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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: CN04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 11/30/2008
MCO Response Due Date: 09/01/2008

Requirement:

Required Contract Provisions: Abide by Federal Requirements - The 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:

(A) 1 IPA downstream contract did not contain the provision that the downstream providers, "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." (B) 2 Medicare contracts between the health plan and medical clinics were missing.

Corrective Action Required:

Describe actions AlohaCare is taking to ensure its provider contracts including downstream provider contracts contain the Medicare required provisions in accordance with CMS requirements. Submit to CMS the corrective action for amending the downstream provider contracts and date certain for its completion. Submit the missing Medicare contracts for physicians, EM (general practice) and AD (oncologist). The corrective action must include internal health plan audits to ensure compliance.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: DN04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Refund of Premium - The MAO must refund all amounts incorrectly collected from its Medicare members or from others on their behalf.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: DN05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Involuntary Disenrollment for Non-Payment of Premium (Optional) - The MAO may involuntarily disenroll Medicare members who fail to pay monthly basic or supplementary premiums only after demonstrating to CMS that the MAO has made reasonable efforts to collect the unpaid premium amount, including notifying the individual that the premiums are delinquent, providing the individual with a grace period to pay past premiums due, and advising the individual that failure to pay will result in termination. An MAO may not disenroll members for failure to pay premiums (or notify them of impending disenrollment) in cases where the member has requested that premiums be withheld from his/her Social Securityh benefit check, or any individual considered to be in premium withhold status by CMS, as outlined in Section 50.3.1 of Manual Chapter 2. The MAO may only disenroll the Medicare member when the MAO has not received payment within a grace period of a minimum of 1 calendar month that begins on the first day of the month for which the premium was not paid. The effective date of disenrollment is the first day of the month after the grace period ends.

Deficiencies:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: DN07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Compliant Retroactive Disenrollment Requests - The MAO correctly submits requests to the CMS Regional Office, or Program Safeguard Contractor, for retroactive disenrollments that are permitted by the CMS policy in the MA Enrollment Guidelines, Section 60.5. Supporting information is included in accordance with CMS policy.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: DN08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Involuntary Disenrollment for Disruptive Behavior - The MAO may request disenrollment of a Medicare member for disruptive behavior only when the behavior substantially impairs the MAO"s ability to furnish services to the member or other members. The MAO may only disenroll a member for disruptive behavior if it has MET the requirements of Section 50.3.2 of the MA Enrollment Guidelines and with CMS approval. 42 C.F.R. § 422.74(d)(2); Manual Ch. 2 " Section 50.3.2

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: DN09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Involuntary Disenrollment for Fraud or Abuse - The MAO may disenroll Medicare members when they commit fraud or permit abuse of their enrollment cards. Fraud is limited to knowingly providing, during the election process, fraudulent information that materially affects the determination of the members" eligibility to enroll in an MA plan. Abuse of members" enrollment cards includes intentionally permitting others to use their enrollment cards to obtain services under the MA plan. The MAO disenrolls Medicare members for fraud or abuse only after the MAO mails the members a written notice that includes an explanation of the members" right to a hearing under the MAO"s grievance procedures. The MAO disenrolls members effective the first day of the calendar month after the month in which notice is sent to the members of the intended action. When an MAO disenrolls a member for this reason, it must immediately notify the CMS RO.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: DN10
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Inappropriate Encouragement to Disenroll - The MAO does not, orally or in writing, or by any action or inaction, request or encourage a Medicare member to disenroll.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

CMS Medicare Managed Care Auditing Report

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Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: DN501
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Involuntary Disenrollment Due to Change in Status of Special Need Individuals - If the MAO determines that the member no longer meets the SNP eligibility criteria for that plan, it must continue enrollment of that member as a deemed eligible if it can reasonably be expected that the member will be eligible again within a 6-month period (e.g., dual eligibles that temporarily loses their Medicaid eligibility). The MAO must establish policies and procedures that set a time period from at least 30 days but not to exceed 6 months for deemed eligibility and must apply the policy consistently to all members. The MAO must not retroactively disenroll a beneficiary and must provide 30 days notice prior to termination. A SNP cannot disenroll "grandfathered" members who do not meet the special needs eligibility criteria for their plan if the member was enrolled in the plan prior to the date that the SNP was designated as a SNP.

