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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PC02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/4/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 2/15/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed Mercy Care's and its PBM's policies and procedures to determine compliance with this requirement and found that they do not include the following provisions: (1) A provision to notify authorized prescribers, network pharmacies and pharmacists of negative formulary changes at least 60 days prior to the date the change becomes effective. (Section IV of PBM's policy states that changes will be posted on the plan's website but fails to include prescribing physicians in the list of those to be targeted by this method.) (2) A provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. (Section IV of the PBM's policy and procedure does not address notification/parties to be notified when drugs are deemed unsafe by the FDA or are removed by the manufacturer.)

Corrective Action Required:

Mercy Care must ensure that it's and/or its PBM's policies and procedures are revised to include (1) prescribing physicians (authorized prescribers) in the list of those notified of formulary changes 60 days in advance, and (2) provisions for issuing retrospective notice of formulary changes to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, including the means for doing so.

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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/10/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 3/14/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

To determine compliance with the requirements of the audit element, CMS reviewed plan policies and procedures, documentation submitted by the plan to demonstrate that it conducts ongoing monitoring of marketing activities of internal and external sales representatives, and a sample of sales representatives files to review their contracts with the plan, their compensation structure and evidence that they are licensed by the State. CMS found the following deficiencies: (1) Plan policies and procedures do not include a requirement that all persons marketing on behalf of Mercy Care must be state licensed, certified or registered. (2) Files for 4 sales representatives (external contract) did not include individual agreements/contracts and copy of their compensation schedule. (3) Three of the 7 sales representatives active during the audit period were not licensed by the Arizona Department of Insurance.

Corrective Action Required:

Mercy Care must describe the steps it is taking to become compliant with the requirements of this audit element and include as part of its correct action plan, the following: (1) Revise plan policies and procedures to include a provision that all sales representatives must be licensed or certified by the State. (2) Ensure that all sales representative files include copies of their contracts/agreements to abide by CMS requirements and that include the schedule under which they are compensated. (3) Ensure that all sales representatives, both internal and external, are licensed by the State Department of Insurance. (4) Describe plans to monitor external sales representative performance for compliance with CMS requirements.

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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/11/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 3/14/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed the plan and its PBM's policies and procedures, a sample of formulary change notices and other documentation to determine compliance with requirements for this element. CMS found that (1) Mercy Care's policy and procedures (4500.20) and its PBM's policy and procedures do not include specific provisions stating that (a) if the plan does not provide a 60-day notice prior to a formulary change, it will provide the affected enrollees 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 provide written notice of the formulary change, and (b) if it removes a covered Part D drug immediately from the formulary because it is deemed unsafe by the FDA or the manufacturer removes it from the market, the plan (or if delegated, its PBM) provides retrospective notice to affected enrollees. (2) For the sampled cases, Mercy Care provided a list of members affected by the FDA's withdrawal of Permax (Pergolide) from the market and a generic notice dated April 2007 that its PBM used to notify affected members. The notice issued did not provide details as required about alternative drugs available on Mercy Care's formulary or any change in cost. Refer to section 30.3.4 in Chapter 6 of the Medicare Part D Manual. Additionally, documentation showing that the PBM issued the template notice was not included. An example of such documentation could have been correspondence to Mercy Care from its PBM at the time the PBM completed its actions, stating that it had issued notices to the beneficiaries identified on an attached list.

Corrective Action Required:

Mercy Care must take the following action: (1) Revise its internal policy and procedures and/or ensure that its PBM updates its policy and procedure to specify that (a) if the plan does not provide a 60-day notice prior to a formulary change, it will provide affected enrollees 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 provide written notice of the formulary change, and (b) if it removes a covered Part D drug immediately from the formulary because it is deemed unsafe by the FDA or the manufacturer removes the covered drug from the market, it provides retrospective notice to affected enrollees. (2) Describe the actions it will take to ensure that its PBM whose responsibility it is to notify affected members, complies with CMS notice requirements as specified in section 30.3.4 of Chapter 6 of the Medicare Part D Manual.

