# *CMS Medicare Managed Care Auditing Report*

## Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** GV01
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**08/09/2007
**Element Accepted Date:** 08/13/2007
**Element Release Date:** 09/07/2007
**CAP Released Date:**04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:**11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:**07/31/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.

**Deficiencies:**

AAHP does not meet the CMS 95% compliance standard for this element. CMS reviewed 15 grievances out of a universe of 38, and found that 7 of the cases were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 7 cases are considered misclassified because they dealt with Part D issues rather than Part C issues.

**Corrective Action Required:**

AAHP must determine and report to CMS why it was unable to produce an accurate universe for WSGV1 and describe the steps it is taking, including any changes to its coding or tracking system, to ensure that it's system can distinguish Part C grievances from Part D grievances for reporting and other purposes. It must also produce and submit to CMS a new universe for WSGV1. The review period for the universe is the orginal one, 9/1/07 through 2/28/07.

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Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** GV03
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**08/09/2007
**Element Accepted Date:** 08/13/2007
**Element Release Date:** 09/07/2007
**CAP Released Date:**04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:**11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:**07/31/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.

**Deficiencies:**

AAHP does not meet the CMS 95% compliance standard for this element. CMS reviewed 15 grievances out of a universe of 38, and found that 7 of the cases were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 7 cases are considered misclassified because they dealt with Part D issues rather than Part C issues.

**Corrective Action Required:**

Refer to the CAR for review element GV01.

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Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** GV04
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**08/09/2007
**Element Accepted Date:** 08/13/2007
**Element Release Date:** 09/07/2007
**CAP Released Date:**04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:**11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:**07/31/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.

**Deficiencies:**

AAHP does not meet the CMS 95% compliance standard for this element. CMS reviewed 15 grievances out of a universe of 38, and found that 7 of the cases were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 7 cases are considered misclassified because they dealt with Part D issues rather than Part C issues.

**Corrective Action Required:**

Refer to the CAR for element GV01.

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Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** GV05
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**08/09/2007
**Element Accepted Date:** 08/13/2007
**Element Release Date:** 09/07/2007
**CAP Released Date:**04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:**11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:**07/31/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.

**Deficiencies:**

AAHP does not meet the CMS 95% compliance standard for this element. CMS reviewed 15 grievances out of a universe of 38, and found that 7 of the cases were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 7 cases are considered misclassified because they dealt with Part D issues rather than Part C issues.

**Corrective Action Required:**

Refer to CAR for review element GV01.

# *CMS Medicare Managed Care Auditing Report*

## Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** MR04
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 08/09/2007
**Element Accepted Date:** 11/08/2007
**Element Release Date:** 11/08/2007
**CAP Released Date:** 04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:** 11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:** 10/05/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.

**Deficiencies:**

AAHP did not submit documentation to show that it has information prepared to respond to member requests for the following information: (1) Summary description of methods of compensating physicians. This is a simple description of the various payment methodologies AAHP uses to compensate its physicians, such as capitation, Medicare fee schedule, reduced fee for service, risk pools, etc. It is part of the Physician Incentive regulations. (2) Number and disposition in aggregate of appeals and grievances in the manner and form required by CMS. Refer to Chapter 13 of the Medicare Managed Care Manual, Appendix 2 for the OMB format for this information, and the corresponding instructions in Sections 170 through 170.5.1. (3) Financial condition of the MAO, including the most recently audited information.

**Corrective Action Required:**

AAHP must develop and submit as part of its CAP, materials that meet the disclosure requirements noted above.

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Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** OC06
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**08/09/2007
**Element Accepted Date:** 11/08/2007
**Element Release Date:** 04/04/2008
**CAP Released Date:**04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:**11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:**03/31/2008
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.

**Deficiencies:**

AAHP uses its EOB for claim denials. CMS requirements are not met for the following reasons (1) AAHP's appeal language with its EOBs deviate slightly from the CMS required language by including hours of operations, and by omission of the OMB approval number. (2) Service descriptions are not clear enough. They appear to be truncated. (3) Denial reasons listed in the folder documentation submitted with the sample lack the CMS required specificity. (The denial reason for all of the sampled cases was the same, and was satisfactory.)

**Corrective Action Required:**

AAHP must make the requested revisions to the EOB (H5986_077)and resubmit it for approval. It must also describe the measures it is taking to improve the EOB descriptions of services, and specificity of denial reasons.

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Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** OP04
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 08/09/2007
**Element Accepted Date:** 08/13/2007
**Element Release Date:** 10/05/2007
**CAP Released Date:** 04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:** 11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:** 05/11/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.

**Deficiencies:**

AAHP did not meet CMS 95% compliance standard for this requirement. CMS reviewed a sample of 10 requests for expedited organization determinations from a universe of 72 and found that although all 10 cases were processed and approved within the CMS timeliness requirement of 72 hours for expedited organization determinations, members did not receive oral or written notification of Abrazo Advantage Health Plan's approval decision.

