Managed Care Expansion in Medicaid and Medicare – Benefits, Challenges, and Compliance

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Understanding Managed Care
Managed Care versus Fee-for-Service in Medicare and Medicaid
Managed Care

- A health care delivery system organized to manage cost, utilization, and quality.
- Health benefits and services are provided under contracts with managed care organizations (MCOs).
- MCOs accept a set per member, per month (capitation) payment for the services.
- Goal is to reduce program costs and better manage utilization.

Managed Care

- It seemed logical that the MCO/private health care plan would have all the tools, talent, and processes to be the expert in handling Medicare and/or Medicaid populations’ health care.
- Beneficiaries and providers would transition to the MCO for services at a more efficient cost to the government.
- Government agencies would gain a fixed cost and not be required to increase the staffing and budget to accommodate the increasing populations and oversee the MCOs.
Medicare and Medicaid – Managed Care

• Medicare Managed Care – Part C – Medicare Advantage
  • Beneficiaries still have an option between traditional fee-for-service or managed care (Advantage)
  • Choice of beneficiaries to enroll in Medicare Advantage plans varies across states
• Medicaid Managed Care – States elect to contract with Managed Care or retain fee-for-service or both

Contract Responsibilities

• MCOs contract directly with Medicare and/or Medicaid and
  • Develop and contract their own provider networks
  • Set reimbursement for providers
  • Process and pay claims
  • Address appeals (from beneficiaries and providers)
  • Compliance (internal processes and for providers)
Medicare Managed Care by the Numbers

• In June 2015, 16.8 million beneficiaries, 31% of the Medicare population, were enrolled in Medicare Advantage. [https://www.kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/](https://www.kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/)


Medicaid Managed Care Organizations

• As of September 2017, 39 of 50 states have at least one MCO
Benefits of MCOs

• Value to beneficiaries
  • Coordination of care
  • Additional benefits
    • Travel assistance to providers
    • Drug coverage
    • Telehealth
    • Lower out-of-pocket costs
    • Gym memberships
    • Coverage for mosquito mitigation (zika)
    • Chronic care diseases

Challenges of MCOs

• Complexities of federal/state oversight
• Monitoring
• Negotiations
• Appeals & complaints
• Litigation
• Clawbacks
• Innovation models – lower drug prices
Accountability

- MCOs are required to ensure beneficiaries have
  - Access to care
  - Choice of provider
  - Adequate network
  - Appeals and grievance processes

Accountability

- MCOs are required to have
  - Compliance program
  - Monitoring
    - Internal, network, and claims
  - Reporting to CMS (Medicare) or state (Medicaid)
  - Contract requirements include
    - Reporting
    - Network
    - Marketing (abuse)
It’s Complicated

Florida MCOs and Regions

Region 1: Escambia, Okaloosa, Santa Rosa and Walton
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Levy, Liberty, Walton
Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5: Pasco and Pinellas
Region 6: Hernando, Highlands, Hillsborough, Manatee and Polk
Region 7: Broward, Charlotte, Collier, Dade, Glades, Hendry, Lee, and Monroe
Region 8: Indian River, Martin, Osceola, Palm Beach and St. Lucie
Region 9: Brevard, Indian River, Martin, St. Lucie
Region 10: Miami-Dade and Monroe
Florida Multiple Medicaid MCOs in Regions

This is just the list of General Medicaid (Non-Specialty)

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Medicaid Managed Care

- State Medicaid members continue to expand
  - Expansion of Affordable Care Act to Medicaid
  - Growing population
- State Medicaid budgets continue to shrink
  - CMS 21st Century Cures Act limits state Medicaid payment amounts for DME. Per the Act, the payment amounts may not exceed Medicare payment amounts. This impacts matching funds (clawbacks).
Medicare/Medicaid vs. MCOs

• Focus
  • Government health care plans focus on people
  • MCOs are private insurance companies which focus on profits

• Accountable
  • Government plans are accountable to Congress
  • MCOs are accountable to shareholders

• Compliance
  • Both plans are subject to federal and state laws for fraud, waste, and abuse
  • Both are accountable to beneficiaries for proper, adequate care

Medicare/Medicaid vs. MCOs

• MCOs paid by contract funds from CMS/state Medicaid
  • Receive capitated fee from state
    • Per month, per member
  • The more expensive the member, the less profit for shareholders
  • Limited oversight by state Medicaid/state Office of Inspector General and CMS
Assumptions

• Assumptions about MCOs
  • No fraud – the per month per beneficiary = no fraud
  • Any willing provider that is participating in Medicaid/Medicare could participate in the MCO network
  • MCOs complied with Medicaid/Medicare regulations
  • Appeals and grievance were promptly addressed
  • MCOs are in compliance with their contracts with Medicare and Medicaid

