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: 05 Chicago
Contract Number / Name: H2410 MEDICA HEALTH PLANS

Review ID: 11017

Auditing Guide Version: PFFS Audit Review Guide, Version 2
Auditing Element: CN01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/16/2008
Exit Conference Date: 06/19/2008
Date Report Issued: 07/31/2008
Date Report Due: 08/03/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 12/31/2008
MCO Response Due Date: 09/14/2008

Requirement:

Required Contract Provisions: Privacy and Confidentiality - The MAO"s written contracts with first tier and downstream entities and terms and conditions of payment must contain the provisions that contracting entities agree to safeguard beneficiary privacy and confidentiality, consistent with all Federal and State laws, and ensure accuracy of beneficiary medical, health, and enrollment information and records.

Deficiencies:

Medica does not meet the compliance standard because their terms and conditions of payment do not contain all of the required provisions that contracting entities agree to safeguard beneficiary privacy and confidentiality, consistent with all Federal and State laws, and ensure the accuracy of beneficiary medical, health, and enrollment information and records per 42 C.F.R Section 422.118 and Manual Ch 11, Section 100.4. Medica¿s current terms and conditions for this area only include HIPPA requirements.

Corrective Action Required:

Medica must develop and implement policies and procedures that contain all of the required provisions that contracting entities agree to safeguard beneficiary privacy and confidentiality, consistent with all Federal and State laws, and ensure the accuracy of beneficiary medical, health, and enrollment information and records per 42 C.F.R Section 422.118 and Manual Ch 11, Section 100.4. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of the training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: DN02

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 10/31/2008

MCO Response Due Date: 09/14/2008

Requirement:

Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS.

Deficiencies:

Medica does not meet the CMS compliance standard because CMS audited 30 cases from a universe of 115 and found 6 cases where Medica did not send the disenrollment acknowledgement letter to the member within 10 calendar days as required.

Corrective Action Required:

Medica must ensure that it has a process to send disenrollment acknowledgment letter within 10 calendar days of receipt of the request to disenroll. Medica must establish a mechanism for ongoing monitoring of this area 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

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: DN03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:10/31/2008

MCO Response Due Date: 09/14/2008

Requirement:

Voluntary Disenrollment (Notice Content) - The MAO sends the disenrollment notice to the member in a format specified by CMS, providing the correct effective date of disenrollment.

Deficiencies:

Medica does not meet the CMS compliance standard because CMS audited 30 cases from a universe of 115 and found 25 cases where Medica did not provide the correct effective date of disenrollment in the disenrollment acknowledgement and/or confirmation letters. Medica stated in these letters that coverage would end on the last day of the month. ¿Beginning 12/31/2007 Medica Advantage Solution will not cover any health care you receive.¿ Medica is required to provide coverage on the last day of the month.

Corrective Action Required:

Medica must revise its voluntary disenrollment notices to reflect disenrollment effective the first day of the month following the disenrollment request as well as revise its policies and procedures to reflect this requirement.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: DN05

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 10/31/2008

MCO Response Due Date: 09/14/2008

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:

Medica does not meet the CMS compliance standard because Medica did not have a policy and procedure which requires the plan not to disneroll the beneficiaries for non-payment of premiums in cases where the beneficiary had selected to have their premiums deducted from their Social Security Check or when the plan has been notified that a State Pharmaceutical Assistance Program (SPAP) or other payer intends to pay the Part D premium on behalf of an individual. The March 23, 2007 from Abby Block released in HPMS requires that plans may not disenroll members in these instances.

Corrective Action Required:

Medica must develop and implement policies and procedures which prevents the plan from disenrolling beneficiaries for nonpayment of premiums in cases where the beneficiary has selected to have their premiums deducted from their Social Security Check or when the plan has been notified that a State Pharmaceutical Assistance Program (SPAP) or other payer intends to pay the Part D premium on behalf of an individual. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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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: 05 Chicago
Contract Number / Name: H2410 MEDICA HEALTH PLANS

Review ID: 11017

Auditing Guide Version: PFFS Audit Review Guide, Version 2
Auditing Element: DN07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/16/2008
Exit Conference Date: 06/19/2008
Date Report Issued: 07/31/2008
Date Report Due: 08/03/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 11/15/2008
MCO Response Due Date: 09/14/2008

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:

Medica does not meet the CMS compliance standard because the plan incorrectly only accepts reinstatement requests for beneficiaries who erroneously loose Part A or B eligibility for up to 30 days after they notify the beneficiary of this information. Section 60.3.l of Chapter 2 of the MA Manual which discusses these reinstatement requests does not include a time limit for these reinstatements.

