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: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: AA01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/17/2008
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Element Projected Completion Date:06/30/2007
MCO Response Due Date: 03/08/2007

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:

MAOs are required to maintain and monitor a network of appropriate providers that is sufficient to provide access to and availability of covered services. Review of the HSD 3 tables and follow-up with Elderplan staff shows there are no contracted transplant facilities in the network. Elderplan has indicated they have been unable to come to contractual terms with any transplant facilities. However, Elderplan has not indicated that they have explored the option of participating in a transplant network, including facilities that provide pancreatic transplants, for which there are no Medicare certified providers in NewYork State. Since there is no evidence that Elderplan has pursued all options in securing transplant facilities, the element is NOT MET.

Corrective Action Required:

Elderplan needs to explore the option of a Transplant Network in order to assure that services are available to any member in need of a transplant.

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

Findings: NOT MET

Review ID: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: AD01
Review Type: Routine
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CAP Accepted Date:04/08/2008
Audit Closed Date:
Element Projected Completion Date:04/30/2007
MCO Response Due Date: 03/08/2007

Requirement:

No Member Discrimination in Delivery of Health CareThe MAO implements procedures to ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Deficiencies:

MAOs are required to implement procedures to ensure that members are not discriminated against in the delivery of health care services consistent with benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. Review of the Provider Manual shows that although Elderplan did not address non-discrimination based on claims experience, evidence of insurability (including conditions arising out of acts of domestic violence) or genetic information. Since Elderplan failed to include claims experience, evidence of insurability (including conditions arising out of acts of domestic violence) or genetic information as part of their antidiscrimination language, the element is NOT MET.

Corrective Action Required:

Elderplan needs to update the Provider Manual to include the missing elements from the non-discrimination section of the Provider Manual. Indicate when the revision will be made, including how and when the current provider network will be informed of the change. Submit a copy of the revision to CMS.

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Review ID: 7397

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Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
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CAP Accepted Date:04/08/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2007
MCO Response Due Date: 03/08/2007

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:

CMS reviewed policies and procedures, the Provider Manual and medical record audits to determine whether health record contained identifying information of the member, identification of all providers participating in the member¿s care and information on services furnished by these providers, a problem list that includes significant illnesses and medical and psychological conditions, presenting complaints, diagnoses and treatment plans, prescribed medications, including dosages and dates of initial or refill prescriptions, information on allergies and adverse reactions or a notation that the patient has no known allergies or history of adverse reactions, information on advance directives, and past medical history, physical examinations, necessary treatments, and possible risk factors for the member relevant to the particular treatment. The documentation was also reviewed to determine whether there were monitoring procedures for assessing and improving content, legibility, organization and completeness of member records. Review of the documentation, along with an interview with Elderplan staff showed that policies and procedures were not updated to include reviewing the medical record for presenting complaints, diagnoses and treatment plans, prescribed medications, including dosages and dates of initial or refill prescriptions, a notation that the patient has no known allergies or history of adverse reactions, and possible risk factors for the member relevant to the particular treatment. In addition, although legibility was addressed in Elderplan¿s monitoring procedures, assessing and improving content, organization and completeness of member records was not addressed. Since Elderplan failed to update their policies and procedures to include pertinent medical record standards and audit procedures, the element is NOT MET.

Corrective Action Required:

Elderplan needs to update their policies and procedures for Medical Record Audits to include the required information and submit a copy of the revised policy and procedure to CMS. Indicate how and when the current provider network will be notified of the change in the way Medical Record Audits performed and provide a copy of the notification to CMS.

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Date Report Due: 09/25/2006
CAP Accepted Date:04/08/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 03/08/2007

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:

In virtually all of the 20 contracts reviewed, the 10-year record retention provision and the federal right to audit provision were absent. The element is NOT MET.

