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: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

Review ID: 9177

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: AA01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 02/01/2008
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Visit Start Date: 10/22/2007
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Element Projected Completion Date: 05/01/2008
MCO Response Due Date: 02/04/2008

Requirement:

Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.

Deficiencies:

Coloraod Access utilized CMS HSD tables to describe their provider networks. Narratives were provided to describe situations supporting areas where Colorado Access has no contracted providers. Information in the Provider Network described in Health Service Delivery (HSD) Tables indicates a Provider Network that is not sufficient to provide adequate access to and availability of covered services. Colorado Access does not show a sufficient number of providers under contract which is required for their Medicare Advantage contract.

Corrective Action Required:

Provider Network listings need to indicate contracted providers for all CMS required Providers and Specialists indicated in HSD Table 1 and contracted provider facilities indicated in HSD Table 3. Areas of concern are indicated by those areas listed in HSD Table 1 showing 0 providers and where there are no providers indicated, with the lack of an X, in HSD Table 3. Please explain this situation for each and every healthcare provider this affects. Please keep in mind that in developing your response, any explanation for having members travel outside of the pattern of care to obtain services is not acceptable. For areas where you cannot provide an acceptable delivery of services within CMS guidelines, please provide your plan to contract for the services within the county and/or within local Pattern of Care as required. Should there not be existing providers within any particular county, CMS expectations are that Colorado Access will describe how services will be made available within the local pattern of care, in adjacent counties, with contracted providers. Under certain conditions, when providers do not exist, referring the membership to a neighboring county, provided it is the existing pattern of care, can be acceptable. If Colorado Access plans on providing these services with a healthcare provider within a neighboring county, the provider in the neighboring county must be under contract. As the Colorado Access supplemental benefit for transportation is not a benefit that can be guaranteed from year to year, relying on this supplemental benefit to make healthcare providers available outside the pattern of care, is not acceptable.

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Findings: NOT MET
Region: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

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Auditing Guide Version: MA Audit Review Guide, Version 4
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CAP Released Date: 07/01/2008

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CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date: 05/01/2008
MCO Response Due Date: 02/04/2008

Requirement:

PCP Panel Established and Maintained - The MAO establishes, maintains, and monitors a panel of primary care providers from which the member may select a personal primary care provider.

Deficiencies:

Colorado Access does not have a sufficient quantity of providers in the HSD 1 tables in the majority of their counties which would be sufficient to provide adequate access of covered services to meet the needs of their Medicare population.

Corrective Action Required:

Provider Networks listings need to indicate contracted providers for all CMS required Providers indicated in HSD Table 1. Areas of concern are indicated by those areas listed in HSD Table 1 showing 0 providers. Please explain this situation for each and every healthcare provider this affects. Please keep in mind that in developing your response any explanation that any plan for having members travel outside of the pattern of care to obtain services is not acceptable. For areas where you cannot provide an acceptable delivery of services within CMS guidelines, please provide your plan to contract for the services within the county and/or within local Pattern of Care as required. Should there not be existing providers within any particular county, CMS expectations are that Colorado Access will describe how services will be made available within the local pattern of care, in adjacent counties, with contracted providers. Under certain conditions, when providers do not exist, referring the membership to a neighboring county, provided it is within the existing pattern of care, may be acceptable. If Colorado Access plans on providing these services with a provider within a neighboring county, the provider in the neighboring county must be under contract. As the Colorado Access supplemental benefit for transportation is not a benefit that can be guaranteed from year to year, relying on this supplemental benefit to make healthcare providers outside the pattern of care available, is not acceptable.

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Findings: NOT MET
Region: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

Review ID: 9177

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
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MCO Response Received Date:02/01/2008
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Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date:04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date:
MCO Response Due Date: 02/04/2008

Requirement:

Member Health Record Uses Established StandardsAll MAOs that offer CCPs must ensure that each provider furnishing services to members maintains member health records in accordance with standards established by the MAO, which take into account professional standards.

Deficiencies:

Colorado Access does not maintain members health records in accordance with standards established by the MAO.

Corrective Action Required:

Colorado Access needs to establish policies and procedures for Medical Record Audits to include the required information and submit a copy of the policy and procedure to CMS.