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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: PH03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/10/2008
Element Release Date: 4/14/2008
Element Projected Completion Date: 2/15/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed the policy and procedure (Pharmacy Network Adequacy) of Mercy Care's PBM and Mercy Care's Long Term Care (LTC) Pharmacy to Nursing Bed Ratio Analysis to determine compliance with this review element and found that policies and procedures were missing a provision stating that the PBM, contracted to establish and maintain an adequate pharmacy network, must offer standard contracting terms and conditions (including performance and service criteria for LTC pharmacies that CMS specifies) to any LTC pharmacy in Mercy Care's service area that requests a contract.

Corrective Action Required:

Mercy Care must ensure that its PBM revises its policy and procedure (Pharmacy Network Adequacy) to include a provision stating that it must offer standard contracting terms and conditions (including performance and service criteria for LTC pharmacies that CMS specifies) to any LTC pharmacy in Mercy Care's service area that requests a contract.

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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: FM03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/10/2008
Element Release Date: 6/10/2008
Element Projected Completion Date: 2/15/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed the policy and procedure (Standard Formulary Changes) and documentation from Mercy Care's PBM in order to determine compliance with the requirements of this element, and found that the policy and procedure did not include specific provision for- and a description of the means for notifying CMS, SPAPs and entities providing other prescription drug coverage, should Mercy Care need to remove a drug immediately from its formulary because the FDA has deemed it unsafe, or because the manufacturer removed it from the market.

Corrective Action Required:

Mercy Care needs to work with its PBM to revise its policy and procedure to include a specific provision for- and a description of the means for notifying CMS, SPAPs and entities providing other prescription drug coverage, should Mercy Care need to remove a drug immediately from its formulary because the FDA has deemed it unsafe, or because the manufacturer removed it from the market.

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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: TP02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/10/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 3/14/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed policies and procedures to determine compliance with requirements in this audit element, and found that they do not include a provision to abide by extensions to the transition period for LTC facility residents in accordance with CMS policy. Refer to section 30.4.7 in Chapter 7 of the Medicare Prescription Drug Benefit Manual.

Corrective Action Required:

Mercy Care must ensure that policies and procedures are revised to include a provision to abide by extensions to the transition period in accordance with CMS policy.

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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/12/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 3/31/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

1) MCA does not meet this requirement because CMS reviewed MCAs policies and procedures regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception and found that they do not include the following provisions: a) a provision for arranging with its network pharmacies to post or distribute the 'Medicare Prescription Drug Coverage and Your Rights' notice 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, and b) a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices. 2) MCA also does not meet this requirement because CMS requested MCAs 'Medicare Prescription Drug Coverage and Your Rights' pharmacy notice and MCA was unable to provide a CMS-approved notice template.

Corrective Action Required:

1) MCA must revise its policies and procedures regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include the following provisions: a) a provision for arranging with its network pharmacies to post or distribute the 'Medicare Prescription Drug Coverage and Your Rights' notice 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, and b) a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices. MCA must clearly indicate in its policy and procedures if it conducts oversight of its contracted PBM to ensure that they are conducting ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. 2) MCA must provide CMS with a notice consistent with CMS-issued model notice, Medicare Prescription Drug Coverage and Your Rights. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

MCA does not meet this requirement because CMS reviewed MCAs policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations and found that they do not define coverage determination in accordance with §423.566(b)(1-5). Under §423.566(b)(1-5) the following actions by a Sponsor are considered coverage determinations: - A decision not to provide or pay for a Part D drug (including a decision not to pay because the drug is not on the Part D sponsor's formulary, because the drug is determined not to be medically necessary, because the drug is furnished by an out-of-network pharmacy, or because the Part D sponsor determines that the drug is otherwise excludable) that the enrollee believes may be covered by the plan. - Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the enrollee. - A decision concerning an exceptions request regarding a plan's tiered cost-sharing structure. - A decision concerning an exceptions request regarding a non-formulary drug.