Corrective Action Required:

Elderplan had already taken action to remedy this deficiency before the end of the site visit. A provider contract addendum was being mailed to all network providers. The addendum updated the contracts to include the 10-year records retention requirement and the federal right to audit requirement. Providers rejecting the the addendum within the 30-day time limit (as per current contract provisions for contract amendments) would have 60 days to cure the problem or to leave the network. This corrective action plan should be formalized in writing, signed off by management, and be submitted through HPMS for acceptance by CMS. For the CAP to be released, Elderplan must evidence to CMS that the addendum was sent to network providers (include how many). Elderplan also needs to report which (if any) providers left the network because they refused to accept the addendum. If refusals to accept the addendum resulted in any critical gaps in the network, Elderplan should also report on how it has remedied any resulting network gaps.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
Review Status: Confirmed
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CAP Accepted Date:04/08/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 03/08/2007

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:

Six of the 20 contracts reviewed involved inclusion of individual providers in the Elderplan network because the individual providers were in an IPA or an IPA-like arrangement versus direct contracts with Elderplan. In IPA arrangements (or in IPA-like arrangements at hospitals or medical centers) where a MAO lists the individual IPA (or facility) providers as individual network providers, the MAO has effectively DELEGATED to the IPA (or facility) the selection of individual network providers and has effectively DELEGATED ensuring the legal agreement of such individual network providers to the required terms of participation in the network. In contracts with such IPAs (or facilities), such a delegation should be specific and the way the entity will be held accountable and monitored by the MAO should be operationally specific. This was not the case in 5 of the 6 contracts involving IPA or IPA-like arrangements. The element is NOT MET.

Corrective Action Required:

Elderplan must formally recognize and document that it has delegated to IPAs and/or network hospitals its responsibility to bind downstream network providers (i.e., providers who are listed as network providers and are employed by or owned by the IPAs or hospitals) to meet applicable regulatory requirements through compliant contracts or agreements. Beyond the standard, delegated credentialling requirements, such regulatory requirements for contracts or agreements include Hold Harmless, Abide by Federal Requirements (including continuation of treatment, non-discrimination, honoring patient rights, retention of records, cooperation with Federal reviews or audits, etc.) and Compliance With the MAO's Policies and Procedures (including UM/UR, appeals and grievances, etc.). Elderplan must be able to demonstrate that its contracts with such IPAs or hospitals recognize the above by explicit statements in the contracts or contract amendments, or that the contracts reach to other documents that bind the IPAs or hospitals to perform this delegated responsibility. If Elderplan uses contractual reach to other documents, it must show that the IPAs or hospitals were formally made aware of the reach and the content of these documents containing this responsibility for downstream providers. Elderplan must document its monitoring and enforcement arrangements/processes for ensuring that such delegated entities legally and specifically bind the downstream providers to the applicable network provider requirements in the delegated entities' contracts/agreements with Elderplan. Elderplan must explain in a Plan of Correction when and how it will be able to demonstrate compliance with 422.506(i)(4) and (5) and 422.202(a) and (d) for downstream providers (as separately listed in HSD tables or in provider directories) who are IPA employed or are hospital employed or owned.

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Date Report Generated: 9/30/2008

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Review ID: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
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Date Report Due: 09/25/2006
CAP Accepted Date:04/08/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 03/08/2007

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:

The requirement is not met. A sample of fifteen (15) grievance cases were reviewed. Grievance cases are required to be processed within 30 days of receipt unless an extension is taken, in which case the Medicare Advantage Organization would have a maximum of 44 days to process a grievance. Elderplan did not process six(6)sample cases out of the fifteen (15) within the mandated time frame. Forty per cent(40%)of the cases were non-compliant in regard to the timely notification of the complainant.

Corrective Action Required:

Elderplan must ensure that grievances are processed within the mandated regulatory time-frames. It was noted that in a number of the cases which were non-compliant, the plan also failed to take an extension and the cases involved quality of care issues requiring contact with a physician. The corrective action plan should focus on training Elderplan's staff to recognize when a girevance investigation will take additional time to complete and issuing an extension to the complainant. Also when physician input is required in order to be responsive to enrollee issues, there should be an expedited follow up process to assure that physicians and their office staffs understand that a prompt response is required. Provider representatives should also stress this aspect in their contacts with physicians. Please provide a formalized corrective action plan to resolve this requirement with a training time table and plan for supervisory follow up.

