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: 10 Seattle
Contract Number / Name: H3814 ATRIO HEALTH PLANS

Review ID: 9877

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 03/03/2008
Element Release Date: 07/24/2008
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Visit Start Date: 9/18/2007
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Date Report Issued: 11/02/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

Required Contract Provision: Prompt PaymentThe MAO's written contracts with first tier and downstream entities must contain a prompt payment provision.

Deficiencies:

ATRIO Health Plan did not meet the CMS 95% compliance standard. CMS reviewed 20 provider contracts (WS-CN1) from a universe of 24 and found 6 contracts the MAO/Delegated entity did not meet the required contract language to contain a contract provision for prompt payment. The MAO¿s and delegated entities written contracts with first tier and downstream entities must contain a prompt payment provision.

Corrective Action Required:

ATRIO Health Plan must: 1) Establish and maintain effective oversight of the MAO¿s internal and delegated entities contracting process to ensure direct, downstream and administrative contracts contain the prompt payment provision. 2) Develop and implement a consistent, documented contracting process for direct, downstream and administrative contracts, to include a workflow diagram with timelines. 3) Develop policies and procedures outlining how the MAO will monitor contract compliance for direct, downstream and delegated entity contracting. 4) Develop and implement an internal audit process to ensure contracts comply with Medicare requirements. 5) Provide the Regional Office (RO) with a detailed summary report outlining the MAO¿s audit findings, and corrective action plan. The report should include the title of the auditor(s), the audit methodology, and the results of the audit. 6) Amend direct, downstream and administrative contracts that do not comply with the required Medicare contract provisions. 7) For each of the six tasks of this Corrective Action Request, clearly state in the MAO¿s Corrective Action Plan when the MAO will complete the corrective action.

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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: 9877

Region: 10 Seattle

Contract Number / Name: H3814 ATRIO HEALTH PLANS

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN04
Review Type: Routine
Review Status: Confirmed
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Date Report Due: 11/04/2007
CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

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:

ATRIO Health Plan did not meet the CMS 95% compliance standard. CMS reviewed 20 provider contracts (WS-CN1) from a universe of 24 and found 20 contracts the MAO/Delegated entity did not meet the requirement to, Abide by Federal Requirements. Specifically, the 20 contracts did not contain the provision to maintain records a minimum of 10 years.

Corrective Action Required:

ATRIO Health Plan must: 1) Establish and maintain effective oversight of the MAO¿s internal and delegated entities contracting process to ensure direct, downstream and administrative contracts contain the provision to maintain records for a minimum of 10 years. 2) Develop and implement a consistent, documented contracting process for direct, downstream and administrative contracts, to include a workflow diagram with timelines. 3) Develop policies and procedures outlining how the MAO will monitor contract compliance for direct, downstream and delegated entity contracting. 4) Develop and implement an internal audit process to ensure contracts comply with Medicare requirements. 5) Provide the Regional Office (RO) with a detailed summary report outlining the MAO¿s audit findings, and corrective action plan. The report should include the title of the auditor(s), the audit methodology, and the results of the audit. 6) Amend direct, downstream and administrative contracts that do not comply with the required Medicare contract provisions. 7) For each of the six tasks of this Corrective Action Request, clearly state in the MAO¿s Corrective Action Plan when the MAO will complete the corrective action.

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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: 9877

Region: 10 Seattle

Contract Number / Name: H3814 ATRIO HEALTH PLANS

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN06
Review Type: Routine
Review Status: Confirmed
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Date Report Issued: 11/02/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.

Deficiencies:

ATRIO Health Plan did not meet the CMS 95% compliance standard. CMS reviewed 20 provider contracts (WS-CN1) from a universe of 24 and found 4 contracts that did not meet the required contract provision for compliance with the MAO¿s Policies and Procedures. The MAO¿s written contracts with first tier and downstream entities must specify that provider agrees to comply with the MAO¿s policies and procedures.

