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

Review ID: 8917

Contract Number / Name: H5850 SUMMIT HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4

Auditing Element: CN04

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 12/17/2007

Element Release Date: 07/01/2008

CAP Released Date:07/01/2008

Visit Start Date: 8/28/2007

Exit Conference Date: 08/31/2007

Date Report Issued: 10/15/2007

Date Report Due: 10/15/2007

CAP Accepted Date:12/21/2007

Audit Closed Date: 07/01/2008

Element Projected Completion Date:03/01/2008

MCO Response Due Date: 11/29/2007

Requirement:

Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.

Deficiencies:

Based on the review of WS CN1- Provider Contracts, Summit Heatlh Plan does not meet the CMS 95% compliance standard for element CN04. CMS audited 20 cases and found that 7 of the cases failed to correctly abide by Federal Requirements which state that contracts must include a provision with the required language regarding maintenance of records for a minimum of 10 years [42 C.F.R. 422.504(e)(4).

Corrective Action Required:

Summit Heatlh Plan must revise its provider agreements to include language that will ensure that the element, CN04 - Abides by Federal Requirements provision, be included in all contracts and/or amendments accordingly. Summit Heatlh Plan must revise its policies and procedures to ensure that element CN04 is in compliance. Summit Heatlh Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including but not limited to: the materials used in the training, the individuals conducting the training, and the individuals being trained. Summit Heatlh Plan must also provide a quarterly status report to CMS for the next 6 months as to the progress of this matter. Status report should include, but not limited to, the process in which the MAO intends to implement the amended language into the current provider contracts, timeline for said project, completion dates, responsible staff for each of the tasks that will be included during this process. Provider Contract Templates should be submitted for all types of MAO contracts (i.e., Direct and Downstream, etc.).

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

Findings: NOT MET

Review ID: 8917

Region: 04 Atlanta

Contract Number / Name: H5850 SUMMIT HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR10
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 12/19/2007
Element Release Date: 07/01/2008
CAP Released Date:07/01/2008

Visit Start Date: 8/28/2007
Exit Conference Date: 08/31/2007
Date Report Issued: 10/15/2007
Date Report Due: 10/15/2007
CAP Accepted Date:12/21/2007
Audit Closed Date: 07/01/2008
Element Projected Completion Date:01/31/2008
MCO Response Due Date: 11/29/2007

Requirement:

Materials Provided For Significant Non-English Speaking Population - For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals.

Deficiencies:

This element states that marketing materials should be created in additional languages when a significant segment of the population's primary language is non-English. This can be found in 42 CFR 422.80(c)(5). In addition, the Medicare Marketing Guidelines provide more specific guidance in stating that non-English materials should be created if more than 10% of the population speaks the particular language. In the service area audited, a significant number of beneficiaries do not use English as their primary language; specifically, more than 10% of the population primarily speak Spanish. However, all member correspondence is not created in Spanish. According to the records reviewed and the interview with staff, only materials used by sales agents is currently translated into Spanish. Other materials, such as Grievance and Appeals letters, Enrollment materials, etc. are provided only in English.

Corrective Action Required:

The Medicare Advantage Organization (MAO) must create non-English materials in any language in which more than 10% of their service area uses a specific language other than English as its primary language. This includes marketing material used by sales agents, as well as all member material, pre-enrollment/Appeals/Grievances, etc. correspondence used to communicate plan information to the member. The Medicare Marketing Guidelines can be used as a reference to determine what materials are deemed as Marketing Materials, and therefore, should be translated into the non-English language(s).

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

Findings: NOT MET

Review ID: 8917

Region: 04 Atlanta

Contract Number / Name: H5850 SUMMIT HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 12/20/2007
Element Release Date: 07/01/2008
CAP Released Date:07/01/2008

Visit Start Date: 8/28/2007
Exit Conference Date: 08/31/2007
Date Report Issued: 10/15/2007
Date Report Due: 10/15/2007
CAP Accepted Date:12/21/2007
Audit Closed Date: 07/01/2008
Element Projected Completion Date:04/30/2008
MCO Response Due Date: 11/29/2007

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:

Based on a review of 10 sample cases submitted by the MAO, the reviewer determined the MAO failed to provide a written notice of confirmation after notifying the member orally. There was only (case #9) of the 10 cases, where the reviewer was able to determine that a written notice was provided to the member.