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

Findings: NOT MET
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Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN02
Review Type: Routine
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Element Release Date: 06/30/2008
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Date Report Due: 12/24/2007
CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date: 05/01/2008
MCO Response Due Date: 02/04/2008

Requirement:

Required Contract Provision: Prompt PaymentThe MAO's written contracts with first tier and downstream entities must contain a prompt payment provision.

Deficiencies:

The results of the contract review of 20 provider first tier contracts revealed that all 20 of the first tier contracts had the proper CMS required wording. The results of the contract review of 8 downstream provider contracts revealed that 4 of the contracts did not have a prompt payment provision.

Corrective Action Required:

Colorado Access needs to ensure that all downstream contracts contain the proper wording, to come into compliance with CMS requirements, specifically a prompt payment provision. Please describe your plan for correction.

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Findings: NOT MET
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Contract Number / Name: H0621 COLORADO ACCESS

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Auditing Element: CN03
Review Type: Routine
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MCO Response Received Date: 02/01/2008
Element Accepted Date: 02/15/2008
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Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date: 05/01/2008
MCO Response Due Date: 02/04/2008

Requirement:

Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.

Deficiencies:

The results of the contract review of 20 provider first tier contracts revealed that all 20 of the first tier contracts had the proper CMS required wording. The results of the contract review of 8 downstream provider contracts revealed that 3 of the contracts did not have the a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.

Corrective Action Required:

Colorado Access needs to ensure that all downstream contracts contain the proper wording to come into compliance with CMS requirements, specifically wording related to a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO. Please describe your plan for correction.

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

Findings: NOT MET
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Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN04
Review Type: Routine
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MCO Response Received Date: 02/01/2008
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CAP Released Date: 07/01/2008

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Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date: 05/01/2008
MCO Response Due Date: 02/04/2008

Requirement:

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

Deficiencies:

The results of the contract review of 20 provider first tier contracts revealed that all 20 of the first tier contracts had the proper CMS required wording. The results of the contract review of 8 downstream provider contracts revealed that 4 of the files did not have 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.

Corrective Action Required:

MAO needs to ensure that all downstream contracts contain the proper wording to come into compliance with CMS requirements, specifically wording related to 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. Please describe your plan for correction.

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Auditing Guide Version: MA Audit Review Guide, Version 4
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Date Report Due: 12/24/2007
CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date: 05/01/2008
MCO Response Due Date: 02/04/2008

Requirement:

Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.

Deficiencies:

The results of the contract review of 20 provider first tier contracts revealed that all 20 of the first tier contracts had the proper CMS required wording. The results of the contract review of 8 downstream provider contracts revealed that 4 of the files did not have the proper CMS required wording on Compliance with MAO's Policies and Procedures, indicating that the MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.

Corrective Action Required:

Colorado Access needs to ensure that all downstream contracts contain the proper wording on Compliance with MAO's Policies and Procedures, indicating that the MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures. Please describe your plan for correction.

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Findings: NOT MET

Region: 08 Denver

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Auditing Guide Version: MA Audit Review Guide, Version 4
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MCO Response Received Date:02/01/2008
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Date Report Due: 12/24/2007
CAP Accepted Date:04/24/2008
Audit Closed Date: 07/01/2008
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MCO Response Due Date: 02/04/2008

Requirement:

Required Contract Provisions for Deemable Activities: Delegation RequirementsThe MAO's written contracts with any entity that performs deemable activities that are delegated under its contract with CMS must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation.

Deficiencies:

The results of the contract review of 20 provider first tier contracts revealed that all 20 of the first tier contracts had the proper CMS required wording. The results of the contract review of 8 downstream provider contracts revealed that 4 of the files did not have the proper CMS required wording on Delegation Requirements, indicating that the MAO's written contracts with any entity that performs deemable activities that are delegated under its contract with CMS must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation.

Corrective Action Required:

Colorado Access needs to ensure that all downstream contracts contain the proper wording to come into compliance with CMS requirement. Specifically this means wording related to Delegation Requirements, indicating that the MAO's written contracts with any entity that performs deemable activities that are delegated under its contract with CMS, must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation. Please describe your plan for correction.

