CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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Contract Number / Name: H3810 MID ROGUE INDEPENDENT PHYSICIAN ASSOCIATION

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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:

Mid Rogue Health Plan did not meet the CMS 95% compliance standard because CMS audited 20 contracts (WS-CN1) from a universe of 338 and found that in 6 contracts the delegated entity did not meet the requirement to Abide by Federal Requirements. Specifically, the contracts did not contain a provision to show that the contracting entity would maintain records for a minimum of 10 years.

Corrective Action Required:

Mid Rogue Health Plan must establish and maintain effective oversight of its delegated entities to ensure that their contracts with downstream entities contain the provision to maintain records for a minimum of 10 years. Mid Rogue Health Plan must (1) ensure its delegated entities amend all of their contracts to include the provision, (2) develop policies and procedures describing the types of oversight it will implement for ongoing monitoring of its delegated entities, (3) implement the policies and procedures, (4) train appropriate staff on the policies and procedures, (5) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (6) conduct internal audits of all contracts, (7) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of the entities, (8) provide a summary report to the RO every three months until all of the contracts are amended. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, and (9) for each of the prior eight tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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Review ID: 8217

Region: 10 Seattle

Contract Number / Name: H3810 MID ROGUE INDEPENDENT PHYSICIAN ASSOCIATION

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CAP Accepted Date: 12/07/2007
Audit Closed Date: 06/06/2008
Element Projected Completion Date: 12/30/2007
MCO Response Due Date: 11/24/2007

Requirement:

Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.

Deficiencies:

Mid Rogue Health Plan did not meet the CMS 95% compliance standard because CMS audited all 9 case files (WS-GV1) in the universe and found that in 7 cases, the MAO did not notify the members of its decision no later than 30 days after the receipt date of the oral or written grievance. One case file from the 9 case files was misclassified. Also, the reviewers determined that the organization did not follow written policies and procedures regarding its 14 day extension and notification requirements.

Corrective Action Required:

Mid Rouge Health Plan must notify the member of its decision as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. Mid Rouge Health Plan must (1) revise policies and procedures to ensure that it notifies the member of its decision no later than 30 days after the receipt date of the oral or written grievance. The MAO must submit the revised policies to CMS for review, (2) implement the polices and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits if its Grievance Decision Notification Timeliness process. The audits should evaluate if grievance decisions are being provided to members timely, and if appropriate 14 day extension is taken and members are notified appropriately (6) provide the RO with a mock-up report that demonstrates ongoing monitoring , (7) provide a summary report to the (RO) every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, and (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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Contract Number / Name: H3810 MID ROGUE INDEPENDENT PHYSICIAN ASSOCIATION

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Requirement:

Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.

Deficiencies:

Mid Rogue Health Plan did not meet the CMS 95% compliance standard because CMS audited all 10 case files (WS -GV1) in the universe and found that in 2 cases, the MAO did not appropriately notify the member of the disposition of the case.

Corrective Action Required:

Mid Rouge Health Plan must inform the member of the organization's disposition of the grievance. For Quality of Care issues, it must include the right to file a written complaint with the QIO. Mid Rouge Health Plan must (1) revise policies and procedures including provisions that the MAO notifies a member of the organization's disposition of the grievance. For Quality of Care issues, it must include the right to file a written complaint with the QIO. Mid Rogue must submit the revised policies to CMS for review, (2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of all Grievance case files (WS GV1), (6) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (7) provide a summary report to the RO every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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Requirement:

Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.

Deficiencies:

Mid Rogue Health Plan did not meet the CMS 95% compliance standard because CMS audited all 9 case files (WS-GV1) in the universe and found that the MAO misclassified 1 case and in 3 cases did not respond in writing to written complaints.

Corrective Action Required:

Mid Rouge Health Plan must respond to written grievances in writing. Mid Rouge Health Plan must (1) revise policies and procedures to ensure that it responds to written grievances in writing, (2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of its Grievance Decision Notification procedures, (6) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (7) provide a summary report to the RO every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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CAP Accepted Date: 12/07/2007
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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:

Mid-Rogue IPA did not meet the CMS compliance standard because CMS audited all 30 cases (WS-OC2) in the universe and found 22 cases for which there was no documentation of claims' development. Specifically, there were 3 lab claims that were denied as not meeting emergent/urgent care qualifications without development. All 3 claims were subsequently paid after internal review or after the MAO was contacted by the provider. Also, there were 14 ambulance claims denied as not meeting emergent/urgent care qualifications without development. The claims did not follow the MAO's policy and procedure for ambulance claims, or Medicare coverage guidelines for ambulance services. The remaining 5 claims for a variety of services were denied without documentation of claim development. Three (3) of the 5 claims were subsequently reversed and paid. The MAO did not have clear documentation and/or policies regarding claim development.

