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: 7217

Region: 02 New York

Contract Number / Name: H4011 FIRST MEDICAL HEALTH PLAN, INC.

Auditing Guide Version: MA Monitoring Review Guide, Version 3
Auditing Element: GV02
Review Type: Ad-Hoc Compliance Event
Review Status: Confirmed
MCO Response Received Date: 11/01/2006
Element Accepted Date: 01/17/2007
Element Release Date: 10/24/2007
CAP Released Date: 10/24/2007

Visit Start Date: 8/1/2006
Exit Conference Date: 08/04/2006
Date Report Issued: 09/09/2006
Date Report Due: 09/18/2006
CAP Accepted Date: 10/24/2007
Audit Closed Date: 10/24/2007
Element Projected Completion Date: 11/03/2006
MCO Response Due Date: 10/24/2006

Requirement:

Grievance Adjudication - The MAO must adjudicate internal grievances in a manner fully consistent with the MAO's written grievance procedure, as stated in the EOC.

Deficiencies:

This element is not met. Five of fifteen grievances sampled were not adjudicated correctly. Two grievances were received by the Plan's Compliance Manager and not forwarded to the Grievance and Appeals Department upon receipt. They were found in his office two months later. As a result, the acknowledgement letters were not issued timely and resolution took place more than 30 days after receipt of the grievance by First Plus. There were other delays in the remaining three grievances. Most of the grievances sampled included complaints against sales representatives (which are referred to as "Marketing incidents.") These incidents included possible marketing violations such as "door-to-door solicitation" and "inducement to enroll" by sales representatives. These complaints required immediate referral to the Compliance Department for investigation. The plan failed to refer them and as a result, the complaints were never investigated. Review of the sales representative files in the marketing area, revealed that in one case, the representative's file contained two complaints considered possible "marketing violations" that were not investigated. See MR08.

Corrective Action Required:

- First Plus Compliance Department must immediately investigate all identified "marketing incidents" from the sample. - First Plus must prepare a report with its findings and corrective action taken. The report must be submitted to the CMS Regional Office with its Corrective Action Plan. - First Plus must ensure that it follows its Grievance Process as it is explained in its Policies and Procedures and Evidence of Coverage. All Marketing Incidents received either by phone or in writing must be referred to the Sales Department for investigation. Results of its investigations must be included in the grievance file.

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Findings: NOT MET

Review ID: 7217

Region: 02 New York

Contract Number / Name: H4011 FIRST MEDICAL HEALTH PLAN, INC.

Auditing Guide Version: MA Monitoring Review Guide, Version 3
Auditing Element: MR08
Review Type: Ad-Hoc Compliance Event
Review Status: Confirmed
MCO Response Received Date: 11/01/2006
Element Accepted Date: 01/17/2007
Element Release Date: 10/24/2007
CAP Released Date: 10/24/2007

Visit Start Date: 8/1/2006
Exit Conference Date: 08/04/2006
Date Report Issued: 09/09/2006
Date Report Due: 09/18/2006
CAP Accepted Date: 10/24/2007
Audit Closed Date: 10/24/2007
Element Projected Completion Date: 12/31/2006
MCO Response Due Date: 10/24/2006

Requirement:

No Engagement in Activities which Mislead, Confuse or Misrepresent MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO and:· May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; · May not 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; · May not 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; · May not accept plan applications in provider offices or other places where health care is delivered;· May not 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);· May not offer gifts or payment as an inducement to enroll in the organization;· May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and· May not conduct door-to-door solicitation of Medicare beneficiaries.

Deficiencies:

Review of sales representative files sampled, revealed that one sales representative file contained allegations that he had possibly engaged in activities which Mislead, Confuse or Misrepresent MAO - The two allegations in the representative's file were not investigated. In addition, review of grievances also revealed many alledged marketing violations by sales representatives. The plan calls them "marketing incidents" which were never investigated. See GV02.

Corrective Action Required:

