CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 08 Denver
Review ID: 9197
Contract Number / Name: H5608 DENVER HEALTH MEDICAL PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/14/2008
Element Accepted Date: 04/04/2008
Element Release Date: 04/15/2008
CAP Released Date:07/09/2008

Visit Start Date: 12/3/2007
Exit Conference Date: 12/20/2007
Date Report Issued: 01/30/2008
Date Report Due: 02/03/2008
CAP Accepted Date:04/11/2008
Audit Closed Date: 07/09/2008
Element Projected Completion Date:04/15/2008
MCO Response Due Date: 03/15/2008

Requirement:

Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.

Deficiencies:

7 out of 15 samples were not categorized correctly. These cases should have been appeals since the complaint was addressing a billing concern that should be addressed as on organizational determination.

Corrective Action Required:

Denver Health must conduct training of appropriate staff on the identification of grievances. Specifically, Denver health should ensure that staff understand the proper distinction between grievances and appeals and the appropriate categorization of both. Denver Health should submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Denver Health should conduct an internal audit of the grievances received. This audit should evaluate whether the grievances were appropriately catogorized and processed timely. The plan should submit a summary report to the Regional Office of its findings during the first six months of 2008. In addition, Denver Helath must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.

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Findings: NOT MET

Review ID: 9197

Region: 08 Denver

Contract Number / Name: H5608 DENVER HEALTH MEDICAL PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/14/2008
Element Accepted Date: 04/04/2008
Element Release Date: 07/03/2008
CAP Released Date:07/09/2008

Visit Start Date: 12/3/2007
Exit Conference Date: 12/20/2007
Date Report Issued: 01/30/2008
Date Report Due: 02/03/2008
CAP Accepted Date:04/11/2008
Audit Closed Date: 07/09/2008
Element Projected Completion Date:06/15/2008
MCO Response Due Date: 03/15/2008

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:

4 out of 15 of the member notifications did not include a complete resolution to the grievance. Supporting information does show that the follow up work was completed, but the written member notification does not make that clear or it was completed after the member notice was mailed.

Corrective Action Required:

Denver Health must describe the actions it is taking to ensure that the notices sent members after investigating a complaint include a clear description of the final disposition, as appropriate. Denver Health must send the Regional Office copies of grievances and corresponding notices for three cases received after the staff has been trained to include a complete resolution in the notice. Release Updatee - (7/3/2008) - The plan provided the three grievance examples for review and they are now complete.

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Findings: NOT MET

Review ID: 9197

Region: 08 Denver

Contract Number / Name: H5608 DENVER HEALTH MEDICAL PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/14/2008
Element Accepted Date: 04/02/2008
Element Release Date: 04/02/2008
CAP Released Date:07/09/2008

Visit Start Date: 12/3/2007
Exit Conference Date: 12/20/2007
Date Report Issued: 01/30/2008
Date Report Due: 02/03/2008
CAP Accepted Date:04/11/2008
Audit Closed Date: 07/09/2008
Element Projected Completion Date:04/01/2008
MCO Response Due Date: 03/15/2008

Requirement:

No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered;· Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000);· Offer gifts or payment as an inducement to enroll in the organization;·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.

Deficiencies:

Unable to determine what type of management control and oversight occurs with agents. The Plan has minimal controls in place to test understanding of the Medicare program by all individuals that sell for the Plan. Documentation does not always exist to ensure monitoring of agent training and activities. Policies and Procedures need to be developed to accurately reflect current practice of agent training, testing and oversight.

Corrective Action Required:

The Plan must develop a program that ensures that agents/brokers are adequately trained, monitored, and evaluated. The program should include: * Initial new hire training manual * Type and content of all subsequent trainings * How Plan will ensure knowledge and understanding of program requirements * If written tests are implemented, indicate expected answers, passing score, number of times a test can be taken and how you will re-educate on deficient areas * A process for ensuring that agents/brokers are informed of current program updates The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The program should include documentation in each agent/broker file of at least the following: * Evidence of current licensure * Date of hire * Evidence of attendance at trainings * Evidence of knowledge and understanding of Medicare and the Plan * Evaluation of presentation skills * Information regarding rapid disenrollment * Information about any sales complaints from current or prospective members * Information regarding disciplinary actions * Evidence of continued monitoring * Evidence of annual evaluation * Salary structure Create and/or revise policies to accurately reflect current practice. Develop a presentation assessment form. Monitor and document, in agent files, rapid disenrollments and disenrollment reasons. Describe how disenrollments will be monitored, frequency of monitoring and how the information will be utilized to monitor agent effectiveness.