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Findings: NOT MET

Region: 08 Denver

Contract Number / Name: H0621 COLORADO ACCESS

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MCO Response Received Date:02/01/2008
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Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date:04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date:05/01/2008
MCO Response Due Date: 02/04/2008

Requirement:

Required Contract Provisions for Non-Deemable Activities: Delegation RequirementsThe MAO's written contracts with any entity that performs non-deemable activities that are delegated under its contract with CMS must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation.

Deficiencies:

The results of the contract review of 20 provider first tier contracts revealed that all 20 of the first tier contracts had the proper CMS required wording. The results of the contract review of 8 downstream provider contracts revealed that 4 of the files did not have the downstream contracts with the proper CMS required wording on Delegation Requirements, that the MAO's written contracts with any entity that performs non-deemable activities that are delegated under its contract with CMS must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation.

Corrective Action Required:

Colorado Access needs to ensure that all downstream contracts contain the proper wording to come into compliance with CMS requirements. Specifically wording related to Delegation Requirements, that the MAO's written contracts with any entity that performs non-deemable activities, that are delegated under its contract with CMS, must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation. Please describe your plan for correction.

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Findings: NOT MET
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Auditing Guide Version: MA Audit Review Guide, Version 4
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Date Report Due: 12/24/2007
CAP Accepted Date:04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date:05/01/2008
MCO Response Due Date: 02/04/2008

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 MAO's involved and unless the materials have received prior approval from CMS; · 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;·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.

Deficiencies:

CMS is unable to determine what type of management control and oversight occurs with agents. Coloraod Access does not have any procedures in place to test understanding of the Medicare program by all individuals that sell for the Plan. Documentation does not always exist to ensure monitoring of agent activities. Policies and Procedures are inconsistent and need to accurately reflect current practice.

Corrective Action Required:

The Plan must develop a program that ensures that agents/brokers are adequately trained, monitored, and evaluated. The program should include: * Initial new hire training manual * Type and content of all subsequent trainings * How Plan will ensure knowledge and understanding of program requirements * If written tests are implemented, indicate expected answers, passing score, number of times a test can be taken and how you will re-educate on deficient areas * A process for ensuring that agents/brokers are informed of current program updates The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The program should include documentation in each agent/broker file of at least the following: * Evidence of current licensure * Date of hire * Evidence of attendance at trainings * Evidence of knowledge and understanding of Medicare and the Plan * Evaluation of presentation skills * Information regarding rapid disenrollment * Information about any sales complaints from current or proseptive members * Information regarding disciplinary actions * Evidence of continued monitoring * Evidence of annual evaluation * Commission structure Revise policies to accurately reflect current practice. At least the following policies and forms need to be updated: * AA402 * AA403 * "Ride Along" form * Sales Performance Improvment Plan * Policy regarding required number of monthly sales

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Findings: NOT MET
Region: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

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Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Routine
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MCO Response Received Date: 02/01/2008
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CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date: 02/04/2008
MCO Response Due Date: 02/04/2008

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:

During the review, CMS identified 2 clean claims that were not paid within 30 days and interest was not paid. The claims identified were paid claims #15 and #27. The MAO should go back and re-adjudicate these claims to pay the correct interest to providers.

Corrective Action Required:

The MAO must revise the following policies and procedures: a) Identifying and adjudicating clean claims within 30 days and b) Interest payment calculation. Although the MAO provided CMS with a process for reporting interest and penalties which was updated after the on-site review, we recommend that the MAO implement this process to ensure that all clean claims are paid within 30 days and, if not, interest is correctly calculated and paid to the provider.

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Region: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

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Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 02/01/2008
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Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
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MCO Response Due Date: 02/04/2008

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 denial reason.

Deficiencies:

After review, CMS determined that the MAO was not sending out notices to beneficiaries when denying claims. 100 percent of the denied claims reviewed did not meet the CMS criteria.

