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: H5431
Audit ID: 3461
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date: 8/1/2008
Element Release Date: 8/1/2008
Element Projected Completion Date: 8/30/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.

Reference:

42 CFR § 423.50(a)(1); § 423.50(a)(3); MA-PD Solicitation; Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

HealthSun does not meet this requirement. CMS requested Part D notice templates that HealthSun uses in the following situations: - requesting additional information consistent with CMS issued model notice, Request for Additional Information, and - requesting a reconsideration consistent with CMS issued model notice, Request for Reconsideration. These notice templates did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left hand corner in accordance with CMS Marketing guidelines.

Corrective Action Required:

HealthSun must submit the following notices consistent with CMS issued model notices to the Region IV Plan Manager for review and approval: - Request for Additional Information, and - Request for Reconsideration.

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Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing (MARK 16 Oversight of Marketing Practices, MARK 13 Marketing Controls and Audits, and MARK 3 Sales Representatives Training) and found they do not include: - a requirement that all persons marketing on behalf of HealthSun be state licensed, certified or registered individuals, and - a requirement that any person directly employed or contracted to market on behalf of HealthSun provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. During Staff Discussions, HealthSun staff stated that it conducts ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that all persons marketing on behalf of HealthSun be state licensed, certified, or registered individuals. However, this requirement must be included in written policies and procedures. CMS requested documentation demonstrating that HealthSun conducts ongoing monitoring of the marketing activities of internal and external marketing representatives. HealthSun did not provide documentation confirming that HealthSun's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. CMS reviewed 6 sample contracts for individuals who perform marketing from a universe of 6 and found that 6 out of 6 samples were noncompliant. Specifically, the 6 samples did not demonstrate a provision within the contract or compensation structure requiring the person employed to perform marketing on behalf of HealthSun provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Additionally, 2 out of the 6 sample contracts did not include a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal healthcare laws (including civil monetary penalty laws).

Corrective Action Required:

HealthSun must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing (MARK 16 Oversight of Marketing Practices, MARK 13 Marketing Controls and Audits, and MARK 3 Sales Representatives Training) to include: - a requirement that all persons marketing on behalf of HealthSun be state licensed, certified or registered individuals, and - a requirement that any person directly employed or contracted to market on behalf of HealthSun provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. HealthSun must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must provide CMS with documentation that its marketing program monitoring activities confirm that HealthSun's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool or sample form used by sales managers or directors in conducting evaluations of sales agents. HealthSun must include provisions within its marketing contract or compensation structure requiring any person employed to perform marketing on behalf of HealthSun provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with HealthSun. The person may be compensated based on your enrollment in a plan'. Additionally, HealthSun must include a provision within its marketing contracts or compensation structures stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal healthcare laws (including civil monetary penalty laws). HealthSun must provide CMS with documentation demonstrating this (i.e., copies of the signed contract or compensation structure containing these required provisions).

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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: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed 10 sample cases for beneficiaries affected by a formulary change from a universe of 82 and found 10 out of 10 samples were noncompliant. In 10 out of 10 samples HealthSun did not demonstrate that the beneficiary notice was provided at least 60 days prior to the date the formulary change became effective. In 10 out of 10 sample cases where 60 day notice was not provided, no evidence was submitted that HealthSun authorized a 60 day supply of the Part D drug under the same terms as previously allowed. Furthermore, the notice used was not CMS compliant. Specifically, the notice did not provide a description of alternate drugs in the same therapeutic category, class, or cost-sharing tier, and the expected cost-sharing for those drugs. The notice also did not contain an explanation of the means by which the enrollee may obtain an updated coverage determination or an exception to a coverage determination.

Corrective Action Required:

Prior to removing a covered Part D drug from its formulary or making any changes to the preferred tiered cost -sharing status of a covered Part D drug, HealthSun must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide enrollees with a 60 day supply of the Part D drug under the same terms previously allowed. Additionally, HealthSun must use a notice that is compliant with the model notice or CMS requirements (Model Notice 10, Chapter 18 of the Prescription Drug Benefit Manual). HealthSun must submit documentation to CMS demonstrating this.

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: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PH03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding access to long term care pharmacies (Medicare Part D Transition Policy) and found it did not include a provision stating that HealthSun must offer standard contracting terms and conditions, including performance and service criteria for long term care pharmacies that CMS specifies, to any long term care pharmacy in its service area that requests the contract.