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

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CAP Accepted Date:04/08/2008
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Element Projected Completion Date:09/30/2007
MCO Response Due Date: 03/08/2007

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:

The MAO must follow a documented process for physician and other health professionals regarding initial credentialing and recredentialing. The process must include, at a minimum, a correctly completed application, primary source verification (PSV) of license, Board certification, highest level of education or training (unless board certified and the board uses PSV), non PSV of clinical privileges, malpractice insurance, DEA or CDS certificate, National Practitioner Data Bank, Medicare/Medicaid Sanction list, Medicare Opt-Out List and quality of care issues for recredentialed candidates. CMS reviewed a sample of 20 credentialing/recredentialing files from a universe of 6866. Of these, nine cases were credentialed or recredentialed by one of Elderplan¿s delegated entities. The remaining cases were credentialed or recredentialed by Elderplan. One case was misclassified. Findings for the remaining cases are as follows: - Credentialing was current in two cases and the reviewer was unable to determine if credentialing was current in two cases. - One case did not have a correctly completed application. - In one case, it could not be determined whether the physician was Board certified or whether the highest level of education or training was verified. - Three cases did contain evidence of PSV of the highest level of education or training. - Eight delegated entity recredentialing files used hospital reappointment in lieu of quality of care information. - In 14 cases, there was no evidence that either the OIG Medicare/Medicaid Sanction List or the Medicare Opt Out List was checked. Since Elderplan failed to meet regulatory compliance for the selection and evaluation of providers in accordance to 42 CFR §422.204(b), the element is Not Met.

Corrective Action Required:

Elderplan must develop a strategy to correct the deficiencies addressed above. The strategy needs to include what changes will be made in auditing delegated entity credentialing/recredentialing and how the plan will monitor their own files to ensure that all files meet credentialing and recredentialing criterion. Include any timelines needed to accomplish objectives and submit copies to CMS.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
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MCO Response Received Date:03/17/2008
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CAP Accepted Date:04/08/2008
Audit Closed Date:
Element Projected Completion Date:08/31/2007
MCO Response Due Date: 03/08/2007

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:

CMS reviewed Credentialing Committee Minutes, policies and procedures and ten ancillary provider credentialing files to determine if Elderplan had written policies and procedures for the selection and evaluation of providers and follows a documented process for facilities regarding initial credentialing and recredentialing that includes: state license to operate, compliance with any applicable State or Federal requirements, including the requirement to be Medicare certified and reviewed and approved by a credentialing body or meets the standards established by the MAO. Review of the ten provider files revealed that CMS was unable to ascertain whether the file was an initial credentialing or a recredentialing file in eight of 10 cases and seven files did not meet credentialing criteria based on the following: - Two of two hospital files reviewed contained only a JCAHO Summary of Quality Information dated August 4, 2006. - One of laboratory files contained no information other than a quality report dated August 4, 2006. - One OPT file contained only a roster of therapists. - One Radiology provider files contained only a roster of radiologists. - One HHA provider file contained only a 2004-2007 JCAHCO certification. - One DME was not checked against the Medicare exclusion list, nor was there any evidence the Medicare Provider Agreement was checked. In addition to not including Renal Dialysis Facilities, outpatient therapy providers, CORFs and radiology/mammography providers in their policies and procedures, Elderplan failed to follow existing policies and procedures when credentialing and recredentialing ancillary providers that included presentation before the Credentialing Committee for approval. Based on these findings, CMS has determined the element is NOT MET.