Corrective Action Required:

Colorado Access must establish policies and procedures to include provisions that ensure the following: 1. That denial notices are sent to enrollees in all cases where the enrollee has financial liability for the services. 2. That claims are denied for the correct reason. 3. That descriptions of services in the denial letter are clear, accurate, and understandable to enrollees (e.g., do not use abbreviations, clinical language, etc.) The MAO must also conduct training of appropriate staff on the revised Policy and Procedure and submit documentation to the CMS Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.

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Region: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

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Date Report Due: 12/24/2007
CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
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MCO Response Due Date: 02/04/2008

Requirement:

Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.

Deficiencies:

5 of 10 samples were not correct. There was no proof in the sample reviewed that a notice of Noncoverage (CMS 10095-A) was ever provided to the member, so there was no follow through showing the ability of Colorado Access to provide a Detailed Explanation of Non-coverage of Provider Services (CMS 10095-B) in a timely manner.

Corrective Action Required:

Colorado Access should create a relationship with facilities that serve their members. They should develop appropriate procedures to gather the required documentation related to the Termination of Provider Services, related to the termination of Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF)Services. They must describe in their process and procedure how they will be able to provide a Detailed Explanation of Non-coverage of Provider Services (CMS 10095-B) in a timely manner. Please describe your plan for correction. CMS will follow-up no later than 3 months after the Process and Procedure has been accepted, and CMS will select another sample from a Colorado Access universe. This element will not be released until Colorado Access has acceptable performance.

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Findings: NOT MET
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Contract Number / Name: H0621 COLORADO ACCESS

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MCO Response Due Date: 02/04/2008

Requirement:

Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.

Deficiencies:

5 of 10 samples reviewed were not correct related to this element. There was no proof that a notice of Noncoverage (CMS 10095-A) was ever provided the member, so there was no follow through showing the ability of Colorado Access to provide a Detailed Explanation of Non-coverage of Provider Services (CMS 10095-B) containing an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered, the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents, and other facts or information relevant to the non-coverage decision.

Corrective Action Required:

Colorado Access should create a relationship with facilities that serve their members. They should develop appropriate procedures to gather the required documentation related to the Termination of Provider Services, related to the termination of Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF)Services. They must describe in their process and procedure how they will be able to provide a Detailed Explanation of Non-coverage of Provider Services (CMS 10095-B) containing an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered, the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents, and other facts or information relevant to the non-coverage decision. Please describe your plan for correction. CMS will follow-up no later than 3 months after the Process and Procedure has been accepted, and CMS will select another sample from a Colorado Access universe. This element will not be released until Colorado Access has acceptable performance.

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Auditing Element: PR02
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Element Accepted Date: 02/22/2008
Element Release Date: 04/22/2008
CAP Released Date:07/01/2008

Visit Start Date: 10/22/2007
Exit Conference Date: 11/09/2007
Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date:04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date:02/04/2008
MCO Response Due Date: 02/04/2008

Requirement:

Consultation with Physicians and Subcontracted Physician Groups - The MAO must establish a formal mechanism to consult with the physicians and subcontracted groups that have agreed to provide services regarding the organization's: medical policy, quality assurance programs, and medical management procedures.

Deficiencies:

Colorado Access has a system for communicating practice guidelines (Interqual) to providers and enrollees contained in job description of Provider Credentialing Manager. However, policies and procedures do not reflect or match the job description.

Corrective Action Required:

Re-write CCS 307 to include provisions for communicating practice guidelines to providers and enrollees including discharge criteria, continued stay, and admission practice guidelines to mirror the tasks and reporting mechanisms as described in the credentialing manager job description.

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: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

Review ID: 9177

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/01/2008
Element Accepted Date: 04/22/2008
Element Release Date: 04/22/2008
CAP Released Date:07/01/2008

Visit Start Date: 10/22/2007
Exit Conference Date: 11/09/2007
Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date:04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date:02/04/2008
MCO Response Due Date: 02/04/2008

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:

Column 14 (Quality of Care Issues) of WS-PR1, Provider Credentialing did not meet requirements for this element. In order to demonstrate compliance with Credentialing Requirements for Physicians and Other Health Care professionals, Colorado Access must establish a Quality Improvement process which encompasses a formal process for reviewing performance indicators including: utilization management system, grievance system, enrollee satisfaction surveys, and other activities of the organization.