Deficiencies:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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

Findings: NOT MET
Region: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.

Deficiencies:

AlohaCare did not meet the CMS compliance standard for this element. CMS reviewed 13 cases from a universe of 51 and found in 12 cases AlohaCare did not correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.

Corrective Action Required:

AlohaCare must describe the actions it is taking to ensure that CMS requirements are followed for requesting information from beneficiaries to make elections complete. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Required Enrollment Notice (Timeliness) - The MAO notifies the beneficiary of receipt of the enrollment election and confirmation of enrollment acceptance within timeframes specified by CMS. This may be done with two separate notices or one combined notice as specified by CMS.

Deficiencies:

AlohaCare did not meet the CMS compliance standard for this element. CMS reviewed 30 cases from a universe of 288 and found in 6 cases AlohaCare did not properly notify the beneficiary of receipt of the enrollment election and/or confirmation of enrollment acceptance within the timeframes specified by CMS.

Corrective Action Required:

AlohaCare must describe the actions it is taking to ensure that beneficiaries are properly notified of receipt of the enrollment election and confirmation of enrollment acceptance within the timeframes specified by CMS. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.

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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
Region: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.

Deficiencies:

AlohaCare did not meet the CMS compliance standard for this element. CMS reviewed 10 cases from a universe of 10 and found in 9 cases the enrollment denial notice was not sent within the timeframes specified by CMS.

Corrective Action Required:

AlohaCare must describe the actions it is taking to ensure that beneficiaries are notified of enrollment denials within the timeframes specified by CMS. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER12
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Retroactive Enrollment Requests - The MAO requests retroactive enrollments, when appropriate, and adheres to CMS requirements in requesting retroactive enrollments from the Regional Office or Program Safeguard Contractor.

Deficiencies:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER13
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

EGHP " Employer/Union Group Retroactive Enrollment - When appropriate and allowed, the MAO accepts retroactive enrollment requests for Employer/Union Group Health Plan (EGHP) applicants

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER16
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Prohibition of Health Screening - The MAO does not deny or discourage enrollment on the basis of health status, except for ESRD, as provided in CMS guidance (including exceptions). SNPs may limit enrollment to individuals who meet the additional eligibility requirements.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER501
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Enrollment for SNP Plans - The MAO must enroll SNP-eligible enrollees into a SNP plan according to CMS guidelines

Deficiencies:

AlohaCare did not meet the CMS compliance standard for this element. CMS reviewed 10 cases from a universe of 96 and found 2 cases that did not contain evidence of Medicaid eligibility to show appropriate enrollment in a Special Needs Plan.

Corrective Action Required:

AlohaCare must describe the actions it is taking to ensure that documentation of Medicaid eligibility is contained in all enrollments into the Special Needs Plan in accordance with CMS policy and regulations. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER502
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Dual Eligible Enrollment (Note: This element is only applicable if auditing a Dual Eligible SNP) - The MAO must designate the type of dual eligible population it will serve and ensure that its enrollment practices are consistent with this designation.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
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Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

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:

Based on a review of the 13 grievance files, the reviewer found that 8 cases were misclassified because they were not Part C grievances. CMS has determined that if 30% or greater of the files are misclassified, the sample is deemed inadequate and all the elements associated with the sample are Not Met.

Corrective Action Required:

AlohaCare must submit a new universe for WSGV1 (Grievances) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe 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
Region: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Grievance Decision Notification (Timeliness) - The MAO must notify the member of its decision 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 complaint involves an MAO"s decision to invoke an extension relating to an organization determination or reconsideration, or the complaint 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 a 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:

Based on a review of the 13 grievance files, the reviewer found that 8 cases were misclassified because they were not Part C grievances. CMS has determined that if 30% or greater of the files are misclassified, the sample is deemed inadequate and all the elements associated with the sample are Not Met.

Corrective Action Required:

AlohaCare must submit a new universe for WSGV1 (Grievances) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe for this sample.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

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 complaint with the QIO.

Deficiencies:

Based on a review of the 13 grievance files, the reviewer found that 8 cases were misclassified because they were not Part C grievances. CMS has determined that if 30% or greater of the files are misclassified, the sample is deemed inadequate and all the elements associated with the sample are Not Met.

