CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PC02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures to determine compliance with this review element and found that the policy and procedures were missing the requirement to provide retrospective notice of a formulary change to authorized prescribers, network pharmacies, and phamacists if a covered Part D drug is removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer.

Corrective Action Required:

Health Choice must revise its policies and procedures to include the requirements noted in the deficiency above. On 6/6/2007, Health Choice submitted a revised policy and procedure dated 5/29/2007 that meets this requirement. No further corrective action is required.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/14/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, plan documentation demonstrating that the plan conducts ongoing monitoring of the marketing activities of internal and external marketing representatives, and a sample of contracts and/or compensation structures with sales representatives to determine compliance with the requirements with this review element. (A) Health Choice's policy and procedures were missing the following requirements: 1)those conducting marketing must provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, 2) all persons marketing on behalf of the Part D sponsor must be state licensed, certified, or registered, 3) a provision stating specifically that the Compliance Officer is responsible for overseeing marketing activities, and 4) how the plan will monitor brokers who are delegated oversight of agents. (B) Health Choice did not provide sufficient documentation to show that its marketing representatives are providing the required written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. (C) Health Choice does not meet the 95% compliance standard in the sample review. CMS audited 8 contracts from a universe of 13 and found 8 cases that did not include provisions 1) prohibiting payments by the agent who is performing marketing to beneficiaries, and 2) requiring the agent to provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment - specifically,"the person that is discussing plan options with you is either employed by or contracted with Health Choice Generations. The person may be compensated based on your enrollment in a plan."

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to include the requirements discussed above. (B) Health Choice 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. (C) Health Choice must revise its contracts with marketing representatives to include the missing provisions and provide a plan to monitor this requirement to prevent deficiencies in the future.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PH03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures and the Long Term Care Pharmacy to Nusing Bed Ratio Analysis to determine compliance with this review element. The policy and procedures were missing the requirement for oversight of the PBM to ensure that standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, are offered to any long-term care pharmacy in the plan's service area that requests the contract.

Corrective Action Required:

Health Choice must revise its policies and procedures to include the requirements discussed above. On 6/6/2007, the plan submitted a revised policy and procedure. However, this revision still does not include the requirement discussed above.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation demonstrating that the plan provides retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsale by the Food and Drug Administration or removed from the market by the manufacturer. CMS found the following: (A) Policy and procedures were missing requirements to 1) specifically address maintenance changes, other changes, and retrospective changes, and 2) mention notification of CMS, SPAPs, and other entities providing other prescription drug coverage, and (B) Health Choice did not submit sufficient documentation to demonstrate compliance with the requirement to provide retrospective notice to all affected parties if a covered Part D drug is deemed unsafe by the FDA or removed from the market by the manufacturer.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to include the requirements discussed above. (B) Health Choice must advise CMS of the actions it is taking to ensure that it notifies the appropriate entities of required changes, including the responsible party or parties and means of communicating the changes. On 6/6/2007, Health Choice submitted a revised policy and procedure which mentions retrospective changes, but Health Choice must revise it further to include a description of the procedures for providing notice of the maintenance changes, other changes, and retrospective changes. The revision now mentions notification of CMS, SPAPs, and other entities providing other prescription drug coverage.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: TP02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures and systems reports regarding the transition process for LTC residents to determine compliance with this requirements for this element and found the following: (A) The policy and procedures were missing the requirement to specifically address the immediate transition drug needs of LTC beneficiaries or to provide for an emergency supply of drugs beyond 90 days if an exception is being processed. Also, the Express Scripts policy incorrectly limits a temporary fill to maintenance drugs. (B) Health Choice did not submit adequate documentation (e.g., system reports of LTC drug utilization for individuals in the transition period) to demonstrate that it has correctly implemented the transition process for LTC residents and that it covers an emergency supply or "first-fill" of non-formulary Part D drugs to LTC residents.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures, that of Express Scripts, to include the requirements discussed above and implement system reports as described above. (B) Health Choice must describe the actions it is taking to demonstrate that it has implemented LTC transition procedures. (C) Health Choice must also conduct training of appropriate staff on these policies and procedures and system reports and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.