Corrective Action Required:

The MAO must revise and implement policies and procedures to reflect that a member must be notified both verbally and in writing of the plan's decision regarding an expedited organizational determination, regardless of whether the decision is favorable or adverse. The MA organization must conduct appropriate staff training to ensure that notices are sent to members when an expedited decision is rendered. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct monthly self audits for one quarter. Please provide CMS with the results of these audits 30 days after completion.

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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: 8917

Region: 04 Atlanta

Contract Number / Name: H5850 SUMMIT HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 12/20/2007
Element Release Date: 07/01/2008
CAP Released Date:07/01/2008

Visit Start Date: 8/28/2007
Exit Conference Date: 08/31/2007
Date Report Issued: 10/15/2007
Date Report Due: 10/15/2007
CAP Accepted Date:12/21/2007
Audit Closed Date: 07/01/2008
Element Projected Completion Date:10/30/2007
MCO Response Due Date: 11/29/2007

Requirement:

OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).

Deficiencies:

Based on the review of WS OP3- Favorable Standard Pre-Service Organization Determination, the MAO failed to provide an accurate universe for review. Therefore, the reviewer was unable to effectively determine the results of this element. The one sample provided was determined to be misclassified because it did not meet the definition of a standard pre-service organization determination.

Corrective Action Required:

The MAO must develop and implement and internal policy that would enable the Health Plan to accurately provide CMS with the requested data. The MAO must conduct appropriate staff training, provide CMS with copies of the training material and attendance roster reflecting the date and subject matter of training for the staff involved.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8917

Region: 04 Atlanta

Contract Number / Name: H5850 SUMMIT HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4

Auditing Element: PR03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 12/17/2007

Element Release Date: 07/01/2008

CAP Released Date:07/01/2008

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Exit Conference Date: 08/31/2007

Date Report Issued: 10/15/2007

Date Report Due: 10/15/2007

CAP Accepted Date:12/21/2007

Audit Closed Date: 07/01/2008

Element Projected Completion Date:06/30/2008

MCO Response Due Date: 11/29/2007

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:

Based on the review of WS PR1- Provider Credentialing, Vista Health Plan / Vista Health Plan of South Florida / Summit Health Plan do not meet the CMS 95% compliance standard for element PR03. CMS audited 20 cases and found that 4 cases failed to follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing. Specifically, the MAO failed to review and verify the most recently issued Opt Out list and include documentation in the credentialing file accordingly. 42 CFR 422.204(b)(2); Manual Ch. 6 - Section 60.3

Corrective Action Required:

Vista Health Plan / Vista Health Plan of South Florida / Summit Health Plan must revise its policies and procedures to ensure that element PR03 is in compliance, specifically with the Opt Out review process. Vista Health Plan / Vista Health Plan of South Florida / Summit Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including but not limited to the materials used in the training, the individuals conducting the training, and the individuals being trained. Vista Health Plan / Vista Health Plan of South Florida / Summit Health Plan must also provide a quarterly status report to CMS for the next 6 months as to the progress of this matter. Status report should include, but not limited to, the process in which the MAO intends to implement the amended language into the policies and procedures, timeline for said project, completion dates, and responsible staff for each of the tasks that will be included during this process.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8917

Region: 04 Atlanta

Contract Number / Name: H5850 SUMMIT HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 12/20/2007
Element Release Date: 07/01/2008
CAP Released Date:07/01/2008

Visit Start Date: 8/28/2007
Exit Conference Date: 08/31/2007
Date Report Issued: 10/15/2007
Date Report Due: 10/15/2007
CAP Accepted Date:12/21/2007
Audit Closed Date: 07/01/2008
Element Projected Completion Date:07/31/2008
MCO Response Due Date: 11/29/2007

Requirement:

Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.