Corrective Action Required:

AlohaCare must submit a new universe for WSGV1 (Grievances) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe for this sample.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: GV05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Method of Grievance Decision Notification - The MAO must 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:

Based on a review of the 13 grievance files, the reviewer found that 8 cases were misclassified because they were not Part C grievances. CMS has determined that if 30% or greater of the files are misclassified, the sample is deemed inadequate and all the elements associated with the sample are Not Met.

Corrective Action Required:

AlohaCare must submit a new universe for WSGV1 (Grievances) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe for this sample.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: MR01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Appropriate Submission and Distribution of Marketing Materials - The MAO follows the requirements contained in the regulations and Medicare Marketing Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: MR05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in the MA plan and that they understand the rules applicable under the plan.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

No Engagement in Activities Which Mislead, Confuse, or Misrepresent the MAO The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: " Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; " Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; " Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAOs involved and unless the materials have received prior approval from CMS; " Use providers to accept enrollment applications or offer inducement to persuade beneficiaries to join plans; " Use providers to offer anything of value to induce plan enrollees to select them as a provider; " Accept plan applications in provider offices or other places where health care is delivered; " Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); " Offer gifts or payment as an inducement to enroll in the organization; " Offer cash gifts, including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates and gift cards that can be readily converted to cash; " Engage in any discriminatory marketing practice, such as targeted marketing to Medicare beneficiaries from higher income areas, without making comparable efforts to enroll Medicare beneficiaries from lower income areas; " Use high pressure sales tactics to enroll a beneficiary into a plan or require an in-home appointment; " Send unsolicited e-mails unless the Medicare beneficiary agrees to receive e-mails; " Buy or rent e-mail lists to distribute information about MA plans " Conduct door-to-door solicitation of Medicare beneficiaries.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: MR501
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Targeted Marketing to Special Needs Individuals - The MAO must ensure that all SNP-related marketing materials adequately address the eligibility criteria of the SNP. The MAO also must ensure that all SNP-related marketing materials are made accessible to all eligible individuals.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information, when necessary, for: " Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO; " Ambulance services dispatched through 911; " Emergency services; " Urgently needed services; " Post-stabilization care services; and " Renal dialysis services that Medicare members obtain while temporarily out of the service area.

Deficiencies:

CMS reviewed thirty denied claims processed by AlohaCare. AlohaCare did not properly deny these claims for the following reasons: 1) all thirty files did not contain evidence that the plan developed the claims for additional medical documentation needed to reach a decision, 2) none of the files contained documentation verifying that the services performed by non-contracted providers were referred by a contracted provider and approved by the plan, 3) Twenty three claims were denied because no prior authorizations were provided by the provider. Many of these claims were submitted by the same providers. The large volume of claims that were denied because of a procedural requirement suggest that either the contracting provider is not obtaining the necessary prior authorizations or the non-contracted providers provided services without an appropriate referral from the contracted providers, 4) two files, #5 and #6, did not contain documentation regarding the outcome of the plans request for additional information, 5) two other files, #1 and #4, contained notations that these denied claims were later paid. However, the files did not contain any documentation supporting the plans decision to reverse the original denial. The plan noted that a claims development system was implemented as of 3/1/2008. This system did not appear to support the claims that were reviewed for this audit.

Corrective Action Required:

AlohaCare must describe the steps that it is taking to address the identified deficiencies. Corrective action should include at a minimum, the following: 1) documentation to justify the denial of the claim, 2) analysis and correction of its EDI claims look up to permit processors to view referring physicians, 3) analysis and correction of the plans process to ensure prior authorizations are provided for all services provided by non-contracted providers, 4) documentation to support the plans decision to reverse a denied claim, 5) implement appropriate training to ensure staff are instructed on the procedures for processing claims from non-contracted providers, 6) implement appropriate training to instruct contracting and non-contracting providers on the procedures for appropriate referrals and prior authorizations, 7) AlohaCare should conduct an internal audit on denied claims each month. This audit should evaluate whether the claims are being properly denied, processed timely, and whether proper denial language is included in the notices. Lastly, since AlohaCares claims process was revised during the audit period and most of the deficiencies were found for the period prior to the change. AlohaCare must submit a new universe for paid and denied claims. Once produced, CMS will do a focused desk review to determine compliance. Each sample will contain a particular audit period based on potential universe size.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: " Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO; " Ambulance services dispatched through 911; " Emergency services; " Urgently needed services; " Post -stabilization care services; " Renal dialysis services that Medicare members obtain while temporarily out of the service area; and " Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.

