CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8658

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: R5826 HUMANA INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4

Auditing Element: CN01

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:09/14/2007

Element Accepted Date: 10/02/2007

Element Release Date: 02/15/2008

CAP Released Date:05/16/2008

Visit Start Date: 06/11/2007

Exit Conference Date: 06/15/2007

Date Report Issued: 07/30/2007

Date Report Due: 07/30/2007

CAP Accepted Date:10/02/2007

Audit Closed Date: 05/16/2008

Element Projected Completion Date:01/02/2008

MCO Response Due Date: 09/13/2007

Requirement:

Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.

Deficiencies:

CN01 Privacy and Confidentiality Requirement Based on our review of a sample of 20 contracts, we find that Humana does not meet the requirements for this element. The Humana contracts reviewed did not specifically include the word accurate when referencing the maintenance of enrollee records as required in 42 CFR 422.118. Humana has developed a Transition Plan, dated June 1, 2007, to (1) No later than December 31, 2007, send amendments containing revised contract language to currently contracted Humana Medicare Advantage providers (2) Assess what changes, if any, are needed in the Medicare Advantage provider agreements held by CarePlus, Ochsner and Corphealth and address accordingly and (3) No later than August 1, 2007, add applicable language to the existing provider contract templates which are used for new providers. When these actions are completed, the contractor should meet this element.

Corrective Action Required:

(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.

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Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: R5826 HUMANA INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4

Auditing Element: CN03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date: 09/14/2007

Element Accepted Date: 10/02/2007

Element Release Date: 02/15/2008

CAP Released Date: 05/16/2008

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Date Report Issued: 07/30/2007

Date Report Due: 07/30/2007

CAP Accepted Date: 10/02/2007

Audit Closed Date: 05/16/2008

Element Projected Completion Date: 01/02/2008

MCO Response Due Date: 09/13/2007

Requirement:

Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.

Deficiencies:

CN03 MAO Hold Harmless Provision Based on our review of a sample of 20 contracts, we find that Humana did not meet our requirements for this element for the ChoiceCare contracts. 42 CFR 504(g)(1)requires that the Medicare Advantage Organization (MAO) agrees to comply with the following requirement: Each MAO must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability (for example, as a result of an organization insolvency or other financial difficulties)for payment of any fees that are the legal obligation of the MA organization. In the ChoiceCare contracts reviewed, we found that the provider contracts held ChoiceCare harmless, not the beneficiary, in the case of plan insolvency. Humana has developed a Transition Plan, dated June 1, 2007, to (1) No later than December 31, 2007, send amendments containing revised contract language to currently contracted Humana Medicare Advantage providers (2) Assess what changes, if any, are needed in the Medicare Advantage provider agreements held by CarePlus, Ochsner and Corphealth and address accordingly and (3) No later than August 1, 2007, add applicable language to the existing provider contract templates which are used for new providers. When these actions are completed, the contractor should meet this element.

Corrective Action Required:

(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.

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Review ID: 8658

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: R5826 HUMANA INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4

Auditing Element: CN04

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date: 09/14/2007

Element Accepted Date: 10/02/2007

Element Release Date: 02/15/2008

CAP Released Date: 05/16/2008

Visit Start Date: 06/11/2007

Exit Conference Date: 06/15/2007

Date Report Issued: 07/30/2007

Date Report Due: 07/30/2007

CAP Accepted Date: 10/02/2007

Audit Closed Date: 05/16/2008

Element Projected Completion Date: 01/02/2008

MCO Response Due Date: 09/13/2007

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:

CN04 MAO Abide by Federal Requirements Based on the results of our review of a sample of 20 contracts, we find that the Humana written contracts did not meet our requirements for this element. 42 CFR 422.504 (e)(4) gives HHS, GAO and designees the right to inspect, evaluate and audit through 10 years from the end of the final contract period or completion of the audit... The Humana provider contracts must be revised to allow at least 10 years, rather than 6 years, records retention. Humana has developed a Transition Plan, dated June 1, 2007, to (1) No later than December 31, 2007, send amendments containing revised contract language to currently contracted Humana Medicare Advantage providers (2) Assess what changes, if any, are needed in the Medicare Advantage provider agreements held by CarePlus, Ochsner and Corphealth and address accordingly and (3) No later than August 1, 2007, add applicable language to the existing provider contract templates which are used for new providers. When these actions are completed, the contractor should meet this element.

Corrective Action Required:

(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan

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Findings: NOT MET

Review ID: 8658

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: R5826 HUMANA INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 05/16/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/02/2007
Audit Closed Date: 05/16/2008
Element Projected Completion Date: 11/01/2007
MCO Response Due Date: 09/13/2007

Requirement:

Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.

