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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 did not include the following provisions: (A) that the plan notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes at least 60 days prior to the date the change becomes effective. (B) that the plan provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, and (C) a description of the method(s) used to provide notification of formulary changes.

Corrective Action Required:

Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which includes these provisions and no additional 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
Audit ID: 1201
Contract Number: H2931
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/30/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 of this review element. (A) Sierras policies and procedures were missing the following requirements: 1) a provision to conduct monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws. Monitoring is based upon general information received in Government Affairs, 2) a provision that any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, 3) a requirement that all persons marketing on behalf of the Part D sponsor be state licensed, certified or registered individuals, and 4) designation of an individual responsible for overseeing the marketing activities. (B) CMS has not received sufficient documentation from Sierra to support its efforts to be compliant with the requirement that it conduct ongoing monitoring of the marketing activities of internal and external marketing representatives. Sierra provided a power point presentation used in training marketing representatives and this presentation includes the requirement to provide the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. However, Sierra 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) Sierra does not meet the 95% compliance standard in the sample review. Of the 10 sampled contracts, all except sample #1 lacked the required provision prohibiting payments by a person performing marketing to beneficiaries and all 10 contracts sampled lacked the provision requiring any person directly employed or contracted to marketing on behalf of the plan to provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment stating the following: The person that is discussing plan options with you is either employed by or contracted with PLAN NAME. The person may be compensated based on your enrollment in a plan.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the requirements discussed above. (B) Sierra must develop and implement a plan to monitor sales staff that includes monitoring of the requirement to provide this written disclosure. (C) Sierra 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
Audit ID: 1201
Contract Number: H2931
Part D Sponsor Name: HEALTH PLAN OF NEVADA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

Requirement:

Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.

Reference:

42 CFR § 423.120(b)(5)(i-iii); § 423.120(b)(7); § 423.578(d); Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation demonstrating that the plan provides retrospective notice to affected enrollees if a covered Part D drugs is removed from the formulary because it is deemed unsafe by the Food and Drug Administration or removed from the market by the manufacturer. Sierras policy and procedures were missing the following requirements: 1) provide for direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and are provided written notice of the formulary change and 2) a provision that the plan provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer.

Corrective Action Required:

Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which includes these provisions and no additional 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 Nursing Bed Ratio Analysis to determine compliance with this review element. The policy and procedures were missing the that the plan include a provision stating that the Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to any long-term care pharmacy in its service area that requests the contract.

Corrective Action Required:

Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which includes this provision and no additional 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 drugs is removed from the formulary because it is deemed unsafe by the Food and Drug Administration or removed from the market by the manufacturer. The policies and procedures were missing the following requirements: 1) a provision with a description of the procedures for providing a notice of maintenance formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, 2) a description of the procedures for providing a notice of other formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, 3) a description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer and 4) a description of the method(s) used to provide notification of formulary changes.

Corrective Action Required:

Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which include these provisions and no additional 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 these requirements for this element. The policies and procedures were missing a provision to abide by extensions to the transition period in accordance with CMS policy.

Corrective Action Required:

Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which include this provision and no additional 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CN05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 8/31/2007
Date Report Due: 10/15/2007
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Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

Requirement:

Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) 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 a sample of contracts with Long-Term Care Pharmacies to determine compliance with the requirements with this review element. Sierra does not meet the 95% compliance standard in the sample review. CMS found that three of the five sampled contracts lacked the full provision for ordering supplies. The full provisions is as follows: NLTCP must provide reports, forms and prescription ordering supplies necessary for the delivery of quality pharmacy care in the LTC setting. Such reports, forms and prescription ordering supplies may include, but will not necessarily be limited to, provider order forms, monthly management reports to assist the LTC facility in managing orders, medication administration records, treatment administration records, interim order forms for new prescription orders, and boxes/folders for order storage and reconciliation in the facility. Also, one sample is a contract with MNA which, in turn, contracts with Abilene State School. However, the contract between MNA and the plan did not include a list of pharmacies which should have been found at Attachment B. Although the plan later produced a listing of MNA pharmacies, the list did not appear to be the missing Attachment B. Also, since it is necessary to update the list of pharmacies related to agreements with chains such as MNA, the agreement with chain pharmacies should be amended to provide a mechanism for this constant updating.