First Plus submitted during the CMS's audit of August 2, 2006 the following Corrective Action Plan: OCCURRENCE REPORT CORRECTIVE ACTION PLAN Type of Incident:Regional Sales Supervisors Failure to Report Marketing Incidents and Grievances to Compliance Officer First+Plus Parties Involved: Sales & Marketing Department Government Affairs Department Non-First+Plus Parties Involved:Members First+Plus Plans Involved:All Date of Occurrence:August 1, 2006 Date Compliance Notified:August 1, 2006 Date Investigation Completed: August 2, 2006 Person Completing Investigation:Carlos Fournier Gustavo Pérez Summary: While reviewing Sales Representative files during the CMS audit, it was noted that Regional Sales Supervisors had been documenting marketing incidents and member grievances in memorandums to Sales Representatives, however, the Compliance Officer and Grievances and Appeals Coordinator was not notified of the occurrences. CMS regulations require that Medicare Advantage organizations monitor and log all grievances and appeals as well as monitor sales activities. It was noted that the dates of the occurrences were prior to the Grievances and Appeals training that was conducted on May 26, 2006 by the Compliance Officer. Corrective Action Plan: ¿ The Compliance Officer will send a memorandum to the Sales & Marketing Manager and all Regional Sales Supervisors reminding them of the Grievances and Appeals training and requirement that the Compliance Officer be notified of all oral or written grievances and appeals for monitoring and tracking purposes. ¿ The Regional Sales Managers will be notified that the Compliance Officer and Sales Manager are to receive copies of all memorandums or correspondence regarding Marketing Incidents. ¿ The Regional Sales Managers are being requested to provide the Compliance Officer with all copy of all memorandums issued to date regarding any marketing incidents, grievances or appeals within thirty days. ¿ The Sales & Marketing Manager will review all future memorandums regarding marketing incidents to ensure that it documents a copy was submitted to the Compliance Officer. ¿ The Compliance Officer will conduct a follow-up audit of at least 20 sales representative files within four months to ensure that Government Affairs was notified of all marketing incidents, grievances or appeals. Conclusion: First+Plus failed to track all grievances regarding Sales and Marketing matters. A Grievances and Appeals training session was provided to all First+Plus Regional Sales Managers on May 26, 2006. The Compliance Officer is requesting copies of all prior incidents so that the grievances log can be updated and additional investigation conducted, if needed. The Sales Representative files will be audited within four months to ensure compliance or identify outliers or if additional training needs to be conducted. Based on our review of First Plus' CAP, further actions are required. They are the following: - First Plus must provide evidence that the two marketing incidents found in the sales representatives file's were investigated and the resolution reached. This information must be documented in the sales representative's files. - First Plus must conduct periodic audits on sales representative's files to ensure that any marketing incident is investigated according to CMS marketing guidelines. - A monthly report on these audits should be submitted to CMS beginning in September of 2006 and ending in December of 2006. In addition, First Plus must provide proof to demonstrate that all departments involved in customer relations/service are cross-trained and have a clear understanding of what a marketing incident/violation is and grievances and appeals via training. Policies and procedures must be revised to include the CAP items listed in First Plus' CAP. The CAP for this element will be closed when all requirements have been met.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 7217

Region: 02 New York

Contract Number / Name: H4011 FIRST MEDICAL HEALTH PLAN, INC.

Auditing Guide Version: MA Monitoring Review Guide, Version 3
Auditing Element: OC01
Review Type: Ad-Hoc Compliance Event
Review Status: Confirmed
MCO Response Received Date: 11/01/2006
Element Accepted Date: 01/17/2007
Element Release Date: 10/24/2007
CAP Released Date: 10/24/2007

Visit Start Date: 8/1/2006
Exit Conference Date: 08/04/2006
Date Report Issued: 09/09/2006
Date Report Due: 09/18/2006
CAP Accepted Date: 10/24/2007
Audit Closed Date: 10/24/2007
Element Projected Completion Date: 10/25/2006
MCO Response Due Date: 10/24/2006

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:

The requirement is not met. Seven of thirty non-contracted provider Denied Claims failed the sample. It appears that when First Plus prepared the universes for sampling, it included the incorrect date of denial. The plan used the Explanation of Payment Date instead of the adjudication date, which skewed the sample results. In addition, a review of non-contracted provider paid claims revealed that in three cases, claims had been incorrectly denied due to no preauthorization. These claims were reopened (due to an internal audit) and interest was paid.

Corrective Action Required:

While the CMS team was onsite, First Plus submitted a Corrective Action Plan (CAP) detailing the steps that it will take to cure the deficiencies. The CMS Reviewer reviewed the CAP while on site and accepted it as submitted. Type of Incident: Claims-OC2 denied claims universe provided incorrect date. (THIS WORKSHEET MEASURES ELEMENT OC01) Summary: During the CMS audit, it was determined that the OC2 Denied Claims sample included an incorrect date. The date provided should have been the adjudication date but instead reflected the Explanation of Payment date. Corrective Action Plan: In the future, the denied date will be defined as the adjudication date of the claim. Further Comment/Suggestions: Re-write report with the correct date and will be reflected on any future reports. Further Action Required: In regard to the incorrectly denied claims (denied for pre-authorization)- included in Worksheet OC01- First Plus must provide a Corrective Action plan detailing the actions taken to correct this error. For example: How many claims were affected? Was there a systems error? Was there a keying error? The plan made reference to this discovery during the review and did not provide a CAP for the claims affected.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 7217

Region: 02 New York

Contract Number / Name: H4011 FIRST MEDICAL HEALTH PLAN, INC.