Corrective Action Required:

ATRIO Health Plan must: 1) Establish and maintain effective oversight of the MAO¿s internal and delegated entities contracting process to ensure direct, downstream and administrative contracts contain the provision to comply with the MAO¿s policies and procedures. 2) Develop and implement a consistent, documented contracting process for direct, downstream and administrative contracts, to include a workflow diagram with timelines. 3) Develop policies and procedures outlining how the MAO will monitor contract compliance for direct, downstream and delegated entity contracting. 4) Develop and implement an internal audit process to ensure contracts comply with Medicare requirements. 5) Provide the Regional Office (RO) with a detailed summary report outlining the MAO¿s audit findings, and corrective action plan. The report should include the title of the auditor(s), the audit methodology, and the results of the audit. 6) Amend direct, downstream and administrative contracts that do not comply with the required Medicare contract provisions. 7) For each of the six tasks of this Corrective Action Request, clearly state in the MAO¿s Corrective Action Plan when the MAO will complete the corrective action.

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

Findings: NOT MET
Region: 10 Seattle
Contract Number / Name: H3814 ATRIO HEALTH PLANS

Review ID: 9877

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Status: Confirmed
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Date Report Issued: 11/02/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 02/29/2008
MCO Response Due Date: 12/17/2007

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 review of case files submitted for grievances indicates the MAO is not compliant in this area. Reviewed all cases (WS-GV1) from a universe of 5. Two (40%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met.

Corrective Action Required:

ATRIO Health Plan must: 1) Submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. 2) Develop grievance polices and procedures that allows the organization to differentiate between Part C grievances and Part D grievances. Polices and procedures must clearly map the workflow of grievance staff, including the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 3) Develop efficient oversight and management of grievance responsibilities by appropriate and consistent documentation of grievances, to include: quality of care complaints, appropriately tracking all grievances, and the ability to accurately distinguish a grievance from an appeal.. 4) Develop processes to ensure grievances are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 5) For each of the four tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.

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Findings: NOT MET
Region: 10 Seattle
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Review ID: 9877

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Date Report Issued: 11/02/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 02/29/2008
MCO Response Due Date: 12/17/2007

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:

The review of case files submitted for grievances indicates the MAO is not compliant in this area. Reviewed all cases (WS-GV1) from a universe of 5. Two (40%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met.

Corrective Action Required:

ATRIO Health Plan must: 1) Submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. 2) Develop grievance polices and procedures that allows the organization to differentiate between Part C grievances and Part D grievances. Polices and procedures must clearly map the workflow of grievance staff, including the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 3) Develop efficient oversight and management of grievance responsibilities by appropriate and consistent documentation of grievances, to include: quality of care complaints, appropriately tracking all grievances, and the ability to accurately distinguish a grievance from an appeal.. 4) Develop processes to ensure grievances are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 5) For each of the four tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.

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CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 02/29/2008
MCO Response Due Date: 12/17/2007

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:

The review of case files submitted for grievances indicates the MAO is not compliant in this area. Reviewed all cases (WS-GV1) from a universe of 5. Two (40%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met

Corrective Action Required:

ATRIO Health Plan must: 1) Submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. 2) Develop grievance polices and procedures that allows the organization to differentiate between Part C grievances and Part D grievances. Polices and procedures must clearly map the workflow of grievance staff, including the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 3) Develop efficient oversight and management of grievance responsibilities by appropriate and consistent documentation of grievances, to include: quality of care complaints, appropriately tracking all grievances, and the ability to accurately distinguish a grievance from an appeal.. 4) Develop processes to ensure grievances are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 5) For each of the four tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.

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Findings: NOT MET
Region: 10 Seattle
Contract Number / Name: H3814 ATRIO HEALTH PLANS

Review ID: 9877

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Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
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CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 02/28/2008
MCO Response Due Date: 12/17/2007

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:

ATRIO Health Plan did not meet the CMS compliance standard to make correct claim determinations. CMS audited 30 cases (WS-OC2) out of a universe of 454 and found 25 cases for which there was no documentation of claim development for denied services and no clear, supporting documentation or policies and procedures. Specifically, there were (1)seven DME claims denied without development and without supporting documentation or policies and procedures to support how DME claims were paid and authorized, (2)one claim service denied for untimely filing without supporting documentation describing the MAO's timely filing guidelines, (3)fifteen claims for which routine vision frames, lenses or refraction services were denied for SNP members who had no routine vision benefit, with payment responsibility assigned to the provider instead of the beneficiary. The MAO provided a statement on the member EOB stating that the denied services would be submitted to the Medicaid carrier. The MAO did not provide a combined Medicare/Medicaid EOB, but a primary Medicare EOB which should have reflected the appropriate denial and member liability, (4)one diabetic education claim which was denied in error and subsequently reversed and reprocessed and, (5) one home infusion and drug claim denied with no development or documentation to support the denial of the drug. The MAO did not have documentation or policies regarding claim development.