**Corrective Action Required:**

The health plan identified and corrected this deficiency prior to the CMS audit. A written corrective action for expedited organization determinations dated 3/07 was submitted by Abrazo Advantage Health Plan and accepted by CMS during the onsite CMS audit.

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Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** RP01
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 08/09/2007
**Element Accepted Date:** 11/08/2007
**Element Release Date:** 11/08/2007
**CAP Released Date:** 04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:** 11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:** 10/15/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).

**Deficiencies:**

AAHP does not meet the CMS 95% compliance standard for this element. CMS reviewed 2 pre-service reconsideration requests out of a universe of 2. One of the 2 cases was not a pre-service reconsideration request, but a claim reconsideration. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET.

**Corrective Action Required:**

AAHP must generate a new universe for WSRP1 and submit it to CMS for further action. Since there are potentially so few cases in the original universe to consider, the review period for the new universe is being changed to 12/1/06 through 05/30/07 for this sample.

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Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** RP02
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**08/09/2007
**Element Accepted Date:** 09/07/2007
**Element Release Date:** 09/07/2007
**CAP Released Date:**04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:**11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:**07/31/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.

**Deficiencies:**

AAHP did not meet the CMS 95% compliance standard for this requirement. CMS reviewed 7 standard pre-service reconsiderations out of a universe of 7 and found that the plan had not sent 5 of the 7 cases to the IRE within the required 30 day timeframe. In none of the 5 cases had the plan taken an extention. In a sixth case, the CMS reviewer could not determine when AAHP sent the case to the IRE since primary documentation (UPS or FEDEX shipping receipts) was not in the case file. Secondary documentation (a screen print with unreadable headers) sent after the review was insufficient to change the outcome.

**Corrective Action Required:**

AAHP must determine the reason(s) it was late forwarding cases to the IRE when it did not make a fully favorable decisions within the required 30 day time-frame. Its corrective action plan must describe the reason(s)cases were late and the actions it is taking to ensure ongoing compliance.

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Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** RP05
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**08/09/2007
**Element Accepted Date:** 11/08/2007
**Element Release Date:** 11/08/2007
**CAP Released Date:**04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:**11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:**10/05/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.

**Deficiencies:**

AAHP did not submit a universe for this sample. Therefore, CMS determined compliance based on the plan's policies and procedures. Steps 4, 5 and 9 of the desk procedure,"Part C - Effectuation of Member Appeals/Reconsiderations," include some of the requirements, but lack sufficient detail. (1) Step 4 does not provide timeframes for transfer of expedited pre-service reconsiderations to the standard process and for notifying the member of the transfer. It should refer to the right to an expedited grievance. (2)None of the steps mention extensions that may be taken and the effect on processing. (3) Step 9 does not explain that if AAHP provides members with oral notice of favorable determinations within the required time-frame, it must also send them a written notice within 3 days. (4) Step 5 does not include specific time-frames in which the plan must forward expedited uphold determinations to the IRE and does not address the required notice to the member advising him of the transfer.

**Corrective Action Required:**

AAHP must revise its desk procedure, Part C - Effectuation of Member Appeals/Reconsiderations to incorporate the details noted as deficient in the finding above and resubmit it as part of its CAP. It must also conduct training on appeal processing for all staff involved in any way with Part C appeals covering both expedited and standard preservice appeals, as well as payment appeals from members, authorized representatives, and in the case of payment appeals, from non-contracting providers that provided services in question. Advise CMS of the date training is completed with documentation of those who attended.

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Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

**Findings:** NOT MET

**Review ID:** 8097

**Region:** 09 San Francisco

**Contract Number / Name:** H5985 ABRAZO ADVANTAGE HEALTH PLAN

**Auditing Guide Version:** MA Audit Review Guide, Version 4
**Auditing Element:** RP07
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**08/09/2007
**Element Accepted Date:** 11/08/2007
**Element Release Date:** 11/08/2007
**CAP Released Date:**04/04/2008

**Visit Start Date:** 5/10/2007
**Exit Conference Date:** 05/11/2007
**Date Report Issued:** 06/25/2007
**Date Report Due:** 06/25/2007
**CAP Accepted Date:**11/08/2007
**Audit Closed Date:** 04/04/2008
**Element Projected Completion Date:**10/05/2007
**MCO Response Due Date:** 08/09/2007

**Requirement:**

Effectuation of Third Party Expedited Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.

**Deficiencies:**

AAHP did not submit a universe for this sample. Therefore, CMS determined compliance based on the plan's policies and procedures, specifically "Part C-Effectuation of Member Appeals/Reconsiderations." Steps 6b and 7 of this procedure show the wrong entity making decisions and taking other effectuation actions, i.e., the MAO instead of the IRE. Additionally, step 7.b. does not include the time-frame plans have for notifying the IRE of effectuations.

**Corrective Action Required:**

AAHP must revise its procedure (Part C-Effectuation of Member Appeals/Reconsiderations) to address the deficiencies noted above and submit the revised version to CMS as part of the CAP. Additionally, it must provide training on the revised procedure to any staff involved in any way with the appeals process and submit the date of actual/scheduled training, and when completed, the roster of those who attended.