Corrective Action Required:

Sierra must revise its contracts with Long-Term Care Pharmacies to include the missing required language. Also, on contracts with chain pharmacies, Sierra must amend those contracts that do not include a list of pharmacies included in the agreement and include a provision for updating the list.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 1/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 the following: (A) Policies and procedures were missing the following requirements: 1) arranging with plan network pharmacies to post or distribute the Medicare Prescription Drug Coverage and Your Rights notice and 2) sending the Medicare Prescription Drug Coverage and Your Rights notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. (B)The template contracts provided include only a very general requirement that the pharmacy comply with all laws and regulations, but did not include the specific provision requiring pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception. (C) CMS has not received sufficient documentation from Sierra to support its efforts to be compliant with the requirement that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. The plan provided their monitoring program to ensure that network pharmacies meet the requirement for posting or distributing notices. However, the plan to monitor network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception will only start in June 2007, leading us to conclude that the plan had no such program in place before June 2007.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the provisions noticed above. (B) Sierra must revise the template contract and amend the existing contracts to include the provision discussed above. (C) Sierra should provide the results of the audit for CMS review.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 1/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 that the policies and procedures were missing the following requirements: 1) the Pharmacy Coverage Requests policy includes the timeliness standards, but does not include the fact that the determinations must address basic coverage, supplemental benefits, and cost sharing, 2) the Pharmacy Coverage Requests policy needs to include the fact that requests can be received from the enrollees appointed representative, 3) the Grievances and Appeals policy or the Pharmacy Coverage Requests policy both need to include a definition of Coverage Determination, and 4) the Grievance and Appeals policy needs to provide for the quarterly reporting of all data requested in Report Requirements Section V11. Appeals.

Corrective Action Required:

Sierra must revise its policies and procedures to include the requirements noted in the deficiency above.

CMS Part D Audit Report

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Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
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Element Projected Completion Date:

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Estimated Visit Start Date:
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Actual Visit Start Date: 7/17/2007
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Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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. The plan policies and procedures did not include the following requirements: 1) a determination must be made as expeditiously as the enrollees health condition requires and 2) failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollees request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe.

Corrective Action Required:

Sierra must revise its policies and procedures to include the missing provisions as follows: 1) the revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include a provision, but 4.1.3.2.5.5 needs to be revised to read: health condition requires but no later than 72 hours, and 2) the revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include this provision and no additional 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
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Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
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Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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. (A) The policies and procedures were missing the following requirements: 1) to notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, 2) to authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, 3) to 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, and 4) that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollees request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. (B) Sierra does not meet the 95% compliance standard in the sample review. CMS found that the plan is not tracking the date checks are mailed. In 2 of 8 cases, the plan had not made payment when the sample was pulled for this audit. In the remainder of the cases, the date of the check was beyond the allowed 30 days, so we concluded that the date the check was mailed was also beyond the allowed 30 days. Finally, in all of the cases the determinations were made late, the only notification the enrollee received was the EOB and check, and the cases were never forwarded to the IRE as required when a plan does not meet the timeframes for making a determination.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the requirements discussed above. The revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include this provision and no additional corrective action is required. (B) Sierra must describe the steps it is taking to correct the following as well as plans for monitoring to ensure compliance: begin tracking the date checks are mailed, revise its systems and process to ensure that payment is made when there is a favorable decision, in full or in part, ensure that payment is made within the 30 days allowed, and ensure that decisions are made timely and, if not timely, forwarded to the IRE as required. Once Sierra has made the 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. Sierra 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

Requirement:

Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, a notice template for notifying enrollees of an adverse coverage determination, and a sample of adverse decisions. CMS found that the first three steps in 4.1.3.2.6 of the Pharmacy Coverage Requests policy appear to discuss a pre-denial process of notifying the requesting physician and allowing the requesting physician to request reconsideration. This is incorrect and does not provide the enrollee with reconsideration rights until the initial coverage determination is made final.