Reference:

42 CFR § 423.562(a)(3); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures, a template contract, a pharmacy notice, and plan documentation to determine compliance with this review element. CMS found that the policy and procedures were missing the requirement that the plan arrange with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice and for LTC facilities, to send the notice to the location in the LTC facility designated to accept such notices.

Corrective Action Required:

Health Choice must revise its policy and procedures to include these provisions, which it did and submitted on 6/6/2007. The revised policy and procedure meets these requirements, therefore, no further corrective action is required.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/14/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures and documentation demonstrating that the plan has the ability to track and address in a timely manner enrollees' oral and written requests for exceptions, coverage determinations, and redeterminations to determine compliance with this review element. CMS found the following: (A) Policies and procedures were missing the requirements to include 1) a provision to address basic coverage, supplemental benefits, and cost sharing, 2) a provision for tracking or addressing redeterminations, and 3) a provision for quarterly reporting of data requested in the "Reporting Requirements Section VII: Appeals." (B) Documentation demonstrating that the plan has the ability to track and address enrollee oral and written requests for exceptions, coverage determinations and redeterminations was incomplete. A member appeals log was not provided. While the Pharmacy Training Log submitted was evidently meant to track redeterminations, it does not include information for tracking the date of notification, disposition of request, or date of disposition.

Corrective Action Required:

(A) Health Choice must revise its policy and procedures to include the provisions noted above. On 6/6/2007, the plan submitted revised policies and procedures which include provisions in (A)(1) and (3) above. However, the revised policies and procedures still need further revision to address the tracking of redeterminations. (B) Health Choice needs to modify the tracking log now used to include all of the required elements described above. (C) Health Choice must conduct training of appropriate staff on these policies and procedures and use of the tracking log, 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 a list of individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/30/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.568(a); § 423.568(e); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures, a notice template for enrollee notification when a request is forwarded to the IRE, and a sample of standard coverage determination case files to determine compliance with this review element. Health Choice does not meet the CMS 95% compliance standard for the sample review. CMS audited 10 cases from a universe of 265 and found 8 cases in which the determinations were sent to the member late.

Corrective Action Required:

Health Choice must describe the steps it is taking to ensure that it notifies members of standard coverage determinations within the required timeframes. Corrective action must also include a description of Health Choice's plans for ongoing monitoring of its performance and training of appropriate staff on the process. For the later, submit documentation that details the nature of this training, including the materials used in the training, the individuals conducting the training, the names of individuals being trained and the date training is completed.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, a notice template, and a sample of coverage determination case files to determine compliance with this review element. The policy and procedures were missing the requirements to 1) provide notification to enrollees no later than 72 hours after receipt of the physician's supporting statement (if received separately), 2) address payment resulting from a coverage determination, and 3) describe the lack of timely determinations as adverse determinations.

Corrective Action Required:

Health Choice must revise its policies and procedures to include the missing provisions. On 6/6/2007, Health Choice submitted a revised policy and procedure that meets these requirements. No further corrective action is required.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/14/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.

Reference:

42 CFR § 423.570(c)(3); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures and a sample of expedited coverage determination case files to determine compliance with this review element. CMS found the following: (A) The policy and procedures did not include 1) a process for making decisions to approve or deny requests to expedite coverage determinations, 2) telephone number or fax number for receiving oral requests, 3) a provision that oral expedited coverage determination requests be documented in writing, and 4) a provision for making expedited decisions outside of normal business hours. (B) Health Choice's expedited coverage determination sample included one case that Health Choice did not expedite. The case file lacked documentation for the reviewer to determine whether Health Choice's decision was correct.