Corrective Action Required:

Mid Rogue Health Plan must achieve and maintain effective oversight of correct claim determinations, which include developing the claim for additional information. Mid Rogue Health Plan must (1) develop and implement policies and procedures requiring staff to develop claims for the necessary information needed in order to make a correct claim determination, (2) train appropriate staff on the policies and procedures, (3) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (4) conduct internal audits of denied claim determinations on a monthly basis. The audits must evaluate whether denied claims were developed when additional information was required to make a claim determination, what professional level of staff reviewed the documentation and made a claim determination, whether the development was documented and if Medicare guidelines and MAO policies and procedures were evaluated in the coverage decision, (5) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of its processes and progress, (6) provide a summary report to the (RO) every month until further notified, and (7) for each of the prior six tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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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:

Mid-Rogue IPA did not meet the CMS 95% compliance standard because CMS audited 30 cases (WS-OC1) from a universe of 2530 and found 12 cases for which payment was made in greater than 30 days. Six of the 30 cases were misclassified. All 12 claims were paper claims and were held an average of 30 days after receipt, before they were entered into the MAO's claim system. The MAO's policies and procedures documented mail room controls for paper claims, and the process to enter a claim into the system. However, the MAO's policies and procedures lacked controls to define and ensure claim entry timeliness and procedures to identify paper claims backlogs in a timely manner.

Corrective Action Required:

Mid Rogue Health Plan must achieve and maintain effective oversight of claim payment timeliness in order meet the CMS requirement to pay ninety five percent of clean claims from non-contracting providers within 30 calendar days of receipt. Mid Rogue Health Plan must (1) develop and implement policies and procedures requiring staff to pay claims timely. The policies and procedures must include processes for the entire claim flow from mail room to claim entry and must include provisions to identify and resolve paper claim backlogs in a timely manner, (2) train appropriate staff on the policies and procedures, (3) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (4) conduct internal audits of all clean, non-contracted provider paid claims on a monthly basis. The audits must evaluate whether clean, non-contracted provider claims were paid within 30 days of receipt (5) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of its processes and progress. The report should include the total paid claims, the totals claims paid in 1-30 days, and the total paid in over 30 days. (6) provide a summary report to the (RO) every month until further notified, and (7) for each of the prior six tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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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:

Mid-Rogue Health Plan did not meet the CMS compliance standard because CMS audited 30 cases (WS-OC1) from a universe of 2530 and found 2 cases for which payment was made to non-contracted providers in greater than 30 days and the interest payment was underpaid by one cent. Interest was not paid in accordance with 1816(c)(2)(B) and 1842(c)(2)(B) of the Act. Six (6)case files of the 30 sample claims were misclassified.

Corrective Action Required:

Mid Rogue Health Plan must achieve and maintain effective oversight of correct interest payments in order meet the CMS requirement to pay correct interest on clean non-contracted provider claims paid in over 30 days. Mid Rogue Health Plan must (1) develop a work plan that describes its provisions to resolve interest underpayments in its claim system, (2) conduct internal audits of all non-contracted provider interest payments on a monthly basis. The audits must evaluate whether clean, non-contracted provider claims, paid in over 30 days, were paid interest in accordance with regulations (3) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of its processes and progress. The report should include the total number of non-contracted provider claims paid with interest, the date of receipt, paid date, provider claim payment amount without interest, and the interest payment, (4) provide a summary report to the (RO) every month until further notified, and (5) for each of the prior four tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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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:

Mid-Rogue IPA did not meet the CMS compliance standard because CMS audited all 30 cases (WS-OC2) in the universe and found that 22 of the 30 cases did not have a written denial notice (CMS-10003- Notice of Denial of Payment (NDP)) sent to the member.

Corrective Action Required:

Mid Rogue Health Plan must send the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)) to its members when it denies claims, and achieve and maintain effective oversight of claim denial notices. Mid Rogue Health Plan must (1) develop and implement policies and procedures requiring the issuance of the written NDP, (2) train appropriate staff on the policies and procedures, (3) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (4) conduct internal audits of all denied claims on a monthly basis. The audits must evaluate whether each denied claim has resulted in the issuance of an NDP or an RO approved modification of the NDP, and if the denial clearly states the service denied and the denial reason (5) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of its processes and progress. The report should include the total number of denied claims, the number of NDP¿s issued, and the number of clear denial reasons, (6) provide a summary report to the (RO) every month until further notified, and (7) for each of the prior six tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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Requirement:

Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).