Corrective Action Required:

Sierra must revise its policies and procedures to correct the provision discussed 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 that the policies and procedures were missing the following: 1) a discussion of a means for issuing prompt decisions on expediting determinations in accordance with CMS requirements, 2) the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations, 3) that all oral requests must be documented in writing and that documentation of requests must be maintained in case file and 4) a discussion of the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. While all of these policies require decisions within 24 hours, they do not specifically address how requests received outside of normal business hours will be handled to ensure a response within 24 hours.

Corrective Action Required:

Sierra must revise its policies and procedures to include the above noted provisions. The revised policies and procedures dated April 2007 included these requirements and no additional 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/17/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 to determine compliance with this review element. CMS found that the policies and procedures do not include a provision for the timeliness of an expedited coverage determination denial notification following the decision to deny the request for an expedited coverage determination. While the plan maintains that they do not change the disposition noted on the request, they do say that the request must explicitly state that it should be expedited due to potential serious health issues that may seriously jeopardize the members life, health or ability to regain maximum function. The policy and procedures do not address what should be done if a member or prescribing physician request an expedited decision, but do not make this explicit statement.

Corrective Action Required:

Sierra must revise its policies and procedures to include the above noted provision.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/17/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 and a template for notifying enrollees that their request for an expedited coverage determination has been denied to determine compliance with requirements for this element. CMS found that policies and procedures do not address enrollee notification following a decision to deny a request for expedited coverage determination. While the plan maintains that they do not change the disposition noted on the request and, hence, there would be not be any denials, they do say that the request must explicitly state that it should be expedited due to potential serious health issues that may seriously jeopardize the member¿s life, health or ability to regain maximum function. The policy and procedures do not address what should be done if a member or prescribing physician request an expedited decision, but do not make this explicit statement. Specifically, the policies and procedures did not include the following provisions: 1) oral and written notice must provide an explanation that the Part D sponsor must process the request using the 72-hour timeframe for standard determinations, 2) oral and written notice must inform the enrollee of the right to file an expedited grievance, 3) oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support, and 4) oral and written notice must provide instructions about the plans grievance process and its timeframes.

Corrective Action Required:

Sierra must revise its policies and procedures to include the above noted provisions.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 found that the policies and procedures were missing the following requirements: 1) a provision stating that the plan must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollees health condition requires, 2) a provision stating that 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, 3) a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollees request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and 4) a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE.

Corrective Action Required:

Sierra must revise its policies and procedures to include the above noted provisions. The revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include these provisions and no additional 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:
3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 found that the policies and procedures were missing the following requirements: 1) if the decision is adverse, then the Sponsor must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. 2) if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: a)States the specific reason for the denial and take into account the enrollees presenting medical condition, disabilities, and special language requirements, if any, b)Provides information regarding the right to appoint a representative to file an appeal on the enrollees behalf, c) Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.

Corrective Action Required:

Sierra must revise its policies and procedures to include the above noted provision. For (1) above, the revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include this provision and no additional corrective action is required. However, (2) above must still be corrected.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures and a notice template for requesting additional information from the enrollees prescribing physician to determine compliance with this review element. (A) CMS found that the policies and procedures did not include the following requirements: 1) a provision for appointed representatives to submit exception requests, 2) if the plan requires a written statement from the enrollees prescribing physician, it must do so immediately, 3) the prescribing physicians statement must indicate that the preferred drug for the treatment of the enrollees condition (a) would not be effective as the requested drug and/or (b) would have adverse effects, 4) the prescribing physician is required to demonstrate in its written statement one of the two factors discussed in #3 above, 5) the plan must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, and 6) a statement that the number of exception requests submitted per enrollee are not restricted. (B) The plan provided a notice entitled Coverage Request Response to Providers which appears to address both situations when the exception request has been denied or when the plan needs more information from the provider. This notice was not reviewed and approved by CMS. Also, we believe it is inappropriate to use the same template for both situations since the plan should be requesting additional information from the physician within certain timeframes before denying the request for lack of information.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must develop a revised template and submit it for CMS approval.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
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3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 enrollees prescribing physician to determine compliance with this review element. CMS found the following: (A) Plan policies and procedures were missing the following requirements: 1) a provision stating that an enrollees appointed representative may file a request for a non-formulary exception, 2) the prescribing physicians statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (a) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, (b) The number of doses available under a dose restriction for the prescription drug: (1) Has been ineffective in the treatment of the enrollee¿s disease or medical condition or, (2) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug¿s effectiveness or patient compliance, or (c) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollees disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drugs effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee, 3) the plan must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, and 4) a provision that does not restrict the number of exception requests submitted per enrollee. (B) The plan provided a notice entitled Coverage Request Response to Providers which appears to address both situations when the exception request has been denied or when the plan needs more information from the provider. This notice was not reviewed and approved by CMS. Also, we believe it is inappropriate to use the same template for both situations since the plan should be requesting additional information from the physician within certain timeframes before denying the request for lack of information.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must develop a revised template and submit it for CMS approval.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 to determine compliance with requirements of this element. CMS found that plan policies and procedures are missing the following requirements: 1) coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, 2) enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and 3) all approved non-formulary drugs must be placed in existing cost-sharing tier(s).

Corrective Action Required:

Sierra must revise its policies and procedures to include the above noted provisions. The revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include these provisions and no additional 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/19/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 plans 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 discuss the prompt and correct categorization of complaints as inquiries, grievances, or coverage determination/appeals. (B) CMS was not provided documentation demonstrating the plans communication methods for informing enrollees of how Sierra is categorizing their complaint, e.g., phone scripts or a notice template. (C) The plan did not provide a notice that is consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug (Appendix 12). (D) In 2 of the 6 sample cases, the plan did not categorize the cases correctly by including appeals issues in the grievance process. In all 6 cases sampled, the plan did not inform the enrollee whether their complaint was subject to grievance or coverage determination procedures.

Corrective Action Required:

Sierra must (A) revise its policies and procedures to include the requirement discussed above, (B) advise CMS how it plans to communicate to members whether their complaints are subject to grievance or coverage determination procedures, (C) develop and submit for approval a notice that is consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug, and (D) Sierra must describe the steps it is taking to categorize cases as appeals, grievances, or both. Also, once Sierra 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. Sierra 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/17/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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) While the Grievance and Appeals policy does provide for tracking of grievances, it should specifically provide for tracking the date of receipt, disposition, and date of notification. Also, this policy does not provide for the quarterly reporting of all data requested in Report Requirements Section V. Grievances. (B) The tracking document provided by the plan lacks the following elements: mode of receipt, person or entity that filed the grievance, subject of the grievance, disposition of the grievance, and date of notification.

Corrective Action Required:

Sierra must (A) revise its policies and procedures to include the requirements discussed above and (B) revise its tracking document to include the missing elements 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/17/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 found that there is no provision in the Grievances and Appeals policy for staff training.

Corrective Action Required:

Sierra must revise its policy and procedures to 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
Audit ID: 1201
Contract Number: H2931
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/30/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 (A) the policies and procedures did not include 1) notification of all parties of the grievance disposition, 2) a provision for expeditiously resolving grievances based on the enrollee¿s health status, and 3) a provision for an extension of 14 days, not limited by the receipt of required information, allow the enrollee to request an extension, and provide for additional extensions. (B) The plan did not provide a notice consistent with the CMS issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance (Appendix 7). (C) In one case the plan did not justify the need for additional information or document how the delay was in the interest of the enrollee. In three cases the plan did not fully address the issues raised by the member in the grievance.

Corrective Action Required:

Sierra must (A) revise its policies and procedures to include the provisions discussed above, (B) develop a notice consistent with the CMS issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance, and (C) Once Sierra has made the 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. Sierra 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/6/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

Requirement:

Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures, a notice template for notification of grievance disposition, examples of actual responses to quality of care grievances, and documentation demonstrating its cooperation with QIOs. CMS found that the Grievances and Appeals policy does not address the plans commitment to cooperating with the QIO in resolving grievances.