Corrective Action Required:

MCA must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations to define coverage determinations in accordance with §423.566(b)(1-5). MCA 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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

1) MCA does not meet this requirement because CMS reviewed MCAs policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit and found that they do not include a provision stating that MCA must notify the enrollee (and the prescribing physician involved, as appropriate) of its decision regarding a coverage determination concerning drug benefit 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. 2) MCA also does not meet this requirement because CMS reviewed a sample of 10 requests for Standard Coverage Determinations Concerning Drug Benefits out of a universe of 4,048 and found that 9 of the 10 cases did not demonstrate compliance with notifying enrollees of standard coverage determinations concerning benefits within the 72 hour timeframe. Although MCAs documentation indicates that in eight of the nine non-compliant cases, it notified the prescribing physician of the determination within the 72 hour timeframe, MCA was unable to provide documentation as to whether the member was verbally notified of the standard coverage determination within the 72 hour timeframe. One of the 9 cases was not compliant with notifying either the enrollee or prescribing physician within the 72 hour timeframe. Documentation indicating when the enrollee was notified could include screen prints of call notes/phone logs showing the date and time the member was notified. 3) Lastly, MCA does not meet this requirement because CMS requested MCA's notice template for enrollee notification when a request is forwarded to the IRE and MCA was unable to provide a CMS-approved notice template.

Corrective Action Required:

1) MCA must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit to include a provision stating that MCA must notify the enrollee (and the prescribing physician involved, as appropriate) of its decision regarding a coverage determination concerning drug benefit 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. MCA must conduct training of its 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. 2) MCA must explain what actions it will take to ensure that enrollees are notified timely of standard coverage determinations. The response should include documentation demonstrating that MCA has developed a process to ensure that the date and time the member is notified of standard coverage determinations is recorded. 3 MCA must provide CMS with a notice consistent with CMS-issued model notice, Notice of Case Status. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).

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

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

1) MCA does not meet this requirement because CMS reviewed MCAs policies and procedures regarding enrollee notification of coverage determinations concerning payment and found that they do not contain provisions that specifically address the requirements for coverage determinations concerning payment. Specifically, MCAs policies and procedures did not include the following provisions: a) a provision stating that MCA must notify the enrollee of its coverage determination regarding payment decision no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, and b) a provision stating that for favorable coverage determinations concerning payment, MCA 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 c) a provision stating that for favorable coverage determinations concerning payment, MCA 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. 2) MCA also does not meet this requirement because CMS reviewed a sample of 10 requests for Standard Coverage Determinations Concerning Payment out of a universe of 24 and found that 9 of the 10 cases did not demonstrate compliance with notifying enrollees of standard coverage determinations concerning payments timely because the denial notice was not mailed to the enrollee within the 72 hour timeframe. If a coverage determination is denied and initial notification is provided orally, the plan is required to send the written notice of denial to the enrollee within three calendar days of the oral notification. However, MCA was unable to provide documentation as to whether the members were provided oral notice of the coverage determination within the 72 hour timeframe. Documentation indicating when the enrollee was notified could include screen prints of call notes/phone logs showing the date and time the member was notified verbally. Even if MCA had been able to document timely oral notification, 8 of 9 cases would still have been non-compliant with providing timely written notification because MCA failed to send written notice within three calendar days of the expiration of the 72 hour timeframe. If an enrollee is not notified timely, the failure constitutes an adverse determination and MCA should have forwarded the enrollee¿s request to the IRE within 24 hours of the expiration of the adjudication timeframe. In addition, the plan should have notified the enrollee that their request was being forwarded to the IRE. This notification should have been sent within 24 hours of the expiration of the adjudication timeframe. 3) Lastly, MCA does not meet this requirement because CMS requested MCAs notice template for enrollee notification when a request is forwarded to the IRE and MCA was unable to provide a CMS-approved notice template.