Deficiencies:

Mid Rogue Health Plan did not meet the CMS 95% compliance standard because CMS audited all 2 case files (WS-OP1) in the universe and found that in 1 case the MAO did not appropriately notify the member in writing of its decision no later than 14 calendar days after receiving the request. Additionally, the MAO's notice of extension notification letter did not advise the member of the right to submit a grievance if they did not agree with the extension.

Corrective Action Required:

Mid Rouge Health Plan must notify the member in writing of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified), if it makes an adverse standard pre-service organization determination. Mid Rouge Health Plan must (1) revise polices and procedures (including "desk guides/procedures") that address any portion of the Standard Pre-Service Organization Determination process and describe the timelines and issuance of its decision,(2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of Standard Pre-Service Organization Determination process and timelines, (6) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (7) provide a summary report to the RO every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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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:

Mid Rogue Health Plan initially attested that during the review period, they did not receive requests for expedited organization determinations (WS-OP2). In the course of the onsite review and after further discussions with the MAO's staff, the RO determined that the organization was not appropriately identifying expedited organization determinations. Therefore, the MAO did not process requests for expedited organization determinations (WS-OP2) appropriately. Based on the review of the MAO's Policies and Procedures and staff interviews, the RO determined that Mid Rogue Health Plan did not establish efficient and convenient means for individulas to submit oral or written requests for expedited organization determinations. The MAO did not document all oral requests in writing, and did not maintain the documentation in a case file as required by OP03.

Corrective Action Required:

Mid Rouge Health Plan must establish an efficient and convenient means for individuals to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file. Mid Rouge Health Plan must (1) revise its polices and procedures (including "desk guides/procedures") to ensure that members can submit expedited requests both orally and in writing, all oral requests are documented in writing, and all case related documentation is maintained in a case file, (2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of the receipt and documentation of expedited organization determination requests process, (6) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (7) provide a summary report to the RO every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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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:

Mid Rogue Health Plan did not meet the CMS 95% compliance standard because CMS audited 20 cases (WS-PR1) from a universe of 372, and found that in 7 cases the delegated entity did not follow a documented process for physicians and other health care professionals regarding credentialing and recredentialing. Specifically, the delegated entity did not include quality of care information, such as those collected through the MAO's Quality Improvement (QI) Program into their credentialing/recredentialing processes. The delegated entity did not consider QI indicators for its recredentialing process. Also, the MAO did not have an agreement with the delegated entity that specifies activities being delegated, reporting requirements, and remedies.

Corrective Action Required:

Mid Rogue Health Plan must establish and maintain effective oversight of its delegated entities to ensure that they follow a documented process for initial credentialing and recredentiling. Mid Rogue Health Plan must (1) ensure its delegated entities include quality of care information collected through the MAO¿s Quality Improvement (QI) Program, (2) develop policies and procedures requiring delegated entities to follow a documented process for credentialing and recredentialing. If the delegated entity does not include quality indicators in its credentialing and recredentialing processes, develop policies and procedures as to how the MAO will incorporate QI indicators into the delegated credentialing and recredentialing files, (3) implement the policies and procedures, (4) train appropriate staff on the policies and procedures, (5) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (6) conduct internal audits of all credentialing and recredentialing files, (7) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of the entities, (8) provide a summary report to the (RO) every three months until all of the contracts are amended. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (9) develop a delegated agreement which specifies CMS requirements and includes the following provisions: activities being delegated, reporting responsibilities of the delegated entity, revocation of delegated activities and/or remedies for inadequate performance, and (10) for each of the prior nine tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action. (Cross reference QI01 and QI07)

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Requirement:

Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.

Deficiencies:

Mid Rogue Health Plan did not meet the CMS compliance standard, because CMS audited this onsite element and found that the MAO did not have policies and procedures for selection and evaluation of facilities and did not follow a documented process for facilities regarding credentialing and recredentialing.

Corrective Action Required:

Mid Rogue Health Plan must follow a documented process for facilities regarding initial credentialing and recredentialing. Mid Rogue Health Plan must (1) develop policies and procedures for selection and evaluation of facilities. The policies and procedures must specify that the MAO will determine at specified intervals that the facility is licensed to operate in the State, in compliance with all applicable State and Federal requirements including the requirement to be Medicare certified, and reviewed and approved by an accrediting body or meets the standards established by the organization itself, (2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of all credentialing files, (6) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of the facilities, (7) provide a summary report to the RO every three months until all of the facilities are credentialed. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, and (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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Requirement:

QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.

Deficiencies:

The reviewer determined that Mid Rogue Health Plan did not have an ongoing quality assurance program that was administered through clear and appropriate administrative arrangements for its Medicare enrollees. Mid Rogue failed to provide a quality improvement program description document or work plan for this review. Rather, the MAO provided what appeared to be sections of various outdated quality policies and procedures that did not contain CMS Medicare Advantage Program requirements. The reviewer was not able to verify that the Mid Rogue Health Plan has (1) a quality improvement program (QIP) that incorporates information from customer service, appeals and grievances, medical management, credentialing, provider relations, claims, sales, and marketing, (2) designates a full time senior official who is responsible for the oversight and administration of the QIP, (3) has a policy making body that evaluates the effectiveness of the QI program, (4) annually evaluates its QIP and assesses its progress in implementing the QI strategy and the extent to which the strategy is in fact promoting the development of an effective QI program. This includes consideration of whether QIP activities are completed on a timely basis or whether commitment of additional resources is necessary, or (5) determine that MAO includes recommendations for needed changes in program strategy or administration or encourages providers to participate in CMS and HHS quality improvement initiatives in an on-going manner.

Corrective Action Required:

Mid Rogue must develop an ongoing quality improvement (QI) program and quality work plan that is formally evaluated at least annually. Mid Rogue must (1) develop a quality assurance program description, (2) develop a quality work plan that includes an annual review process, (3) incorporate information from customer service, appeals and grievances, medical management, credentialing, provider relations, claims, sales, and marketing in its quality assurance program,(4) ensure that quality activities are reflected in quality minutes,(5) ensure that quality and broad minutes are signed and dated,(6) report quality information and quality indicators to its board,(7) ensure that information reported to the board is reflected in quality and board minutes,(8) revise organizational charts to reflect the appropriate structure, oversight, and reporting responsibilities of the quality committee,(9)develop a process that will encourage providers to participate in CMS and HHS quality improvement initiatives,(10)include dual eligible Special Needs Medicare enrollees (SNP) as a specific focus for QI planning and QI projects, (11) ensure that any variations between Mid Rogue Health Plan's Medicare Advantage enrollees and its Special Needs enrollees are clearly reflected in all policies, procedures, and training, 12) train appropriate staff on QI policies and procedures,(13) implement the policies and procedures,(14) provide the Seattle Regional Office (RO) with documentation on the training as follows:the materials used, the names and titles of the person(s)providing the training,and the name and position of each individual that received the training, and(15) for each of the prior fourteen tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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Requirement:

Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.

Deficiencies:

The reviewer determined that Mid Rogue did not meet CMS' compliance standards for an appropriate utilization management program.Mid Rogue did not have the following utilization management program components in place to ensure that it meets CMS requirements,(1)a formal and structured Medicare Utilization Management Program,(2)written policies and procedures that reflect Medicare coverage rules (national coverage decisions or local medical review policies) or the adoption of clinical practice guidelines used when processing requests for initial or continued authorization of services in a consistent manner,(3)effective mechanisms to detect both underutilization and overutilization of services,(4)effect mechanisms to ensure consistent application of review criteria and compatible decisions,(5)a formalized process for clinical peers review decisions to deny authorization on grounds of medical appropriateness using a consistent formal process,(6)formal utilization management(UM)activities to ensure appropriate documentation, tracking and trending of Medicare authorization requests,or(7)appropriate Medicare UM senior management oversight.

Corrective Action Required:

Mid Rogue must(1)develop an appropriate Medicare Advantage UM Program that meets CMS requirements. At a minimum the UM program must include written policies and procedures that reflect Medicare coverage guidelines, National Coverage Determinations and local medical review polices, 2)develop UM reports that help identify patterns of over and under utilization of services,(3)develop a formalized process to conduct clinical peers review decisions to deny authorization on grounds of medical appropriateness in a consistent manner,(4)formally adopt practice guidelines that are appropriate for Medicare enrollees. Where there are variations between coverage determinations for Special Needs Medicare Advantage enrollees(SNP), Mid Rogue must clearly state and explain variations in all UM policies and procedures,(5)ensure UM criteria is reviewed and approved by a committee of professionals that include practicing and participating providers,(6)communicate UM practice guidelines and UM criteria to providers through newsletter articles, provider educational trainings, and provider manuals,(7)established an inter-rater reliability process to esnure thatUM reviews are consistent and in accordance with established criteria,(8)ensure UM policies and procedures for its Medicare Advantage enrollees include explicit time frames for completing and communicating UM decisions to enrollees and providers,(9)develop case management activities,(10)ensure UM activities do not provide incentives to deny,limit, or discontinue Medicare service(11)train appropriate staff on UM policies and procedures,(12)provide the Seattle Regional Office(RO)with documentation of the training, the name and position of each staff member that received UM training, staff that conducted training, and details regarding the nature of the training, including the materials used in the training,and(13)for each of the prior twelve tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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Requirement:

Significant Problems Corrected - The MAO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

Deficiencies:

Mid Rogue Health Plan did not meet CMS' compliance standards to correct significant systematic problems. The reviewer was unable to verify that Mid Rogue Health Plan has an effective process in place that will allow it to identify, assess, and promptly correct significant problems that come to its attention through internal surveillance, complaints or other mechanisms, incorporate data from satisfaction surveys, conduct appropriate follow up monitoring to ensure that corrective actions are implemented in a timely and consistent manner, or conduct official quality of care reviews.

Corrective Action Required:

Mid Rogue must(1)develop a formal mechanism(s)to ensure that it promptly corrects significant systematic problems that come to its attention through internal surveillance, complaints, or other mechanisms,(2)develop and implement policies and procedures to identify and assess the severity of identified problem(s) and that allows the MAO to take timely and specific action to correct identified problem(s),(3)develop a process to incorporate and implement information or changes from member satisfaction surveys, 4)develop a formalized Medicare quality of care review process, (5)train appropriate staff on internal surveillance and complaints policies and procedures,(6)provide the Seattle Regional Office (RO) with documentation of the training, the name and position of each staff member that received UM training, staff that conducted training, and details regarding the nature of the training, including the materials used in the training, 10) for each of the prior 9 tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.

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Requirement:

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

Deficiencies:

Chronic Care Improvement Program (CCIP). The MAO must have a CCIP and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program. Additionally, the CCIP must have a mechanism for monitoring enrollees' participation in the program.

Corrective Action Required:

Submit to the evaluation entity, MAQRO, evidence that there are systematic processes and procedures in place to appropriately identify members with the CCIP's targeted conditions. The procedure must specify the frequency of data mining and should include how a member is to be notified of his, or her, eligibility. Submit to MAQRO, a written protocol for monitoring enrollee's participation in the program: specify the elements or attributes that are monitored for the CCIP participants, the staff roles involved in the CCIP monitoring and the frequency that the monitoring occurs. Submit to MAQRO, a timeline for implementation of a disease management data base system that the CCIP staff can use to effectively track CCIP participant progress.

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Requirement:

Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.

Deficiencies:

Quality Improvement Projects. The MAO must successfully complete annual QI projects that focus on clinical or non-clinical areas and submit the project reports to the evaluation entity.

Corrective Action Required:

Review the requirements and documentation standards related to Quality Improvement (QI) project methodology and quality indicators in the QI Instructional Guide and Chapter 5 of the Medicare Managed Care Manual. For the 2007 QI project, construct valid QI indicators and performance targets, and ensure that the data sources are appropriate. Resubmit a revised 2007 QI project report to the evaluation entity, MAQRO.

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Requirement:

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

Deficiencies:

Mid Rogue Health Plan initially attested that during the review period they did not receive requests for expedited reconsiderations (RP04). In the course of the onsite review and after further discussions with the MAO's staff, the RO determined that the MAO was not appropriately identifying expedited reconsiderations requests. Therefore, the MAO did not process appropriately requests for expedited reconsideration (RP04). Based on the review of the MAO's Policies and Procedures and staff interviews, the RO determined that Mid Rogue Health Plan did not establish efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, did not document all oral requests in writing, and did not maintain the documentation in case files as required by RP04.

Corrective Action Required:

Mid Rogue Health Plan must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file. Mid Rogue Health Plan must (1) revise polices and procedures (including "desk guides/procedures") to ensure that members can submit expedited requests both orally and in writing, all oral requests are documented in writing, and maintained in an appropriate case file, (2) implement the policies and procedures, (4) train appropriate staff on the policies and procedures, (3) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (4) conduct internal audits of the Expedited Reconsideration Request process, (5) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (6) provide a summary report to the (RO) every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, and (7) for each of the prior six tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.