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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: PC02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 7/31/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a description of the method(s) used to provide notification of formulary changes. It should be noted that although a provision to provide notice is included in the policies and procedures, clear and specific step-by-step 'how-to' procedures, including roles and responsibilities, are not included.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a description of the method(s) used to provide notification of formulary changes, which must include, at a minimum, posting formulary changes on each affected plan's Internet website. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 9/19/2007
Element Release Date:
Element Projected Completion Date: 8/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include the following provisions: - Conduct ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines. Please see note (-1) in the `Recommendation/Note'section below for a detailed explanation for the `Not Met' finding. - Any person directly employed or contracted to market on behalf of Elder Health is required to provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, which states the following: `The person that is discussing plan options with you is either employed by or contracted with Elder Health. The person may be compensated based on your enrollment in a plan.' - All persons marketing on behalf of Elder Health must be state licensed, certified or registered individuals. Please see note (-2) in the 'Recommendation/Note' section below for a detailed explanation for the `Not Met' finding. In addition, Elder Health was unable to provide CMS-requested documentation that demonstrates that Elder Health confirms, via its ongoing monitoring activities, that its marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Please see note (-3) in the `Recommendation/Note' section below for a detailed explanation for the `Not Met' finding. Additionally, CMS reviewed 10 contract/compensation structure samples out of a universe of 74 and found 2 of the samples were misclassified. To account for this, the auditor reduced the sample size by 2 and made the sample size eight. Eight of the eight samples did not include the following provisions: - Any person directly employed or contracted to market on behalf of Elder Health must provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with Elder Health. The person may be compensated based on your enrollment in a plan.' - Any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal health care laws (including civil monetary penalty laws). Although Elder Health's General Agreements/Contracts refer to and explicitly state several regulations, laws, and guidelines, they do not include all of those mentioned above with respect to coordinated marketing. Finally, 1 of the 8 samples that did not include the above provisions was identified as the only employee-specific sample contract/compensation structure submitted by Elder Health. It did not demonstrate that an actual employment relationship existed between Elder Health and the employee, and it did not demonstrate or include the following additional provisions: - A compliant incentive structure avoiding incentives toward misleading beneficiaries, cherry picking certain beneficiaries, or churning beneficiaries between plans. - A person/agency performing marketing to beneficiaries is prohibited from making payments to beneficiaries. - Payment will be withheld or withdrawn if an enrollee disenrolls in an unreasonably short time frame.

Corrective Action Required:

Elder Health must revise its policies and procedures to include the following provisions: - Conduct ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines. - Any person directly employed or contracted to market on behalf of Elder Health is required to provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with Elder Health. The person may be compensated based on your enrollment in a plan.' - All persons marketing on behalf of Elder Health must be state licensed, certified or registered individuals. Elder Health must conduct training of appropriate staff to ensure they are aware of these additions to the policies and procedures, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Elder Health must provide CMS with evidence that it confirms, via its ongoing monitoring activities, that its marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Elder Health must also provide CMS with evidence that it has a current contract/compensation structure in effect that includes the following provisions: - Any person directly employed or contracted to market on behalf of Elder Health must provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with Elder Health. The person may be compensated based on your enrollment in a plan.' - Any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal health care laws (including civil monetary penalty laws). Elder Health must also provide CMS with evidence that it has a current employee-specific contract/compensation structure in effect that demonstrates that an actual contractual/ employment relationship exists between Elder Health and its employees, and demonstrates or includes the above provisions as well as those listed below: - A compliant incentive structure avoiding incentives toward misleading beneficiaries, cherry picking certain beneficiaries, or churning beneficiaries between plans. - A person/agency performing marketing to beneficiaries is prohibited from making payments to beneficiaries. - Payment will be withheld or withdrawn if an enrollee disenrolls in an unreasonably short time frame.

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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/1/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed sample cases and found that over 30% of the samples provided for WS-MR4_D, Provision of Notices Regarding Formulary Changes, were misclassified. The universe provided by Elder Health is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-MR4_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/1/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include the following: - 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, - 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, - 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 - A description of the method(s) used to provide notification of formulary changes. It should be noted that although provisions to provide the above notices may be included in the policies and procedures, clear and specific step-by-step 'how-to' procedures, including roles and responsibilities, are not included.