Corrective Action Required:

Elderplan must revise their policies and procedures to include all ancillary provider types. Elderplan must also develop a plan to determine which ancillary credentialing/recredentialing files are incomplete and how deficiencies in these files will be corrected, including a timeline for correction. Provide CMS with the revised policies and procedures and plan for file review and correction, including timeline.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

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CAP Accepted Date:04/08/2008
Audit Closed Date:
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MCO Response Due Date: 03/08/2007

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:

CMS reviewed the Provider Manual and written notices to providers to determine whether Elderplan discriminates against health care professionals, in terms of participation, reimbursement or indemnification, or those who serve high-risk populations or specialize in the treatment of costly conditions. Although Section 3ciii of the Provider Manual indicates Elderplan does not discriminate against health care professionals in terms of participation, reimbursement or indemnification, there is no indication that the MAO does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions. Since Elderplan failed to include that the MAO does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions as part of their physician non-discrimination language, the element is NOT MET.

Corrective Action Required:

Elderplan needs to revise the Provider Manual to include the absent statement. Indicate when the revision will be made, including how and when the current provider network will be informed of the change. Submit a copy of the revision to CMS.

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Review ID: 7397

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MCO Response Due Date: 03/08/2007

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 MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually. Based upon review of the 2004 and 2005 QI Program Evaluation, the 2006 Workplan, Board of Director Minutes and interview with staff, CMS has determined that Elderplan did not have an ongoing quality assessment and performance improvement program and that oversight by the Board of Directors was minimal as evidenced by the following: 1. Board Minutes showing that the 2004 and 2005 Quality Improvement Plan Evaluations and 2006 QI Workplan was presented to and approved by the Board of Directors on July 18, 2006. QI Workplans and evaluations need to be presented to, and approved by, the Board of Directors no later than the first quarter of a new calendar year. 2. The 2006 Workplan did not were not: - Incorporate the recommendations from the 2005 QI Evaluation. - Incorporate appeals and grievances, provider relations, claims, sales or marketing. - Identify important opportunities to improve services. - Identify appropriate clinical criteria for monitoring the provision of care. - Establish objective, concrete measurements (identifying levels, patterns, trends). - Establish specific, measurable goals/objectives. - Define actions/procedures for meetings goals/objectives. - Establish a reporting timeline and outcome measures. It should be noted that the Medical Director and QI Director positions have been vacant since June. Since Elderplan failed to demonstrate they have an ongoing quality improvement program, the element is NOT MET.

Corrective Action Required:

Elderplan must provide CMS with the following: - A copy their 2006 QI plan evaluation and 2007 Workplan that addressing the deficiencies outlined above. - Signature pages showing the evaluation and workplan were approved by the COO and Medical Director - Copies of the QI Committee minutes, for a minimum of three quarters, that reflect implementation and progress of the 2006 workplan - Copies of the Board of Director Minutes that show when the program was reviewed and approved. - Copies of the Board of Director Minutes, for a minimum of two quarters, showing Board oversight of the QI program. In addition, Elderplan must notify CMS when a Medical Director and QI Director are hired and provide copies of the nomineesؿ resumes. Refer to QY05 and QY09

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MCO Response Due Date: 03/08/2007

Requirement:

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

Deficiencies:

The MAO must have a mechanism for assessing the severity of identified problems and takes timely and specific actions to correct identified problems, depending on the severity and impact of the identified problems. Based on CMS review of policies and procedures, interviews with staff and review of QI Committee minutes there was no evidence that Elderplan had a formal process for fully identifying, assessing or prioritizing problems using internal surveillance measures. Refer to QY01.

Corrective Action Required:

Elderplan must develop a formal process to identify, assess and prioritize problems using internal surveillance measures and integrate the results into the QI minutes for analysis and documentation of corrective actions to be taken on identified trends and problems. Elderplan must submit the developed process to CMS.