Corrective Action Required:

1) MCA must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following provisions that specifically address the requirements for coverage determinations concerning payment: a) a provision stating that MCA must notify the enrollee of its coverage determination regarding payment decision no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, and, b) a provision stating that for favorable coverage determinations concerning payment, MCA 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 c) a provision stating that for favorable coverage determinations concerning payment, MCA 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. MCA must conduct training of its 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. 2) MCA must explain what actions it will take to ensure that enrollees are notified timely of standard coverage determinations. The response should include documentation demonstrating that MCA has developed a process to ensure that the date and time the member is notified of standard coverage determinations is recorded. MCA also must explain what actions it will take to ensure that enrollee¿s requests for standard coverage determinations concerning payment that are not processed timely are forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe. The corrective action must include a detailed description of MCA¿s internal monitoring activities to ensure compliance with this element. 3) MCA must provide CMS with a notice consistent with CMS-issued model notice, Notice of Case Status. This notice should be submitted in HPMS for regional office review. Also include a copy of the notice with your Corrective Action Plan (CAP).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 2/12/2008
Element Release Date: 2/12/2008
Element Projected Completion Date: 1/5/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

MCA does not meet this requirement because CMS reviewed MCAs notice template for notifying enrollees of a standard coverage determination concerning payment and the notices did not contain an OMB control number, as required by CMS.

Corrective Action Required:

MCA must use a notice consistent with the CMS-issued model notice, Notice of Denial of Medicare Prescription Drug Coverage. The OMB control number must be displayed in the upper right hand corner of the notice, as required by 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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/12/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 3/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

MCA does not meet this requirement because MCAs policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations do not include the following provisions: a) the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations, and b) a means for making expedited coverage determination decisions within the appropriate timeframe for requests received outside of normal business hours, and c) a provision that states that all oral requests must documented in writing and that documentation of request must be maintained in case file.

Corrective Action Required:

MCA must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations to include the following provisions: a) the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations, and b) a means for making expedited coverage determination decisions within the appropriate timeframe for requests received outside of normal business hours, and c) a provision that states that all oral requests must documented in writing and that documentation of request must be maintained in case file. MCA must conduct training of its 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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD08
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/12/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 2/4/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

MCA does not meet this requirement because MCAs policies and procedures regarding enrollee notification following a decision to deny a request for expedited coverage determination do not include the following provisions: a) a provision stating oral and written notice must inform the enrollee of the right to file an expedited grievance, and b) a provision stating oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and c) a provision stating oral and written notice must provide instructions about MCAs grievance process and its timeframes.

Corrective Action Required:

MCA must revise its policies and procedures regarding enrollee notification following a decision to deny a request for expedited coverage determination to include the following provisions: a) a provision stating oral and written notice must inform the enrollee of the right to file an expedited grievance, and b) a provision stating oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and c) a provision stating oral and written notice must provide instructions about MCAs grievance process and its timeframes. MCA must conduct training of its 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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/12/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 2/1/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

1) CMS reviewed a sample of 10 requests for Expedited Coverage Determinations from a universe of 750 and found one sample that was 'Voided' by MCA because the request was for a Part B medication. To account for this, CMS categorized this sample as 'misclassified' and reduced the sample size to nine. Out of 9 cases, 8 cases did not meet demonstrate compliance with notifying enrollees of expedited coverage determinations concerning benefits within the 24 hour timeframe because MCA was unable to provide documentation of when the member was verbally notified of the expedited coverage determination. Although MCAs documentation indicates that in each of the 8 non-compliant cases, it notified the prescribing physician of the determination within the 24 hour timeframe, MCA was unable to provide documentation as to whether the member was verbally notified of the standard coverage determination within the 24 hour timeframe. Documentation indicating when the enrollee was notified could include screen prints of call notes/phone logs showing the date and time the member was notified. 2) MCA also does not meet this requirement because CMS reviewed MCAs policies and procedures regarding enrollee notification following decisions on expedited coverage determinations and found they did not include a provision stating that MCA must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. 3) Lastly, MCA does not meet this requirement because CMS requested MCAs notice template for enrollee notification when request is forwarded to the IRE and MCA was unable to provide a CMS-approved notice template.