Corrective Action Required:

Medica must revise its policies and procedures by eliminating the 30 day notification requirement for reinstatement of a beneficiary¿s Part D coverage. Medica must submit these policies and procedures to the regional office. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 05 Chicago
Contract Number / Name: H2410 MEDICA HEALTH PLANS

Review ID: 11017

Auditing Guide Version: PFFS Audit Review Guide, Version 2
Auditing Element: DN08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/16/2008
Exit Conference Date: 06/19/2008
Date Report Issued: 07/31/2008
Date Report Due: 08/03/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 10/31/2008
MCO Response Due Date: 09/14/2008

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.

Deficiencies:

Medica does not meet the CMS compliance standard because they do not have a detailed policy and procedure which describes the steps that they take, including CMS involvement, for beneficiaries for whom they wish to involuntarily disenroll for disruptive behavior per the requirements of Section 50.3.2 of the MA Manual.

Corrective Action Required:

Medica must develop and implement policies and procedures which meet the requirements of Section 50.3.2 for involuntary disenrollment for disruptive behavior. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: DN09

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 10/31/2008

MCO Response Due Date: 09/14/2008

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 determination of the 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:

Medica does not meet the CMS compliance standard because their policies and procedures for involuntary disenrollment for fraud and abuse do no include detailed procedures for requesting CMS review of potential termination of members for fraud and abuse, nor do they mail the disenrollment notice to the members before submission of the disenrollment notice to CMS.

Corrective Action Required:

Medica must revise its policies and procedures to include detailed procedures for requesting CMS review of potential termination of members for fraud and abuse, and a requirement to mail the disenrollment notice to the members before submission of the disenrollment notice to CMS. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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

Findings: NOT MET

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Review ID: 11017

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: ER04

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

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Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 11/15/2008

MCO Response Due Date: 09/14/2008

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:

Medica does not meet the CMS compliance standard because during the review of samples we found that Medica had not been completing the enrollment type field on the enrollment form. We also were informed during interviews with Medica staff that if CMS rejected the enrollment due to enrollment type errors after two submission attempts the Medica then submits the enrollment under a different enrollment type. In addition, we also determined through reviewing the policies and procedures as well as sample reviews that the Medica does not have policies and procedures in place to determine how a beneficiary is eligible for a special election period (SEP) as required in Section 30.4 of Chapter 2 of the Medicare Managed Care Manual, nor do they document this information and maintain it in their files.

Corrective Action Required:

Medica must develop and implement policies and procedures which require the eligibility type field of the enrollment form to be completed by Medica staff. Medica must develop and implement policies and procedures which require that whenever Medica receives enrollment rejections for improper enrollment type incorrectly, they must contact their account manager for assistance and open a CMS trouble ticket with the CMS help desk. In addition, Medica must develop and implement policies and procedures to determine eligibility for SEPs per section 30.4 of Chapter 2 of the Medicare Managed Care Manual, including proper documentation of this eligibility and record retention. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: ER05

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 11/15/2008

MCO Response Due Date: 09/14/2008

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:

Medica does not meet the CMS compliance standard because CMS audited 30 cases from a universe of 224 and found 7 cases where Medica did not notify the member of receipt of the enrollment election and confirmation of enrollment acceptance within CMS required timeframes.

Corrective Action Required:

Medica must ensure that it has a process to send enrollment acknowledgment letter within 10 calendar days of receipt of the completed enrollment election. Medica must ensure that it has a process to send enrollment confirmation letters within 10 calendar days of receipt of the reply listing. Medica must establish a mechanism for ongoing monitoring of this area 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

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: ER08

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

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Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 11/15/2008

MCO Response Due Date: 09/14/2008

Requirement:

Denial of Enrollment Prior to Transmission to CMS (Notice Content) - The MAO gives beneficiaries denial notice that meets CMS requirements. If the MA plan is currently enrolled to capacity, the notice explains the procedures that will be followed when vacancies occur.