Auditing Guide Version: MA Monitoring Review Guide, Version 3
Auditing Element: OC03
Review Type: Ad-Hoc Compliance Event
Review Status: Confirmed
MCO Response Received Date: 11/01/2006
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
CAP Released Date: 10/24/2007

Visit Start Date: 8/1/2006
Exit Conference Date: 08/04/2006
Date Report Issued: 09/09/2006
Date Report Due: 09/18/2006
CAP Accepted Date: 10/24/2007
Audit Closed Date: 10/24/2007
Element Projected Completion Date: 02/20/2007
MCO Response Due Date: 10/24/2006

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:

The requirement is not met. A review of thirty (30) non-contracted provider paid claims reviewed revealed that three of thirty non-contracted provider paid claims were not paid in thirty days.

Corrective Action Required:

CMS reviewed First Plus's CAP provided on site detailing the steps that it will take to cure the identified deficiencies. CMS reviewed the CAP and partially accepts it as submitted. The actions that First Plus states it will implement to cure the identified deficiencies address only how it will pay the interest on claims over 30 days. However, the CAP must also include what measures the plan will take to avoid claims being delayed beyond the required 30 days. The submitted CAP follows: OCCURRENCE REPORT CORRECTIVE ACTION PLAN Type of Incident:Claims Payment Failure to Pay Interest First+Plus Parties Involved: Claims Department Accounting Department Information Systems Department Non-First+Plus Parties Involved: Providers / Members First+Plus Plans Involved: All Date of Occurrence:May 2006 Date Compliance Notified:May 2006 Date Investigation Completed:June 30, 2006 Person Completing Investigation:Carlos Fournier Kristin Greeley and Luis Estrada Summary: While conducting an internal self audit, Claims determined that interest had not been calculated or paid on claims paid greater than 30 days for non-participating providers and greater than 45 days for member reimbursements and participating providers. Puerto Rico state regulations require that members and participating providers are paid interest on claims payments made greater than 45 days at the state interest rate and non-participating providers are paid interest on claims payments made greater than 30 days at the federal interest rate. Corrective Action Plan: Information Systems created a one-time program to analyze past claims payments and calculate interest that should have been paid. On June 2, 2006 First+Plus processed a batch of checks for all prior paid claims where interest should have been paid and was not paid. The Claims and Accounting Payment System was updated to ensure future claims payments include interest if applicable. Claims Manager will continue to monitor interest payment calculations during the check processing cycles. Conclusion: First+Plus failed to pay interest on claims and was in violation of CMS and state regulations. The deficiency was rectified by making interest payments on previously processed claims. The Claims Processing system was updated to ensure future interest payments are processed with the weekly check process. Further Comment/Suggestions: Claims Manager will perform an audit in 30 days to ensure that interest is being paid and that the interest calculations are correct. End of Plan CAP---- Further action required by CMS: First Plus must establish systems flags to alert the plan when claims are approaching the 30 days benchmark. First Plus must conduct weekly audits to ensure that claims are being paid on time and interest paid where applicable. First Plus must submit a monthly report to the Regional Office starting with the month of October (for the month of September 06) showing the claims received, processing time and interest paid.

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

Findings: NOT MET

Review ID: 7217

Region: 02 New York

Contract Number / Name: H4011 FIRST MEDICAL HEALTH PLAN, INC.

Auditing Guide Version: MA Monitoring Review Guide, Version 3
Auditing Element: OC05
Review Type: Ad-Hoc Compliance Event
Review Status: Confirmed
MCO Response Received Date: 11/01/2006
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
CAP Released Date: 10/24/2007

Visit Start Date: 8/1/2006
Exit Conference Date: 08/04/2006
Date Report Issued: 09/09/2006
Date Report Due: 09/18/2006
CAP Accepted Date: 10/24/2007
Audit Closed Date: 10/24/2007
Element Projected Completion Date: 12/31/2006
MCO Response Due Date: 10/24/2006

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:

The requirement is not met. Review of thirty denied claims revealed that: six claims had an "unknown date claim denied" because the plan failed to enter the "date claim denied" when preparing the universes for sampling. In addition, in 20 cases, the plan provided a denial date that was different than the denial date entered in the universe.

