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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) and did not find a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Additionally, WellCare's policies and procedure did not contain a provision stating that WellCare 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. On October 30, 2007 WellCare submitted the following statement: 'Every coverage determination made by WellCare takes into consideration the enrollee's health although not specifically stated in our P and Ps.' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. CMS reviewed WellCare's notice template for enrollee notification when a request is forwarded to the IRE and found the notice was consistent with CMS-issued model notice, Notice of Case Status. However, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. Additionally, CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefit from a universe of 10,741 and found 10 out of the 10 samples were not compliant. Specifically, 10 out of the 10 samples did not demonstrate that WellCare provided notification of the coverage determination decision to the enrollee. Failure to notify the enrollee of WellCare's decision within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the IRE within 24 hours of the adjudication timeframe. WellCare did not demonstrate that any of the 10 sample cases were forwarded to the IRE.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - WellCare 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. WellCare 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. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification of coverage determinations concerning payment (C7RX-041, C7RX-039, and C7RX-040) and found they did not include the following: - a provision stating that WellCare 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, - a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CMS reviewed WellCare's notice template for enrollee notification when a request is forwarded to the IRE and found the notice was consistent with CMS-issued model notice, Notice of Case Status. However, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: - a provision stating that WellCare 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, - a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare 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. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) and found this policy did not: -State that all oral requests must be documented in writing and that documentation of the request must be maintained in case file, and -Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Over 30% of samples provided for WS-CD3_D, Expedited Coverage Determinations, were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: - State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and - Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare 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. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.

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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
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Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because over 30% of samples provided for WS-CD3_D, Expedited Coverage Determinations, were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.

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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
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Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification following the decision to deny a request for an expedited coverage determination (C7RX-039) and found it did not include a provision stating that 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. CMS reviewed WellCare's notice template for enrollee notification when a request to expedite a coverage determination is denied and found the notice was consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance. However, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. Additionally, over 30% of samples provided for WS-CD3_D, Expedited Coverage Determinations, were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that 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. WellCare 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. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.

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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification following the decision on an expedited coverage determination (C7RX-039) and found it did not include: - a provision stating that WellCare must inform the enrollee, 'within 24 hours', when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe 'constitutes an adverse determination' requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks is missing. CMS reviewed WellCare's notice template for enrollee notification when a request is forwarded to the IRE and found the notice was consistent with CMS-issued model notice, Notice of Case Status. However, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. Additionally, over 30% of samples provided for WS-CD3_D, Expedited Coverage Determinations were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare 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. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.

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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification following the decision on an expedited coverage determination (C7RX-039) and found it did not include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - 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. Over 30% of samples provided for WS-CD3_D, Expedited Coverage Determinations, were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - 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. WellCare 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. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.

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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
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Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) and found it did not include provisions stating: - if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, and - WellCare 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. Additionally WellCare's policies and procedures do not include a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. On October 30, 2007 WellCare submitted the following statement: 'Although WellCare does not have a P and P that states that request cannot be left open indefinitely, WellCare follows the CMS guidelines in regard to exception processing requirements. No requests are kept open indefinitely. This can be confirmed in the universe supplied, as there are no open cases in the universe, indicating cases are not left open indefinitely.' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. Furthermore WellCare's policies and procedures do not include a provision stating that if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare 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. On October 30, 2007 WellCare submitted the following statement: 'WellCare did not have a policy on waiting 96 hours at the time of the audit review period. However, not withstanding, WellCare did operationally meet the CMS requirement timeframes. WellCare reaches out to the physician to obtain the necessary supporting documentation in order to meet the expedited or standard request timeframes.' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. CMS reviewed WellCare's notice template for requesting additional information from the enrollee's prescribing physician and found the notice was consistent with CMS-issued model notice, Request for Additional Information. However, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines.

Corrective Action Required:

WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost -sharing structure (C7RX-038) to include provisions stating: - if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, - WellCare 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, - WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare 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. WellCare 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. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) and found it did not include: - a provision 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. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. Additionally WellCare's policies and procedures do not include a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. On October 30, 2007 WellCare submitted the following statement: 'Although WellCare does not have a P and P that states that request cannot be left open indefinitely, WellCare follows the CMS guidelines in regard to exception processing requirements. No requests are kept open indefinitely. This can be confirmed in the universe supplied, as there are no open cases in the universe, indicating cases are not left open indefinitely.' Furthermore WellCare's policies and procedures do not include a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare 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. On October 30, 2007 WellCare submitted the following statement: 'WellCare did not have a policy on waiting 96 hours at the time of the audit review period. However, not withstanding, WellCare did operationally meet the CMS requirement timeframes. WellCare reaches out to the physician to obtain the necessary supporting documentation in order to meet the expedited or standard request timeframes.' In order to demonstrate compliance with CMS requirements these provisions must be included in written policies and procedures. CMS reviewed WellCare's notice template for requesting additional information from the enrollee's prescribing physician and found the notice was consistent with CMS-issued model notice, Request for Additional Information. However, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines.