Deficiencies:

CMS reviewed 4 samples from a universe of 4 and found 2 samples where Medica inappropriately denied the enrollment application because the enrollee selected a future effective date of coverage. Chapter 2, Section 30.5 of the Medicare Managed Care Manual states beneficiaries may not request their effective dates, except for some special election periods and when election periods overlap. In addition, Medica¿s denial letter should be updated to comply with current standards.

Corrective Action Required:

Medica should revise its policies and procedures to contact the applicant to discuss CMS requirements regarding the effective date of enrollment. If the applicant does not wish to enroll for the current effective date, Medica should document that information in its notes and send the denial letter. If the applicant wishes to enroll for the current effective date, Medica should document that information and process the enrollment application.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: ER12

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 10/31/2008

MCO Response Due Date: 09/14/2008

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:

Medica does not meet the CMS compliance standard because CMS audited 4 cases from a universe of 4 and found 2 cases where Medica did not send in retroactive enrollment requests timely. Chapter 2, Section 60.4 of the Medicare Managed Care Manual states that the retroactive enrollment request should be made within 45 calendar days of the availability of the first transaction reply report. In addition, Medica¿s policies and procedures are out of date and do not meet CMS requirements for retroactive enrollments.

Corrective Action Required:

Medica must revise its policies and procedures to request retroactive enrollments when appropriate and ahear to CMS requirements in the process of requesting these enrollments. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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

Findings: NOT MET
Region: 05 Chicago
Contract Number / Name: H2410 MEDICA HEALTH PLANS

Review ID: 11017

Auditing Guide Version: PFFS Audit Review Guide, Version 2
Auditing Element: ER17
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/16/2008
Exit Conference Date: 06/19/2008
Date Report Issued: 07/31/2008
Date Report Due: 08/03/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:07/28/2008
MCO Response Due Date: 09/14/2008

Requirement:

Working Aged Survey - The MAO must conduct an annual working aged survey. It must submit one Excel file for both members who were working aged in the annual survey and for those members who did not respond to the survey. The name and HIC# for each member must be included in this file.

Deficiencies:

Medica does not meet the CMS compliance standard because CMS audited 10 cases from a universe of 1,682 and found 3 cases where Medica did not send a working aged survey because these members had disenrolled as of 3/1/2007. Medica is required to send a working aged survey to all members that are listed on the March Monthly Membership Report (MMR), even if the member is no longer enrolled when the survey is conducted.

Corrective Action Required:

Medica must develop and implement policies and procedures to require that Medica send out a working aged survey to members listed on the March Monthly Membership Report (MMR), including those who have disenrolled from the plan even if the member is no longer enrolled when the survey is conducted.

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

Findings: NOT MET
Region: 05 Chicago
Contract Number / Name: H2410 MEDICA HEALTH PLANS

Review ID: 11017

Auditing Guide Version: PFFS Audit Review Guide, Version 2
Auditing Element: MR01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/16/2008
Exit Conference Date: 06/19/2008
Date Report Issued: 07/31/2008
Date Report Due: 08/03/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 10/31/2008
MCO Response Due Date: 09/14/2008

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:

Medica is using enrollment and disenrollment letters where the content does not comply with current CMS models and in some cases does not reflect new regulatory requirements or policy requirements. This includes the enrollment acknowledgement letter, enrollment confirmation letter, denial of enrollment letter, and the acknowledgement of receipt of disenrollment request letter. Medica must make appropriate changes to its marketing materials based on these new requirements. The model letters are available in Chapter 2.

Corrective Action Required:

Medica enrollment acknowledgement and confirmation letters should be updated to reflect current model language that has been developed for PFFS plans. In addition the confirmation letter should remove the language that members must stay with the premium payment option you choose for the rest of the year. Medica denial letter should be updated to reflect current model language and to add that the customer service call center is open from 8 am to 8 pm seven days a week. Medica disenrollment acknowledgement and confirmation letters should be updated to reflect current model language that has been developed for PFFS plans. Medica should ensure that it states the correct date of disenrollment in its member notices. Further, Medica must add that the customer call center is open from 8 am to 8 pm seven days a week. Medica must submit the updated letters to CMS for review and approval.