Corrective Action Required:

Health Choice must revise its policies and procedures to include the missing provisions noted above. On 6/6/2007, Health Choice submitted revised policies and procedures which included provisions for 1) and 2) above, but 3) and 4)above are still missing.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

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Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD07
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
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Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures and a sample of expedited coverage determination case files to determine compliance with this review element. CMS had the following findings: (A) Plan policy and procedures were missing the requirement to make timely decisions on requests to expedite coverage determination. (B) The sample included one coverage determination request that Health Choice did not expedite. The case file did not include documentation to indicate that Health Choice had ever notified the member of its decision to process the request under standard timeframes.

Corrective Action Required:

(A) Health Choice must revise its policy and procedures to include the above noted provision. It submitted a revised policy and procedure on 6/6/2007 which meets this requirement. (B) Health Choice must describe the measures it is taking to ensure that members are notified appropriately within the required timeframes whenever Health Choice decides not to expedite an expedited coverage determination request.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD08
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, a template for notifying enrollees that their request for an expedited coverage determination has been denied, and a sample of expedited coverage determination files to determine compliance with requirements for this element. CMS had the following findings: (A) Policy and procedures do not include provisions stating that oral and written notice must 1) explain that the plan must process the denied requests using the 72 hour timeframe for standard determinations, 2) inform members of the right to file an expedited grievance, 3) inform the member of the right to resubmit requests for an expedited determination with support from the prescribing physician, 4) instruct the member about the plan's grievance process and its timeframes. (B) The notices that Health Choice submitted as documentation were for denying requests to expedite Part C services rather than Part D drugs. Although similar, there are some material differences between the notices. (C) The sample for WSCD3_D included only one case (#5) that Health Choice had not expedited. The case file did not include documentation showing that the plan had notified the member of its decision to transfer the case from the expedited to the standard process.

Corrective Action Required:

(A) Health Choice must revise its policy and procedures to include the provisions noted in (A) above. On 6/6/2007, the plan submitted a revised policy and procedure which meets this requirement and no further corrective action for the deficiency noted in (A) above is required. (B) Health Choice must submit for CMS approval a notice consistent with the CMS-issued model notice, Notice of Right to an Expedited Grievance. Refer to Appendix 3 of Chapter 18. (C) Health Choice must describe the actions it is taking to ensure ongoing compliance with the requirement to issue appropriate notice whenever it denys a request to expedite a coverage determination.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.570(e); § 423.572(a-b); § 423.572(d); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures, a notice template for enrollee notification when requests are forwarded to the IRE, and a sample review of expedited coverage determination case files to determine compliance with this review element. CMS had the following findings: (A) Plan policy and procedures are missing provisions 1) for making decisions and notifying members of expedited coverage determinations as expeditiously as members' health conditions require, but no later than 24 hours after receiving requests, or, for coverage exceptions, receipt of a physician's supporting statement, and 2) for notifying members within 24 hours of adverse determinations that Health Choice has forwarded to the IRE. (B) In the sample review, CMS audited 9 cases and found 4 in which Health Choice had not made determinations and notified members within 24 hours of its receipt of requests. Also, physician documentation (if included) did not warrant changing the receipt date of the request. Health Choice must either make expedited decisions and notify members of the decision within 24 hours of receipt, or if unable to do so, forward cases to the IRE and notify members of the transfer.

Corrective Action Required:

Health Choice must take the following action: (A) revise its policies and procedures to include the provisions noted above, (B) describe the actions it is taking to implement and monitor its ongoing performance to ensure that it makes decisions and notifies members within 24 hours of receiving expedited coverage determination requests (or for exceptions, receipt of supporting documentation), or, if unable to do so, forwards requests to the IRE within 24 hours of the adjudication timeframe. On 6/6/2007, Health Choice submitted a revised policy and procedure which meet requirements in (A) above. No further action is needed for (A) above.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/14/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, a notice template for notifying enrollees of adverse expedited coverage determinations, and a sample of expedited coverage determination case files to determine compliance with this review element. CMS had the following findings: (A) The policy and procedures were missing provisions 1) to use a notice consistent with the CMS issued standard notice, "Notice of Denial of Medicare Prescription Drug Coverage" for adverse decisions, and 2) to specify that oral notifications must include the same elements as written notifications. (B) CMS audited 9 cases and found 2 cases that were not compliant. The first request was denied because the beneficiary was no longer enrolled, but there was no notice to the beneficiary. The second case did not contain any documentation to indicate notification had been sent.

