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: 7797

Region: 02 New York

Contract Number / Name: H3370 EMPIRE HEALTHCHOICE HMO, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 03/01/2007
Element Release Date: 02/11/2008
CAP Released Date:06/02/2008

Visit Start Date: 9/12/2006
Exit Conference Date: 09/15/2006
Date Report Issued: 01/08/2007
Date Report Due: 10/30/2006
CAP Accepted Date:03/06/2007
Audit Closed Date: 06/02/2008
Element Projected Completion Date:
MCO Response Due Date: 02/22/2007

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:

Seventeen of the twenty contracts reviewed did not contain the new 10-year record retention provisions. Although many of the contracts pre-dated the federal 10-year record retention requirement, the federal 10-year record retention requirement provisions must still be specifically stated in contracts with Senior Plan Direct (H3370) network providers.

Corrective Action Required:

Empire must ensure that the federal 10-year record retention requirement provision is specified in all contracts with Senior Plan Direct (H3370) network providers. Prior to the CMS team departure from the onsite review, Empire staff presented an unsigned draft of the MAO's proposed corrective action plan for element CN04. The draft stated that Empire would treat this topic in near-term provider communication vehicles and that the provision would be included in a broader amendment to all provider contracts scheduled for 1st quarter of 2007. CMS finds this draft acceptable. It should be signed and approved by Empire management and be formally submitted as the CAP for this element.

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: 7797

Region: 02 New York

Contract Number / Name: H3370 EMPIRE HEALTHCHOICE HMO, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 03/01/2007
Element Release Date: 06/02/2008
CAP Released Date:06/02/2008

Visit Start Date: 9/12/2006
Exit Conference Date: 09/15/2006
Date Report Issued: 01/08/2007
Date Report Due: 10/30/2006
CAP Accepted Date:03/06/2007
Audit Closed Date: 06/02/2008
Element Projected Completion Date:
MCO Response Due Date: 02/22/2007

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. CMS requires that grievances should be processed no later than 30 days after the receipt date of the grievance unless an extension is taken in which case the grievance must be processed no later than 44 days after receipt. A sample of fifteen grievances were reviewed and the team found that in six of those complaints the complainant was not notified in a tmely manner of the results of the review. It should also be noted that Empire did not take an extension in any of the fifteen cases reviewed.

Corrective Action Required:

Empire must ensure that Medicare grievance cases are processed in a timely manner in accordance with federal requirements and timeframes. Prior to the CMS team departure from the onsite review, Empire staff presented an unsigned draft of the MAO's proposed corrective action plan for element GV03 indicating that the Grievance and Appeal Coordinator would maintain a complaint tracking spreadsheet in order to assure that prompt follow up action is implemented to eliminate non-compliant trends. The proposed CAP also called for follow up by Provider Relations coodinators to impress on providers the need for a rapid response to enrollee quality of care complaints. CMS believes the proposed CAP responds to the review findings and suggests that it be signed and implemented.