DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

December 22, 2010

Report Number: A-04-10-07010

Michael A. Seltzer
Chief Executive Officer
Medicare and Medicaid Products
Humana, Inc.
3501 SW 160 Avenue
Miramar, FL 33027

Dear Mr. Seltzer:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Humana Inc., Health Maintenance Organization Controls Over Durable Medical Equipment Suppliers in Florida*. We will forward a copy of this report to the HHS action official noted below.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-04-10-07010 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Timothy B. Hill, Deputy Director
Centers for Drug and Health Plan Choice
Centers for Medicare & Medicaid Services
Mail Stop C5-19-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HUMANA INC., HEALTH MAINTENANCE ORGANIZATION CONTROLS OVER DURABLE MEDICAL EQUIPMENT SUPPLIERS IN FLORIDA

Daniel R. Levinson
Inspector General

December 2010
A-04-10-07010

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

INTRODUCTION

BACKGROUND

Medicare Advantage Program

The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, revised Medicare Part C and renamed the program the Medicare Advantage (MA) program. Organizations that participate in the MA program include health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, makes monthly capitated payments to MA organizations for beneficiaries enrolled in the organizations' health care plans.

MA organizations must enter into a contract with CMS to enroll and provide all Medicare covered services to Medicare beneficiaries. As a condition of the contract, the MA organization must have a compliance plan, which must include measures to detect, correct, and prevent fraud, waste, and abuse. Among other requirements, the compliance plan shall also include written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.[1]

Integrity of Durable Medical Equipment Suppliers

Although the vast majority of health care providers and suppliers are honest and well-intentioned, the large Federal Government expenditures on the Medicare program attract certain individuals and entities that seek to exploit the health care system for their own financial gain. Ensuring the integrity of the program's provider and supplier enrollment processes is an integral part of preventing exploitation of the system. Therefore, it is imperative that MA organizations use rigorous enrollment standards and screening processes when contracting with providers and suppliers.

Actively protecting the Medicare program and its beneficiaries from unqualified, fraudulent, or abusive providers and suppliers is more efficient and effective than trying to recover payments or redress fraud or abuse after it occurs. Ensuring adequate and appropriate provider and supplier enrollment standards and screening is an essential first step in strengthening the integrity of Medicare programs.

[1] 42 CFR § 422.503 (a)4(vi).

Durable Medical Equipment

Medicare pays for the purchase, rental, and maintenance of new and used durable medical equipment (DME) that is prescribed by a physician[2] and delivered to Medicare beneficiaries. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to an individual in the absence of an illness or injury, and is appropriate for use in the home or an institution that qualifies as a home.

DME is part of the traditional Medicare-covered services that MA plans must provide. MA plans generally contract with DME suppliers to provide the services.

Humana Medical Plan in Florida

Humana, Inc., headquartered in Louisville, Kentucky, is one of the nation's largest publicly traded health and supplemental benefits companies, reporting over 10 million medical members nationwide, including nearly 4 million Medicare members in 2009. With offices in Miramar, Florida, Humana, Inc. offers Medicare Advantage Health Maintenance Organization (HMO) plans to Florida's Medicare beneficiaries through Humana Medical Plan, Inc. (Humana) under CMS contract number H1036.

Humana's HMO compliance plan is intended to promote appropriate and efficient use of health care services, and to increase understanding of compliance and fraud prevention. The plan outlines a set of guidelines to comply with Federal and State regulations. Humana's Special Investigation Unit is responsible for detection, correction, and prevention of health insurance fraud, waste, and abuse in an effort to facilitate proper business practices and preserve reasonable premium rates. Humana requires compliance not only for the company and its employees, but also for all contracted providers, suppliers, and vendors providing services to its members.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Humana had established adequate controls to ensure that DME services were adequately supported and that beneficiaries received the DME paid for through its HMO plan in Miami-Dade and Broward counties.

Scope

Our review covered the period January 1, 2008, through December 31, 2009. During this period, Humana had a capitation contract with only one DME supplier (the supplier), and spent over 43 percent of its total statewide costs for DME supplies in Miami-Dade and Broward counties alone. Humana has used the supplier to provide DME services to Humana beneficiaries in these two counties since 2002.

[2] Section 1834 (a)(1)(E)(ii) of the Social Security Act.

Our review included Humana's controls over DME services provided through its sole supplier. We excluded diabetic and nebulizer solutions from the review because Humana managed and distributed those items primarily through its owned pharmacies.

We did not assess Humana's overall internal controls for administering Florida HMO plans. Instead, we limited our review to gaining an understanding of those significant monitoring controls that Humana implemented over its DME supplier to ensure the medical need of the DME was documented and to validate the delivery of services.

Based on Humana's long working relationship with a sole capitated DME supplier, and our assessment of Humana's monitoring controls over that supplier, we limited our substantive testing of DME transactions.

We conducted our fieldwork at Humana's and the supplier's offices in Miramar, Florida.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed documentation provided by Humana, including DME delivery methodology, policies, procedures, and controls applicable to DME services, marketing information available to the public, the supplier's contract, payment terms, internal quality assessment reviews, and Humana's compliance plan;
- held discussions with Humana officials to identify procedures to monitor DME services;
- identified DME recipients using Humana's database;
- selected a judgmental sample of 30 DME items from Humana's database, based on dates of service;
- reviewed the DME files maintained at the supplier's office for the 30 DME items to determine whether (1) the files included the appropriate supporting documentation, (2) Humana monitored the delivery of services, (3) the DME delivery was acknowledged by the beneficiary or by a caretaker, and (4) the DME was ordered by a physician and the medical need of the DME was documented by a prescription; and
- determined that it was not necessary to expand our judgmental sample of 30 DME items because our review of internal controls and our substantive testing disclosed no control weaknesses or improper payments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

RESULTS OF REVIEW

Humana had established adequate controls to ensure that DME services were adequately supported and that beneficiaries received the DME paid for through its HMO plan in Miami-Dade and Broward counties. Therefore, we do not offer any recommendations.