Corrective Action Required:

Sierra must revise its policy and procedures to include the provision 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV07
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/9/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

Requirement:

Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures and a sample of expedited grievance cases. CMS found that the Grievances and Appeals policy does not address expedited grievances and the 24-hour timeframe for responding to an enrollees expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.

Corrective Action Required:

Sierra must revise its policies and procedures to 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/9/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 that the policies and procedures did not include the following requirements: 1) the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals and 2) a provision for maintaining documentation of expedited redetermination requests in a case file.

Corrective Action Required:

Sierra must revise its policies and procedures to include the above noted provisions.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/9/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 reviewed plan policies and procedures to determine compliance with this review element. CMS found that the policies and procedures did not include the following requirements: 1) while the Grievances and Appeals policy states that an expedited appeal may be requested because the normal process could jeopardize the life or health or regaining of maximum functioning for the enrollee, the policy needs to be revised to include a provision that the decision to provide an expedited reconsideration should be based on this, 2) the plan automatically expedites a request when the enrollee's physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollees life, health, or ability to regain maximum function, and 3) any additional medical information the Part D sponsor requires must be requested within 24 hours of receiving the initial request for an expedited redetermination.

Corrective Action Required:

Sierra must revise its policies and procedures to include the above noted provisions.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/19/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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. CMS found that: (A) The plans policies and procedures did not include a provision stating that the plan must transfer denied requests for an expedited redetermination to the standard redetermination timeframe. (B) The template for denying a request to expedite an appeal found in RE02 was reviewed. This letter is not consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice template consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 1201
Contract Number: H2931
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 2/14/2008
Element Release Date: 2/14/2008
Element Projected Completion Date: 1/30/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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, various notice templates, and a sample of requests for standard redeterminations concerning drug benefits to determine compliance with the requirements for this element. CMS found the following: (A) The Grievance and Appeals policy needs to be revised to include the following requirements: 1) a provision for effectuating the favorable redetermination as expeditiously as the enrollees health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, 2) that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the Part D sponsor to forward the enrollees complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe (the policy does not state that the failure to comply is considered an adverse redetermination and the policy directs that the request is forwarded to the wrong IRE), and 3) the plan must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. (B) The plan did not submit their notice consistent with CMS-issued model notice, Request for Reconsideration. (C) The plan did not timely notify the enrollee of the redetermination and effectuate a favorable decision on a timely basis. In 6 of 10 cases, the decisions were not favorable and the plan failed to provide a notice consistent with CMS issued model, Request for Reconsideration. Also, in one case out of 10, the plan did not use a notice consistent with the CMS issued model, Notice of Case Status.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice template consistent with CMS-issued model notice, Request for Reconsideration. (C) Sierra must describe the steps it is taking to ensure that enrollees are timely notified of a redetermination, effectuate favorable decisions on a timely basis, and when applicable, notify the enrollee of the status of a case. Once Sierra has made the 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. Sierra 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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/19/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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. CMS found the following: (A) The plan policies and procedures did not include the following requirements: 1) that the plan must authorize payment within 72 hours (rather than 7 calendar days as now stated), 2) that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision, that the file should be sent to CHDR not the IRE, and provide a timeframe for forwarding the file to the IRE, and 3) notifying the enrollee when their case has been forwarded to the IRE. (B) The plan did not provide a notice template consistent with CMS-issued model notice, Request for Reconsideration.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice template consistent with CMS-issued model notice, Request for Reconsideration.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/19/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 policies and procedures, a notice template for informing enrollees of adverse expedited redetermination decisions, a template for requesting reconsiderations, and a notice template for informing enrollees that Sierra has forwarded the case to the IRE, to determine compliance with requirements for this element. CMS found the following: (A) The plan policies and procedures did not include the following requirements: 1) that the notification to the enrollee must be sent within 72 hours, 2) that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, 3) that medical information must be requested within 24 hours of the enrollees initial request, 4) that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the plan to forward the enrollees request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe and 5) that the plan must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. (B) The notice the plan submitted as consistent with CMS-issued model notice, Notice of Redetermination (Appendix 4), was approved by CMS, but is not consistent with the model notice because it does not include the reason why the redetermination was denied and does not include the correct language regarding appeal rights to the IRE. Also, the plan did not submit a notice template consistent with CMS-issued model notice, Request for Reconsideration.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval notice templates consistent with CMS-issued model notice, Notice of Redetermination and Request for Reconsideration.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/19/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:
3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 enrolleeís 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 demonstrating its systems for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination to determine compliance with the requirements for this element. CMS found the following: (A) The Grievance and Appeals policy needs to be revised to include a provision for authorizing or providing the benefits in dispute within the 72-hour required timeframe. (B) The plan did not provide documentation demonstrating its systems for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination. The documentation provided was for tracking requests, but not for authorizing or providing a benefit.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must develop and implement a system for authorizing and providing a benefit under dispute within 72 hours of receiving the request for redetermination.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 11/7/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 policies and procedures and a sample of requests for standard redeterminations concerning drug benefits if the enrollee requested reconsideration and the IRE requested the file from the plan to determine compliance with requirements for this review element. CMS found that the policies and procedures did not include the requirement 1) that case files must be sent the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file and 2) that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number.

