August 4, 2011

Report Number: A-04-10-07017

Mr. Michael A. Seltzer,
Chief Executive Officer
Florida 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., Preferred Provider Organization Controls Over Durable Medical Equipment Suppliers in Florida. We will forward a copy of this report to the HHS action official noted below.


If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-04-10-07017 in all correspondence.

Sincerely,

/John T. Drake, Sr./
Acting Regional Inspector General for Audit Services

Enclosure

HHS Action Official:

Timothy B. Hill, Deputy Director
Centers for Drug and Health Plan Choice (CPC)
Centers for Medicare & Medicaid Services
Mail Stop C5-19-16
7500 Security Boulevard
Baltimore, MD  21244-1850
REVIEW OF HUMANA, INC.,
PREFERRED PROVIDER ORGANIZATION
CONTROLS OVER DURABLE MEDICAL
EQUIPMENT SUPPLIERS IN FLORIDA

Daniel R. Levinson
Inspector General
August 2011
A-04-10-07017
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:

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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 the Medicare program.

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. Medicare Preferred Provider Organization (PPO) plans give Medicare beneficiaries the option to choose which DME suppliers, physicians, and hospitals to visit. Beneficiaries are responsible for service copayments to health care providers.

Humana Preferred Provider Organization Plans in Florida

Humana, Inc., (Humana) 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 offers HumanaChoice PPO plans to Florida’s Medicare beneficiaries under CMS contract numbers R5826 and H5415.

DME services are part of Humana’s PPO health care plans. Humana PPO plans gave Medicare managed care beneficiaries the flexibility to either receive DME services within its PPO network of health care providers or choose providers with no contractual arrangements with Humana, as long as those providers accepted Humana’s payment terms. In addition to paying DME service copayments, beneficiaries were responsible for the full cost of DME services if out-of-network providers did not accept Humana’s payment amounts.

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

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Humana had established controls to ensure that DME services were adequately supported and that beneficiaries received the DME paid for through its PPO plans in Florida.

\(^2\) Section 1834 (a)(1)(E)(ii) of the Social Security Act.
Scope

Our audit covered 48,671 DME claim lines totaling $3,468,912 that Humana paid to DME suppliers for items and services provided to its PPO members in Florida during calendar year (CY) 2009. Our review included Humana’s controls over DME services provided through various suppliers.

We did not assess Humana’s overall internal controls for administering Florida’s PPO plans. Rather, we limited our review to gaining an understanding of those significant controls Humana had implemented to monitor DME suppliers and assure the medical need and the delivery of services to PPO plan members.

We conducted our fieldwork at Humana’s offices in Miramar, Florida, and at various DME suppliers throughout Florida.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with Humana officials to identify procedures to monitor DME services;
- reviewed documentation provided by Humana, including DME delivery methodology, policies, procedures, and controls applicable to DME services, marketing information available to the public, suppliers’ contracts, payment terms, and Humana’s compliance plan;
- obtained DME claims data from Humana’s PPO plan database consisting of 48,671 claim lines totaling $3,468,912 paid during CY 2009;
- selected a stratified random sample of 100 claim lines from 11,074 claim lines and analyzed them by:
  - verifying the physical existence of the DME suppliers’ offices;
  - reviewing DME files maintained at the suppliers’ offices to determine whether (1) the files included the appropriate supporting documentation (e.g., the name of the DME supplier, the name of the PPO member, the DME item, etc.); (2) the DME was ordered by a physician and the medical need for DME services was documented by a prescription; and (3) the DME deliveries were acknowledged by PPO plan members or their caretakers; and
  - assessing Humana’s controls to ensure that the DME claim lines were adequately supported and that beneficiaries received the DME paid for through its PPO plans in Florida; and
determined that it was not necessary to estimate our results to our sampling frame because our review of internal controls and our substantive testing disclosed no control weaknesses or improper payments.

The Appendix contains details on our sample design and methodology.

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 controls to ensure that DME services were adequately supported and that beneficiaries received the DME paid for through its PPO plans in Florida during calendar year 2009. Therefore, we do not offer any recommendations.
APPENDIX
APPENDIX: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was all Durable Medical Equipment (DME) claim lines paid by Humana to DME suppliers, for services to its Medicare Advantage Preferred Provider Organization (PPO) plan members, during calendar year 2009.

SAMPLING FRAME

We obtained from Humana 48,671 claim lines totaling $3,468,912 from its paid claims files. From this population, we eliminated all claim lines: under $10, paid to national pharmacy chains, paid to DME suppliers with service addresses outside of Florida, and paid to DME suppliers in Florida cities with fewer than five suppliers. The resulting sampling frame was 11,074 unique DME claim lines totaling $1,048,415.

SAMPLE UNIT

The sample unit was an individual claim line for DME supplies paid by Humana to DME suppliers for items and services provided to Humana’s PPO members.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into two strata: (1) DME claim lines paid to Humana’s participating/contracted DME suppliers and (2) DME claim lines paid to Humana’s non-participating/non-contracted DME suppliers.

<table>
<thead>
<tr>
<th>Stratum</th>
<th>Description</th>
<th>No. of Line Items</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Participating Suppliers</td>
<td>8,632</td>
<td>$796,015</td>
</tr>
<tr>
<td>2</td>
<td>Non-Participating Suppliers</td>
<td>2,442</td>
<td>252,400</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>11,074</td>
<td>$1,048,415</td>
</tr>
</tbody>
</table>

SAMPLE SIZE

We selected a sample of 100 claim lines consisting of 50 claim lines per stratum.

SOURCE OF THE RANDOM NUMBERS

A Region IV statistical specialist generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software, RAT-STATS 2010 Random Number Generator.
METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the DME line items from 1 to 8,632 in stratum 1 and from 1 to 2,442 in stratum 2. After generating 50 random numbers per stratum, we selected the corresponding frame items.