Corrective Action Required:

ATRIO Health Plan must achieve and maintain effective oversight of correct claim determinations, which include developing the claim for additional information. ATRIO Health Plan must (1)develop and implement policies and procedures (a)requiring its staff and delegated entities to develop claims for the necessary information needed in order to make a correct claim determination, (b)that require staff with the appropriate professional level to review development information and make a claim determination, (c)describing when authorizations are required, (d)describing its claim timeliness guidelines, (e)instructing staff and delegated entities to fully document all claim development and, (f)describing its oversight plan for continued monitoring of its delegated entities, (2)train appropriate staff and delegated entities 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. 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 fully 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 progress and monitoring of its processes, (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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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 9877

Region: 10 Seattle

Contract Number / Name: H3814 ATRIO HEALTH PLANS

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC02
Review Type: Routine
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MCO Response Received Date: 12/18/2007
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CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 02/28/2008
MCO Response Due Date: 12/17/2007

Requirement:

Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement 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, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.

Deficiencies:

ATRIO Health Plan did not meet the CMS compliance standard to provide reasonable reimbursement for services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO. ATRIO Health Plan did not have policies and procedures or written guidelines sufficient to determine if it was using the appropriate Medicare fee-for-service payment mechanisms when determining payment amounts to non-contracted providers.

Corrective Action Required:

ATRIO Health Plan must achieve and maintain effective oversight of correct claim payments for non-contracted providers, which include developing written documentation of its payment mechanisms. ATRIO Health Plan must (1)develop and implement policies and procedures that document how it uses Medicare fee-for-service schedules, Groupers and Pricers to pay non-contracted provider claims of all types, (2)document its process for updating fee schedules, (3)update its Claim and Record Retention policy to reflect that records must be retained for ten years-see CN04, (4)train appropriate staff and delegated entities 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 non-contracted paid claims. The audits must evaluate whether the appropriate Medicare fee-for-service payment mechanisms were used in the payment of those claims, (7)provide the RO with a mock-up report that demonsrates how it will report on its progress and monitoring of its processes, (8)provide a summary report to the RO every month until further notified, and (9)for each of the prior eight 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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Review ID: 9877

Region: 10 Seattle

Contract Number / Name: H3814 ATRIO HEALTH PLANS

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
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CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
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MCO Response Due Date: 12/17/2007

Requirement:

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

Deficiencies:

The review of case files submitted for Reguests for Expedited Organization Determinations indicates the MAO is not compliant in this area. Reviewed all cases (WS-OP2) from a universe of 8. Four (50%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met.

Corrective Action Required:

ATRIO Health Plan must: 1) Submit a new universe and sample case files for Reguests for Expedited Organization Determinations per the RO Plan Manager's instructions. 2) Develop efficient oversight and management of Reguests for Expedited Organization Determinations responsibilities by appropriate and consistent documentation of requests, to include: the ability to promptly determine whether to expedite an organization determination and provide appropriate and timely oral and written member notification on the determination of the requests. 3) Develop processes to ensure Reguests for Expedited Organization Determinations are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 4) For each of the three tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.

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CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.

Deficiencies:

The review of case files submitted for Reguests for Expedited Organization Determinations indicates the MAO is not compliant in this area. Reviewed all cases (WS-OP2) from a universe of 8. Four (50%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met.

Corrective Action Required:

ATRIO Health Plan must: 1) Submit a new universe and sample case files for Reguests for Expedited Organization Determinations per the RO Plan Manager's instructions. 2) Develop efficient oversight and management of Reguests for Expedited Organization Determinations responsibilities by appropriate and consistent documentation of requests, to include: the ability to promptly determine whether to expedite an organization determination and provide appropriate and timely oral and written member notification on the determination of the requests. 3) Develop processes to ensure Reguests for Expedited Organization Determinations are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 4) For each of the three tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.