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MCO Response Due Date: 03/08/2007

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:

Each MAO is required to undertake one new QI project annually that can be expected to have a favorable effect on health outcomes and/or enrollee satisfaction. CMS interviewed Elderplan staff to determine whether the plan has QI projects that focus on both clinical and non-clinical areas and follows the current quality improvement process. CMS learned Elderplan had not initiated any QI projects, nor selected a topic at the time of the monitoring audit. Since Elderplan failed to initiate a 2006 QI Project eight months into the calendar year, the element is NOT MET. Refer to QY01

Corrective Action Required:

Elderplan needs to select a topic for their 2006 from the possible subjects presented to CMS during the monitoring audit. In addition to informing CMS of the subject, Elderplan must indicate how the topic was selected and the baseline data used.

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MCO Response Due Date: 03/08/2007

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:

This requirement is not met. CMS reviewed a sample of ten cases for the worksheet RC1 (Favorable Claims Reconsiderations). In eight of the ten cases of favorable claims reconsiderations, the claim was not paid within the requirement of notice and payment within 60 calendar days of receiving the reconsideration request.

Corrective Action Required:

Elderplan must submit a Corrective Action Plan (CAP) on how it will ensure that favorable claims reconsiderations are paid timely (i.e., within 60 days of receiving the request for reconsideration). The CAP must include how Elderplan will monitor and verify that favorable reconsiderations of claims are paid timely over at least two consecutive quarters. For the CAP to be released, Elderplan must present this verification to the CMS RO.

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: 02 New York
Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Review ID: 7397

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 03/17/2008
Element Accepted Date: 04/08/2008
Element Release Date: 09/23/2008
CAP Released Date:

Visit Start Date: 8/7/2006
Exit Conference Date: 08/11/2006
Date Report Issued: 01/22/2007
Date Report Due: 09/25/2006
CAP Accepted Date: 04/08/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 03/08/2007

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:

This requirement is NOT MET. In a sample of ten cases reviewed for worksheet RC2 (Unfavorable Claims Reconsiderations), Elderplan did not process the adverse claims reconsiderations in a timely manner in six of the cases. CMS requires that once a claims reconsideration request is received by the plan in house and the plan upholds its original determination (no action, by default, is an uphold), the plan must forward the case to an Independent Review Entity (IRE) within 60 days of reception of the request and the plan must notify the member of the uphold and forwarding within the same 60 days.

Corrective Action Required:

Elderplan must submit a Corrective Action Plan (CAP) on how it will ensure that adverse claims reconsiderations are processed timely (i.e., within 60 days of receipt at the plan). This includes both forwarding the case to the IRE and notifying the member when Elderplan upholds its original determination. The CAP must include how Elderplan will monitor and verify that unfavorable reconsiderations of claims are forwarded timely to IRE and that members are notified timely over at least two consecutive quarters. For the CAP to be released, Elderplan must present this verification to the CMS RO.

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: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 03/17/2008
Element Accepted Date: 04/08/2008
Element Release Date: 09/23/2008
CAP Released Date:

Visit Start Date: 8/7/2006
Exit Conference Date: 08/11/2006
Date Report Issued: 01/22/2007
Date Report Due: 09/25/2006
CAP Accepted Date: 04/08/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 03/08/2007

Requirement:

Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.

Deficiencies:

This requirement is NOT MET. In a sample of 4 applicable cases (taken from the sample of 10 original cases) reviewed for worksheet RC2 (Unfavorable Claims Reconsiderations), Elderplan did not effectuate the IRE decision and pay the claim within 30 days of receiving the IRE reversal on 2 of the cases. CMS requires that reversed claims determinations (whether reversed by IRE or the plan itself) must be paid within 30 days of receiving the notice from IRE or of making the reversal decision itself.

Corrective Action Required:

Elderplan must submit a corrective action plan on how it will ensure that unfavorable claims reconsiderations that are reversed (by Elderplan or by the IRE) are paid within 30 calendar days. The CAP must include how Elderplan will monitor and verify that reversed claims denials are paid timely. For the CAP to be released, Elderplan must present this verification to the CMS RO.