Corrective Action Required:

WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision 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. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare 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. WellCare 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. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) and did not find a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year.

Corrective Action Required:

WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare 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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's notice template for informing enrollees about inquiries involving excluded drugs and found the notice was consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug, however, it did not display the contract number and CMS approval date in the lower left-hand corner in accordance with CMS Marketing guidelines. Additionally, WellCare stated that the notice provided was not yet CMS approved, as it was submitted for CMS approval in October 2007. CMS reviewed a sample of 15 standard grievances from a universe of 1003 and found 12 out of 15 samples were not compliant. Specifically, nine samples were incorrectly categorized as they were grievances unrelated to Part D. In one sample the enrollee was not informed whether their complaint was subject to grievance procedures. Additionally, two samples were incorrectly categorized and the enrollees were not informed whether their complaint was subject to grievance procedures. CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefits from a universe of 10,741. Seven out of the 10 samples were incorrectly categorized. These samples were requests for coverage/payment of office visits, not Part D coverage determinations. Over 30% of the samples submitted for WS-CD3_D, Expedited Coverage Determinations, were misclassified. The universe provided by WellCare is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), 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. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.

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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's notice template for informing enrollees of grievance deadline extension and found the notice was consistent with CMS-issued model notice, Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance, however, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. Additionally, CMS reviewed a sample of 15 standard grievance samples from a universe of 1003 and found in 7 samples WellCare did not demonstrate that grievance adjudication was compliant. Specifically, in 5 out of 15 sample cases WellCare did not demonstrate the issue was resolved. In one sample WellCare did not demonstrate that the enrollee was not notified of the grievance resolution within timeframes that are CMS compliant. In one sample WellCare did not demonstrate that the issue was resolved or that the enrollee was notified of the grievance resolution within timeframes that are CMS compliant

Corrective Action Required:

WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), 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. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare 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.

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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's notice template for notification of grievance disposition and found the notice was consistent with CMS-issued model notice, Notice of Plan's Decision Regarding a Grievance, however, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. Additionally, CMS reviewed samples of 15 standard grievances from a universe of 1003 and found that in 15 of the 15 samples WellCare notified enrollees of grievance resolution with notices that were not CMS compliant. Specifically, the notice did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines.

Corrective Action Required:

WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.

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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's notice template for notification of grievance disposition and found the notice was consistent with CMS-issued model notice, Notice of Plan's Decision Regarding a Grievance, however, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines.

Corrective Action Required:

WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.

Reference:

42 CFR § 423.584(d-e); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

WellCare does not meet this requirement because CMS reviewed WellCare's notice template for notifying an enrollee that a request for an expedited redetermination is denied and found the notice was consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance, however, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines

Corrective Action Required:

WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (C7RX-036) and found it does not include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, whn the case is forwarded to the IRE. During Staff Discussions, WellCare stated that it informs the enrollee within 24 hours when the case is forwarded to the IRE. Additionally, on October 30, 2007 WellCare submitted the following statement: 'Although this process is not documented in the P and P, the approved letter that WellCare sends to members is attached as an addendum. The Notice of Case Status letter states 'The law requires us to forward your case file to an independent review organization within 24 hours if the plan does not provide you with an answer within the required time frame.'' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. CMS requested WellCare's notice template for requesting a reconsideration and WellCare did not provide this notice template. CMS reviewed WellCare's notice template for notifying enrollees of an adverse standard redetermination and found the notice was consistent with CMS-issued model notice, Notice of Redetermination, however, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. CMS reviewed WellCare's notice template for enrollee notification when a request is forwarded to the IRE and found the notice was consistent with CMS-issued model notice, Notice of Case Status. However, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. Additionally, CMS reviewed a sample of 10 standard redetermination requests for drug benefit from a universe of 57 and found that one sample was misclassified, as it was a redetermination request for payment, and therefore the auditor reduced the sample size by one and made the sample size nine. The auditor reviewed the nine samples and found that four out of the nine samples were noncompliant. More specifically, one sample did not demonstrate that the enrollee was notified of the redetermination decision in a timeframe that is CMS compliant, nor did it demonstrate that the benefit requested was authorized or provided timely. Two samples in which the redetermination decision was adverse did not demonstrate the use of CMS compliant notices (specifically, Notice of Redetermination and Request for Reconsideration). Finally, one sample did not demonstrate that the enrollee was notified of the redetermination decision in a timeframe that is CMS compliant, nor did it demonstrate the use of CMS compliant notices (specifically, Notice of Redetermination and Request for Reconsideration), as it was an adverse decision.