Corrective Action Required:

Elder Health must revise its policies and procedures to include the following: - 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, - 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, - 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 - A description of the method(s) used to provide notification of formulary changes. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: TP02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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); PDP Solicitation; Information for Part D Sponsors on Requirements for a Transition Process

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a provision to abide by extensions to the transition period in accordance with CMS policy. In addition, Elder Health submitted a description of how its claims system records transition transactions (described in the memo Elder Health's PBM (Medco) submitted). This description demonstrates noncompliance because it indicates that members who are residents of long-term care facilities are required to request a coverage determination in order to receive an 'emergency supply' or 'first fill' of a non-formulary drug when the member is outside the initial transition period.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision to abide by extensions to the transition period in accordance with CMS policy. Specifically, policies and procedures must describe how Elder Health will continue to provide necessary covered Part D drugs to an enrollee via an extension of the transition period, on a case-by-case basis, to the extent that his or her exception request or appeal has not been processed by the end of the minimum transition period. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Elder Health must ensure that its transition process for residents of long-term care facilities does not require members to request a coverage determination in order to receive an 'emergency supply' or 'first fill' of a non-formulary drug when the member is outside the initial transition period. Elder Health must submit documentation to CMS to demonstrate that its claims system issues an override code for the pharmacist to use in these situations.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

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Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CN05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/1/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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.

Reference:

42 CFR § 423.120(a)(5); PDP Solicitation; Long Term Care Guidance

Deficiencies:

Elder Health does not meet this requirement because CMS requested and reviewed five network long-term care pharmacy contracts and found the following: - Elder Health was unable to provide a signed long-term care pharmacy addendum for one of the sample cases (Sample #2). Elder Health indicated that the required addendum may not have been returned by the pharmacy with the executed contract. - None of the sample case long-term care pharmacy contract addenda included a provision to require the pharmacy to provide information on the differential between the price of a covered Part D drug and its lowest price generically equivalent version that is available at that pharmacy, if one exists for the beneficiary's prescription. This information must be provided to Part D plans for inclusion in the written Explanation of Benefits.

Corrective Action Required:

Elder Health must provide CMS with a copy of the signed long-term care pharmacy addendum for each sample contract that was missing it. Elder Health must also amend its long-term contract addenda to include a provision to require the pharmacy to provide price differential information to Part D plans for inclusion in the written Explanation of Benefits. Elder Health must provide a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.

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: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 9/19/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the long-term care (LTC) facility designated to accept such notices, or, if the network or preferred pharmacy is on-site, delivering the notice described to the location in the LTC facility designated to accept such notices. In addition, Elder Health is unable to provide documentation demonstrating that it conducts ongoing monitoring of its network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception, and more specifically that Elder Health's network pharmacies meet the requirement for posting or distributing notices.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices. Also Elder Health must revise its policies and procedures to include a provision stating that if the network or preferred pharmacy is on-site, it must deliver the notice described to the location in the LTC facility designated to accept such notices. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS that demonstrates it has developed and implemented procedures to conduct ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception and more specifically that Elder Health's network pharmacies meet the requirement for posting or distributing notices. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.

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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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/6/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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); PDP Solicitation; Reporting Requirements Section VII: Appeals; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions: - for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits and cost-sharing, and - for tracking and addressing all request for redeterminations.

Corrective Action Required:

Elder Health must revise its policies and procedures to include provisions: - for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits and cost-sharing, and - for tracking and addressing all request for redeterminations. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

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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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/6/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health did not meet this requirement because CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefits from a universe of 4,400 and found 4 samples did not demonstrate that enrollees are notified of standard coverage determination decisions within the CMS-approved timeframes. Elder Health did not provide documentation demonstrating it forwarded the untimely requests to the IRE, as CMS requires. ElderHealth provided a written statement in `PDP Audit Tracking Sheet' for each sample that read: `No Coverage Determination requests in the samples were forwarded to the IRE during the audit period.' Additionally, during Staff Discussions, Elder Health indicated that the CMS-approved 72 hour timeframe for resolving standard coverage determinations begins upon receipt of the physician's supporting statement regardless of whether the coverage determination was an exceptions request.