CMS Medicare Managed Care Auditing Report

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

Findings: NOT MET

Review ID: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 03/17/2008
Element Accepted Date: 04/08/2008
Element Release Date: 09/23/2008
CAP Released Date:

Visit Start Date: 8/7/2006
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Date Report Due: 09/25/2006
CAP Accepted Date: 04/08/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 03/08/2007

Requirement:

Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).

Deficiencies:

The requirement is not met. There were only two cases in the Favorable Standard Pre-Service Reconsideration category during the review period. The Medicare processing requirement mandates that the plan must issue a notice to the enrollee and authorize or provide the service no later than 30 calendar days after receiving the request, or an additional 14 calendar days if an extension is justified. No extension was taken by Elderplan, and both cases exceeded the 30 day requirement. In one of the cases reviewed, it actually took the plan seven months to process the reconsideration request prior to authorization of the service.

Corrective Action Required:

Elderplan must ensure that pre-service reconsiderations are processed promptly. Staff should be given training in the reconsideration area to stress the importance of meeting federal time-frames.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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

Findings: NOT MET

Review ID: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 03/17/2008
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Element Release Date: 09/23/2008
CAP Released Date:

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Date Report Issued: 01/22/2007
Date Report Due: 09/25/2006
CAP Accepted Date: 04/08/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 03/08/2007

Requirement:

Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.

Deficiencies:

The requirement is not met. There were seven cases in the Adverse Standard Pre-Service Reconsideration category processed during the review period, and all of them were reviewed. Three of the seven cases were found to be misclassified. One case involved an expedited reconsideration, rather than a standard reconsideration. The second case resulted in the vendor replacing a defective piece of durable medical equipment, and therefore the case should not have been categorized as unfavorable. In the third situation, the enrollee, who had received a pre -service denial for eye surgery, directly arranged and paid for the surgery, and then submitted the bills for reimbursement, and the issue was no longer a pre-service determination, but rather, a claims submission. Since over 30 per cent of the sample was misclassified, the audit protocol requires that element RP02 must be determined to be not met.

Corrective Action Required:

Elderplan must ensure that appropriate case classification is carried out. Since the validity of data and compliance with processing requirements is dependent on correct case categorization, it is essential that this systems aspect be resolved. Elderplan staff should be given training to assure that future cases are classified properly. Elderplan must supply a new universe of cases that meet the definition of the universe (standard pre-service determinations that were not favorable to the member) and CMS must do a new worksheet WsRP2 as a later focused review of elements depending on that universe and worksheet (i.e., elements RP02 and RP03).

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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Findings: NOT MET

Review ID: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/17/2008
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CAP Released Date:

Visit Start Date: 8/7/2006
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Date Report Due: 09/25/2006
CAP Accepted Date:04/08/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 03/08/2007

Requirement:

Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.

Deficiencies:

The requirement is not met. Please cross-reference to element RP02. The misclassification of three cases also applies to the third party effectuation standards element RP03, which must also be determined to be not met under audit protocol requirements.

Corrective Action Required:

Please cross reference to the Corrective Action Required for Element RP02.

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: 7397

Region: 02 New York

Contract Number / Name: H9101 ELDERPLAN, INC. - SHMO

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/17/2008
Element Accepted Date: 04/08/2008
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Visit Start Date: 8/7/2006
Exit Conference Date: 08/11/2006
Date Report Issued: 01/22/2007
Date Report Due: 09/25/2006
CAP Accepted Date:04/08/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 03/08/2007

Requirement:

Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.

Deficiencies:

The requirement is not met. When processing an Expedited Reconsideration, the plan is required to make a determination and notify the member no later than 72 hours from the time it receives the request unless it justifies an extension. Of the ten Elderplan sample cases reviewed no extensions were taken, and in two of the cases the members were not notified on a timely basis.

Corrective Action Required:

Elderplan must ensure that staff are aware of federal time-frames and documentation requirements in processing expedited reconsiderations when such requests are received. This aspect should be included in appeal training for staff.