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

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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

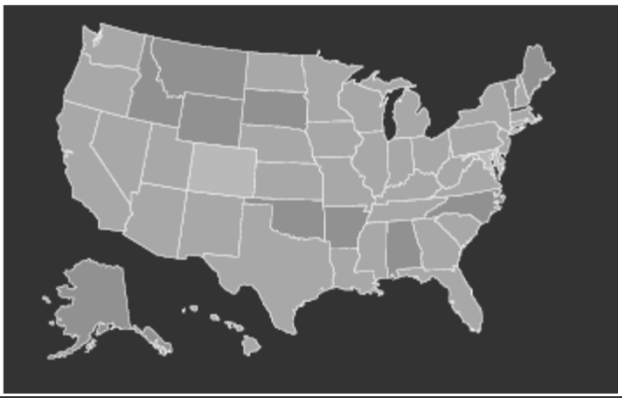
- MCOs contract directly with Medicare and/or Medicaid and
  - Develop and contract their own provider networks
  - Set reimbursement for providers
  - Process and pay claims
  - Address appeals (from beneficiaries and providers)
  - Compliance (internal processes and for providers)

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/
- All-time enrollment high in 2019 with more than 36% of Medicare beneficiaries enrolled in Medicare Advantage with expected 22.6 million beneficiaries. https://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Pages/2018/October%202018/October%2005%202018/MA-Enrollment-Continues-to-Grow-CMS-Reports-.aspx?utm_campaign=Weekly%20eNewsletters&utm_source=hs_email&utm_medium=email&utm_content=66477603&_hsenc=p2ANqtz--nAZ8DPiHrl2v-D6JEK60quH_taofP-cIHE2VYOUGOquGllZ86q1BuuKltpHu10qwHR9s-PiqKwkjNsCJFGP25gyDVRw&_hsmi=66481818

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

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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)

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It's Complicated

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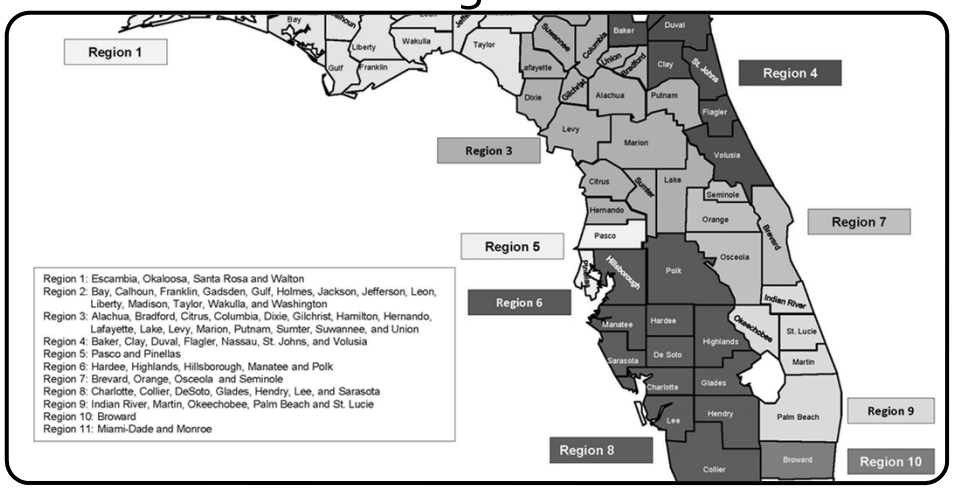
Florida MCOs and Regions



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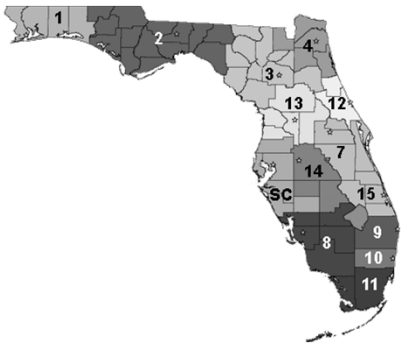
Florida Multiple Medicaid MCOs in Regions

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

Regions / MCO	1	2	3	4	5	6	7	8	9	10	11	
Amerigroup						X	X	X				X
Better Health							X					X
Coventry											X	
Humana	X					X			X	X	X	
Molina	X			X		X	X	X	X		X	
Prestige	X	X		X	X	X	X	X	X			
Community Care Plan (CCP)											X	
Simply											X	
Staywell		X	X	X	X	X	X	X			X	
Sunshine			X	X	X	X	X	X	X	X	X	
United Health			X	X			X				X	



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 $1,368200
  - 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

https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html

Current Issues

- Medicaid MCOs
  - 11/23/2018 – OIG audit of two Arizona Medicaid MCOs = identified numerous security vulnerabilities https://oig.hhs.gov/oas/reports/region18/181709302.asp
  - 11/16/2018 – OIG Work Plan 2019 – Audit States' MCO reimbursements and data used to set rates under the state plan https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000050.asp
  - 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 …. "

http://qctimes.com/news/local/government-and-politics/elections/candidates-pan-privately-managed-medicaid-solutions/article_cd5100da-0428-5943-b1f4-03f9f9738018.html

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

- 2017 – Freedom Health, Inc., settles for $32 million Whistleblower
  - 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

https://www.nytimes.com/2017/05/19/business/dealbook/unitedhealth-sued-medicare-overbilling.html

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.

https://www.nytimes.com/2018/01/11/health/centene-health-insurance-lawsuit.html

Litigation – Medicaid Managed Care

- 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

http://www.santafenewmexican.com/news/local_news/molina-healthcare-sues-state-over-loss-of-medicaid-contract/article_a719e849-58c1-551b-9038-c6fdf4f5d735.html

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

https://www.law360.com/health/articles/1020781/centene-hit-with-suit-over-6-8b-health-net-buy?nl_pk=7fbe86bc-3595-42cd-8532-ad4b32568f50&utm_source=newsletter&utm_medium=email&utm_campaign=health

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

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

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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

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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