Corrective Action Required:

HealthSun must revise its policies and procedures regarding access to long term care pharmacies (Medicare Part D Transition Policy) to include a provision stating that HealthSun must offer standard contracting terms and conditions, including performance and service criteria for long term care pharmacies that CMS specifies, to any long term care pharmacy in its service area that requests the contract. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/28/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policies and procedures for providing notification of formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage (Policy Com PT 002 Response To Immediate Threat To Health and Safety Situations, Policy MED PT 001 Formulary Changes) and found the policies and procedures did not include: - a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, - 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, - a provision with a description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, and - a description of the method(s) used to provide notification of formulary changes.

Corrective Action Required:

HealthSun must revise its policies and procedures for providing notification of formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage (Policy Com PT 002 Response To Immediate Threat To Health and Safety Situations, Policy MED PT 001 Formulary Changes) to include: - a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, - 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, - a provision with a description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, and - a description of the method(s) used to provide notification of formulary changes. HealthSun must conduct training of appropriate staff on these policies and procedures, including appropriate time frames and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: TP02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding the transition process for residents of long term care facilities (Medicare Part D Transition Policy) and found it did not include: - requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and - a provision to abide by extensions to the transition period in accordance with CMS policy. In addition, CMS requested system reports regarding HealthSun's transition process utilization for LTC residents. HealthSun was unable to provide system reports demonstrating that it implements the transition process for LTC residents as described in its policy and procedure and consistent with its contractual requirements. HealthSun was also unable to demonstrate that it has and implements a transition process that covers an emergency supply or 'first fill' of nonformulary Part D drugs.

Corrective Action Required:

HealthSun must revise its policy and procedure regarding the transition process for residents of long-term care facilities (Medicare Part D Transition Policy) to include: - requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and -a provision to abide by extensions to the transition period in accordance with CMS policy. HealthSun must conduct training of appropriate staff on each of this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must develop a system report regarding its transition process utilization for LTC residents to demonstrate that: - it correctly implements the transition process for LTC residents as described in its policy and procedure and consistent with its contractual requirements, and - it has and implements a transition process that covers an emergency supply or `first fill' of nonformulary Part D drugs.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5431
Audit ID: 3461
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CN05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.

Reference:

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

Deficiencies:

Over 30% of the cases provided for worksheet WS-CN2_D were misclassified. The universe provided by HealthSun is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

HealthSun must provide CMS with an analysis and explanation of why the universe submitted for WS-CN2_D contained misclassified samples. Based on this analysis, HealthSun must provide to CMS the root cause as well as a detailed corrective action plan.

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Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 8/30/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's documentation demonstrating that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception and found it did not demonstrate that HealthSun's network pharmacies meet the requirement for posting or distributing notices.

Corrective Action Required:

HealthSun must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits conducted by HealthSun or its pharmacy benefit manager. HealthSun must conduct training of appropriate staff on the process regarding ongoing monitoring of network pharmacies and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date: 8/1/2008
Element Release Date: 8/1/2008
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
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Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

42 CFR § 423.566(a); § 423.566(b); § 423.566(c); § 423.570(c)(1-2); 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:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure for receiving, tracking, addressing, and maintaining records of coverage determinations (G and A Part D 12 Part D Standard and Expedited Coverage Determinations Process) and found that the policy did not include provisions: -for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing, -fully defining coverage determination in accordance with § 423.566(b)(1-5), and -for quarterly reporting of all data requested in Reporting Requirements: Appeals.

Corrective Action Required:

HealthSun must revise its policy and procedure for receiving, tracking, addressing, and maintaining records of coverage determinations (G and A Part D 12 Part D Standard and Expedited Coverage Determinations Process) to include provisions: -for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing, -fully defining coverage determination in accordance with § 423.566(b)(1-5), and -for quarterly reporting of all data requested in Reporting Requirements: Appeals HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
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Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefits from a universe of 68 and found 10 out of 10 samples were noncompliant. Specifically, 10 out of 10 samples did not demonstrate that HealthSun provided timely notification of the coverage determination decision to the enrollee. Failure to notify the enrollee of HealthSun's decision within a timeframe that is CMS compliant constitutes an adverse coverage determination requiring HealthSun to forward the enrollee's case file to the IRE and provide notification of this to the enrollee within 24 hours of the expiration of the adjudication timeframe. HealthSun did not demonstrate that the 10 case files were forwarded to the IRE or that the enrollee was notified.

Corrective Action Required:

HealthSun must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If HealthSun fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, HealthSun must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding enrollee notification of coverage determinations concerning payment (G and A Part D 12 Part D Standard and Expedited Coverage Determinations Process) and found that the policy did not include provisions stating that: -HealthSun must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -HealthSun must 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.

Corrective Action Required:

HealthSun must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (G and A Part D 12 Part D Standard and Expedited Coverage Determinations Process) to include provisions stating that: -HealthSun must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -HealthSun must 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. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding enrollee notification following a decision on an expedited coverage determination (G and A Part D 12 Part D Standard and Expedited Coverage Determinations Process) and found that the policy did not contain a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.

Corrective Action Required:

HealthSun must revise its policy and procedure regarding enrollee notification following decision on expedited coverage determination (G and A Part D 12 Part D Standard and Expedited Coverage Determinations Process) to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. HealthSun must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding processing requests for exceptions to its tiered cost-sharing structure (G and A Part D 13 Tiering and Formulary Exception Process) and found the policy did not include provisions stating that: - if HealthSun requires a written statement from the enrollee's prescribing physician, it must request one immediately, and - HealthSun must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. Additionally, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm the provision stating that if HealthSun is waiting on a physician's statement in support of a tiering exception request, HealthSun 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, HealthSun staff stated that HealthSun waits a maximum of 72 hours for both standard and expedited requests before issuing a determination, and therefore, did not state the appropriate timeframe.

Corrective Action Required:

HealthSun must revise its policy and procedure regarding processing requests for exceptions to its tiered cost-sharing structure (G and A Part D 13 Tiering and Formulary Exception Process) to include provisions stating that: - if HealthSun requires a written statement from the enrollee's prescribing physician, it must request one immediately, and - HealthSun must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must conduct training of appropriate staff to ensure that staff is aware that HealthSun must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding processing requests for exceptions for non-formulary drugs (G and A Part D 13 Tiering and Formulary Exception Process) and found the policy did not include a provision stating that HealthSun `must grant a formulary exception when it determines that one of the three factors (listed below) has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug'. (1) All covered Part D drugs on any tier of HealthSun's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. Specifically, the language in quotation marks is missing. Additionally, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm the provision stating that if HealthSun is waiting on a physician's statement in support of a formulary exception request, HealthSun 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, HealthSun staff stated that HealthSun waits a maximum of 72 hours for both standard and expedited requests before issuing a determination, and therefore, did not state the appropriate timeframe.

Corrective Action Required:

HealthSun must revise its policy and procedure regarding processing requests for exceptions for non-formulary drugs (G and A Part D 13 Tiering and Formulary Exception Process) to include a provision stating that HealthSun must grant a formulary exception when it determines that one of the three factors (listed above) has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must conduct training of appropriate staff to ensure that staff is aware that HealthSun must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding determining cost-sharing for approved exceptions (G and A Part D 13 Tiering and Formulary Exception Process) and found the policy did not include a provision stating that all approved non-formulary drugs must be placed in existing cost-sharing tiers. Additionally, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm the provision stating that enrollees are not required to request an approval of a request for a tiering or nonformulary exception following the initial prescription for the remainder of the plan year, HealthSun staff stated that approvals are granted for 3 to 6 months, but normally for 3 months and never for more than 6, and therefore, did not state the appropriate timeframe.

Corrective Action Required:

HealthSun must revise its policy and procedure regarding determining cost-sharing for approved exceptions (G and A Part D 13 Tiering and Formulary Exception Process) to include a provision stating that all approved non-formulary drugs must be placed in existing cost-sharing tiers. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must conduct training of appropriate staff to ensure that staff is aware that enrollees are not required to request an approval of a request for a tiering or nonformulary exception following the initial prescription for the remainder of the plan year and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding the categorization of complaints as inquiries, grievances, or coverage determinations (Policy 009 General Responsibilities for Categorizing Complaints as either a Grievance, Coverage Determination, or Both) and found it did not include a provision for promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals. In addition, CMS requested documentation that demonstrates that HealthSun has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures, and HealthSun was unable to provide this documentation. During Staff Discussions, HealthSun staff stated that members are notified verbally, and annually through the Evidence of Coverage of whether complaints are subject to grievance procedures or coverage determination procedures. However, HealthSun was unable to provide documentation that demonstrated this. Furthermore, CMS reviewed a sample of 15 standard grievances from a universe of 24 and found that 15 out of 15 samples were noncompliant. Specifically, in all 15 samples the enrollee was not informed whether their complaint was subject to grievance procedures or coverage determination procedures. Additionally, in 3 out of the 15 samples the cases were incorrectly categorized, as they were coverage determinations and not grievances.

Corrective Action Required:

HealthSun must revise its policy and procedure regarding the categorization of complaints as inquiries, grievances, or coverage determinations (Policy 009 General Responsibilities for Categorizing Complaints as either a Grievance, Coverage Determination, or Both) to include a provision for promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must provide documentation to CMS demonstrating that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. HealthSun must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures and submit documentation demonstrating this to CMS. HealthSun must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.

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: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding tracking, addressing, and maintaining records of grievances (Policy 11 Part D Standard and Expedited Grievance Process) and found it did not include a provision for accepting information or evidence concerning the grievance. In addition, CMS reviewed HealthSun's documentation demonstrating its means for ensuring the timely resolution of enrollee grievances, (Part D Grievance/Coverage Determinations, template) and found it is unable to demonstrate tracking, addressing or timely resolution of enrollee grievances and did not track at a minimum: - the date of receipt of the grievance, - mode of receipt (e.g., fax, telephone, letter, etc.), and - the date HealthSun notified the enrollee of the disposition.

Corrective Action Required:

HealthSun must revise its policies and procedures regarding tracking, addressing, and maintaining records of grievances (Policy 11 Part D Standard and Expedited Grievance Process) to include a provision for accepting information or evidence concerning the grievance. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must revise its systems for logging and capturing enrollee grievances in a centralized location, to include at a minimum: - the date of receipt of the grievance, - mode of receipt (e.g., fax, telephone, letter, etc.), and - the date HealthSun notified the enrollee of the disposition.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure regarding enrollee notification of grievance disposition (Policy 11 Part D Standard and Expedited Grievance Process) and found it did not include a provision stating that all concerned parties must be notified of the grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but not later than 30 days after HealthSun receives the oral or written grievance. In addition, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when asked to confirm the provision stating that the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if HealthSun justifies a need for additional information and documents how the delay is in the interest of the enrollee, HealthSun staff stated `we deal with everything in 72 hours.' The question was repeated and HealthSun staff stated `if we are missing any documents they are usually from the doctor' and once again stated `we deal with everything within 72 hours,' and, therefore, did not state the appropriate requirement or timeframe. Furthermore, CMS reviewed a sample of 15 standard grievances from a universe of 24 and found that 11 out of 15 samples were noncompliant. Specifically, in 11 of the 15 samples HealthSun did not demonstrate that the enrollee was notified of the grievance resolution within the CMS approved timeframe.

Corrective Action Required:

HealthSun must revise its policy and procedure regarding enrollee notification of grievance disposition (Policy 11 Part D Standard and Expedited Grievance Process) to include a provision stating that all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but not later than 30 days after HealthSun receives the oral or written grievance. HealthSun must conduct training of appropriate staff on this policy and procedure, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must conduct training of appropriate staff to ensure that staff is aware the 30 day timeframe for a grievance may be extended by 14 days or less if the enrollee requests the extension or if HealthSun justifies a need for additional information and documents how the delay is in the interest of the enrollee and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must always notify the enrollee of grievance resolutions within the CMS approved timeframes and submit documentation demonstrating this to CMS.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed a sample of 15 standard grievances from a universe of 24 and found 11 out of 15 samples were noncompliant. Specifically, in 11 out of 15 samples HealthSun was unable to provide documentation demonstrating the method of grievance response was correct, as 11 out of 15 samples did not demonstrate the enrollee was notified of grievance resolution.

Corrective Action Required:

HealthSun must always notify the enrollee the of grievance resolution and provide documentation demonstrating this to CMS. Specifically, all written grievances must be responded to in writing. If a grievance is submitted orally and the enrollee requests a written response, HealthSun must respond in writing.

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: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement. While the policy and procedure (Policy 11 Part D Standard and Expedited Grievance Process) submitted for this audit is compliant with CMS requirements regarding grievances related to quality of care, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked how a quality of care complaint is handled and how the enrollee would be informed, HealthSun staff stated the Medical Director handles all QIO issues and the enrollee is informed orally, and, therefore, did not state the appropriate requirement.

Corrective Action Required:

HealthSun must conduct training of appropriate staff to ensure that staff is aware that all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/28/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement because CMS reviewed HealthSun's policy and procedure for accepting and addressing requests for expedited redeterminations (G and A Part D 15, Standard and Expedited Redetermination (Appeals) of an Adverse Coverage Determination) and found it did not include: - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing.

Corrective Action Required:

HealthSun must revise its policy and procedure for accepting and addressing requests for expedited redeterminations (G and A Part D 15, Standard and Expedited Redetermination (Appeals) of an Adverse Coverage Determination) to include: - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. HealthSun must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement. While the policy and procedure entitled G and A Part D 15, Standard and Expedited Redetermination (Appeals) of an Adverse Coverage Determination submitted for this audit is compliant with CMS requirements, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm the provision stating that any medical information HealthSun requires must be requested within 24 hours of receiving the initial request for an expedited redetermination, HealthSun staff stated that the timeframe used for requesting additional medical information was 30 days and, therefore, did not state the appropriate timeframe.

Corrective Action Required:

HealthSun must conduct training of appropriate staff to ensure that staff is aware that any medical information HealthSun requires must be requested within 24 hours of receiving the initial request for an expedited redetermination and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement. While the policy and procedure G and A Part D 15, Standard and Expedited Redetermination (Appeals) of an Adverse Coverage Determination submitted for this audit is compliant with CMS requirements, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm the provision stating that HealthSun must transfer denied requests for an expedited redetermination to the standard timeframe, HealthSun did not indicate requests are transferred to a standard redetermination timeframe.

Corrective Action Required:

HealthSun must conduct training of appropriate staff to ensure that staff is aware that HealthSun must transfer denied requests for an expedited redetermination to the standard timeframe and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement. While the policy and procedure G and A Part D 15, Standard and Expedited Redetermination (Appeals) of an Adverse Coverage Determination submitted for this audit is compliant with CMS requirements, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm the provision stating that any medical information HealthSun requires must be requested within 24 hours of receiving the initial request for expedited redetermination, HealthSun staff stated that the timeframe used for requesting additional medical information was 30 days and, therefore, did not state the appropriate timeframe.

Corrective Action Required:

HealthSun must conduct training of appropriate staff to ensure that staff is aware that any medical information HealthSun requires must be requested within 24 hours of receiving the initial request for expedited redetermination and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Contract Number: H5431
Audit ID: 3461
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

HealthSun does not meet this requirement. While the policy and procedure G and A Part D 15, Standard and Expedited Redetermination (Appeals) of an Adverse Coverage Determination submitted for this audit is compliant with CMS requirements, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm the provision 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, HealthSun staff stated that the timeframe used for sending the information for a standard request to the IRE was 7 days, and, therefore, did not indicate the appropriate timeframe.

Corrective Action Required:

HealthSun must conduct training of appropriate staff to ensure that staff is aware 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 submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

While the policy and procedure (G and A Part D 16 Preparation and Processing Case Files for Independent Review Entity Level 2 of the Appeals Process) submitted for this audit is compliant with CMS requirements, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision, HealthSun staff stated that the benefit under dispute must be authorized or provided within 7 days from the date it receives notice reversing the decision, and therefore, did not state the appropriate timeframe.

Corrective Action Required:

HealthSun must conduct training of appropriate staff to ensure that staff is aware that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

While the policy and procedure (Policy G and A Part D 16, Preparation and Processing Case Files for Independent Review Entity Level 2 of the Appeals Process) submitted for this audit is compliant with CMS requirements, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm the provision stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision, HealthSun staff stated that payment was authorized within 7 days, and therefore, did not state the appropriate timeframe.

Corrective Action Required:

HealthSun must conduct training of appropriate staff to ensure that staff is aware that payment must be authorized no later than 72 hours from the date it receives notice reversing the decision and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3461
Contract Number: H5431
Part D Sponsor Name: HEALTHSUN HEALTH PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/15/2008
Date Report Due: 4/29/2008
Element Accepted Date:
Element Release Date:
Element Projected Completion Date: 4/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/28/2008
Estimated Visit Start Date: 2/1/2008
Actual Visit Start Date: 1/28/2008
Actual Visit End Date: 2/1/2008
Part D Sponsor Response Received Date: 5/1/2008
Part D Sponsor Response Due Date: 4/29/2008
CAP Release Date:
CAP Accepted Date:

Requirement:

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

Reference:

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

Deficiencies:

While the policy and procedure (G and A Part D 16 Preparation and Processing Case Files for Independent Review Entity Level 2 of the Appeals Process) submitted for this audit is compliant with CMS requirements, evidence obtained during Staff Discussions demonstrated that HealthSun is not implementing this policy and procedure in compliance with CMS requirements. Specifically, when HealthSun was asked to confirm the provision that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision, HealthSun staff stated that the benefit under dispute must be authorized within 72 hours for expedited requests, and therefore, did not state the appropriate timeframe.

Corrective Action Required:

HealthSun must conduct training of appropriate staff to ensure that staff is aware that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.