Deficiencies:

When the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request. Based on the review of a sample of 10 cases taken from H1076, H1013 and H5850, the reviewer determined that 5 of the 10 cases were found to be out of compliance as a result of untimely payment. Specifically case numbers 4, 5, 7 and 9 from H1076 and case #3 from H5850 were not paid within 60 calendar days after receiving the reconsideration request.

Corrective Action Required:

The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are processed and effectuated timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self auidts and provide CMS with the results of the audit for a period not to exceed six months.

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

Findings: NOT MET

Review ID: 8917

Region: 04 Atlanta

Contract Number / Name: H5850 SUMMIT HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4

Auditing Element: RE01

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 12/17/2007

Element Release Date: 07/01/2008

CAP Released Date:07/01/2008

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Date Report Issued: 10/15/2007

Date Report Due: 10/15/2007

CAP Accepted Date:12/21/2007

Audit Closed Date: 07/01/2008

Element Projected Completion Date:07/31/2008

MCO Response Due Date: 11/29/2007

Requirement:

Acceptance of Standard Reconsideration Requests - The MAO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).

Deficiencies:

Based on the NOT MET findings for RC01, RP01 and RP05 as it relates to the misclassification of reconsideration requests, the reviewer has determined that element RE01 is also NOT MET.

Corrective Action Required:

The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are processed and effectuated timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self auidts and provide CMS with the results of the audit for a period not to exceed six months. [Repeat Finding]

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8917

Region: 04 Atlanta

Contract Number / Name: H5850 SUMMIT HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 12/17/2007
Element Release Date: 07/01/2008
CAP Released Date:07/01/2008

Visit Start Date: 8/28/2007
Exit Conference Date: 08/31/2007
Date Report Issued: 10/15/2007
Date Report Due: 10/15/2007
CAP Accepted Date:12/21/2007
Audit Closed Date: 07/01/2008
Element Projected Completion Date:07/31/2008
MCO Response Due Date: 11/29/2007

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:

When the MA Organization 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). Nine samples were reviewed from H1013, H1076 and H5850. The reviewer determined that two cases were misclassified (Case # 1 and Case # 2 from H1013). Case #1 is misclassified because it is a claims denial and not a pre-service denial. Case #2 is misclassified because it is a Part D issue, not a Part C issue.

Corrective Action Required:

This corrective action applies to misclassified cases that were included in the sample universes for RP01. Based on the documentation presented, the reviewer has determined that the MA Organization does not have an effective process in place to properly identify and /or categorize reconsideration requests. The MA Organization is required to implement a process that will correctly identify and / or categorize reconsideration requests according to 42 CFR 422.590(a)(1). The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are appropriate classified. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA Organization must conduct quarterly self audits and provide CMS with the results of the audit for a period not to exceed six months. [Repeat Finding]

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8917

Region: 04 Atlanta

Contract Number / Name: H5850 SUMMIT HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 12/17/2007
Element Release Date: 07/01/2008
CAP Released Date:07/01/2008

Visit Start Date: 8/28/2007
Exit Conference Date: 08/31/2007
Date Report Issued: 10/15/2007
Date Report Due: 10/15/2007
CAP Accepted Date:12/21/2007
Audit Closed Date: 07/01/2008
Element Projected Completion Date:07/31/2008
MCO Response Due Date: 11/29/2007

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:

Based on the regulations found at 42 CFR 422.584 c2 and d and 422.590d1-3 and 5e and f, the MA Organization must provide timely member notice when processing member requests for expedited reconsiderations and must meet regulatory requirements for effectuating pre-service denial reversals by CMS' Independent Review Entity or higher levels of appeal when the request for reconsideration was expedited. In five out of the ten samples reviewed, the MA Organization did not process expedited reconsiderations timely. The five cases are Case #1 from H5850, Case #1 and 3 from H1076 and Case #2 and 3 from H1013.

Corrective Action Required:

The MA Organization must conduct appropriate staff training to ensure that requests for written and verbal expedited reconsiderations are processed timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self audits and provide CMS with the results of the audit for a period not to exceed six months.