Corrective Action Required:

Health Choice must take the following actions: (A) revise its policies and procedures to include the requirements discussed above, (B) describe the actions that it is taking to ensure that members receive appropriate notice (written and/or oral) of decisions, as well as its plans for ongoing monitoring of its performance to ensure continued compliance.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/14/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures as well as a notice template for requesting additional information from the enrollee's prescribing physician to determine compliance with this review element. CMS found the following: (A) Plan policy and procedures were missing 1) specific information about dosage and step therapy requirements that must be included on prescribing physicians' supporting statements (refer to section 30.2.2, page 38, Chapter 18 of the Prescription Drug Benefit Manual), 2) a provision stating that the plan may not keep an exception request open indefinitely when a physician does not submit a supporting statement, 3) a provision stating that the plan must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before it issues a determination on the formulary exception, 4) a provision stating that the plan must grant a formulary exception if the prescriber's documentation includes the required information indicated in (A)1) above, and 5) a provision stating that the plan may not restrict the number of exception requests an enrollee may submit. (B) The notice template for requesting additional information from a prescribing physician (Notice to Prescribing Physician) that Health Choice submitted is actually a notice to the prescribing physician advising him of a redetermination denial.

Corrective Action Required:

((A) Health Choice must revise its policies and procedures to include the requirements noted in the deficiency above. (B) Health Choice must stop using the notice it submitted to CMS as audit documentation for this requirement and develop a new notice for requesting additional information for coverage exceptions from prescribing physicians. Refer to page 37 in Chapter 18 of the Prescription Drug Benefit Manual. The notice template in Appendix 11 of Chapter 18, although intended for members, may also be helpful in developing a notice for requesting information from prescribing physicians.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.

Reference:

42 CFR § 423.578(c)(3); § 423.578(c)(4)(i-ii); EP Attestation Addendum; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures and non-formulary exceptions that were part of the coverage determination sample of coverage to determine compliance with requirements of this element. CMS found that plan policy and procedures were missing provisions stating that when the plan approves a coverage exception, 1) members are not required to seek a new approval for refills or a new prescription for the remainder of the plan year, and 2) the plan must place all approved non-formulary drugs in existing cost-sharing tiers.

Corrective Action Required:

Health Choice must revise its policies and procedures to include the provisions noted in the deficiency above.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/17/2008
Element Release Date: 9/17/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, plan documentation demonstrating the plan's communications methods for informing enrollees of complaint categorization, a notice template for informing enrollees about inquiries involving excluded drugs, and a sample of grievance case files to determine compliance with this element. CMS had the following findings: (A) The policies and procedures did not include language explaining how to distinguish a grievance from an inquiry. (B) CMS was not provided documentation demonstrating the plan's communication methods for informing enrollees of how Health Choice is categorizing their complaint, e.g., phone scripts or a notice template. (C) CMS audited 1 case from a universe of 1 and found that the enrollee was not informed whether the complaint was subject to grievance or coverage determination procedures.

Corrective Action Required:

Health Choice must (A) revise its policies and procedures to include a description of the difference between a grievance and an inquiry, (B) advise CMS how it plans to communicate to members whether their complaints are subject to grievance or coverage determination procedures, (C) once Health Choice has made required revisions to its policy and procedures for this and all other grievance elements, conduct training for all staff involved in the grievance process in any way - from intake of complaints to final adjudication - to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. Health Choice should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation demonstrating that the plan has a means for ensuring the timely resolution of enrollee grievances and has a system for logging or capturing enrollee's grievances in a centralized location to determine compliance with this review element. CMS had the following findings: (A) Policy and procedures were missing provisions 1) requiring prompt appropriate action, including a full investigation of grievances, if necessary and 2) reporting quarterly all data requested in Reporting Requirements, V:Grievances. (B) Health Choice did not submit sufficient documentation demonstrating its means or systems for ensuring that it tracks and resolves grievances timely. Health Choice should have a system for logging or capturing member information about member grievances in a centralized location.