Reality

• MCO encounter data was rarely audited and few guidelines were provided for such audits to determine if
  • Beneficiaries were receiving the entitled care
  • Providers were receiving appropriate reimbursement
  • Access to care was available
  • The provider network was adequate
  • Appeals and grievance were promptly addressed
  • MCOs were in compliance with their contracts with Medicare and Medicaid
Current Issues

• Medicare audits and litigation regarding MCO Advantage Plans
  - 05/09/2018 - CMS audit of Anthem Medicare Advantage (MA) Part D (Prescription Drug) = Civil Monetary Penalty (CMP) $243,200
  - 02/06/2018 – CMS audit of Merit Health Insur. Co. Part D = CMP $1,368,200
  - 12/20/2017 – CMS audited Riverside Healthy Sys. PACE services = suspension of enrollment of Medicare/dual eligible beneficiaries
  - 02/23/2017 – CMS audit of WellCare Health Plans MA Part D = CMP $1,174,300
  - 11/22/2016 – CMS audit of UnitedHealthcare MA Part D = CMP $2,498,850


• Medicaid MCOs
  - 2010 OIG Work Plan on Managed Care
    - Marketing of MA plans by sales agents
    - Encounter data
    - Fraud and abuse safeguards
    - Beneficiary appeals to MA program
Medicaid MCOs Accountability

• The state Medicaid agencies’ contracts with MCOs do not always turn out to be the saving grace that the state Medicaid program was hoping for.

  • Iowa Medicaid (Nov. 2017)
    • All six candidates running for Governor (Democrats and Republicans) campaigned to repeal the privately managed $5 billion Medicaid Managed Care system and replace it with a “state-run system offering quality, reliable services and paying Iowa providers on time.”
    • “Never witnessed more imbalance in health care across the state.”
    • “This privatization of Medicaid is a failure and the sooner they admit it and take this back into the successful government-run program ... the better off we’re all going to be ....”

  [Link to article]

Medicaid MCOs Accountability

• The MCOs efforts to limit the network and exclude providers with a sole source provider contract

  • A contract for a product or service that is only available through a specific vendor or supplier or provider

  or

  • A contract with identified, specified justifications to allow awarding a contract to a specific provider or supplier

  and

  • Sole source contracts preclude providers or suppliers that meet the conditions for providing the services and supplies
MCO Sole Source Contract

- Diminished competition
- Promotes favoritism
- Does not secure the best services and products at the best price
- Denies beneficiaries a choice
- Increases risk of fraud, waste, and abuse
- Risk of inability to provide services and products to beneficiaries

Litigation – Medicare Advantage

  - Two subsidiary companies
    - Freedom Health and Optimum Healthcare
  - Alleged the MA plans exaggerated how sick patients were (higher risk score) to falsely increase reimbursement
  - Billed for patients who did not have medical conditions and/or for services not rendered

https://www.npr.org/sections/health-shots/2017/05/31/530868367/medicare-advantage-insurers-settle-whistleblower-suit-for-32-million
Litigation – Medicare Advantage

• May 2017 – DOJ sued United Healthcare Group (MA) – joined whistleblower case filed by former United Healthcare finance director in 2011, which alleged
  • United Healthcare routinely combed through millions of patients’ medical charts to use data to make the patients look sicker than they were (increase risk score)
  • Increase of payment to UnitedHealthcare of $3 billion from 2010-2015
  • Alleged civil fraud and sought CMPs and triple damages


Litigation – Medicare Advantage

• September 2018 – Court granted UnitedHealthcare’s Motion for Summary Judgment and vacated CMS’s 2014 overpayment rule based on how CMS calculated payments to MA compared to traditional Medical

https://www.npr.org/sections/health-shots/2017/03/28/521691406/justice-department-joins-second-lawsuit-against-unitedhealth
Litigation – Medicaid Managed Care

- December 2017 – Washington State regulators fined Centene up to $1.5 million for an insufficient network of physicians for plans sold under the Affordable Care Act.