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CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
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MCO Response Due Date: 12/17/2007

Requirement:

Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.

Deficiencies:

The review of case files submitted for Reguests for Expedited Organization Determinations indicates the MAO is not compliant in this area. Reviewed all cases (WS-OP2) from a universe of 8. Four (50%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met.

Corrective Action Required:

ATRIO Health Plan must: 1) Submit a new universe and sample case files for Reguests for Expedited Organization Determinations per the RO Plan Manager's instructions. 2) Develop efficient oversight and management of Reguests for Expedited Organization Determinations responsibilities by appropriate and consistent documentation of requests, to include: develop process that allows the organization to correctly distinguish between organization determinations and reconsiderations. 4) For each of the two tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.

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Region: 10 Seattle

Contract Number / Name: H3814 ATRIO HEALTH PLANS

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP09
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CAP Accepted Date: 04/17/2008
Audit Closed Date: 07/28/2008
Element Projected Completion Date: 02/29/2008
MCO Response Due Date: 12/17/2007

Requirement:

OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination 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:

The review of case files submitted for Favorable Standard Pre-Service Organization Determinations indicates the MAO is not compliant in this area. Reviewed 15 cases (WS-OP3) from a universe of 3332. All fifteen (100%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met.

Corrective Action Required:

ATRIO Health Plan must: 1) Submit a new universe and sample case files for Favorable Standard Pre-Service Organization Determinations per the RO Plan Manager's instructions.

CMS Medicare Managed Care Auditing Report

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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:

ATRIO Health Plan did not meet the CMS 95% compliance standard. CMS reviewed 20 credentialing/re-credentialing files (WS-PR1) from a universe of 109 and found 20 credentialing/re-credentialing files did not follow a consistent documented process for physician and other health care professionals regarding credentialing and re-credentialing. Specifically, the delegated entities did not include quality of care information, such as those collected through the MAO¿s Quality Improvement (QI) Program into the re-credentialing processes. In addition, the three delegated entities did not have a consistent process in place to track or monitor the most current Medicare/Medicaid Sanction list or the Medicare Opt Out list. The MAO did not have an agreement with the three delegated entities that specifies activities being delegated, reporting requirements, and remedies.

Corrective Action Required:

ATRIO Health Plan must: 1) Amend its contracts with the Independent Physicians Associations to specify activities delegated, reporting requirements and remedies. (See elements CN02, CN04 and CN6) 2) Establish and maintain effective oversight of the MAO¿s delegated entities to ensure there is a documented process for initial credentialing and re-credentialing that complies with Medicare credentialing requirements. Include a workflow diagram with timelines. 3) Provide the Regional Office (RO) a copy of the MAO¿s approved credentialing/re-credentialing policy and procedure utilized by the MAO and delegated entities. 4) Ensure its delegated entities include Quality of Care complaints collected through the MAO¿s Quality Improvement (QI) Program in the re-credentialing process, as documented by the MAO¿s policies and procedures. 5) Ensure the delegated entities review the most current Medicare/Medicaid Sanction list, and Medicare Opt Out list in the delegated process. 6) Develop and implement an internal audit process to ensure the credentialing/re-credentialing process comply with Medicare requirements. 7) Provide the Regional Office (RO) with a detailed summary report outlining the MAO¿s audit findings, and corrective action plan. The report should include the title of the auditor(s), the audit methodology, and the results of the audit. 7) For each of the seven tasks of this Corrective Action Request, clearly state in the MAO¿s Corrective Action Plan when the MAO will 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:

ATRIO Health Plan did not (1)follow written polices and procedures that reflect medical coverage, practice guideline, and current standards of medical practice when processing request for initial or continued authorization of services,(2)have an effect mechanism to ensure consistent application of review criteria and compatible decisions, and (3) did not have evidence that it complies with national coverage decisions, general Medicare coverage guidelines, and written coverage decisions of local Medicare contractors.