Corrective Action Required:

Elder Health must notify enrollees of its decision regarding standard coverage determinations concerning benefits within the CMS-approved timeframe, and provide documentation of this to CMS. In cases where Elder Health fails to notify the enrollee of its decision on a coverage determination concerning drug benefit within the required timeframe, Elder Health must forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 9/19/2007
Element Release Date:
Element Projected Completion Date: 8/30/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions stating that: - Elder Health 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, - Elder Health must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - Elder Health must make payment (i.e. mail the payment) within 30 calendar days of the request, or, for an exception request, after receiving the physician's supporting statements. Elder Health did not meet the CMS compliance standard because CMS reviewed a sample of 10 requests for standard coverage determinations concerning payments from a universe of 479 and found 10 samples did not demonstrate that Elder Health notified enrollees of standard coverage determinations concerning payments within the CMS approved timeframes.

Corrective Action Required:

Elder Health must revise its policies and procedures to include provisions stating that: - Elder Health 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, - Elder Health must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - Elder Health must make payment (i.e. mail the payment) within 30 calendar days of the request, or, for an exception request, after receiving the physician's supporting statements. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must notify enrollees of its decision regarding standard coverage determinations concerning payments within the CMS-approved timeframes, and provide documentation of this to CMS.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/7/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed 3 samples where Elder Health made an adverse standard coverage determination concerning drug benefits decision from a universe of 4,400 and found that in 3 of those 3 samples, Elder Health's denial notice was not consistent with the CMS-issued notice `Notice of Denial of Medicare Prescription Drug Coverage'. Additionally, CMS reviewed 3 samples where Elder Health made an adverse standard coverage determinations concerning payments decision from a universe of 479 and found that in 3 of those 3 samples, Elder Health's denial notice was not consistent with the CMS-issued notice `Notice of Denial of Medicare Prescription Drug Coverage'.

Corrective Action Required:

Elder Health must notify enrollees of an adverse coverage determination decision using a notice consistent with CMS-issued notice `Notice of Denial of Medicare Prescription Drug Coverage', and provide documentation of this to CMS. Elder Health must conduct training of appropriate staff on the use of the appropriate notice and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/7/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not: - include a provision discussing the means for issuing prompt decisions on expediting determinations in accordance with CMS requirements (i.e. `Elder Health must grant a request for an expedited determination if it determines, based on the enrollee's request, or as indicated in the prescribing physician's request that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health or ability to regain maximum function'.), - include the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited coverage determinations, and - discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours.

Corrective Action Required:

Elder Health must revise its policies and procedures to include: - a provision for discussing the means for issuing prompt decisions on expediting determinations in accordance with CMS requirements, - provisions stating the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations, and - a means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/7/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a provision stating that Elder Health must inform the enrollee, within 24 hours, when the case is forwarded to the IRE.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision stating that Elder Health must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/7/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a provision stating that if the expedited coverage determination decision is adverse, then Elder Health must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. Elder Health's policies and procedures do not include a provision stating that if oral notice is provided for adverse decision, the notice must satisfy the following requirements: -state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities and special language requirements, if any, -provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and -provide 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:

Elder Health must revise its policies and procedures to include a provision stating that if the decision is adverse, then Elder Health must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. Elder Health must revise its policies and procedures to include a provision stating that if oral notice is provided for an adverse decision, the notice must satisfy the following requirements: -state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities and special language requirements, if any, -provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and -provide 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. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/7/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

42 CFR § 423.578(a)(1-2); § 423.578(a)(4); PDP 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 ¿

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions stating that: - if Elder Health requires a written statement from the enrollee's prescribing physician, it must do so immediately, - if Elder Health makes a request for additional supporting medical documentation, Elder Health must clearly identify the type of information that must be submitted, - Elder Health must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, - if Elder Health is waiting on a physician's statement in support of a tiering exception request, Elder Health must wait a minimum 96 hours after receiving a standard request or a minimum or 48 hours after receiving an expedited request before issuing its determination on the tiering exception, and - Elder Health 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.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision stating that: - if Elder Health requires a written statement from the enrollee's prescribing physician, it must do so immediately, - if Elder Health makes a request for additional supporting medical documentation, Elder Health must clearly identify the type of information that must be submitted, - Elder Health must not keep the exception request open indefinitely when a physician does not submit a supporting statement, - if Elder Health is waiting on a physician's statement in support of a tiering exception request, Elder Health must wait a minimum 96 hours after receiving a standard request or a minimum or 48 hours after receiving an expedited request before issuing its determination on the tiering exception, and - Elder Health 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. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/7/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

42 CFR § 423.578(b); § 423.578(b)(1); § 423.578(b)(2); § 423.578(b)(5); PDP Solicitation and EP Attestation Addendum; Reporting Requirements for Section VI: Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions; Prescription Drug

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions stating: - if Elder Health makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - Elder Health must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if Elder Health is waiting on a physician's statement in support of a formulary exception request, Elder Health must wait a minimum of 96 hours after receiving a standard request or a minimum or 48 hours after receiving an expedited request before issuing its determination on the formulary exception.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision stating: - if Elder Health makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - Elder Health must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if Elder Health is waiting on a physician's statement in support of a formulary exception request, Elder Health must wait a minimum of 96 hours after receiving a standard request or a minimum or 48 hours after receiving an expedited request before issuing its determination on the formulary exception. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 9/19/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a provision stating that all approved non-formulary drugs must be placed in existing cost-sharing tier(s). CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefits from a universe of 4,400 and found that of the 2 applicable cases, 2 did not demonstrate that Elder Health placed approved non-formulary drugs into existing cost-sharing tier(s). CMS reviewed a sample of 10 requests for standard coverage determinations concerning payments from a universe of 479 and found that of the 7 applicable cases, 7 did not demonstrate that Elder Health placed approved non-formulary drugs into existing cost-sharing tier(s). CMS reviewed 10 requests for standard coverage determinations concerning drug benefits from a universe of 4,400 and found that of the 3 applicable cases, 3 did not demonstrate that Elder Health provided coverage for approved tiering exceptions at the same cost-sharing level as preferred drugs. CMS reviewed 10 requests for standard coverage determinations concerning payments from a universe of 479 and found that of the 7 applicable cases, 7 did not demonstrate that Elder Health provided coverage for approved tiering exceptions at the same cost-sharing level as preferred drugs.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision stating that all approved non-formulary drugs must be placed in existing cost-sharing tier(s). Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS that Elder Health places all approved non-formulary drugs into existing cost-sharing tier(s). Elder Health must provide documentation to CMS that Elder Health provides coverage for approved tiering exceptions at the same cost-sharing level as preferred drugs.

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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/6/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions for promptly and correctly categorizing complaints as inquiries, grievances or coverage determinations/appeals. In addition, Elder Health did not provide documentation demonstrating that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. CMS requested Elder Health's notice template for informing enrollees about inquiries involving excluded drugs, and Elder Health was unable to provide a CMS-approved 'Notice of Inquiry Regarding an Excluded Drug' and attested that such a notice was never submitted to CMS for approval in 2006. Elder Health did not meet the CMS compliance standard because CMS reviewed a sample of 7 standard grievances from a universe of 7 and found that 3 did not demonstrate that enrollees were informed whether their complaint was subject to grievance or coverage determination procedures.

Corrective Action Required:

Elder Health must revise its policies and procedures to include provisions for promptly and correctly categorizing complaints as inquiries, grievances or coverage determinations/appeals. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS demonstrating that it has developed and implemented a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees about inquiries involving excluded drugs (consistent with the CMS-issued model notice `Notice of Inquiry Regarding an Excluded Drug'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/6/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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); PDP Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Reporting Requirements for Section V: Grievances

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include: - requirements for transmitting grievances to appropriate decision-making levels when appropriate and in a timely fashion, - a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary, - provisions for tracking and maintaining, at a minimum, the date of receipt, disposition of the grievance and the date that the enrollee was notified of the disposition, and - a provision for quarterly reporting of all data requested in Reporting Requirements Section V: Grievances. In addition, Elder Health did not provide documentation demonstrating that it has a system for logging or capturing enrollees¿ grievances in a centralized location and for tracking and maintaining, at a minimum, the following information: - Receipt date, - Mode of receipt (e.g., fax, telephone, letter, etc.), - Person or entity that filed the grievance, - Subject of the grievance, - Disposition of the grievance, and - Date ElderHealth notified the enrollee of the disposition.