Corrective Action Required:

Sierra must revise its policies and procedures to include the above noted provisions.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/19/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

Requirement:

Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

42 CFR § 423.636(b)(1); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

CMS reviewed policies and procedures and a notice template for notifying the IRE of effectuation of a decision. CMS found the following: (A) Sierra needs to revise policies and procedures to include the requirement that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. The current policy appears to address services (Part C) and not benefits (Part D). (B) The template notification to the IRE of the effectuation of a decision discusses organization determinations, which is Part C, instead of coverage determinations. Also, the template provided only provides notification regarding payment and does not include notification regarding a benefit.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice consistent with the CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, 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: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/19/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

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 and a notice template for notifying the IRE of effectuation of a decision to determine compliance with this review element. CMS found the following: (A) Plan policies and procedures do not include the requirement that payment must be authorized within 72 hours from the date it receives notice reversing the decision, payment must be made no later than 30 days from the date it receives notice reversing the decision, and a provision requiring a notice to be sent informing the IRE of the effectuation. The current policy does not address payment after the IRE reverses a decision at all. (B) The template notification to the IRE of the effectuation of a decision discusses organization determinations, which is Part C, instead of coverage determinations. Also, the template provided only provides notification regarding payment and does not include notification regarding a benefit.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice consistent with the CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity.

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: H2931
Audit ID: 1201
Part D Sponsor Name: HEALTH PLAN OF NEVADA, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 8/31/2007
Date Report Due: 10/15/2007
Element Accepted Date: 12/19/2007
Element Release Date: 2/14/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 7/17/2007
Actual Visit End Date: 7/18/2007
Part D Sponsor Response Received Date: 10/15/2007
Part D Sponsor Response Due Date: 10/15/2007
CAP Release Date: 2/14/2008
CAP Accepted Date: 2/14/2008

Requirement:

Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

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

Deficiencies:

CMS reviewed plan policies and procedures and a notice template for notifying the IRE of effectuation of a decision to determine compliance with this review element. CMS found the following: (A) Plan policies and procedures do not address effectuation of Part D expedited appeals for which the IRE has reversed the decision. The policy in effect did not include 1) a statement that the benefit under dispute must be authorized or provided as expeditiously as the enrollees health requires but no later than 24 hours after the date it receives notice reversing the decision and 2) a provision requiring a notice to be sent informing the IRE of the effectuation. (B) The template notification to the IRE of the effectuation of a decision discusses organization determinations, which is Part C, instead of coverage determinations. Also, the template provided only provides notification regarding payment and does not include notification regarding a benefit.

Corrective Action Required:

(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice consistent with the CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity.