthSpring must revise its policies and procedures to include a provision that indicates that notification of a favorable decision may be made orally or in writing. HealthSpring must document that it notifies enrollees of the expedited redetermination decision and request for medication information within the approved CMS timeframes, and provide this documentation to CMS. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 361
Contract Number: H4407
Part D Sponsor Name: HEALTHSPRING OF TENNESSEE, INC.

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: 4/27/2007
Date Report Due: 6/11/2007
Element Accepted Date: 11/8/2007
Element Release Date: 11/8/2007
Element Projected Completion Date: 11/6/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 2/21/2007
Estimated Visit Start Date: 2/26/2007
Actual Visit Start Date: 2/21/2007
Actual Visit End Date: 2/26/2007
Part D Sponsor Response Received Date: 2/20/2008
Part D Sponsor Response Due Date: 6/11/2007
CAP Release Date: 2/20/2008
CAP Accepted Date: 2/20/2008

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:

HealthSpring does not meet this requirement because CMS reviewed samples of requests for standard redeterminations concerning drug benefits and found that HealthSpring was unable to demonstrate that the person or persons involved in making the coverage determination were different from the person(s) involved in conducting the redetermination.

Corrective Action Required:

HealthSpring must provide documentation to CMS that demonstrates that it uses appropriate personnel to conduct redeterminations. HealthSpring 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, HealthSpring 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 HealthSpring is in compliance with this requirement.