Corrective Action Required:

In order to demonstrate compliance with Credentialing Requirements for Physicians and Other Health Care professionals, Colorado Access must develop and establish a Quality Improvement process which encompasses a formal process for reviewing performance indicators including: utilization management system, grievance system, enrollee satisfaction surveys, and other activities of the organization. The corrective action must include regular internal auditing of credentialing files including but not exclusive to Quality of Care Issues.

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: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

Review ID: 9177

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/01/2008
Element Accepted Date: 02/22/2008
Element Release Date: 04/22/2008
CAP Released Date:07/01/2008

Visit Start Date: 10/22/2007
Exit Conference Date: 11/09/2007
Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date:04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date:02/04/2008
MCO Response Due Date: 02/04/2008

Requirement:

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

Deficiencies:

Colorado Access does not identify in Policies and procedures to indicate they do not discriminate against professionals wo serve high-risk populations or who specialize in the treatment of costly conditions.

Corrective Action Required:

Colorado Access must amend Policy and Procedure CR301 to demonstrate there is not discrimination against Health Care Professionals based on those who serve high-risk populations or who specialize in the treatment of costly conditions.

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: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

Review ID: 9177

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 02/01/2008
Element Accepted Date: 04/03/2008
Element Release Date: 04/04/2008
CAP Released Date: 07/01/2008

Visit Start Date: 10/22/2007
Exit Conference Date: 11/09/2007
Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 02/04/2008

Requirement:

Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).

Deficiencies:

The MAO must have a chronic care improvement program (CCIP) and must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program. In CCIP reporting, the MAO must describe the types of measures that the plan uses to assess program performance. The evaluation entity, MAQRO, determined that Colorado Access has not clearly defined criteria for CCIP eligibility and does not have systematic processes in place for identifying eligible members. Further, Colorado Access has not defined valid measures for assessing CCIP performance.

Corrective Action Required:

Colorado Access is to provide evidence to the evaluation entity, MAQRO, that clearly defined criteria have been established for identifying members for the CCIP. Colorado Access is to provide evidence that a systematic process is being implemented to identify CCIP-eligible members based on the defined criteria. Colorado Access is to define valid quantitative measure(s) to assess program performance. Submit the measure description(s), including numerator and denominator, to the MAQRO evaluator.

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: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

Review ID: 9177

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 02/01/2008
Element Accepted Date: 04/10/2008
Element Release Date: 06/12/2008
CAP Released Date: 07/01/2008

Visit Start Date: 10/22/2007
Exit Conference Date: 11/09/2007
Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date: 04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date:
MCO Response Due Date: 02/04/2008

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:

CA did not have a universe for this element and after review, it was determined that their policies and procedures were incomplete. Since CA did not mail any notices to beneficiaries for claim denials for the review period, the beneficiary would never know if they were liable for some service. Therefore, a beneficiary would not have asked for CA to reconsider its claim denial.

Corrective Action Required:

Colorado Access must establish policies and procedures to include provisions that ensure that denial notices, with appropriate appeal rights, are sent to enrollees in all cases where the enrollee has financial liability for any denied services.

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: 08 Denver
Contract Number / Name: H0621 COLORADO ACCESS

Review ID: 9177

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/01/2008
Element Accepted Date: 04/10/2008
Element Release Date: 06/12/2008
CAP Released Date:07/01/2008

Visit Start Date: 10/22/2007
Exit Conference Date: 11/09/2007
Date Report Issued: 12/21/2007
Date Report Due: 12/24/2007
CAP Accepted Date:04/24/2008
Audit Closed Date: 07/01/2008
Element Projected Completion Date:
MCO Response Due Date: 02/04/2008

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:

CA did not have a universe for this element and after review, it was determined that their policies and procedures were incomplete. Since CA did not mail any notices to beneficiaries for claim denials for the review period, the beneficiary would never know if they were liable for some service. Therefore, a beneficiary would not have asked for CA to reconsider its claim denial.

Corrective Action Required:

Colorado Access must establish policies and procedures to include provisions that ensure that denial notices, with appropriate appeal rights, are sent to enrollees in all cases where the enrollee has financial liability for any denied services.