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
Region: 04 Atlanta
Contract Number / Name: H5938 CAPITAL HEALTH PLAN

Review ID: 8137

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/28/2007
Element Accepted Date: 01/30/2008
Element Release Date: 01/30/2008
CAP Released Date: 01/30/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/21/2007
Date Report Issued: 11/08/2007
Date Report Due: 11/05/2007
CAP Accepted Date: 01/30/2008
Audit Closed Date: 01/30/2008
Element Projected Completion Date:
MCO Response Due Date: 12/23/2007

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:

A sample of fifteen (15) cases were reviewed from a universe of 127 reported grievances received during the audit review period. Of those fifteen cases, three were misclassified. Two of the cases involved denials of requests for DME and medical services, and the third case related to a claim by an enrollee for reimbursement of a medical expense, which he had paid.

Corrective Action Required:

Capital Health Plan should ensure that its staff is properly trained to recognize the difference between a grievance and appeal. It is noted that the same Capital staff process grievances for both commercial and Medicare product lines. Refresher training should be sceduled which would highlight the difference between the definitions of grievances for the respective product lines.

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Region: 04 Atlanta
Contract Number / Name: H5938 CAPITAL HEALTH PLAN

Review ID: 8137

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/28/2007
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Visit Start Date: 9/18/2007
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Date Report Due: 11/05/2007
CAP Accepted Date: 01/30/2008
Audit Closed Date: 01/30/2008
Element Projected Completion Date:
MCO Response Due Date: 12/23/2007

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:

Please cross refer to element GV01. As previously noted, three of the fifteen sample cases were misclassified. Two of the cases related to pre-service denials and one to an enrollee's claim to be reimbursed for a medical outlay. These cases involved appeals rather than grievances, but the content of the notice to the enrollee failed to advise the enrollee of appeal rights applicable to the case.

Corrective Action Required:

Capital Health Plan must ensure that appeals are properly distinguished from grievances and that the appropriate appeal rights are communicated to enrollees. As noted, in the CAR for GV01, Capital should arrange for staff to have refresher training in this area.

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Region: 04 Atlanta
Contract Number / Name: H5938 CAPITAL HEALTH PLAN

Review ID: 8137

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/28/2007
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CAP Released Date: 01/30/2008

Visit Start Date: 9/18/2007
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Date Report Due: 11/05/2007
CAP Accepted Date: 01/30/2008
Audit Closed Date: 01/30/2008
Element Projected Completion Date:
MCO Response Due Date: 12/23/2007

Requirement:

Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.

Deficiencies:

CMS reviewed policies, procedures and provider files to determine whether CHP followed a documented process for the credentialing and recredentialing of physicians and other health care professionals. A review of a sample of 20 files from a universe of 431 revealed the following: - Malpractice insurance or the alternate option of an escrow account or unexpired, irrevocable letter of credit as required by Title XXXII, Chapter 458, Section 458.320 of Florida State law was not obtained in one case. - License verification: One file did not verify there was a current Florida license, only the Pennsylvania license was verified. For five files recredentialed by the vendor, licenses were verified through the vendor¿s data warehouse and not through the primary source as required by CMS. - Fourteen recredentialing cases contained no quality information. - The Medicare Opt-Out List was not checked at the time of credentialing/recredentialing in fifteen cases. CHP indicated they did not begin checking the Carrier Opt-Out list until September 2007. Since there are greater than three defectives (errors) in a sample of twenty with a universe of 451, and the standard for compliance is less than three defectives (errors), the element is "Not Met".

Corrective Action Required:

CHP must obtain proof that the physician without malpractice insurance has established and maintained an escrow account consisting of cash or assets eligible for deposit in accordance with Title XXXII, Chapter 458, Section 458.320(a), or obtained and maintained an unexpired, irrevocable letter of credit in with Title XXXII, Chapter 458, Section 458.320(c) of Florida State law. Submit a copy to CMS. In the event the physician is unable to provide the alternative evidence, CHP needs to remove the physician from their network. CHP needs to review the existing credentialing to determine whether other providers do not maintain malpractice insure or the alternatives allowed by law. If other providers are identified, CHP must follow the procedure outlined above. Submit a plan for review the existing files along with a timeline for accomplishment to CMS. Submit a plan, including a timeline to assure the vendor uses primary source verification for credentialing and recredentialing in lieu of verifying licensure through their data warehouse and indicate how CHP will monitor vendor files to assure compliance. Indicate the person responsible for verifying compliance. Submit a plan, include timelines and the responsible department/person, indicating how CHP will incorporate quality information prior to recredentialing and indicate how CHP will assure compliance.

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Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5938 CAPITAL HEALTH PLAN

Review ID: 8137

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/28/2007
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Date Report Due: 11/05/2007
CAP Accepted Date: 01/30/2008
Audit Closed Date: 01/30/2008
Element Projected Completion Date:
MCO Response Due Date: 12/23/2007

Requirement:

Discrimination Against Health Care Professionals ProhibitedAn MAO may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license.

Deficiencies:

CMS reviewed policies, procedures and written notices to providers to determine whether CHP discriminates against any health care professional in terms of participation, reimbursement, or indemnification, professionals who serve high-risk populations or who specialize in the treatment of costly conditions, and provides written notice to providers of the reason that it is declining to accept that provider or group of providers. CHP policies and procedures do not address non-discrimination against any health care professional in terms of participation, reimbursement, or indemnification or health professional who serve high-risk populations or who specialize in the treatment of costly conditions. Since CHP policy failed to include the anti-discrimination language pertaining to terms of participation, reimbursement, or indemnification and regarding professionals who serve high-risk populations or who specialize in the treatment of costly conditions as specified in Element PR06, the element is Not Met.

Corrective Action Required:

CHP needs to modify their policy to include the missing language and notify their providers of the change. Submit a copy of the revised policy and a copy of the notification sent to the providers to CMS.

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Review ID: 8137

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/28/2007
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Audit Closed Date: 01/30/2008
Element Projected Completion Date:
MCO Response Due Date: 12/23/2007

Requirement:

No Prohibition on Health Care Professional Advice to PatientsAn MAO may not prohibit a health care professional from advising or advocating on behalf of a patient.

Deficiencies:

CMS reviewed the Primary Care Physician Services Agreement and the Consultant Physicians Services Agreement templates, and a practitioner newsletter to determine whether CHP prohibits a health care professional from advising or advocating on behalf of a patient and allows health care providers to give the following information: The members¿ health status, medical care or treatment options (including alternative treatments that may be self administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options The risks benefits and consequences of treatment or non-treatment, and The opportunity for the member to refuse treatment and to express preferences about future treatment decisions. Since CHP has no policy or other mechanism that addresses the specific language outlined in PR07, the element is ¿Not Met¿.

Corrective Action Required:

CHP needs to develop a policy, contract addendum or other vehicle that addresses the specific language outlined in this element and notify providers. Submit a copy of the policies, procedures or other vehicle used to meet this element along with the notification sent to providers to CMS.