Corrective Action Required:

Health Choice must (A) revise its policies and procedures to include the requirements discussed above and (B) develop and implement a system for logging or capturing enrollees' grievances in a centralized location that will ensure their timely resolution. (C) conduct training of appropriate staff on these policies and procedures and the tracking system, and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

MA-PD Solicitation

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation demonstrating that the plan has trained relevant staff and contractors on grievance policies and procedures to determine compliance with this review element. CMS had the following findings: (A) Policy and procedures were missing the requirement to include member services staff and contractors. (B) CMS did not received sufficient documentation from Health Choice to determine compliance with the grievance training requirement. Documentation submitted indicated that training is voluntary, but should be mandatory for all those involved in any part of the process. Also, documentation does not specify whether a contractor is involved in the grievance process, or if not, what it needs to do if it receives complaints.

Corrective Action Required:

(A) Health Choice must revise its policy and procedures, which it did and submitted on 6/6/2007. The revised policy and procedure meets this requirement, therefore no further corrective action is required for (A). (B) Health Choice must conduct grievance training for its staff and its contractor(s), if involved.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/15/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, a notice template for informing enrollees of grievance deadline extensions, and a sample of grievance cases to determine compliance with this review element. CMS found that policy and procedures were missing (A) a requirement to base grievance response time on the enrollee's health status, and (B) a definition of "immediately" for notifying enrollees about extensions and specifying the procedure for doing so.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to include the provisions noted in the deficiency above. (B) Once Health Choice has made required revisions to its policy and procedures for this element and all other grievance elements, it must conduct training for all staff involved in the grievance process in any way from intake of complaints to final adjudication to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. Health Choice should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, a notice template, and a sample of grievance cases to determine compliance with this review element. CMS found that the plan's policy and procedures had a contradiction. It stated that all non-quality of care grievances must be responded to in writing, but then goes on to say that they may be responded to orally unless a written response it requested by the enrollee. The requirement should state that all non-quality of care grievances submitted in writing must be responded to in writing. The plan has the option to allow a response to oral grievances to be made orally or in writing, unless the enrollee requests a written response.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to remove the contradictory information and replace it with the correct information as noted in the deficiency above. (B) Once Health Choice has made required revisions to its policy and procedures for this element and all other grievance elements, it must conduct training for all staff involved in the grievance process in any way from intake of complaints to final adjudication to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. Health Choice should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/15/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures as well as plan documentation to determine compliance with this review element. CMS had the following findings: (A) The policy and procedures are missing provisions stating 1) that standard redetermination requests be submitted within 60 days of initial coverage determinations, and 2) that staff must provide enrollees with a reasonable opportunity to submit evidence and allegations of law and fact, in person or in writing, related to the disputed issue. (B) Health Choice did not submit sufficient documentation to show that it has a system in place to accept written requests from an enrollee for a redetermination within the 60 calendar day timeframe. The log submitted does not include the appropriate elements to meet CMS requirements. Refer to finding (B) for review element CD02.

Corrective Action Required:

(A) Health Choice must revise its policy and procedures to include the provisions noted in (A) above. On 6/6/2007, the plan submitted a revised policy and procedures which meets the requirement for 1) above, but not 2). (B) Health Choice must revise the Pharmacy Tracking Log to include the missing items noted in (B) above.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/15/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures as well as plan documentation to determine compliance with this review element. CMS found the following: (A) Policy and procedures were missing provisions 1) that differentiate the processing of expedited redeterminations from standard redeterminations, 2) that discuss oral requests and state that the plan must document them in writing when received, and 3) that lists a telephone number for oral requests and/or a fax number to facilitate receipt of expedited appeal requests. (B) Health Choice did not submit sufficient documentation to show that it has an effective system for accepting requests for expedited redeterminations.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to include the requirements discussed above. (B) Health Choice must describe the actions it is taking to capture, track and process expedited Part D redetermination requests according to CMS requirements and submit documentation to support its plans. Corrective action should also include training for all staff involved in any way with identifying and processing expedited redetermination requests.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.

