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: H5430
Audit ID: 481
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, and a sample of Plan Responsibilities for Persons Employed or Contracted to Perform Marketing (Part D) to determine compliance with requirements for this element and found that the sponsor is missing a provision including a requirement that any person directly employed or contracted to market on behalf of the sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment and the sponsor did not provide documentation of the sponsors Marketing Program monitoring activities that confirm that the sponsors marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. In the universe of 5, 5 cases were provided for review. The 5 cases failed because the plan failed to provide evidence that employee or contractors were informed or trained regarding: provisions prohibiting payment (all five), provisions for withholding payment (4 of the five), provisions for disclosure statement (all five) and provisions coordinating marketing (all five).

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include the requirement that any person directly employed or contracted to market on behalf of the sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment and the sponsor did not provide documentation of the sponsors Marketing Program monitoring activities that confirm that the sponsors marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. And provide documentation that staff and contractors involved in marketing are properly trained and provide evidence of this in their CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed a sample Provision of Notices Regarding Formulary Changes (Part D) to determine compliance with requirements for this element and found that the in a universe of 15, 6 cases (of 10 cases) were not compliant with CMS requirements for issuing notice to a member regarding pulling a drug by order of the FDA. In the information provided by the plan, no notice was in file.

Corrective Action Required:

Care1st of AZ must submit a notice consistent with CMS requirements, to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures to determine compliance with requirements for this element and found that policies and procedures are missing (1) procedures for providing a notice of maintenance formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. (2) a provision with a description of the procedures for providing a notice of other formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. (3) a provision including 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. (4) a provision that includes a description of the method(s) used to provide notification of formulary changes.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, (1) procedures for providing a notice of maintenance formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. (2) a provision with a description of the procedures for providing a notice of other formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. (3) a provision including 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. (4) a provision that includes a description of the method(s) used to provide notification of formulary changes. Please refer to 42 CFR§ 423.120(b)(5)(i), 423.120(b)(5)(i), 423.578(d) and the Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans, and submit the corrected policies and procedures to CMS as part of the CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures and a notice template to determine compliance with requirements for this element and found that the policies and procedures do not contain: (1) A provision for sending the Medicare Prescription Drug Coverage and Your Rights notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to receive such notices. (2) A provision requiring pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception. (3) A provision detailing how Part D Sponsors network pharmacies meet the requirement for posting or distributing notices.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, A provision for sending the Medicare Prescription Drug Coverage and Your Rights notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to receive such notices, a provision requiring pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception, and a provision detailing how Part D Sponsors network pharmacies meet the requirement for posting or distributing notices. Care1st must either submit documentation showing the number and percentage of network pharmacies its has audited to ensure that pharmacies are posting or distributing notices describing how members may obtain coverage determinations or request exceptions or it may develop a monitoring process and submit it along with a schedule to CMS with its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures to determine compliance with requirements for this element and found that policies and procedures are missing provisions: that individuals who can request a standard or expedited coverage determination are, the enrollee, the enrollees appointed representative on behalf of the enrollee, and the prescribing physician, provisions for tracking and addressing all requests for redeterminations, including a provision for quarterly reporting of all data requested in Reporting Requirements Section VII: Appeals, and documentation demonstrating it has systems to track and address in a timely manner enrollees oral and written requests for exceptions, coverage determinations, and redeterminations.

Corrective Action Required:

Care1st of AZ must revise its policies and procedures to include that individuals who can request a standard or expedited coverage determination are, the enrollee, the enrollees appointed representative on behalf of the enrollee, and the prescribing physician, provisions for tracking and addressing all requests for redeterminations, including a provision for quarterly reporting of all data requested in Reporting Requirements Section VII: Appeals, and documentation demonstrating it has systems to track and address in a timely manner enrollees oral and written requests for exceptions, coverage determinations, and redeterminations. Refer to 42 CFR § 423.566 (a-c) and Chapter 18 Part D Enrollment Grievances, Coverage Determinations, and Appeals, 10.4.1, 10.4.2, and 10.5 It must submit the revised policies and procedure to CMS with its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Standard Coverage Determinations Concerning Benefits (Part D) to determine compliance with requirements for this element and found that policies and procedures are missing a provision that the sponsor use a notice consistent with CMS-issued model notice, Notice of Case Status, which is to be sent to enrollee when the plan has sent a request to the IRE. In the universe provided of 781 cases, 10 cases were selected and in 3 of the cases, the plan failed to make the coverage determination timely.