Corrective Action Required:

Elder Health must revise its policies and procedures to include: - provisions for transmitting grievances to appropriate decision-making levels when appropriate and in a timely fashion, - a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary, -provisions for tracking and maintaining, at a minimum, the date of receipt, disposition of the grievance and the date that the enrollee was notified of the disposition, and - provisions for quarterly reporting of all data requested in Part D Reporting Requirements Section V: Grievances. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. In addition, Elder Health must develop and implement a system for logging or capturing enrollees' grievances in a centralized location and for tracking and maintaining, at a minimum, the following information, and provide documentation of this to CMS: - Receipt date, - Mode of receipt (e.g., fax, telephone, letter, etc.), - Person or entity that filed the grievance, - Subject of the grievance, - Disposition of the grievance, and - Date Elder Health notified the enrollee of the disposition.

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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/6/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

PDP Solicitation

Deficiencies:

Elder Health does not meet this requirement because Elder Health provided documentation attesting to having no policies and procedures in place for training relevant staff and subcontractors on its grievance policies and procedures during 2006.

Corrective Action Required:

Elder Health must develop policies and procedures to include a provision for training relevant staff and contractors on grievance policies and procedures. Elder Health must conduct training of appropriate staff to ensure they are aware of this addition to the policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 9/19/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions stating that: - all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee¿s health status, but no later than 30 days after ElderHealth receives the oral or written grievance, - the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if Elder Health justifies a need for additional information and documents how the delay is in the interest of the enrollee, and that the enrollee must immediately be notified in writing when Elder Health extends the deadline for processing a grievance, and - the enrollee must immediately be notified in writing when Elder Health extends the deadline. Elder Health did not meet the CMS compliance standard because CMS reviewed a sample of 7 standard grievances from a universe of 7 and found that 2 samples did not demonstrate that enrollees were notified of grievance resolution within the CMS approved timeframes. Additionally, in 3 samples the auditors were unable to determine if the Elder Health's actions fully addressed the issues raised by the member's grievance.

Corrective Action Required:

Elder Health must revise its policies and procedures to include provisions stating that: - all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 days after ElderHealth receives the oral or written grievance, - the 30-day timeframe for processing a grievance may be extended by 14 days or less if the enrollee requests the extension or if Elder Health justifies a need for additional information and documents how the delay is in the interest of the enrollee, and - enrollees must immediately be notified in writing when Elder Health extends the deadline for processing a grievance. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with documentation that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/6/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed a sample of 7 standard grievances from a universe of 7 and found that 4 did not demonstrate that the method of response to the enrollee was correct. Specifically, one out of the 4 cases did not demonstrate that Elder Health used a notice that was CMS approved. Three out of the four cases did not demonstrate the means by which Elder Health responded to the member.

Corrective Action Required:

Elder Health must use a CMS-approved notice consistent with the CMS-issued model notice `Notice of Plan's Decision Regarding a Grievance' when notifying enrollees in writing of grievance disposition and provide documentation that demonstrates this to CMS. Elder Health must provide documentation to CMS demonstrating the means by which Elder Health responds to standard grievances. Elder Health must conduct training of appropriate staff on the use of the appropriate notice and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/6/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's documentation and did not find evidence that Elder Health cooperates with the Quality Improvement Organization (QIO) to resolve complaints related to quality of care.