Deficiencies:

AlohaCare did not meet the CMS compliance standard of this element. CMS reviewed thirty cases and found seven claims that were not paid within 30 days after the date of receipt. According to the notes in the files, the payments for these claims were delayed because the case was either referred to provider relations or there was an internal backlog.

Corrective Action Required:

AlohaCare must describe the actions that it is taking to ensure that it pays clean claims to non-contracted providers within 30 days of receipt. Corrective action should include an analysis of the non-complaint claims (#1, #15, #16, #17, #18, #20, and #21) to determine outcome of the referrals and internal backlog. AlohaCare should also develop a system to track referrals of clean claims to other departments and the results of these referrals. Furthermore, it should develop a system to identify clean claims that may not be paid in a timely manner and plan for monitoring its own performance for compliance on an ongoing basis.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OC04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842(c)(2)(B).

Deficiencies:

AlohaCare does not meet the CMS compliance standard for this element. CMS reviewed thirty clean claims from non-contracted providers and found seven claims were not paid within 30 days after the date of receipt. The interest for late payments was not included in the claim documents. After CMS selected the sample, AlohaCare identified the claims that they did not pay interest payments on and paid this interest for these claims retrospectively. The plan also paid interest on all other claims for the providers who had submitted these seven claims.

Corrective Action Required:

AlohaCare must describe the actions it is taking to ensure that interest paid on clean claims from non-contracted providers is in accordance with CMS policy and regulations. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OC05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/01/2008
MCO Response Due Date: 09/01/2008

Requirement:

Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.

Deficiencies:

CMS reviewed thirty-seven cases and found four cases that were not paid or denied within 60 days after the date of receipt.

Corrective Action Required:

AlohaCare must revise its policies and procedures to ensure that claims are processed timely. AlohaCare should also conduct periodic internal audits to evaluate whether claims are being developed appropriately, processed accurately and resolved timely.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 11/30/2008
MCO Response Due Date: 09/01/2008

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 specific denial reason. The notice must also inform the enrollee of his or her right to a standard reconsideration and describe the appeal process.

Deficiencies:

AlohaCare does not meet the CMS compliance standard for this element. CMS reviewed thirty denied claims that were processed by AlohaCare. For all thirty claims, AlohaCare did not use the written denial notice CMS-10003-Notice of Denial of Payment (NDP) or an RO approved modification of the NDP. The Explanation of Benefits (EOB) that was used to notify the member of the denied claim did not clearly state the service that was denied, the specific denial reason and in some cases the accurate denial amount. The EOB and Remittance Advice did not include categories to document interest on clean claims that were paid late.

Corrective Action Required:

The policy and procedures on Claim Denial Member Notices which became effective on March 1, 2008 incorporates some of the required information for a denial notice. It should further revise the policy to ensure that the notice to the member clearly states the service that was denied, the specific denial reason and the specific denial amount. The revised EOB must be reviewed by the RO. AlohaCare should revise the Remittance Advice to the provider to include the same elements as those found in the EOB. It should also revise the Evidence of Coverage and Remittance Advice to document interest paid on clean claims.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OC07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/08/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 10/31/2008
MCO Response Due Date: 09/01/2008

Requirement:

Adverse Standard Pre-Service Organization Determinations (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision 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 a review of 4 files for adverse standard pre-service organization determinations from a universe of 4, the reviewer found 2 cases non-compliant with the CMS requirement to process pre-service organization determinations within 14 calendar days. The first untimely case was 7 days late. The second untimely case was 8 days late.