- January 2018 – People who bought policies from Centene filed a federal class-action lawsuit in Washington State claiming lack of medical coverage, alleging it did not provide adequate access to physicians in 15 states.
  - Alleged that “Centene misrepresents the number, location and existence of purported providers by listing physicians, medical groups and other providers – some of whom have specifically asked to be removed – as participants in their networks and by listing nurses and other non-physicians as primary care providers.”
  https://www.fiercehealthcare.com/regulatory/centene-lawsuit-network-adequacy-individual-market-plans
Litigation – Medicaid Managed Care

• January 2018 – New Mexico Medicaid announced that United Healthcare and Molina would not be providing Medicaid Managed Care services beginning 2019.
  • New Mexico would retain BCBS NM and Presbyterian Health Plan and add a new managed care plan, “Western Sky Community Care” – Centene subsidiary.
  • Molina filed a lawsuit alleging
    • NM Medicaid used a consulting firm, Mercer, to assist with the contracting process
    • Mercer has a multibillion dollar contract with a sister company to Western Sky Community Care


Litigation – Medicaid Managed Care

• September 2018 – Centene seeks to avoid class action over provider network
  • Proposed class alleged Centene misrepresented the size of the provider network
  • Plaintiff claims she overpaid for insurance and didn’t receive benefits promised
  • Centene said Washington State Office of Insurance Commissioner accepted the rates and that it passed on the adequacy of the Centene’s provider network*
  • Complaint asserts the listed network includes providers who have asked to be taken off the network list, non-physicians and nurses are listed as primary care providers

*However, Washington state regulators fined Centene $1.5 million for inadequate network in December 2017
Litigation – Medicaid Managed Care

• March 2018 – Centene hit with suit over $6.8 billion buy of Health Net
  • An investor and Police Pension Fund filed a derivative lawsuit claiming Centene
    • Knowingly misstated Health Net’s revenues, income and liabilities before the $6.8 billion merger
    • Hide the fact that the merger included millions in liability
    • Failed to correct the alleged misstatements over 9 months while asking shareholders to vote for the merger
    • Breached their fiduciary duties
    • Violated multiple federal securities laws
    • Caused Centene stock to drop 8.5%

Litigation – Medicaid Managed Care

• March 2018 – Centene hit with suit over $6.8 billion buy of Health Net
  (continued)
  • Once the accounting was corrected, more than $1 Billion of shareholder value was erased
  • Knew Health Net had losses in 2014 of $120 million, 2015 of $286 million, increased spending for drug testing and substance abuse facilities going up in 2014 and 2015
  • Stopped paying substance abuse treatment centers to curtail policy losses and increasing liabilities which has resulted in the centers’ lawsuits for failure to cover claims

Medicaid Managed Care

- Centene’s failure to provide adequate care and networks was highlighted in a series of articles by the Dallas Morning News
  - *The Preventable Tragedy of D’ashon Morris*
    - When a giant health care company wanted to save money, a foster baby paid the price
  - *As Patients Suffer, Companies Profit*
    - Years of poor state oversight have allowed companies to skimp on essential care for sick kids and disabled adults
  - *Texas Pay Companies Billions for "Sham Networks" of Doctors*
    - Managed-care companies overstate the number of physicians available to treat the state's sickest patients

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Medicaid Managed Care

- Centene’s failure to provide adequate care and networks was highlighted in a series of articles by the Dallas Morning News (continued)
  - *Glossover of the Horror*
    - Texas fails to act when health-care companies put patients in peril
  - *Parents vs. the Austin Machine*
    - Texas families take the fight for fragile kids to the Legislature
New Developments

Medicaid Managed Care

• CMS Proposed Rule
  • November 8, 2018, CMS issued a Notice of Proposed Rule for Medicaid Managed Care setting forth several key goals
    • Promoting flexibility in limited, actuarially sound rate ranges, transition period requirements for state-directed and pass-through payments
    • Flexibility to set meaningful network adequacy standards and new service delivery models like telehealth
    • Electronic communications with beneficiaries when appropriate
    • Strengthen accountability of CMS to issue guidance to states for rate reviews, appropriate oversight to ensure patient protections and fiscal integrity; requirements for Quality Rating System to help beneficiary choice and promote transparency
Medicaid Managed Care

- CMS Proposed Rule
  - November 8, 2018, CMS issued a Notice of Proposed Rule for Medicaid Managed Care setting forth several key goals (continued)
    - Maintain & enhance program integrity
    - Setting actuarially sound capitation rates, network adequacy standards and facilitate processes for appeals/grievances and adopt applicable proposals for medical loss ratio standards

Medicaid Managed Care

- State Monitoring
  - The state Medicaid agency
    - Must have in effect a monitoring system for all Managed Care programs 42 CFR 438.601(c)(7) – July 2017
    - The state must periodically audit MCOs at least 1 time per 3 years for "accuracy, truthfulness and completeness of the encounter and financial data submitted" by the MCO
  - 42 CFR 438.602 – State responsibilities
    - (a) Monitoring contractor compliance
    - (e) Periodic Audits