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Findings: NOT MET

Review ID: 9197

Region: 08 Denver

Contract Number / Name: H5608 DENVER HEALTH MEDICAL PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/14/2008
Element Accepted Date: 04/02/2008
Element Release Date: 05/12/2008
CAP Released Date:07/09/2008

Visit Start Date: 12/3/2007
Exit Conference Date: 12/20/2007
Date Report Issued: 01/30/2008
Date Report Due: 02/03/2008
CAP Accepted Date:04/11/2008
Audit Closed Date: 07/09/2008
Element Projected Completion Date:03/14/2008
MCO Response Due Date: 03/15/2008

Requirement:

Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.

Deficiencies:

Plans are required to provide a 30 day notice when a provider is no longer under contract as a participating plan provider. The policy and the examples provided only gave 15 days.

Corrective Action Required:

Develope a Policy and Procedure that states that the Plan will make a good faith effort to give members 30 days notice for all provider terminations. Describe the process for staff training and implementation.

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Findings: NOT MET

Review ID: 9197

Region: 08 Denver

Contract Number / Name: H5608 DENVER HEALTH MEDICAL PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/14/2008
Element Accepted Date: 04/03/2008
Element Release Date: 07/01/2008
CAP Released Date:07/09/2008

Visit Start Date: 12/3/2007
Exit Conference Date: 12/20/2007
Date Report Issued: 01/30/2008
Date Report Due: 02/03/2008
CAP Accepted Date:04/11/2008
Audit Closed Date: 07/09/2008
Element Projected Completion Date:05/15/2008
MCO Response Due Date: 03/15/2008

Requirement:

Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.

Deficiencies:

The denial notices used by the MAO were difficult for a Medicare/Medicaid member to understand and the notice also contained incorrect appeals language.

Corrective Action Required:

Denver Health must either revise the verbiage of the denial messages generated on the explanation of benefits (EOBs) or send an individual notice of denial of payment for the denied claim. Medicare Advantage Organizations must use Form No. CMS-10003-NDP. The language explaining the denial that is provided to the beneficiary must be clear and easily understood. Denver Health must also include the CMS approved appeal rights language along with the notice of denial.

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Findings: NOT MET

Review ID: 9197

Region: 08 Denver

Contract Number / Name: H5608 DENVER HEALTH MEDICAL PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/14/2008
Element Accepted Date: 04/07/2008
Element Release Date: 04/07/2008
CAP Released Date:07/09/2008

Visit Start Date: 12/3/2007
Exit Conference Date: 12/20/2007
Date Report Issued: 01/30/2008
Date Report Due: 02/03/2008
CAP Accepted Date:04/11/2008
Audit Closed Date: 07/09/2008
Element Projected Completion Date:03/01/2008
MCO Response Due Date: 03/15/2008

Requirement:

Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.

Deficiencies:

WS-PR1, Column 14 indicates whether or not quality of care performance metrics are being observed and recorded. Denver Health currently has a system to check provider quality contained in Medical Record Policy P-6.11, but not specific or measurable to monitor performance metrics such as utilization management system, grievance system, enrollee satisfaction surveys etc.

Corrective Action Required:

In order to demonstrate compliance with Credentialing requirements for physicians and other health care professionals, Denver Health must establish a Quality Improvement process which encompasses a formal process for reviewing performance indicators including: utilization management system, grievance system, enrollee satisfaction surveys, and other activities of the organization. The quality improvement process should be included in policies and procedures for both DHHA and UPI.

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Region: 08 Denver

Contract Number / Name: H5608 DENVER HEALTH MEDICAL PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
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CAP Accepted Date:04/11/2008
Audit Closed Date: 07/09/2008
Element Projected Completion Date:03/14/2008
MCO Response Due Date: 03/15/2008

Requirement:

Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.

Deficiencies:

Denver Health did not have a universe for this element. In addition, Denver Health did not have any policies and procedures developed to handle a member appeal of a denied claim, if Denver Health should receive such an appeal. Therefore, CMS must find this element not met.

Corrective Action Required:

Denver Health must develop policies and procedures, in accordance with CMS requirements, to be used when Denver Health receives a member appeal of a denied claim for which the member is financially liable.

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Contract Number / Name: H5608 DENVER HEALTH MEDICAL PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:03/14/2008
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Audit Closed Date: 07/09/2008
Element Projected Completion Date:03/14/2008
MCO Response Due Date: 03/15/2008

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:

This element had a universe/sample of one. The decision for this sample was not provided within 30 days. Even if an extension had been requested, that would have added only 14 days to the timeline. This decision took almost two months. However, the Denver Health policy/procedure is correct.

Corrective Action Required:

Denver Health must analyze its processes and take necessary action to ensure that authorizations for services reversed upon reconsideration are issued within the required timeframe. Corrective action submitted to the Regional Office should include the results of Denver Health¿s analysis as to the cause(s) of the delay, steps Denver Health is taking to correct the process, and a description of how it will monitor its compliance with this requirement.