Corrective Action Required:

Elder Health must provide documentation to CMS that demonstrates it has developed and implemented procedures for cooperating with QIOs to resolve complaints related to quality of care. Elder Health must conduct training of appropriate staff on these procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: GV07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/6/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not contain a provision to include a 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by Elder Health 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:

Elder Health must revise its policies and procedures to include a 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by Elder Health 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. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. CMS reviewed Elder Health's documentation and it did not demonstrate a system to accept written requests from the enrollee for a redetermination within the 60 calendar day timeframe. Over 30% of the samples submitted for WS-RE1_D, Requests for Standard Redetermination Concerning Drug Benefits, were misclassified. The universe provided by Elder Health is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Elder Health must provide CMS with documentation demonstrating its system for accepting requests for standard redeterminations which documents the ability to accept written request from the enrollee for a redetermination within the 60 calendar day timeframe. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing.

Corrective Action Required:

Elder Health must revise its policies and procedures to include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date: 9/5/2007
Element Projected Completion Date: 7/7/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a provision stating that any additional medical information Elder Health requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision stating that any additional medical information that Elder Health requires, must be requested within 24 hours of receiving the initial request for an expedited 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
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions: - for effectuating the favorable redetermination concerning drug benefit as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Elder Health to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that the Elder Health must inform the enrollee within 24 hours, when the case is forwarded to the IRE. CMS requested Elder Health's CMS-approved notice template for notifying enrollees of an adverse standard redetermination, and Elder Health was unable to provide this notice template. CMS requested Elder Health's notice template for requesting a reconsideration. However, Elder Health was unable to provide a CMS-approved notice template for requesting a reconsideration, and Elder Health attested that such a notice was never submitted to CMS for approval in 2006. Over 30% of the samples submitted for WS-RE1_D, Requests for Standard Redetermination Concerning Drug Benefits, were misclassified. The universe provided by Elder Health is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

Elder Health must revise its policies and procedures to include provisions: - for effectuating the favorable redetermination concerning drug benefit as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Elder Health to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that Elder Health must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not: - state that for a redetermination favorable to the enrollee, Elder Health must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Elder Health to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Elder Health must inform the enrollee within 24 hours, when the case is forwarded to the IRE. CMS requested Elder Health's CMS-approved notice template for notifying enrollees of an adverse standard redetermination, and Elder Health was unable to provide this notice template. CMS requested Elder Health's notice template for requesting a reconsideration. However, Elder Health was unable to provide a CMS-approved notice template for requesting a reconsideration, and Elder Health attested that such a notice was never submitted to CMS for approval in 2006.

Corrective Action Required:

Elder Health must revise its policies and procedures to: - state that for a redetermination favorable to the enrollee, Elder Health must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Elder Health to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Elder Health must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions: - indicating that notification of a favorable decision may be made orally or in writing, - stating that medical information must be requested within 24 hours of the enrollee's initial request, - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Elder Health to forward the enrollee's request to the IRE within 24 hrs of the expiration of the adjudication timeframe, and - stating that Elder Health must inform the enrollee, within 24 hours when the case is forwarded to the IRE. CMS requested Elder Health's CMS-approved notice template for notifying enrollees of an adverse expedited redetermination, and Elder Health was unable to provide this notice template. CMS requested Elder Health's notice template for requesting a reconsideration. However, Elder Health was unable to provide a CMS-approved notice template for requesting a reconsideration, and Elder Health attested that such a notice was never submitted to CMS for approval in 2006. CMS reviewed a sample of 2 requests for expedited coverage redeterminations from a universe of 2 and found both samples did not demonstrate compliance with notifying enrollees in a timely manner of expedited redetermination decisions and untimely requests for medical information.

Corrective Action Required:

Elder Health must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing, - stating that medical information must be requested within 24 hours of the enrollee's initial request, - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Elder Health to forward the enrollee's request to the IRE within 24 hrs of the expiration of the adjudication timeframe, and - stating that Elder Health must inform the enrollee, within 24 hours when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE08
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 9/19/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a provision for authorizing or providing the benefits in dispute within the 72 hour timeframe. Elder Health's documentation did not demonstrate its systems for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically, the documentation did not demonstrate Elder Health has a system for expedited coverage determination reversals. CMS reviewed a sample of 2 requests for expedited coverage redeterminations from a universe of 2 and found 1 case did not demonstrate Elder Health was compliant in providing timely notification of expedited redetermination decisions.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision for authorizing and providing the benefit in dispute within the 72 hour timeframe. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically that Elder Health has a system for expedited coverage determination reversals. Elder Health must provide documentation to CMS that it provides timely notification of expedited redetermination decisions.