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Findings: NOT MET

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: MR08

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MCO Response Received Date:

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Date Report Issued: 07/31/2008

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CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 11/15/2008

MCO Response Due Date: 09/14/2008

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; " 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; " 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); " 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; or " 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:

Medica does not meet the compliance standard because they do not yet have procedures in place to test understanding of the Medicare program by all individuals who sell MAO plans. This is required in the November 28, 2007 memo from David Lewis, ¿Information on PFFS marketing oversight¿ found in HPMS. Medica does not meet the compliance standard because they did not have training materials which met the CMS training content requirements. This is required in the November 28, 2007 memo from David Lewis, ¿Information on PFFS marketing oversight¿ found in HPMS.

Corrective Action Required:

Medica must implement policies and procedures to test the understanding of the Medicare program by all individuals who sell MAO plans. Medica must submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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

Findings: NOT MET
Region: 05 Chicago
Contract Number / Name: H2410 MEDICA HEALTH PLANS

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Auditing Element: MR201
Review Type: Routine
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MCO Response Received Date:
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CAP Released Date:

Visit Start Date: 6/16/2008
Exit Conference Date: 06/19/2008
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Date Report Due: 08/03/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/14/2008

Requirement:

Marketing Materials Disclaimer - MAOs offering PFFS plans must prominently display the required PFFS disclaimer in all materials, including but not limited to advertisements, enrollment materials, and materials used at sales presentations.

Deficiencies:

Medica does not meet the compliance standard because their enrollment acknowledgement and confirmation letters do not include the required PFFS disclaimer language.

Corrective Action Required:

Medica enrollment acknowledgement and confirmation letters should be updated to reflect the PFFS disclaimer language. Medica must submit the updated letters to CMS for review and approval.

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

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: MR204

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:07/07/2008

MCO Response Due Date: 09/14/2008

Requirement:

Outbound Education and Verification Calls - All MAOs offering PFFS plans are required to conduct outbound education and verification calls to all applicants to ensure beneficiaries requesting enrollment understand the plan rules, except enrollments into employer or union sponsored PFFS plans or switches from one PFFS plan to another PFFS plan offered by the same MA organization.

Deficiencies:

Medica does not meet the compliance standard because they have not mailed a CMS-approved verification/education letter after the first unsuccessful telephone attempt. According to Medica policy they mail these letters after the third phone attempt.

Corrective Action Required:

Medica must revise its policies and procedures to mail a CMS-approved verification/education letter after the first unsuccessful telephone attempt. Medica must provide a copy of this updated policy to the regional office.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: OC06

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:03/31/2009

MCO Response Due Date: 09/14/2008

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:

Medica does not meet the CMS compliance standard because CMS audited 30 cases from a universe of 4,115 and found 30 cases that did not include the proper notice content. Medica did not send out an EOB in cases where there was no beneficiary liability. Also, in cases where they did send out an EOB the written denial did not clearly state the service denied and the specific denial reason in understandable terms.

Corrective Action Required:

Medica must revise its policies and procedures to clearly state the service denied and the specific denial reason per Chapter 13, section 40.2.3. Medica must submit this updated information to the regional office for review in understandable terms.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 11017

Region: 05 Chicago

Contract Number / Name: H2410 MEDICA HEALTH PLANS

Auditing Guide Version: PFFS Audit Review Guide, Version 2

Auditing Element: OC202

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/16/2008

Exit Conference Date: 06/19/2008

Date Report Issued: 07/31/2008

Date Report Due: 08/03/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:03/31/2009

MCO Response Due Date: 09/14/2008

Requirement:

Information on Enrollee Liability - The MAO must provide to plan enrollees, for each claim filed by the enrollee or the provider that furnished the service, an appropriate explanation of benefits. The explanation must include a clear statement of the enrollee"s liability for deductibles, coinsurance, copayment, and balance billing.

Deficiencies:

Medica does not meet the CMS compliance standard because CMS audited 30 cases from a universe of 4,115 and found 30 cases that did not include the proper notice content. Medica did not send out an EOB in cases where there was no beneficiary liability. Also, incases where they did send out an EOB the written denial did not clearly state the service denied and the specific denial reason.

Corrective Action Required:

Medica must develop and implement policies and procedures that requires the MAO provide to plan enrollees, for each claim filed by the enrollee or the provider that furnished the service, an appropriate explaination of benefits, even when there is no beneficiary liability per 42 CFR Section 422.216(d)(1). The explanation must include a clear statement of the enrollee¿s liability for deductibles, coinsurance, copayments, and balance billing. Medica must submit this updated information to the regional office for review.