Corrective Action Required:

ATRIO Health Plan must (1) develop an appropriate Medicare Advantage Utilization (UM) Program that meets CMS requirements. At a minimum,the UM program must include written policies a procedures that reflect Medicare coverage guidelines and National coverage determinations and local medical review polices, (2) develop a formalized process to conduct clinical peers review decisions to deny authorization on grounds of medical appropriateness in a consistent manner, (3) develop policies and procedures that clearly reflect Medicare coverage rules (national coverage decisions and local medical review policies) or formally adopt practice guidelines that are appropriate for Medicare enrollees. Where there are variations between coverage determinations for Special Needs Medicare Advantage enrollees (SNP), ATRIO Health Plan must clearly state and explain variations in all UM policies and procedures, (4) ensure that the UM criteria are reviewed and approved by a committee of professionals that include practicing and participating providers,(5) communicate practice guidelines and UM criteria to providers through newsletter articles, provider educational trainings, and provider manuals, (6) established an inter-rater reliability process in order to verify that reviews are made consistently and in accordance with established criteria, (7) ensure UM policies and procedures for its Medicare Advantage enrollees include explicit time frames for completing and communicating UM decisions to enrollees and providers, (8) develop case management activities, (9) ensure UM activities do not provide incentives to deny, limit, or discontinue Medicare services, (10) train appropriate staff on UM policies and procedures, (11) 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 (12) for each of the prior eleven 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:

This element was reviewed by CMS' contractor, the MAQRO. A full review report is provided to the Regional Office and the MAO. A summary of the findings is as follows: Criteria for program participation: Upon request for clarification, Atrio provided more detail regarding the criteria for program participation as well as the frequency that data is mined to identify eligible members. Process for informing and enrolling members in the CCIP: Atrio did not describe any direct outreach to members identfied as eligible for the CCIP or a specific enrollment or risk screening process. Members are sent mailings, and local diabetes educators are notified. CCIP implemented for conditions relevant to the member population: Upon request, Atrio submitted information regarding the relevance of the CCIP to its member population. Recommendations for improvement are made. CCIP intervention strategy: The current intervention strategy is very passive, and consists mostly of mailed education pieces and referral for education. It appears some members receive more intensive services such as medication review, home visits, and pharmacy consultations, however, this does not appear to be organized in a systematic manner, and occurs only when external notification regarding high risk is made by a provider, educator or other health professional working with the member. There is limited information regarding care coordination activities. In addition, from the information reported, the specific role of the internal staff is not clear. Many of the services are provided by external parties, and it is not clear how this is integrated into a comprehensive program. Periodic monitoring of participants: From the information reported, educational mailings and educational programs are tracked, and members are sent ongoing mailings. There is not a systematic process for ongoing contact and monitoring of member progress, or tracking of individual status or outcomes. Quantitative measures of improvement: Atrio did not provide sufficient detail in the report to assess compliance for this review element. The measures reported were not fully defined and are not clear and the data sources not fully described. It does not appear that measuring of program outcomes is done in a systematic manner. Finally, the CCIP lacks an overall program description, as well as accompanying policies and procedures. A call was held on October 31 with CMS Region X, Atrio, and the MAQRO to discuss the review findings and the CAR/CAP. A summary of the recommendations and CAR is provided.

Corrective Action Required:

A call was held on October 31 with CMS Region X, Atrio, and the MAQRO to discuss the review findings and the CAR/CAP. A summary of the recommendations and CAR is provided. Atrio should submit a workplan and timeline to address the CCIP deficiencies within 90 days. The specific areas that should be addressed include: *Development of a comprehensive program description and accompanying policies and procedures. *Process to contact, inform,and screen or risk stratify eligible members *Interventions to improve care coordination and health status, including staff and roles, and how services are integrated and organized between external and internal staff, and how members at high risk are pro-actively identified by the MAO for more intensive services. *Periodic monitoring of individual CCIP participants and tracking of individual status or outcomes *Quantitative measures of improvement including specific measures and data sources and data collection. Some additional recommendations for improvement are made in the full review report.