Corrective Action Required:

Describe actions AlohaCare is taking to ensure it is meeting the timeliness standards for standard pre-service organization determinations in accordance with CMS policy and regulations. The corrective action must include internal health plan audits to ensure compliance.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/08/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 10/31/2008
MCO Response Due Date: 09/01/2008

Requirement:

Adverse Standard Pre-Service Organization Determinations (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and the specific denial reason. The notice must also inform the enrollee of his or her right to a standard or expedited reconsideration, including the rights to, and conditions for, obtaining an expedited reconsideration, as well as describe the appeal process

Deficiencies:

Based on a review of 4 files for adverse standard pre-service organization determinations from a universe of 4, the reviewer found all 4 Notices of Denial of Medical Coverage (NDMCs) non-compliant. AlohaCare was not using the CMS required NDMC (implementation of the Medicare Advantage Appeals Notices was due 2/15/08). The reviewer also found all 4 NDMCs non-compliant because the denial reasons were vague and lacked the CMS required specificity needed to facilitate the Medicare member's understanding of what is being denied and the reason for the denial.

Corrective Action Required:

Describe actions AlohaCare is taking to ensure that it issues the CMS required NDMC or an RO-approved modification of the NDMC for adverse standard or expedited pre-service organization determinations. AlohaCare must also describe the actions it is taking to ensure that the NDMC contains denial reasons that are specific, clear and easily understood by the beneficiary in accordance with CMS policy and regulations. The corrective action must include internal health plan audits to ensure compliance.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/08/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 10/31/2008
MCO Response Due Date: 09/01/2008

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, promptly provide oral notice to the member of the decision not to expedite, 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:

CMS reviewed a sample of 10 expedited organization determinations from a universe of 24. One case was misclassified. Of the remaining 9 cases, CMS found all 9 cases non-compliant because AlohaCare had not notified members of the decisions either orally or in writing. (Decisions for 8 of the cases had been made within the required 72 hour time-frame.)

Corrective Action Required:

Describe actions AlohaCare is taking to ensure that it is meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations. The corrective action must include internal health plan audits to ensure compliance.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/08/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 10/31/2008
MCO Response Due Date: 09/01/2008

Requirement:

Adverse Expedited Organization Determinations (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and the specific denial reason. The notice must also inform the enrollee of his or her right to a standard or expedited reconsideration, including the rights to, and conditions for, obtaining an expedited reconsideration, as well as describe the appeal process.

Deficiencies:

There were no cases in the sample (WS-OP2) to evaluate compliance with this element. Evaluation of this element was based on the Notice of Denial of Medical Coverage (NDMC) issued to the beneficiary for standard pre-service denials (WS-OP1). The WS-OP1 sample uses the same notice as the WS-OP2 sample and the WS-OP1 sample demonstrated that the NDMC was noncompliant. AlohaCare was not using the CMS required NDMC (implementation of the Medicare Advantage Appeals Notices was due 2/15/08). The reviewer also found all 4 NDMCs non-compliant because the denial reasons were vague and lacked the CMS required specificity needed to facilitate the Medicare member's understanding of what is being denied and the reason for the denial.

Corrective Action Required:

Describe actions AlohaCare is taking to ensure that it issues the CMS required NDMC or an RO-approved modification of the NDMC for adverse standard or expedited pre-service organization determinations. AlohaCare must also describe the actions it is taking to ensure that the NDMC contains denial reasons that are specific, clear and easily understood by the beneficiary in accordance with CMS policy and regulations. The corrective action must include internal health plan audits to ensure compliance.

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: 09 San Francisco

Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OP15

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date: 09/02/2008

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/2/2008

Exit Conference Date: 06/05/2008

Date Report Issued: 07/18/2008

Date Report Due: 07/20/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 11/30/2008

MCO Response Due Date: 09/01/2008

Requirement:

Detailed Notice of Discharge of Inpatient Hospital Care - Prior to discharging the individual or lowering the level of care within the hospital setting, the MAO must secure concurrence from the physician responsible for the enrollee"s inpatient care. When the QIO has notified an MAO that an enrollee has requested an immediate review of an MAO or hospital"s determination that inpatient care is no longer necessary, the MAO must, directly or by delegation, provide the Detailed Notice of Discharge to the enrollee as soon as possible but no later than noon of the day after the QIO"s notification. The detailed notice must include a detailed explanation of why services are either no longer reasonable and necessary or are no longer covered in an inpatient hospital setting; a description of any applicable Medicare coverage rule, instruction, or other Medicare policy used in this determination, including information about how the enrollee may obtain a copy of the Medicare policy; any applicable MA organization policy, contract provision, or rationale upon which the discharge determination was based; and facts specific to the enrollee and relevant to the coverage determination sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee"s case. During the review process, the plan ensures that all information the QIO needs to make its determination is provided, either directly (with hospital cooperation) or by delegation, no later than noon of the day after the QIO notifies the MAO that a request for an immediate review has been received from the enrollee.

Deficiencies:

CMS reviewed AlohaCares policy and procedure, Behavioral Health and Medical Management Concurrent\Continued Stay Review. The policy and procedure must be revised to describe the correct process for the CMS regulation, "Hospital Discharge Appeals Rights" process, implemented 7/2/07. The policy and procedure must include the health plan¿s delivery of the Detailed Notice of Discharge of Inpatient Hospital Care.

Corrective Action Required:

AlohaCare must submit to CMS a revised policy and procedure, including flowcharts and appropriate CMS notices, correctly describing the "Hospital Discharge Appeals Rights" process. The corrective action must include internal health plan audits to ensure compliance with CMS requirements.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 11/30/2008
MCO Response Due Date: 09/01/2008

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 20 credentialing files from a universe of 3582. Four were misclassified. Of the remaining 16, CMS found all 16 files non-compliant with CMS requirements for the following reasons: (A) 15 were not reviewed for Medicare opt-out (1 file was a chiropractor, Medicare opt-out is not applicable for chiropractors), (B) 4 initial credentialing files were missing a 5 year work history, (C) 1 file did not contain current (within 180 days) information for the recredentialing process, (D) 1 file contained an expired DEA certificate (5/30/07) for recredentialing 6/14/07, and (E) 1 file contained an expired malpractice insurance certificate (10/03/06) verified on 11/22/06 for recredentialing 10/26/06.

Corrective Action Required:

Describe actions AlohaCare is taking to ensure it credentials/recredentials contracted providers in accordance with CMS requirements. This must include policy and procedure revisions as applicable for the health plan. The corrective action must include internal health plan audits to ensure compliance.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

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:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS" independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS" independent review entity.

Deficiencies:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Effectuation of Third-Party Claims Reconsideration Reversals - If the MAO"s determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization 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.

Deficiencies:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RE01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

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:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RE02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Appropriate Person(s) Conduct the Reconsideration - A person or persons who were not involved in making the organization determination must conduct the reconsideration. When the issue is a denial based on lack of medical necessity, the reconsidered determination must be made by a physician with the expertise in the field of medicine that is appropriate for the service at issue. The physician making the reconsidered determination need not be, in all cases, of the same specialty or subspecialty as the treating physician.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 10/01/2008
MCO Response Due Date: 09/01/2008

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:

CMS reviewed 2 requests for favorable standard pre-service reconsiderations, both of which were misclassified. Neither case was a favorable standard pre-service reconsideration. CMS has determined that if 30% or greater of the files are misclassified, the sample is deemed inadequate and all the elements associated with the sample are Not Met.

Corrective Action Required:

AlohaCare must submit a new universe for WSRP1 (Favorable Standard Pre-Service Reconsiderations) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe for this sample.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

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:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Effectuation of Third-Party Standard Pre-Service Reconsideration Reversals - If the MAO"s determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member"s health requires (but no later than 14 calendar days from that date). 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.

Deficiencies:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Receipt and Documentation of Expedited Reconsideration Requests - The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

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 prompt oral notice to the member of the decision not to expedite, 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:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Decisions Not to Expedite a Reconsideration (Notice Content) If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician"s support, and provide instructions about the MAO grievance process and its timeframes.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
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Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

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:

There were no samples to review for this element. CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.

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: 09 San Francisco
Contract Number / Name: H5969 ALOHACARE

Review ID: 10417

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/02/2008
Element Accepted Date: 09/26/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 6/2/2008
Exit Conference Date: 06/05/2008
Date Report Issued: 07/18/2008
Date Report Due: 07/20/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/01/2008

Requirement:

Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

Deficiencies:

CMS reviewed plan policies and procedures and plan documentation to determine whether the plan met the requirements for this element. AlohaCare did not meet the requirements for this element. Accurate plan policy and procedures were not in place for the entire audit period. The correct policy and procedures were first implemented by the plan in March 2008.

Corrective Action Required:

AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.