Corrective Action Required:

First Plus must ensure that it makes a determination on a denied claim within the required 60 days. First Plus must submit a monthly report that will include date of receipt, and date of denial determination. The first report must be submitted in October for the month of September 06.

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

Findings: NOT MET

Review ID: 7217

Region: 02 New York

Contract Number / Name: H4011 FIRST MEDICAL HEALTH PLAN, INC.

Auditing Guide Version: MA Monitoring Review Guide, Version 3
Auditing Element: OP03
Review Type: Ad-Hoc Compliance Event
Review Status: Confirmed
MCO Response Received Date: 11/01/2006
Element Accepted Date: 01/17/2007
Element Release Date: 10/24/2007
CAP Released Date: 10/24/2007

Visit Start Date: 8/1/2006
Exit Conference Date: 08/04/2006
Date Report Issued: 09/09/2006
Date Report Due: 09/18/2006
CAP Accepted Date: 10/24/2007
Audit Closed Date: 10/24/2007
Element Projected Completion Date: 10/25/2006
MCO Response Due Date: 10/24/2006

Requirement:

Receipt and Documentation of Expedited Organization Determination Requests - The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.

Deficiencies:

The requirement is not met. Eight of ten requests sampled were misclassified as expedited organization determinations. They were entered in the PLEXIS system as expedited in error when they were actually standard requests for services that did not meet the expedited request criteria. In addition, the plan had only been accepting requests from physicians when the regulations clearly allow for "individuals" (member, member's court-appointed guardian or their applicable representatives and/or their physician) to submit a request. Please refer to 42 - Code of Federal Regulations 422.570 (c)(1). The process and the departmental policies and procedures did not include accepting requests from the above individuals and as a result, required revisions. This applied to the Customer Service, UM and Grievances and Appeals departmental policies.

Corrective Action Required:

Required corrective actions: Refresher training on full expedited organization determination requests process (including accepting verbal and written requests from all acceptable individuals). Revised policies and procedures for all departments that include acceptance from acceptable individuals: member, court-appointed representative, physician, etc). Actions taken: Departmental staff were instructed as to the full process; accepting expedited organization determination requests from all acceptable individuals (not just physicians)during the onsite. In addition, they were instructed as to what to do with verbal requests received by Customer Service, Grievance and Appeals and UM departments). Internal policies and procedures for all departments involved were revised while CMS staff was onsite. They were reviewed and accepted as written. Therefore, no further action is required in this element.

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Findings: NOT MET

Review ID: 7217

Region: 02 New York

Contract Number / Name: H4011 FIRST MEDICAL HEALTH PLAN, INC.

Auditing Guide Version: MA Monitoring Review Guide, Version 3
Auditing Element: OP04
Review Type: Ad-Hoc Compliance Event
Review Status: Confirmed
MCO Response Received Date: 11/01/2006
Element Accepted Date: 01/17/2007
Element Release Date: 10/24/2007
CAP Released Date: 10/24/2007

Visit Start Date: 8/1/2006
Exit Conference Date: 08/04/2006
Date Report Issued: 09/09/2006
Date Report Due: 09/18/2006
CAP Accepted Date: 10/24/2007
Audit Closed Date: 10/24/2007
Element Projected Completion Date: 10/25/2006
MCO Response Due Date: 10/24/2006

Requirement:

Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.

Deficiencies:

The requirement is not met. Seven of ten requests for expedited organization determinations were incorrectly included in the sample and therefore marked as "misclassified in the worksheet." Because this represented more than 30% of the sample universe, the requirement was not met for this element. However, the reviewer wishes to note that including the cases in the sample was due to human error when entering the cases into the plan's PLEXIS system and not due to lack of knowledge or incorrect process. Interview with the UM staff revealed that they posses the correct understanding of the process. Policies and procedures were mostly correct and complete with the exception of the fact that they lack instructions on how to provide written notice to members (with a copy of the provider), when changing requests from expedited to the standard process and written notice to the member when the plan received a request from a provider via fax. In addition, process for receiving verbal requests (for calls received at Customer Service), were not being accepted. There was no process outlined for them.

Corrective Action Required:

First Plus must accept verbal requests (received at Customer Service) nd must continue to ensure that it promptly decides whether to expedite an organization determination based on regulatory requirements. If it decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of reeipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If First Plus 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 First Plus 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. See 42 CFR 422.(c)(2) and (d); 422.572(a)-(c). First Plus staff must be careful in entering case information into the PLEXIS system. Because First Plus provided all required revisions to Policies and Procedures for UM, and Customer Service Departments while the team was onsite, no further documentation will be required.