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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:

This element was reviewed by CMS' contractor - the MAQRO. The MAQRO reviewed Atrio's 2006 and 2007 QIP reports.Full review reports are provided to the Regional Office and MAO. A summary of the 2006 QIP findings are as follows: Atrio selected a project topic that addresses an important clinical preventive service - flu shots. Upon request, Atrio more fully explained the data and process used to select this topic, however, some recommendations for improvement are made below. The indicator, as originally reported, was incomplete and flawed, and the measurement periods did not meet CMS requirements. Upon request, Atrio was able to better explain the indicator construction, however, the indicator timeframe still did not meet CMS requirements. Upon request, Atrio provided a more detailed rationale for its selected performance target, however, some recommendations for improvement are made. Upon request, Atrio more fully explained the data sources used to calculate the quality indicator and efforts to assure validity and reliability. Atrio implemented a variety of system-level interventions targeting providers, members, and participating pharmacies. Atrio addressed system level barriers by implementing roster billing and conducted barrier analysis by making member follow up calls. A summary of the 2007 QIP findings are as follows: Atrio selected a project topic that addresses important clinical preventive services, flu and pneumonia vaccinations. However, Atrio's 2006 QIP addressed flu vaccination, and repeating a topic is not permissible. A new project topic must be selected annually. Upon consulting with CMS, Atrio may use the topic pneumonia vaccines for its 2007 QIP, as it is participating in a statewide collaboration. Upon request, Atrio more fully explained the data and process used to select this topic, however, some recommendations for improvement are made. The pneumonia vaccine indicator, as stated, was incomplete and flawed, and the measurement period did not meet CMS requirements. In addition, the pneumonia vaccination indicator, as constructed, was not clinically appropriate. Upon request, Atrio provided a more detailed rationale for its selected performance target, however, some recommendations for improvement are made. The data used to calculate the quality indicators, as described, was not reliable and valid. Atrio has planned a variety of system-level interventions targeting providers, members, and participating pharmacies. Atrio is addressing system barriers by implementing new contracting and roster billing. Full review reports are provided to the Regional Office and MAO. A call was held on October 31 with CMS Region X, CMS CO, Atrio, and the MAQRO to discuss the review findings and the CAR/CAP. Specific recommendations are provided below.

Corrective Action Required:

A call was held on October 31 with CMS Region X, Atrio, and the MAQRO to discuss the review findings and the CAR/CAP. A summary of the recommendations and CAR is provided: Atrio should seek available training opportunities for QIP conduct. Resources include: ICE Conference, December 2007, CMS Quality and Compliance Conference, April 2008, as well as the QIP Tools and Guides which will be posted to the CMS Health Plans page. 2006 QIP - Flu Vaccinations In order to meet CMS requirements, Atrio should revise its measurements periods as: baseline - 2005 flu season, re-measurement - 2006 flu season. In order that the measurements are comparable, Atrio should report the 2006 rates calculated both using claims sources only (comparable to 2005 rate) and using all data sources (comparable to future measurements). Atrio should submit a revised QIP report, reflecting the changes, within 90 days. Atrio is also advised to conduct a second re-measurement for the 2007 flu season period. 2007 QIP - Pneumonia Vaccinations In order to meet CMS requirements, Atrio may conduct a project on pneumonia vaccination for its 2007 QIP. Atrio should revise its indicator, and use the CAHPS pneumonia vaccination question as the project indicator, as it will be very difficult to re-formulate the current indicator and methodology. Atrio should submit a revised QIP report, reflecting the changes, within 90 days. For both 2006 and 2007 QIP Additional recommendations for improvement to already compliant processes regarding topic selection, performance targets, and data validity and reliability are provided in the full review reports.

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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:

CMS reviewed all cases (WS-RP1) from a universe of 3. ATRIO Health Plan did not meet the 95% compliance standard. In 2 of the cases, the MAO did not authorize or provide the service timely (within 30 days).

Corrective Action Required:

ATRIO Health Plan must: 1) Revise its polices and procedures (including "desk guides/procedures") to ensure that when the organization makes a fully favorable decision on a standard pre-service reconsideration, a decision is issued to the member and the service is authorized no later than 30 calendar days after receiving the reconsideration request. 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 favorable standard pre-service reconsideration request. 5) 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. 6) For each of the prior five tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.