Corrective Action Required:

1) MCA must explain what actions it will take to ensure that enrollees are notified timely of expedited coverage determinations. The response should include documentation demonstrating that MCA has developed a process to ensure that the date and time the member is notified of expedited coverage determinations is recorded. 2) MCA must revise its policies and procedures regarding enrollee notification following decisions on expedited coverage determinations to include a provision stating that MCA must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. MCA must conduct training of its 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. 3) MCA must provide CMS with a notice consistent with CMS-issued model notice, Notice of Case Status. This notice should be submitted in HPMS for regional office review. Also include a copy of the notice with your Corrective Action Plan (CAP).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD10
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/12/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 2/4/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

MCA does not meet this requirement because CMS reviewed MCAs policies and procedures regarding enrollee notification following decisions on expedited coverage determinations and found they do not include the following provisions: a) a provision stating if the expedited coverage determination decision is adverse, MCA must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and b) a provision stating if oral notice is provided for adverse decision, the notice must satisfy the following requirements: - state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.

Corrective Action Required:

MCA must revise its policies and procedures regarding enrollee notification following decisions on expedited coverage determinations to include the following provisions: a) a provision stating if the expedited coverage determination decision is adverse, MCA must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and b) a provision stating if oral notice is provided for adverse decision, the notice must satisfy the following requirements: - state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. MCA must conduct training of its 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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/12/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 2/4/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

MCA does not meet this requirement because CMS reviewed MCAs policies and procedures regarding processing requests for exceptions for non-formulary drugs and found they do not include the following provisions: a) a provision stating that an enrollee, an enrollee¿s appointed representative, or an enrollee¿s prescribing physician shall be permitted to file a request for a non-formulary exception, and b) a provision stating that if the MCA makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, and c) a provision stating that the MCA must grant a formulary exception when it determines that one of the three factors needed in the prescribing physician¿s supporting statement has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, and d) a provision stating that MCA does not restrict the number of exception requests submitted per enrollee.

Corrective Action Required:

MCA must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs to include the following provisions: a) a provision stating that an enrollee, an enrollee¿s appointed representative, or an enrollee¿s prescribing physician shall be permitted to file a request for a non-formulary exception, and b) a provision stating that if the MCA makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, and c) a provision stating that the MCA must grant a formulary exception when it determines that one of the three factors needed in the prescribing physician¿s supporting statement has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, and d) a provision stating that MCA does not restrict the number of exception requests submitted per enrollee. MCA must conduct training of its 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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

1) MCA does not meet this requirement because CMS reviewed MCAs policies and procedures regarding approval of exceptions and found they do not include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. 2) In reviewing the samples provided for both Standard Coverage Determinations Concerning Drug Benefit and Expedited Coverage Determinations, CMS found that many of MCAs notices to the prescribing physician for favorable coverage determinations not only state that there is a limit on the number of fills that MCA is approving, but also set forth a date that the authorization is set to expire that precedes the end of the plan year. In accordance with 42 CFR §423.578(c)(3), following approval of a request for a tiering or non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that the (i) the enrollee¿s prescribing physician continues to prescribe the drug, (ii) the drug continues to be safe for treating the enrollee¿s disease or medical condition, and (iii) the enrollment period has not expired. The refill limitations and authorization expiration included on MCAs notices to the prescribing physician indicate that MCA is out of compliance with this requirement.

Corrective Action Required:

1) MCA must revise its policies and procedures regarding approval of exceptions to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. MCA must conduct training of its 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. 2) MCA must review its exceptions authorization process to ensure that it is compliant with the requirement that enrollees not be required to request an approval following the initial prescription for the remainder of the plan year. Additionally, MCAs notices to the prescribing physician must be amended to remove any limitation on the number of fills that MCA is approving as well as any reference to an authorization expiration date.

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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV01
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/12/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 2/29/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

1) MCA does not meet this requirement because CMS requested MCAs documentation demonstrating its communication methods for informing enrollees of complaint categorization and MCA was unable to demonstrate that it has means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. CMS reviewed a sample of 15 Standard Grievances out of a universe of 16, and found that 15 out of 15 cases are not compliant with case categorization procedures because MCA was unable to provide documentation indicating that the enrollees where informed whether their complaints were subject to grievance procedures or coverage determination procedures. 2) In addition, MCA does not meet this requirement because CMS reviewed a sample of 10 requests for Standard Coverage Determinations Concerning Payment out of a universe of 24 and found that 5 of the 10 cases were not compliant with case categorization procedures because they concerned Low Income Subsidy (LIS) co-pay reimbursement requests that should have been processed as grievances rather than coverage determinations. An LIS co-pay reimbursement request should not be processed as a coverage determination because the enrollee has received coverage for the drug(s). 3) Lastly, MCA does not meet this requirement because CMS requested MCAs notice template for informing about inquiries involving excluded drugs and MCA was unable to provide a CMS-approved notice template.

Corrective Action Required:

1) MCA must provide documentation to CMS demonstrating its communication methods for informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures (e.g., phone scripts and notice template for informing enrollees of complaint categorization) 2) MCA must conduct training of appropriate staff on correctly categorizing grievances and coverage determinations 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 individuals being trained. 3) MCA must provide CMS with a notice consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug. This notice should be submitted in HPMS for regional office review. Also include a copy of the notice with your Corrective Action Plan (CAP).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: GV04
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

1) MCA does not meet this requirement because CMS reviewed MCAs policies and procedures regarding enrollee notification of grievance disposition and found that they do not include a provision stating that the enrollee must immediately be notified in writing when MCA extends the deadline. 2) MCA also does not meet this requirement because 7 out of 15 Standard Grievance samples reviewed do not demonstrate compliance with grievance adjudication because the plan did not provide adequate detail on either the member grievance form or in attached case documentation to reflect the outcome of the investigation of the enrollee's grievance. Two of the 7 non-compliant samples are also not compliant with grievance adjudication because the Plan extended the disposition timeframe by 14 days in order to obtain additional information, but MCAs notice to the enrollee of the plan¿s decision to extend the deadline failed to document how the delay was in the best interest of the enrollee.

Corrective Action Required:

1) MCA must revise its policies and procedures regarding enrollee notification of grievance disposition to include a provision stating that the enrollee must immediately be notified in writing when MCA extends the deadline. MCA 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. 2) MCA must explain what actions it will take to ensure that grievance outcomes are clearly explained on the grievance form. MCA must also explain what actions it will take to ensure that the notice to the enrollee of the plan's decision to extend the grievance deadline documents how the delay is in the best interest of the enrollee.

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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE02
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 6/12/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 1/31/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

MCA does not meet this requirement because CMS reviewed MCAs policies and procedures for accepting and addressing requests for expedited redeterminations and found that they do not include the following provisions: a) 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 b) a provision for documenting all oral requests in writing, and c) a provision for maintaining documentation of expedited redetermination requests in a case file.

Corrective Action Required:

MCA must revise its policies and procedures for accepting and addressing requests for expedited redeterminations to include the following provisions: a) 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 b) a provision for maintaining an efficient and convenient means for an enrollee or prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, and c) a provision for maintaining documentation of expedited redetermination requests in a case file. MCA 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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

1) MCA does not meet this requirement because CMS reviewed a sample of 10 requests for Standard Redeterminations Concerning Drug Benefit out of a universe of 32 and found that 9 of the 10 cases did not demonstrate compliance with timely notification and effectuation of standard redeterminations. Specifically, 1 of 2 cases that had a favorable redetermination was not compliant with notifying the enrollee in writing of the redetermination within 7 calendar days from the date of receipt of the request for redetermination. In addition, 4 of the 8 cases that had an adverse redetermination decision were not compliant with notifying the enrollee within the CMS-approved timeframe. If an enrollee is not notified timely, the failure constitutes an adverse decision and the plan should have forwarded the enrollee¿s request to the IRE within 24 hours of the expiration of the adjudication timeframe. In addition, the plan should have notified the enrollee that their request was being forwarded to the IRE. This notification should have been sent within 24 hours of the expiration of the adjudication timeframe. Lastly, all 8 cases that had an adverse redetermination decision were not compliant in sending the Request for Reconsideration form to the enrollee with the adverse Redetermination Notice. 2) MCA also does not meet this requirement because CMS requested MCAs notice templates for a) notifying enrollees of an adverse standard redetermination, b) requesting a reconsideration, and c) for notifying enrollees when a request has been forwarded to the IRE, and MCA did not provide notices that are CMS-approved.

Corrective Action Required:

1) MCA must explain what actions it will take to ensure that enrollees are notified timely of standard redetermination decisions concerning drug benefit. The corrective action must include a description of MCAs internal monitoring activities to ensure compliance with this requirement. MCA also needs to explain what actions it will take to ensure that enrollee¿s requests for redeterminations that are not adjudicated timely are forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe. The corrective action must include a detailed description of MCAs internal monitoring activities to ensure compliance with this element. MCA must explain what actions it will take to ensure that a Request for Reconsideration form is sent to enrollee with each adverse redetermination notice. 2) MCA must provide CMS with notices consistent with the following three CMS-issued model notices: Notice of Redetermination, Request for Reconsideration, and Notice of Case Status. These notices should be submitted in HPMS for regional office review. Please also include copies of the notices with your Corrective Action Plan (CAP).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE06
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

1) MCA does not meet this element because CMS reviewed the one sample provided under the universe for Requests for Standard Redeterminations Concerning Payment and found that this case did not demonstrate compliance with timely notification and effectuation of standard redeterminations. Specifically, MCA was not compliant with notifying the enrollee in writing of the redetermination within 7 calendar days from the date of receipt of the request. If an enrollee is not notified timely, the failure constitutes an adverse determination and MCA should have forwarded the enrollee¿s request to the IRE within 24 hours of the expiration of the adjudication timeframe. In addition, the plan should have notified the enrollee that their request was being forwarded to the IRE. This notification should have been sent within 24 hours of the expiration of the adjudication timeframe. In addition, MCA was not compliant in sending the Request for Reconsideration form to the enrollee with the adverse Redetermination Notice. 2) MCA also does not meet this requirement because CMS requested MCAs notice templates for a) notifying enrollees of an adverse standard redetermination, b) requesting a reconsideration, and c) for notifying enrollees when a request has been forwarded to the IRE, and MCA did not provide notices that are CMS-approved.

Corrective Action Required:

1) MCA must explain what actions it will take to ensure that enrollees are notified timely of standard redetermination decisions concerning payment. The corrective action must include a description of MCAs internal monitoring activities to ensure compliance with this requirement. MCA also needs to explain what actions it will take to ensure that enrollee¿s requests for redeterminations that are not adjudicated timely are forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe. The corrective action must include a detailed description of MCA¿s internal monitoring activities to ensure compliance with this element. MCA must explain what actions it will take to ensure that a Request for Reconsideration form is sent to enrollee with each adverse redetermination notice. 2) MCA must provide CMS with notices consistent with the following three CMS-issued model notices: Notice of Redetermination, Request for Reconsideration, and Notice of Case Status. These notices should be submitted in HPMS for regional office review. Also include copies of the notices with your Corrective Action Plan (CAP).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE07
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