Reference:

42 CFR § 423.584(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviews plan policies and procedures as well as a sample of expedited redetermination case files to determine compliance with this review element, however Health Choice did not generate redetermination universes for the audit. CMS had the following findings: (A) Plan policy and procedures were missing a provision stating that the plan must request additional medical information within 24 hours of receiving initial requests for expedited redeterminations from the member and/or the prescribing physician. (B) Health Choice's inability to generate redeterminations universes was due to its failure to identify and correctly categorize requests as redeterminations. During discussions prior to the site visit with the plan about why it had no redetermination universes, CMS learned that the plan was reprocessing previously denied coverage determinations during the review period as new coverage determinations requests rather than as redeterminations when they were resubmitted. Further, the plan's "Notice to Prescribing Physician," which was part of the audit documentation to show that the plan had a notice for requesting additional documentation from prescribing physicians, invites physicians to file NEW coverage determinations along with necessary supporting documentation.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to include the requirement noted in the deficiency above. (B) CMS will conduct a second focused audit of plan redeterminations 6 months after Health Choice has submitted acceptable revised policies and procedures for redeterminations and coverage determinations as part of its CAP, to ensure that the plan has appropriately implemented them.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

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:

CMS reviewed plan policies and procedures and a notice template for notifying enrollees that the plan is denying their requests for expedited redeterminations. Health Choice had no redetermination universes for sampling which CMS generally reviews as well to assess compliance with this element. (A)CMS found that policy and procedures do not include a timeframe for providing the required oral notice to the enrollees whenever it transfers an expedited redetermination request for processing under standard timeframes. (B)Refer to finding (B) for audit element RE03.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to include the requirement noted in the deficiency above. (B) Refer to CAR(B) for audit element RE03.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.590(a)(1-2); § 423.590(c); § 423.590(g)(1-4); § 423.636(a)(1); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures and various notice templates to determine compliance with the requirements for this element. Health Choice had no redetermination universes. CMS found the following: (A) Plan policy and procedures were missing a provision stating that the plan must inform enrollees within 24 hours, when it forwards cases to the IRE. (B) Plan documentation submitted did not include a template "Request for Reconsideration" consistent with the CMS issued model. Additionally, the notice Health Choice submitted to inform enrollees of adverse standard redetermination decisions is outdated. (C) Refer to finding (B) for audit element RE03.

Corrective Action Required:

(A) Health Choice must revise its policy and procedures to include the required provision discussed in (A) above. (B) Health Choice must 1) update the notice for informing enrollees of adverse standard redeterminations, and 2) establish a form/notice for requesting reconsiderations to be sent with adverse redetermination notices. Refer to Chapter 18, Appendix 4 and Appendix 13 respectively of the Prescription Drug Benefit Manual for model documents. Forms must be submitted through HPMS for approval or for acceptance, under file and use certification if adopted without changes. (C) Refer to CAR(B) for audit element RE03.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/17/2008
Element Release Date: 9/17/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

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:

CMS reviewed plan policies and procedures and various notice templates to determine compliance with this review element. Health Choice had no redetermination samples to review which are also normally used to assess compliance with this element. CMS found the following: (A) Plan policy and procedures are missing a provision to inform enrollees within 24 hours when the plan sends a case to the IRE because it failed to make and notify the member of its redetermination decision within CMS required adjudication timeframes. (B) Plan documentation submitted did not include a template "Request for Reconsideration" consistent with the CMS issued model. Additionally, the notice Health Choice submitted to inform enrollees of adverse standard redetermination decisions is outdated. Refer to finding for RE05(B). (C) Refer to finding (B) for audit element RE03.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to include the requirement discussed in (A)above. (B) Refer to the CAR for audit element RE05 (B) for notice deficiencies. (C) Refer to CAR (B) for audit element RE03.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.584(e); § 423.590(d-e); § 423.638(a); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policy and procedures, a notice template for informing enrollees of adverse expedited redetermination decisions, a template for requesting reconsideration, and a notice template for informing enrollees that Health Choice has forwarded the case to the IRE, to determine compliance with requirements for this element. Health Choice had no redetermination universe from which to pull a sample. CMS had the following findings: (A) Plan policy and procedures were missing provisions stating that 1) the plan must request any supporting or necessary medical information from members and/or prescribing physicians within 24 hours of receiving requests, and 2) must inform members within 24 hours when it forwards cases to the IRE. (B) Health Choice does not have an approved (or accepted) "Request for Reconsideration" form consistent with the CMS-issued model notice, to send with redetermination denial letters. Refer to finding (B) for RE05. (C) Refer to finding (B) for audit element RE03.

Corrective Action Required:

A) Health Choice must revise its policies and procedures to include the requirements discussed above. (B) Health Choice must establish a notice consistent with CMS-issued model notice, "Request for Reconsideration." Refer to the CAR for review element RE05. (C) Refer to CAR(B) for audit element RE03.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE08
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 11/30/2007
Element Release Date: 6/20/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, as well as plan documentation to determine compliance with the requirements for this element. Health Choice had no redetermination universes. (A) CMS found that the documentation Health Choice submitted did not demonstrate that it had systems in place for authorizing or providing disputed benefits for the cases it reversed within 72 hours of receiving requests. (B) Refer to finding(B) for audit element RE03.

Corrective Action Required:

(A) Health Choice must establish a system for authorizing or providing benefits under dispute within 72 hours of receiving requests for expedited redeterminations, when it reverses in whole or in part its prior coverage determinations. Corrective action must include a description of the system Health Choice implements, as well its plans for monitoring to ensure ongoing compliance. (B) Refer to CAR(B) for audit element RE03.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

Requirement:

Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.

Reference:

42 CFR § 423.590(f)(1-2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed plan policies and procedures to determine compliance with this review element. Health Choice had not redetermination universes from which to select sample cases for review. Refer to deficiency(B) for audit element RE03.

Corrective Action Required:

Refer to the CAR(B) for audit element RE03.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

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:

CMS reviewed plan policy and procedures to determine compliance with requirements for this review element. Health Choice had no redetermination universes from which to select a sample. CMS had the following findings: (A) Plan policy and procedures were missing a provision stating that the plan is required to ship a hard copy of any requested case files to the IRE by overnight delivery at the designated address, or by fax at its designated fax number. (B) Refer to finding(B) for audit element RE03.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to include the requirement discussed in (A) above. (B) Refer to CAR(B) for audit element RE03.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5587
Audit ID: 581
Part D Sponsor Name: HEALTH CHOICE ARIZONA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 7/18/2007
Date Report Due: 9/1/2007
Element Accepted Date: 9/21/2007
Element Release Date: 9/21/2007
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 5/21/2007
Estimated Visit Start Date: 5/22/2007
Actual Visit Start Date: 5/21/2007
Actual Visit End Date: 5/22/2007
Part D Sponsor Response Received Date: 8/29/2007
Part D Sponsor Response Due Date: 9/1/2007
CAP Release Date: 9/17/2008
CAP Accepted Date: 9/17/2008

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:

CMS reviewed plan policies and procedures as well as a notice template for notifying the IRE of the plan's effectuation of decisions. CMS found that plan policy and procedures were missing a provision stating that payment must be authorized within 72 hours from the date that the plan receives notice from the third party reversing a decision.

Corrective Action Required:

(A) Health Choice must revise its policies and procedures to include the requirement discussed above. (B) Health Choice must describe the plans it has to monitor its own performance to ensure that it meets this effectuation requirement on an continuing basis.