# *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:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** PC02
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 10/12/2007
**Element Projected Completion Date:** 9/12/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS requested Humana's policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) and found they were dated outside of the audit period. Specifically, the revision date is 04/03/2007. Humana was unable to provide the auditors with a document that contained provisions that was in effect during the audit period.

**Corrective Action Required:**

Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.

# *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:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 10/12/2007
**Element Projected Completion Date:** 9/12/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed Humana's policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing and they do not include a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: `The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' CMS requested documentation demonstrating that Humana conducts ongoing monitoring of the marketing activities of internal and external marketing representatives. The documentation submitted by Humana (field evaluation tool/sample form in Enclosure VI, MR06, Attachment 6) did not demonstrate that Humana's Marketing Program monitoring activities confirm that Humana's marketing representatives are providing a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The field evaluation tool only monitors for providing an oral disclosure statement, not written. CMS reviewed 10 samples cases for individuals who perform marketing from a universe of 22,776 and found the following: - 10 out of 10 samples did not include a provision requiring any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with (insert plan name(s). The person may be compensated based on your enrollment in a plan. - 8 out of 10 samples did not prohibit payments by person performing marketing to beneficiaries.

**Corrective Action Required:**

Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana 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. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana'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/sample form used by sales managers/directors in conducting evaluations of sales agents.

# *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:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/11/2007
**Element Release Date:** 10/11/2007
**Element Projected Completion Date:** 9/12/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS requested Humana's policies and procedures regarding beneficiary notification of formulary changes and found they were dated outside of the audit period (Formulary Change Notification During a Plan Year 2007-003). Specifically, the revision date is 04/03/2007. Humana was unable to provide the auditors with a document that contained provisions that was in effect during the audit period.

**Corrective Action Required:**

Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, `or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/11/2007
**Element Release Date:** 10/11/2007
**Element Projected Completion Date:** 9/12/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS requested Humana's policies and procedures regarding beneficiary notification of formulary changes and found they were dated outside of the audit period (Formulary Change Notification During a Plan Year 2007-003). Specifically, the revision date is 04/03/2007. Humana was unable to provide the auditors with a document that contained provisions that was in effect during the audit period.

**Corrective Action Required:**

Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) 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. Humana 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:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/11/2007
**Element Release Date:** 10/11/2007
**Element Projected Completion Date:** 9/12/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed Humana's policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations and found they were dated outside of the audit period (Standard Coverage Determinations). Specifically, the revision date is 04/05/2007. Humana was unable to provide the auditors with a document that contained provisions that was in effect during the audit period. Additionally, CMS requested Humana's policies and procedures regarding reporting requirements for appeals data elements and Humana did not submit any documentation.

**Corrective Action Required:**

Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/11/2007
**Element Release Date:** 7/15/2008
**Element Projected Completion Date:** 11/1/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed Humana's policies and procedures regarding enrollee notification of coverage determinations concerning drug benefits (Standard Coverage Determinations) and found they were dated outside of the audit period. Specifically, the revision date is 04/05/2007. Humana was unable to provide the auditors with a document that contained provisions that was in effect during the audit period. During Staff Discussions, Humana staff stated that the timeframe for all requests does not start until the supporting medical information is received. The sample case files reviewed support this finding. This is not compliant, as the timeframe for non-exceptions requests begins when the request is received. Additionally, during staff discussions Humana staff stated that it sends the notification letter to whoever initiated the request. In all cases the enrollee must be notified of the coverage determination decision. Moreover, sample case files demonstrated that when the physician initiated the request, Humana only notified the physician of its decision. CMS reviewed a sample of 10 requests from a universe of 22,066 cases of standard coverage determinations concerning drug benefits and found that in 5 of the 10 samples Humana did not demonstrate that it made a coverage determination concerning drug benefit in a timeframe consistent with CMS requirements.

**Corrective Action Required:**

Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new 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. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, 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, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.

# *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:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 3/15/2008
**Element Release Date:** 3/15/2008
**Element Projected Completion Date:** 12/31/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS requested Humana's policies and procedures regarding enrollee notification of coverage determinations concerning payment and Humana did not submit any policies and procedures for this area. The auditors did review a policy entitled `Letters of Notification Standard Coverage Determinations', however, that document did not contain the required provisions. This element requires provisions specific for coverage determinations concerning payment. CMS determined that the universe submitted for WS-CD2_D is not representative of samples that CMS requested and is inadequate for determining compliance.

**Corrective Action Required:**

Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana 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, - a provision stating that Humana 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 - a provision stating that Humana 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. Humana 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. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Audit ID:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CD05
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/11/2007
**Element Release Date:** 3/15/2008
**Element Projected Completion Date:** 11/1/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefits from a universe of 22,066. In four out of the four samples in which the standard coverage determination concerning drug benefits decision was adverse, the notice Humana used was not compliant. Specifically, the notice (Notice of Denial of Medicare Prescription Drug Coverage) did not contain the OMB control number in the upper right hand corner. Additionally, CMS determined that the universe submitted for WS-CD2_D is not representative of samples that CMS requested and is inadequate for determining compliance.

**Corrective Action Required:**

When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CD09
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/11/2007
**Element Release Date:** 7/15/2008
**Element Projected Completion Date:** 10/15/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS requested its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination (Expedited Coverage Determinations) and found they do not include a provision stating that the Part D sponsor must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks was not found. CMS reviewed expedited coverage determination cases and found that two out of the 10 cases provided from a universe of 69 were misclassified and, to account for this, the auditor reduced the sample size by two and made the sample size 8. CMS reviewed the sample of 8 requests for expedited coverage determinations and found that in 5 out of the 8 samples the enrollee was not notified of the expedited coverage determination decision in a timeframe that is compliant with CMS requirements.

**Corrective Action Required:**

Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, `within 24 hours' must be added. Humana 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. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.

# *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:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/11/2007
**Element Release Date:** 2/28/2008
**Element Projected Completion Date:** 10/1/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed Humana's policies and procedures regarding enrollee notification following a decision on an expedited coverage determination and found they do not include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. The policy Humana submitted for this element (`Letters of Notification Expedited Coverage Determinations') does not include any provisions for oral notification. Two out of the 10 cases provided from a universe of 69 cases of expedited coverage determinations were misclassified and, to account for this, the auditor reduced the sample size by 2 and made the sample size 8. CMS reviewed the sample of 8 requests for expedited coverage determinations and found that in 5 cases Humana did not use a standard notice when notifying the enrollee of an adverse expedited coverage determination decision. Specifically, the notice used (Notice of Denial of Medicare Prescription Drug Coverage) did not contain the required OMB control number in the upper right hand corner. Additionally, in one out of the 8 samples Humana did not demonstrate that the enrollee was notified of the expedited coverage determination decision.

**Corrective Action Required:**

Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana 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. Humana must also provide documentation to CMS demonstrating that it is using this notice when informing enrollees of its expedited coverage determination decisions.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 10/12/2007
**Element Projected Completion Date:** 9/12/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed Humana's policies and procedures regarding determining cost-sharing for approved exceptions and found they do not include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. The auditors reviewed HCPR 056, page 1, Attachment 1, and did not find this part of the required provision: `that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs'. CMS determined that the universe submitted for WS-CD2_D is not representative of samples that CMS requested and is inadequate for determining compliance.

**Corrective Action Required:**

Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana 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. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Audit ID:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/11/2007
**Element Release Date:** 3/15/2008
**Element Projected Completion Date:** 10/31/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS requested documentation demonstrating Humana's communication methods for informing enrollees of complaint categorization. Humana was unable to demonstrate that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Acceptable examples of this documentation would be phone scripts or copies of notices sent to the enrollee informing them of receipt of the grievance. The audit contractors did review Mentor. However, Humana has stated that Mentor is an online reference tool. This system is not capable of demonstrating that Humana staff informs enrollees of complaint categorization. CMS requested Humana's notice template for informing enrollees about inquiries involving excluded drugs. The notice Humana supplied was not consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug. Over 30% of samples provided for WS-GV1_D, Standard Grievances, were misclassified. The universe provided by Humana is not representative of samples that CMS requested, and is therefore inadequate for determining compliance. CMS determined that the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, is not representative of samples that CMS requested, and is inadequate for determining compliance.

**Corrective Action Required:**

Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Audit ID:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/11/2007
**Element Release Date:** 10/11/2007
**Element Projected Completion Date:** 9/12/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS requested Humana's policies and procedures regarding reporting requirements for grievances data elements and Humana did not submit this documentation.

**Corrective Action Required:**

Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 10/12/2007
**Element Projected Completion Date:** 10/31/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because over 30% of samples provided for WS-GV1_D, Standard Grievances, were misclassified. The universe provided by Humana is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

**Corrective Action Required:**

Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Audit ID:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 10/12/2007
**Element Projected Completion Date:** 10/31/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because over 30% of samples provided for WS-GV1_D, Standard Grievances, were misclassified. The universe provided by Humana is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

**Corrective Action Required:**

Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE01
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 2/29/2008
**Element Projected Completion Date:** 10/1/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed policies and procedures for accepting requests for standard redeterminations (Medicare Hand Delivery of Evidence #43, and Medicare Appeals P and P) and found they do not include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Medicare Hand Delivery of Evidence #43 only speaks to allowing `hand delivery' of a request for a standard redetermination. Hand delivery suggests the enrollee can only present evidence in person to support the redetermination request. The enrollee must be able to submit evidence in person or in writing. Over 30% of sample cases submitted for WS-RE2_D were misclassified. The universe provided by Humana is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

**Corrective Action Required:**

Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana 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. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Audit ID:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE05
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 2/29/2008
**Element Projected Completion Date:** 10/1/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS requested Humana's policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit and found they do not contain the following: - a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks was not found in Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). CMS requested Humana's notice template for requesting a reconsideration, and Humana was unable to provide the correct notice template. CMS reviewed a sample of 10 requests for standard redeterminations concerning drug benefits from a universe of 178 and found that in 10 out of 10 samples Humana made an adverse standard redetermination concerning drug benefits decision. 10 out of these 10 samples did not demonstrate that Humana used CMS compliant notices when informing the enrollee of the decision. Specifically, Humana did not provide the Notice of Redetermination and the Request for Reconsideration. Additionally, in 2 out of 2 samples in which Humana's decision was untimely, Humana was unable to demonstrate that the case was forwarded to the IRE as required by CMS.

**Corrective Action Required:**

Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana 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. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.

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

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE06
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 2/28/2008
**Element Projected Completion Date:** 10/1/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed Humana's policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (First Level Review PDP Appeal, Second Level Review - MAXIMUS PDP Standard and Expedited Appeal, and Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) and found they do not include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, these documents did not contain the following: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks was not found. CMS requested Humana's notice template for requesting a reconsideration, and Humana was unable to provide the correct notice template. Over 30% of sample cases submitted for WS-RE2_D were misclassified. The universe provided by Humana is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

**Corrective Action Required:**

Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana 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. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

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

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 3/15/2008
**Element Projected Completion Date:** 10/1/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS requested Humana's policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (First Level Review PDP Appeal, Second Level Review - MAXIMUS PDP Standard and Expedited Appeal, and Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) and found they do not include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks was not found. CMS requested Humana's notice template for requesting a reconsideration, and Humana was unable to provide the correct notice template. Additionally, CMS reviewed a sample of 10 requests for expedited coverage redeterminations from a universe of 49 and found that in 6 out of 10 samples Humana made an adverse expedited redetermination decision. Six out of these 6 samples did not demonstrate that Humana used CMS compliant notices when informing the enrollee of the decision. Specifically, Humana did not provide the Notice of Redetermination and the Request for Reconsideration notices. Additionally, 2 out of the 6 samples demonstrated that the expedited redetermination decision was untimely, and Humana did not demonstrate that the case was forwarded to the IRE as CMS requires.

**Corrective Action Required:**

Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana 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. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.

# *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:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE09
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 10/12/2007
**Element Projected Completion Date:** 10/1/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because over 30% of sample cases submitted for WS-RE2_D were misclassified. The universe provided by Humana is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

**Corrective Action Required:**

Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 10/12/2007
**Element Projected Completion Date:** 10/1/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed a sample of 10 requests for standard coverage redeterminations concerning drug benefits from a universe of 178 and found that in 1 of 2 cases in which the standard coverage redetermination decision was adverse and the enrollee requested a reconsideration, Humana was unable to demonstrate that the file was forwarded to the IRE in a timely manner. Over 30% of sample cases submitted for WS-RE2_D were misclassified. The universe provided by Humana is not representative of cases that CMS requested, and is therefore inadequate for determining compliance. CMS reviewed a sample of 10 requests for expedited redeterminations from a universe of 49 and found that in 1 out of 1 case in which the expedited redetermination decision was adverse and the enrollee requested a reconsideration Humana was unable to demonstrate that the file was forwarded to the IRE in a timely manner.

**Corrective Action Required:**

When the IRE requests a case file from Humana, Humana must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation of this to CMS. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

**Findings:** Not Met
**Contract Number:** H1804
**Audit ID:** 721
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 3/15/2008
**Element Projected Completion Date:** 10/15/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because CMS reviewed internal data provided by Maximus to CMS on Humana's compliance with reconsideration decisions where Humana's determination was fully or partially reversed, and found that in 1 of 6 reconsideration cases for drug benefit (standard priority) Humana did not effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 72 hours after the date it received notice reversing the determination.

**Corrective Action Required:**

Humana must demonstrate to CMS that it effectuates third party reversals for standard drug benefit cases within the timeframes required by CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of third party reversals of a standard request for benefit that were received from Maximus that month, the number of these reversals that Humana effectuated, the number of these effectuations that were made in the CMS required timeframe, and the number of times Humana notified Maximus that it made the effectuation.

# *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:** 721
**Contract Number:** H1804
**Part D Sponsor Name:** HUMANA INSURANCE COMPANY

**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:** 7/31/2007
**Date Report Due:** 9/14/2007
**Element Accepted Date:** 10/12/2007
**Element Release Date:** 3/15/2008
**Element Projected Completion Date:** 10/15/2007

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 6/11/2007
**Estimated Visit Start Date:** 6/15/2007
**Actual Visit Start Date:** 6/11/2007
**Actual Visit End Date:** 6/15/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 9/14/2007
**CAP Release Date:**
**CAP Accepted Date:** 7/15/2008

**Requirement:**

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

**Reference:**

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

**Deficiencies:**

Humana does not meet this requirement because over 30% of sample cases submitted for WS-RE2_D were misclassified. The universe provided by Humana is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

**Corrective Action Required:**

Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.