1) CMS reviewed a sample of 4 requests for expedited redeterminations provided under the universe for Requests for Expedited Redeterminations and found that one cases was 'misclassified' because it was not a request for an expedited redetermination. This reduced the sample size to 3 cases. MCA does not meet this element because 1 of 3 cases was not compliant with timely notification of expedited redetermination. Specifically, MCA failed to provide written notification of the adverse redetermination within the 72 hour timeframe and MCA was unable to provide documentation indicating that the enrollee was verbally notified of the adverse redetermination within the 72 hour timeframe. If an enrollee is not notified timely, the failure constitutes an adverse determination and MCA should have forwarded the enrollee¿s request to the IRE within 24 hours of the expiration of the adjudication timeframe. In addition, the plan should have notified the enrollee that their request was being forwarded to the IRE. This notification should have been sent within 24 hours of the expiration of the adjudication timeframe. In addition, MCA was not compliant in sending the Request for Reconsideration form to the enrollee with the adverse Redetermination Notice. 2) MCA also does not meet this requirement because CMS requested MCAs notice templates for a) notifying enrollees of an adverse standard redetermination, b) requesting a reconsideration, and c) for notifying enrollees when a request has been forwarded to the IRE, and MCA did not provide notices that are CMS-approved.

Corrective Action Required:

1) MCA must explain what actions it will take to ensure that enrollees are notified timely of expedited redeterminations. The corrective action must include a description of MCAs internal monitoring activities to ensure compliance with this requirement. MCA also needs to explain what actions it will take to ensure that enrollee¿s requests for redeterminations that are not adjudicated timely are forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe. The corrective action must include a detailed description of MCAs internal monitoring activities to ensure compliance with this element. 2) MCA must provide CMS with notices consistent with the following three CMS-issued model notices: Notice of Redetermination, Request for Reconsideration, and Notice of Case Status. These notices should be submitted in HPMS for regional office review. Please also include copies of the notices with your Corrective Action Plan (CAP).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

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

Findings: Not Met
Audit ID: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE08
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

CMS reviewed a sample of 4 requests for expedited redeterminations provided under the universe for Requests for Expedited Redeterminations and found that one cases was 'misclassified' because it was not a request for an expedited redetermination. This reduced the sample size to 3 cases. MCA does not meet this requirement because 1 of the 2 cases that reflected a decision favorable to the enrollee was not compliant with authorizing or providing the benefit within the required timeframe.

Corrective Action Required:

MCA must explain what actions it will take to ensure that it authorizes or provides the benefit within the required timeframe when the plan reverses, in whole, or in part, its coverage determination. The corrective action must include a description of MCAs internal monitoring activities to ensure compliance with this requirement.

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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE09
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 4/11/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

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:

MCA does not meet this requirement because CMS reviewed MCAs policies and procedures regarding personnel conducting redeterminations and found that they did not include the following provisions: a) a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination, and b) a provision stating that if the issue is a denial based on lack of medical necessity, then the Sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue.

Corrective Action Required:

MCA must revise its policies and procedures regarding personnel conducting redeterminations to include the following provisions: a) a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination, and b) a provision stating that if the issue is a denial based on lack of medical necessity, then the Sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. MCA 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: 3161
Contract Number: H5580
Part D Sponsor Name: SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV03
Audit Type: Routine
Audit Location: Onsite
Date Report Issued: 11/18/2007
Date Report Due: 1/2/2008
Element Accepted Date: 4/11/2008
Element Release Date: 6/12/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date:
Estimated Visit Start Date:
Actual Visit Start Date: 10/3/2007
Actual Visit End Date: 10/4/2007
Part D Sponsor Response Received Date: 1/18/2008
Part D Sponsor Response Due Date: 1/2/2008
CAP Release Date: 6/13/2008
CAP Accepted Date: 6/13/2008

Requirement:

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

Reference:

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

Deficiencies:

MCA does not meet this requirement because CMS reviewed MCAs policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit and found that they do not include a provision stating 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.

Corrective Action Required:

MCA must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit to include a provision stating 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. MCA must conduct training of its 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.