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: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Elder Health's policies and procedures do not include a provision stating that if the issue is a denial based on lack of medical necessity, then Elder Health must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Additionally, during Staff Discussions, Elder Health indicated that it was their understanding and policy that a physician does not need to conduct the redetermination, when the initial denial was based on lack of medical necessity, if Elder Health approves the redetermination. This is not compliant with CMS requirements. CMS reviewed a sample of 2 requests for expedited coverage redeterminations from a universe of 2 and found that 2 cases did not demonstrate that Elder Health uses appropriate personnel to conduct redeterminations. Over 30% of the samples submitted for WS-RE1_D, Requests for Standard Redetermination Concerning Drug Benefits, were misclassified. The universe provided by Elder Health is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Elder Health must revise its policies and procedures to include a provision stating that if the issue is a denial based on lack of medical necessity, then Elder Health must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS demonstrating that Elder Health uses appropriate personnel to conduct redeterminations. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions stating that: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file, and - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at is designated fax number. CMS reviewed a sample of 2 requests for expedited coverage redeterminations from a universe of 2 and found that 2 cases did not demonstrate that Elder Health forwarded untimely cases to the IRE. Over 30% of the samples submitted for WS-RE1_D, Requests for Standard Redetermination Concerning Drug Benefits, were misclassified. The universe provided by Elder Health is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

Elder Health must revise its policies and procedures to include a provision stating that: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file, and - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at is designated fax number. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS demonstrating that Elder Health forwards untimely cases to the IRE. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision, and - include a provision requiring a notice to be sent informing the IRE of the effectuation. CMS requested Elder Health's CMS-approved notice template for notifying the IRE of the effectuation of decision, and Elder Health was unable to provide this notice template.

Corrective Action Required:

Elder Health must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision, and - include a provision requiring a notice to be sent informing the IRE of the effectuation. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template for notifying the IRE of effectuation of decision (consistent with CMS-issued model notice 'Notice of Effectuation to Part D Independent Review Entity'). If ElderHealth does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: S1566
Audit ID: 281
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision, - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision, and - requiring a notice to be sent informing the IRE of the effectuation. CMS requested Elder Health's CMS-approved notice template for notifying the IRE of the effectuation of decision, and ElderHealth was unable to provide this notice template.

Corrective Action Required:

Elder Health must revise its policies and procedures to include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision, - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision, and - requiring a notice to be sent informing the IRE of the effectuation. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template for notifying the IRE of effectuation of decision (consistent with CMS-issued model notice 'Notice of Effectuation to Part D Independent Review Entity'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 281
Contract Number: S1566
Part D Sponsor Name: BRAVO HEALTH TEXAS, INC.

Audit Guide Version: PDP Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 5/23/2007
Date Report Due: 7/7/2007
Element Accepted Date: 8/8/2007
Element Release Date:
Element Projected Completion Date: 7/31/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 3/15/2007
Estimated Visit Start Date: 3/21/2007
Actual Visit Start Date: 3/15/2007
Actual Visit End Date: 3/21/2007
Part D Sponsor Response Received Date: 7/9/2007
Part D Sponsor Response Due Date: 7/7/2007
CAP Release Date:
CAP Accepted Date:

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:

Elder Health does not meet this requirement because CMS reviewed Elder Health's policies and procedures and found that they do not: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision, and - include a provision requiring a notice to be sent informing the IRE of the effectuation. CMS requested Elder Health's CMS-approved notice template for notifying the IRE of the effectuation of decision, and Elder Health was unable to provide this notice template.

Corrective Action Required:

Elder Health must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision, and - include a provision requiring a notice to be sent informing the IRE of the effectuation. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template for notifying the IRE of effectuation of decision (consistent with CMS-issued model notice 'Notice of Effectuation to Part D Independent Review Entity'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.