Corrective Action Required:

Care1st of AZ must revise its policies and procedures to include a provision that the sponsor use a notice consistent with CMS-issued model notice, Notice of Case Status, which is to be sent to enrollee when the plan has sent a request to the IRE. Refer to 42 CFR § 423.568 (c)(2) and Chapter 18 Part D Enrollment Grievances, Coverage Determinations, and Appeals, 40.3.3, 40.4 and Appendix 6. It must submit the revised policies and procedure and the approved Notice of Case Status to CMS with its CAP. Care1st must describe the steps it is taking to ensure that it notifies members of standard coverage determinations within the required timeframes. Corrective action must also include a description of Care1st plans for ongoing monitoring of its performance and training of appropriate staff on the process. For the later, submit documentation that details the nature of this training, including the materials used in the training, the individuals conducting the training, the names of individuals being trained and the date training is completed, and submit to CMS as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Standard Coverage Determinations Concerning Benefits (Part D) to determine compliance with requirements for this element and found that policies and procedures are missing a provision that the sponsor use a notice consistent with CMS-issued model notice, Notice of Case Status, which is to be sent to enrollee when the plan has sent a request to the IRE. In the universe of 6 cases, there was one case that was incorrectly entered in the plan system. This caused each drug on a single claim to be entered separately, when the case should have been treated as a single claim, and therefore caused the other cases to be misclassified.

Corrective Action Required:

Care1st of AZ must revise its policies and procedures to include a provision that the sponsor use a notice consistent with CMS-issued model notice, Notice of Case Status, which is to be sent to enrollee when the plan has sent a request to the IRE. Refer to 42 CFR § 423.568 (c)(2) and Chapter 18 Part D Enrollment Grievances, Coverage Determinations, and Appeals, 40.3.3, 40.4 and Appendix 6. The plan must also correct their internal coding to make sure that cases are correctly coded and resubmit corrected universe for Standard Coverage Determinations Concerning Payments (WSCD2_D) for the same review period, 9/1/06 through 2/28/07 as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

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:

In the universe provided for Standard Coverage Determinations Concerning Benefits (Part D) (WSCD1_D), there were 340 cases. There were 3 cases reviewed, and in 2 of them, the plan did not use a notice compliant with CMS requirements. The plan used a letter of Suggested Formulary Agents and not a notice consistent with CMSs Notice of Denial of Medicare Prescription Drug Coverage. The notice used did not afford the member appeal rights. In the universe provided for Standard Coverage Determinations Concerning Payments (Part D) (WSCD2_D) was not met because of misclassification errors.

Corrective Action Required:

Care1st of AZ must stop using the Suggested Formulary Letter and only use the Notice Denial of Medicare Prescription Drug Coverage notice, when denying Coverage Determination. The plan must also correct their internal coding to make sure that cases are correctly coded and resubmit a corrected universe for Standard Coverage Determinations Concerning Payments (Part D) (WSCD2_D) for the same review period, 9/1/06 through 2/28/07 as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures and a sample of Expedited Coverage Determinations (Part D) to determine compliance with requirements for this element and found them missing (1) a discussion of means for issuing prompt decisions on expediting determinations in accordance with CMS requirements. (2) A statement that all oral requests must be documented in writing and that documentation of request must be maintained in case file. (3) A discussion of a means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, a provision for issuing prompt decisions on expediting determinations in accordance with CMS requirements, a statement that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Please refer to 42 CFR § 423.570(c)(3) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.1, 50.2 and 50.4. The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD07
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
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Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures and a sample of Expedited Coverage Determinations (Part D) to determine compliance with requirements for this element and found that policies and procedures are missing a provision for the timeliness of an expedited coverage determination denial notification following the decision to deny request for and expedited coverage determination.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include missing a provision for the timeliness of an expedited coverage determination denial notification following the decision to deny request for and expedited coverage determination. Please refer to 42 CFR § 423.570(d) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.3. The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD08
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a Sample Expedited Coverage Determinations (Part D) to determine compliance with requirements for this element and found that the plans policies and procedures are missing (1) a provision stating that oral and written notice must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations. (2) a provision that oral and written notice must inform the enrollee of the right to an expedited grievance. (3) a provision that oral and written notice must inform the enrollee or the right to resubmit a request for an expedited determination with the prescribing physicians support. (4) a provision that oral and written notice must provide instructions about the Part D sponsors grievance process and timeframes. (5) The plans denial notice is not consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, (1) a provision stating that oral and written notice must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations. (2) a provision that oral and written notice must inform the enrollee of the right to an expedited grievance. (3) a provision that oral and written notice must inform the enrollee or the right to resubmit a request for an expedited determination with the prescribing physicians support. (4) a provision that oral and written notice must provide instructions about the Part D sponsor¿s grievance process and timeframes. Please refer to 42 CFR § 423.570(d)(2) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.3. The plan must submit corrected Policies and Procedures as part of its CAP. Also, Care1st must submit a notice consistent with CMS-issued model notice, Notice of Right to and Expedited Grievance by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Expedited Coverage Determinations (Part D) to determine compliance with requirements for this element and found that policies and procedures are missing (1) A provision stating that the sponsor must make its expedited coverage determination and notify the enrollee of its decision as expeditiously as the enrollees health condition requires, but no later than 24 hours after receiving the request, or for an exceptions request, the physicians supporting statement. (2) A provision stating that if the decision is adverse and the sponsor first notifies the enrollee of the determination orally, the sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. (3) A provision stating that the sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, (1) A provision stating that the sponsor must make its expedited coverage determination and notify the enrollee of its decision as expeditiously as the enrollees health condition requires, but no later than 24 hours after receiving the request, or for an exceptions request, the physicians supporting statement. (2) A provision stating that if the decision is adverse and the sponsor first notifies the enrollee of the determination orally, the sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. (3) A provision stating that the sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Please refer to 42 CFR § 423.570(e), 423.572 (a-b), 423.572 (d), 423.578 (c) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.4 and 50.6. The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Expedited Coverage Determinations to determine compliance with requirements for this element and found that policies and procedures are missing a provision stating that if the decision is adverse, then the sponsor must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and must include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy CMS requirements. The sponsor did not demonstrate use of the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. In the universe of 133 cases CMS reviewed 10 and in these 10 cases the plan did not provide a copy of the notice used or used a notice that was not consistent with CMS Notice of Denial of Medicare Prescription Drug Benefits.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, missing a provision stating that if the decision is adverse, then the sponsor must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and must include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy CMS requirements. Please refer to 42 CFR § 423.570(c) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.5. The plan must submit corrected Policies and Procedures as part of its CAP. Also Care1st must submit a notice consistent with CMS-issued model notice, Notice of Denial of Medicare Prescription Drug Coverage by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, and a notice to determine compliance with requirements for this element and found that policies and procedures are missing provisions (1) stating that an enrollee, and enrollees appointed representative, or an enrollees prescribing physician is permitted to file a request for a tiering exception. (2) stating that if a sponsor requires a written statement from the prescribing physician, it must do so immediately. (3) stating that the physicians statement must indicate that the preferred drug for the treatment of the enrollees condition would not be effective as the requested drug and/or would have adverse effects, further the prescribing physician must demonstrate in his written statement on for the two factors. (4) that if a sponsor makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. (5) stating that the sponsor must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, in support of a tier exception request, the sponsor must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the exception. (6) that a sponsor must grant a tier exception when it determines that the preferred drug for treatment of the enrollees condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. (7) noting that the sponsor cannot restrict the number of exception requests submitted by the enrollee. The sponsor did not demonstrate it uses a notice consistent with the CMS-issued standard notice, Request for Additional Information.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, missing provisions (1) stating that an enrollee, and enrollees appointed representative, or an enrollees prescribing physician is permitted to file a request for a tiering exception. (2) stating that if a sponsor requires a written statement from the prescribing physician, it must do so immediately. (3) stating that the physicians statement must indicate that the preferred drug for the treatment of the enrollees condition would not be effective as the requested drug and/or would have adverse effects, further the prescribing physician must demonstrate in his written statement on for the two factors. (4) that if a sponsor makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. (5) stating that the sponsor must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, in support of a tier exception request, the sponsor must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the exception. (6) that a sponsor must grant a tier exception when it determines that the preferred drug for treatment of the enrollees condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. (7) noting that the sponsor cannot restrict the number of exception requests submitted by the enrollee. Please refer to 42 CFR § 423.578(b)(1,2 and 5) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 30.2.2. The plan must submit corrected Policies and Procedures as part of its CAP. Also Care1st must submit a notice consistent with CMS-issued model notice for requesting additional information from the enrollees prescribing physician submitting it to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

