


Combatting Fraud, Waste, and Abuse in Managed Care

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Overview

- OIG – who we are
- Managed Care Top Management Challenge
- Risk Areas and OIG Action
- Compliance Guidance
- Program Integrity in Medicaid MCO Rule
- Coordination with Key Stakeholders


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OIG Mission


Mission: To protect the integrity of HHS programs and the welfare of the people they serve.

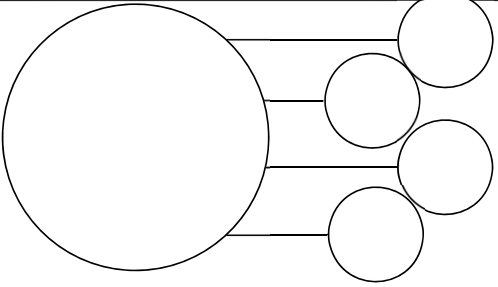
Vision: To drive positive change in HHS programs and in the lives of the people served by these programs.


Values: To be relevant, impactful, customer focused, and innovative



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 **OIG Components**








OIG Locations

1,550+ employees


70+ offices






 **OIG's Unique Role**

- Identify
- Educate
- Enforce





Managed Care:
Top Management Challenge



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Managed Care:
Top Management Challenge

- 1) Combatting fraud, waste, and abuse by health care providers billing managed care plans
- 2) Ensuring integrity and compliance by managed care plans and Part D sponsors.

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Risk Area: Fraud by Providers

- Challenges to oversight
- Shared program integrity obligations
 - CMS, plans, States, and contractors
- Detection of suspected provider fraud varies widely



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Risk Area: Fraud by Providers

- Limitations in MA and Medicaid MCO encounter data poses a challenge to effective oversight of the programs.
- Lack of complete data

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Work Plan Items: Providers

- Medicaid MCO identification of fraud and abuse by network providers
- Integrity of MA encounter data
- Risk Adjustment Data
- Medicaid MCO payments to providers for treating health-care acquired conditions
- Questionable billing by pharmacies, information provided by plans to CMS, and billing of compounded topical drugs

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Enforcement: Providers

- *Issac Thompson, No. 15-80012 (S.D. Fla.)*
 - Network provider allegedly submitted false diagnoses to health plan
 - Plead guilty to one count health care fraud
 - OIG Exclusion: 25 years




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Enforcement: Providers

- **Billing Fraud**
 - Coordination with MEDICS, MCOs, CMS, States, and other government partner
- **Unlicensed NJ Dentist Agrees to Pay \$1.1 Million and 50-year voluntary exclusion**




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Enforcement: Providers


- **Region 8 Mental Health Services: \$6.93M settlement and CIA**
 - allegations that it was paid for services that it either did not provide or that were not provided by qualified individuals as part of its preschool Day Treatment program.
- **CIA with pediatric mental health provider includes claims review of managed care claims**

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 **Risk Area: Plans**

- Ensuring integrity and compliance by managed care plans and Part D sponsors
- Incentives to maximize capitated payments while minimizing costs
- Risk to beneficiaries and HHS funds

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 **Risk Areas: Plans**

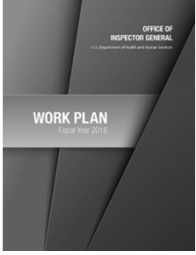
- Risk adjustment fraud
- Capitated payments made for ineligible beneficiaries
 - Deceased
 - No longer in the plan




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Work Plan Items: Plans

- Review of MCO's use of Medicaid funds to provide services
- Managed care payments made for dead beneficiaries




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 **Work Plan Items: Plans**

- Risk Adjustment Data
- Part D Sponsor compliance with remuneration reporting requirements


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 **Enforcement: Plans**

- United Litigation
 - Risk adjustment fraud
- Freedom Health Settlement
 - Wide ranging Part C fraud
 - Resolved with CIA, Part C reviews
- City of New York
 - improper Medicaid MCO payments




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 **Risk Area: Quality of Care**


- Access to providers, provider network adequacy
- Access to services
- Part D sponsors inclusion of drugs on formularies

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 **Risk Area: Quality of Care**

Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing

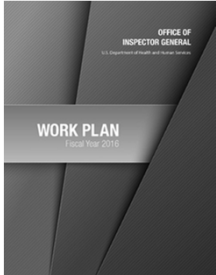
- 90K beneficiaries at serious risk
- 400 prescribers had questionable opioid prescribing patterns.




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Work Plan Items: Quality of Care


- Availability of Behavioral Health Services in Medicaid MCOs
- Denials by Part C and D plans



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 **Compliance Resources**

- Board of Directors Compliance Guidance
- Compliance Resource Guide
- TMC, Work Plan, and other media




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 **Program Integrity in Medicaid Managed Care Regulation**




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 **Medicaid MCO Regulation**

Program Integrity in the MCO contract

- 42 C.F.R. 438.608
- Robust, effective compliance program
- Core component
- Applies to subcontractors


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 **Medicaid MCO Regulation**

Provider Screening and Enrollment


- 42 C.F.R. 438.608(b)
- Network providers required to be enrolled in Medicaid
- Core component
- Applies to subcontractors

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 Medicaid MCO Regulation

Treatment of Overpayment Recoveries

- 42 C.F.R. 438.608
- Must be addressed in contract
- States have a lot of flexibility




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 Medicaid MCO Regulation


Partnering with States

- Strong partnership between plans and states
- Payment suspension
- Coordination with law enforcement


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 Maximizing Fraud Fighting Impact

- National Health Care Anti-Fraud Association
- Healthcare Fraud Prevention Partnership
- Managed care plan SIU



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 **Conclusion**

- OIG is tackling fraud, waste and abuse in the managed care programs head on
- OIG's focus in two key areas:
 - Combatting fraud, waste, and abuse by health care providers billing managed care plans, and
 - Ensuring integrity and compliance by managed care plans and Part D sponsors

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 **Questions?**



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