Deficiencies:

Humana uses in the following situations: - notification of Part D grievance disposition (i.e., a notice consistent with CMS-issued model notice, Notice of Plan's Decision Regarding a Grievance), - enrollee notification when a Part D request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, Notice of Case Status), - enrollee notification that a request for an expedited coverage determination is denied (i.e., a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance), and - when requesting additional information from the enrollee¿s prescribing physician (i.e., a notice consistent with the CMS-issued model notice, Request for Additional Information). These notice templates did not display the contract/MRT number in the lower left-hand corner in accordance with CMS Marketing guidelines. Additionally, CMS requested Humana's standard Part D notice templates (i.e. Medicare Prescription Drug Coverage and Your Rights, and Notice of Denial of Medicare Prescription Drug Coverage) and the notices supplied by Humana did not display the OMB control number in the upper right-hand corner in accordance with CMS Marketing guidelines.

Corrective Action Required:

Humana must use Part D notice templates that have been CMS approved and display the contract/MRT number with the approval date in the lower left-hand corner for the following model notices: - Notice of Plan's Decision Regarding a Grievance, - Notice of Case Status, - Notice of Right to an Expedited Grievance, and - Request for Additional Information. Humana must use Part D standard notices that display the OMB control number in the upper right-hand corner for the following standard notices: - Medicare Prescription Drug Coverage and Your Rights, and - Notice of Denial of Medicare Prescription Drug Coverage.

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Findings: NOT MET

Review ID: 8658

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: R5826 HUMANA INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4

Auditing Element: MR05

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date: 09/14/2007

Element Accepted Date: 10/02/2007

Element Release Date: 03/12/2008

CAP Released Date: 05/16/2008

Visit Start Date: 06/11/2007

Exit Conference Date: 06/15/2007

Date Report Issued: 07/30/2007

Date Report Due: 07/30/2007

CAP Accepted Date: 10/02/2007

Audit Closed Date: 05/16/2008

Element Projected Completion Date: 12/15/2007

MCO Response Due Date: 09/13/2007

Requirement:

Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.

Deficiencies:

Both Humana and CMS continue to receive complaints from enrolled beneficiaries which demonstrate that they did not understand their election. Humana's present verification process is only used on agent assisted enrollments, and Humana reports in their present Corrective Action Plan that many times the verification process is not completed. The verification process is done while the agent in still in the home or with the enrollee. CMS believes this process should be completed after the representative leaves the enrollee. Many complaints received by CMS are from beneficiaries who believe that they were enrolling in a prescription drug plan, but then find themselves in an MA-PD plan. This demonstrates that enrollees are not fully educated on understanding their enrollment choice. Humana should implement a better process to educate the beneficiary on the choices they made.

Corrective Action Required:

Humana should implement a more rigorus verification call process separate from the sales process. Humana should demonstrate that it has oversight over the verification process and therefore, should submit to CMS verification call audit results. Humana should also implement processes to better educate all enrollees about their plan choice, such as new member orientation sessions, outbound calls to enrollees to educate the member on how to use their plan, etc.

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Review ID: 8658

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: R5826 HUMANA INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4

Auditing Element: MR08

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:09/14/2007

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Element Release Date: 05/07/2008

CAP Released Date:05/16/2008

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Date Report Issued: 07/30/2007

Date Report Due: 07/30/2007

CAP Accepted Date:10/02/2007

Audit Closed Date: 05/16/2008

Element Projected Completion Date:11/01/2007

MCO Response Due Date: 09/13/2007

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:

1.) The CMS and Humana continue to receive numerous complaints about Humana's sales and marketing practices during the seven months prior to the review. -Humana has implemented a detailed process to investigate each and every complaint received and to discipline agents and brokers who are found to be out of compliance, however, recently Humana reports that they have not been able to keep up with the number of complaints received. Humana states that the reason for the delay in entering all complaints into the investigaton process is due to moving the process to national oversight rather than regional. 2.)Many of the complaints that Humana has received indicate that an agent gave incorrect information to a beneficiary. The CMS then questions the effectiveness of the training of these agents and the oversight that Humana has over these agents in the field. One file (refer to sample 7) indicated that an agent had destroyed an enrollment at the manager's request and indicated NO personnel action on the agent. 3.) While Humana admits to tracking rapid disenrollment rates, one of the agent's files indicated that he had the highest number of cancellations and rapid disenrollments on the list, but no personnel action concerning this (refer to sample 2). 4.) Humana does not have a process to quickly be able to communicate to all of their agents and brokers when it is necessary to dispense information concerning CMS or Humana policy changes, etc. Indeed, the plan admits that many times their own agents do not respond to them on requests for details of an enrollment. 5.) CMS, there is no proof of a verification call being completed. Yet Humana's policies and procedures state that an agent is required to do a verification while still in the home. The policy and procedure also says that Humana will make three attempts to contact a beneficiary after a sale and then send a letter. But many of the allegations in the report show no verification of any kind.

Corrective Action Required:

Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly report to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, (3) better oversee agent/broker licenses and appointments for the states they sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are competed in a timely fashion with the recommendation that they be completed after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.