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

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, provisions stating that coverage is provided for approved tiering exceptions as the same cost-sharing level as preferred drugs and that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and further that all approved non-formulary drugs must be placed in existing cost-sharing tier(s). Please refer to 42 CFR § 423.578(c)(3 and 423.578(c)(4)(i-ii). The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures and a notice template to determine compliance with requirements for this element and found that the plan either did not provide or is not using a CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug. In reviewing the samples that Care1st of AZ provided for this requirement, CMS found that cases were not correctly categorized, and in a universe of 10, 8 cases were classified incorrectly.

Corrective Action Required:

Care1st of AZ must develop a notice that is consistent with CMS issued notice, Notice of Inquiry Regarding an Excluded Drug and submit it to CMS using HPMS to obtain approval, and submit the approve notice as part of its CAP. The plan must also correct it internal coding to make sure that cases are correctly coded and resubmit corrected universe for Standard Grievances (Part D) (Worksheet GV1_D) for the same review period, 9/1/06 through 2/28/07 as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures and a notice template to determine compliance with requirements for this element and found that the plan does not have a provision for tracking and maintaining, at a minimum, the date or receipt, disposition of the grievance, and the date that the enrollee was notified of the disposition, nor does the plan have documentation demonstrating its systems for capturing enrollees grievances in a centralized location.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include a provision for tracking and maintaining, at a minimum, the date or receipt, disposition of the grievance, and the date that the enrollee was notified of the disposition, nor does the plan have documentation demonstrating its systems for capturing enrollees grievances in a centralized location. Refer to 42 CFR § 423.564 (g) to obtain this information. It must be submitted the revised policies and procedures to CMS with its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

MA-PD Solicitation

Deficiencies:

CMS reviewed policies and procedures to determine compliance with requirements for this element and found that the plan does not have a provision for training relevant staff and contractors on grievance policies and procedures, nor do they document that it has and implemented trainings on grievance policies and procedures. Examples acceptable to document this include: Attendance logs, Sign-in sheets, etc.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include a provision for training relevant staff and contractors on grievance policies and procedures, the plan must document that it has implemented trainings on grievance policies and procedures. Examples acceptable to document this include: Attendance logs, Sign-in sheets, etc. The plan must develop and implement a training program and provide documentation of training conducted. Care1st must submit the revised/new policies and procedures to CMS with its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Standard Grievances (Part D) to determine compliance with requirements for this element and found that the sponsor is not using a notice consistent with CMS-issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance.

Corrective Action Required:

Care1st of AZ must develop and submit a notice consistent with CMS-issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Standard Grievances (Part D) to determine compliance with requirements for this element and found that the sponsor is not using a notice consistent with CMS-issued model notice, Notice of Plans Decision Regarding a Grievance.

Corrective Action Required:

Care1st of AZ must develop and submit a notice consistent with CMS-issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures and notice template to determine compliance with requirements for this element and found that (1) policies and procedures are missing a provision stating that all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing. (2) policies and procedures are missing a provision stating the sponsors commitment to cooperating with the QIO in resolving grievance cases. (3) policies and procedures are missing a provision stating that sponsor responds to quality of care grievances in writing. (4) the sponsor is missing an approved notice consistent with CMS-issued model notice, Notice of Plans Decision Regarding a Grievance.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include missing a provision stating that all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing, a provision stating the sponsors commitment to cooperating with the QIO in resolving grievance cases, missing a provision stating that sponsor responds to quality of care grievances in writing. Please refer to 42 CFR § 423.564(e)(3)(iii) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 20.2.1. The plan must submit corrected Policies and Procedures as part of its CAP. Care1st must submit a notice consistent with CMS-issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures to determine compliance with requirements for this element and found that policies and procedures are missing a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Please refer to 42 CFR § 423.586 and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.5. The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures to determine compliance with requirements for this element and found that policies and procedures are missing provisions that names a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals, and a provision for documenting all oral request in writing, and further a provision for maintaining documentation of expedited redetermination requests in a case file.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, provisions that names a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals, and a provision for documenting all oral request in writing, and further a provision for maintaining documentation of expedited redetermination requests in a case file. Please refer to 42 CFR § 423.570(d)(2) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.3. The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures and the Sample WS-RE3_D to determine compliance with requirements for this element and found that policies and procedures are missing provisions (1) stating that the decision to accept or deny an expedited redetermination request is based on the enrollees request indicating that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollees life, health or ability to regain maximum function. (2) stating that the sponsor automatically expedites a request when the enrollees physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollees life, health, or ability to regain maximum function. (3) stating that any additional medical information the sponsor requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, (1) stating that the decision to accept or deny an expedited redetermination request is based on the enrollees request indicating that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollees life, health or ability to regain maximum function. (2) stating that the sponsor automatically expedites a request when the enrollees physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollees life, health, or ability to regain maximum function. (3) stating that any additional medical information the sponsor requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. Please refer to 42 CFR § 423.584(c)(2) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.8.1. The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Requests for Expedited Redeterminations (Part D) to determine compliance with requirements for this element and found that policies and procedures are missing a provision stating that the sponsor must provide prompt oral notice to the enrollee, and provide equivalent written notice with 3 calendar days of the oral notice. The sponsor did not provide evidence of using a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, a provision stating that the sponsor must provide prompt oral notice to the enrollee, and provide equivalent written notice with 3 calendar days of the oral notice. The sponsor did not provide evidence of using a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance. Please refer to 42 CFR § 423.584(d, e) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.8.1. The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Requests for Standard Redeterminations Concerning Drug Benefits (Part D) (WS-RE1_D) to determine compliance with requirements for this element and found that policies and procedures are missing a provision stating that the sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. The sponsor did not provide documentation to demonstrate use of the CMS-issued model notices, Notice of Redetermination, Request for Reconsideration, or Notice of Case Status. From a universe of 5, 5 cases were provided by Care1st of AZ, and the 5 cases were not compliant in providing the member with the CMS Request for Reconsideration Notice or a notice consistent with CMS requirements. Therefore, we were not able to determine whether Care1st is making timely standard redeterminations.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, provision stating that the sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. The sponsor did not provide documentation to demonstrate use of the CMS-issued model notices, Notice of Redetermination, Request for Reconsideration, or Notice of Case Status. Please refer to 42 CFR § 423.590(a)(1-2), 423.590(c), 423.590(g)(1-4), 423.636(1), and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.1, 70.7, and 130.1. The plan must submit corrected Policies and Procedures, and the notices once they are approved by CMS as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures and a notice to determine compliance with requirements for this element and found that policies and procedures are missing a provision stating that the sponsor must inform the enrollee, within 24 hour, when the case is forwarded to the IRE. The sponsor did not provide documentation of use CMS-issued model notices, Notice of Redetermination, Request for Reconsideration, or Notice of Case Status.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, a provision stating that the sponsor must inform the enrollee, within 24 hour, when the case is forwarded to the IRE. The sponsor did not provide documentation of use CMS-issued model notices, Notice of Redetermination, Request for Reconsideration, or Notice of Case Status. Please refer to 42 CFR § 423.636(a)(2) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.10. The plan must submit corrected Policies and Procedures as part of its CAP. Also Care1st must submit a notice consistent with CMS-issued model notices, Notice of Redetermination and Request for Reconsideration to CMS using HPMS to obtain approval, and submit the approve notice as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Requests for Expedited Redeterminations (Part D) to determine compliance with requirements for this element and found that policies and procedures are missing a provisions (1) stating that the sponsor must inform the enrollee (and the prescribing physician involved, as appropriate) of its redetermination as expeditiously as the enrollees health condition requires, but no later than 72 hours after it received the request for an expedited redetermination. (2) indicating that notification of a favorable decision be made orally or in writing. (3) that medical information must be requested within 24 hours of the enrollees initial request. (4) that sponsor must inform enrollee within 24 hour, when the case is forwarded to the IRE. The sponsor did not provide documentation of use CMS-issued model notices, Notice of Redetermination, Request for Reconsideration, or Notice of Case Status. There was only one case in the universe for Requests for Expedited Redeterminations and this case did not contain evidence that the Request for Reconsideration notice was sent to member.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include, provisions (1) stating that the sponsor must inform the enrollee (and the prescribing physician involved, as appropriate) of its redetermination as expeditiously as the enrollees health condition requires, but no later than 72 hours after it received the request for an expedited redetermination. (2) indicating that notification of a favorable decision be made orally or in writing. (3) that medical information must be requested within 24 hours of the enrollees initial request. (4) that sponsor must inform enrollee within 24 hour, when the case is forwarded to the IRE. Please refer to 42 CFR § 423.584 (e), 423.590(d-e), 423.638(a) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.8.1. The plan must submit corrected Policies and Procedures as part of its CAP. Also, Care1st must submit a notice consistent with CMS-issued model notices, Notice of Redetermination and Request for Reconsideration to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE08
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures to determine compliance with requirements for this element and found that policies and procedures are missing a provision for authorizing or providing the benefits in dispute within 72 hour required timeframe.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include a provision for authorizing or providing the benefits in dispute within 72 hour required timeframe. Please refer to 42 CFR § 423.638(a) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 130.2.2. The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures to determine compliance with requirements for this element and found that policies and procedures are missing a provision stating that if the issue is a denial based on lack of medical necessity, then the 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.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include a provision stating that if the issue is a denial based on lack of medical necessity, then the 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. Please refer to 42 CFR § 423.590(f)) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.6. The plan must submit corrected Policies and Procedures as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures and samples to determine compliance with requirements for this element and found that policies and procedures are missing 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 that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. There was only one case in the universe for Requests for Expedited Redeterminations and this case did not contain evidence that the Request for Reconsideration notice was sent to member.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to 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 that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. The plan must develop a process to make sure it sends the required notices to members. Please refer to Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.20, 70.30 and Appendix 6. The plan must submit corrected Policies and Procedures, and process to monitor notices being sent to members as part of its CAP.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Requests for Standard Redeterminations Concerning Drug Benefit (Part D) to determine compliance with requirements for this element and found that the sponsor did not demonstrate use of a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity

Corrective Action Required:

Care1st of AZ must submit a notice consistent with CMS-issued model notices, Notice of Effectuation to Part D Independent Review Entity to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP. Please refer to Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 130.3.1 and Appendix 9.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Requests for Standard Redeterminations Concerning Drug Benefit (Part D) to determine compliance with requirements for this element and found that the sponsor did not demonstrate use of a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity.

Corrective Action Required:

Care1st of AZ must submit a notice consistent with CMS-issued model notices, Notice of Effectuation to Part D Independent Review Entity to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP. Please refer to Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 130.3.1 and Appendix 9.

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: 481
Contract Number: H5430
Part D Sponsor Name: CARE1ST HEALTH PLAN OF ARIZONA

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 10/12/2007
Date Report Due: 11/26/2007
Element Accepted Date: 12/9/2007
Element Release Date: 12/9/2007
Element Projected Completion Date: 12/1/2007

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 8/28/2007
Actual Visit End Date: 8/29/2007
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 11/26/2007
CAP Release Date: 12/12/2007
CAP Accepted Date: 12/12/2007

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures, a notice and a sample of Requests for Standard Redetermination Concerning Drug Benefits (Part D) to determine compliance with requirements for this element and found that the sponsor is missing a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollees health requires but no later than 24 hours after the date it receives notice reversing the decision, and the sponsor did not demonstrate use of a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity.

Corrective Action Required:

Care1st of AZ must update its policies and procedures to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollees health requires but no later than 24 hours after the date it receives notice reversing the decision. Please refer to Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 130.3.1 and Appendix 9. The plan must submit corrected Policies and Procedures as part of its CAP. Also, Care1st must submit a notice consistent with CMS-issued model notices, Notice of Effectuation to Part D Independent Review Entity to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.