Corrective Action Required:

WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare 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. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is adverse, WellCare must notify the enrollee using CMS compliant notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating 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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 1/16/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) and found it did not include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. During Staff Discussions, WellCare stated that it informs the enrollee within 24 hours when the case is forwarded to the IRE. Additionally, on October 30, 2007 WellCare submitted the following statement: 'Although this process is not documented in the P and P, the approved letter that WellCare sends to members is attached as an addendum. The Notice of Case Status letter states `The law requires us to forward your case file to an independent review organization within 24 hours if the plan does not provide you with an answer within the required time frame.'' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. CMS requested WellCare's notice template for requesting a reconsideration and WellCare did not provide this notice template. CMS reviewed WellCare's notice template for notifying enrollees of an adverse standard redetermination and found the notice was consistent with CMS-issued model notice, Notice of Redetermination, however, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. CMS reviewed WellCare's notice template for enrollee notification when a request is forwarded to the IRE and found the notice was consistent with CMS-issued model notice, Notice of Case Status. However, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. CMS reviewed eight samples of standard redetermination requests concerning payment from a universe of eight and found that 5 out of the 8 samples were not compliant. Specifically, 1 out of the 5 samples did not demonstrate that payment was authorized or provided within timeframes consistent with CMS requirements, while the remaining 4 samples did not demonstrate that WellCare used CMS-approved notices when informing enrollees of the denial decisions. In particular WellCare did not demonstrate the use of CMS-approved Notices of Redetermination and did not demonstrate the use of Request for Reconsideration notices.

Corrective Action Required:

WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare 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. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report
Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, 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: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed WellCare's policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) and found it did not include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. During Staff Discussions, WellCare stated that it informs the enrollee within 24 hours when the case is forwarded to the IRE. Additionally, on October 30, 2007 WellCare submitted the following statement: 'Although this process is not documented in the P and P, the approved letter that WellCare sends to members is attached as an addendum. The Notice of Case Status letter states 'The law requires us to forward your case file to an independent review organization within 24 hours if the plan does not provide you with an answer within the required time frame.'' In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures. CMS requested WellCare's notice template for requesting a reconsideration and WellCare did not provide this notice template. CMS reviewed WellCare's notice template for notifying enrollees of an adverse standard redetermination and found the notice was consistent with CMS-issued model notice, Notice of Redetermination, however, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. CMS reviewed WellCare's notice template for enrollee notification when a request is forwarded to the IRE and found the notice was consistent with CMS-issued model notice, Notice of Case Status. However, it did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. CMS reviewed a sample of 4 requests for expedited redeterminations from a universe of 4 and found that 2 out of 4 samples were noncompliant. Two out of these 2 samples did not demonstrate that WellCare used CMS-approved notices when informing the enrollee of an adverse decision. Specifically, WellCare did not provide a CMS-approved Notice of Redetermination and WellCare did not provide the Request for Reconsideration notices.

Corrective Action Required:

WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare 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. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating 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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

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:

WellCare does not meet this requirement because CMS reviewed a sample of 8 requests for standard redeterminations concerning payment from a universe of eight and found one sample was not compliant. One sample demonstrated that the enrollee filed a reconsideration request with the IRE. The documentation provided by WellCare did not demonstrate when the case file was forwarded to the IRE.

Corrective Action Required:

When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating 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: 3225
Contract Number: H1416
Part D Sponsor Name: HARMONY HEALTH PLAN OF ILLINOIS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 12/3/2007
Date Report Due: 1/17/2008
Element Accepted Date:
Element Release Date:
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 10/15/2007
Estimated Visit Start Date: 10/19/2007
Actual Visit Start Date: 10/15/2007
Actual Visit End Date: 10/19/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 1/17/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

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

Deficiencies:

WellCare does not meet this requirement because CMS reviewed a sample of eight requests for standard redeterminations concerning payment from a universe of 8 and found that in one out of 8 samples effectuation was not compliant because documentation did not demonstrate that payment was authorized timely. Additionally, WellCare was unable to demonstrate that the IRE was notified of the effectuation. On October 30, 2007 WellCare submitted the following statement: 'WellCare has developed a QA process and re-training program to ensure IRE effectuation and compliance. Quarterly and on an ad hoc basis, meetings are scheduled with Maximus to address such issues as timely effectuation of IRE decisions.' WellCare's QA process has been documented, however data provided from Maximus to CMS for the audit period of January 1, 2007 to June 30, 2007 does not demonstrate compliance.

Corrective Action Required:

WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.