Combatting Fraud, Waste, and Abuse in Managed Care

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Overview

• OIG – who we are
• OIG Priorities
• Managed Care Top Management Challenge
• Risk Areas and OIG Action
• Compliance Guidance
• Coordination with Key Stakeholders
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.
OIG Components

Audit Services
Evaluation & Inspections
Investigations
Counsel to the IG

OIG Locations

1,550+ employees  70+ offices
OIG’s Unique Role

- Identify
- Educate
- Enforce

OIG By The Numbers

- Oversee the $1.1 trillion HHS budget
- $700M oversight per employee
- FY 17 OIG ROI = $13:$1
OIG by the Numbers FY14-18

- $23.3 billion in expected recoveries
- 1,371 reports issued
- 4,485 criminal actions
- 3,562 civil actions
- 17,720 exclusions

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OIG by the Numbers FY18

- Expected recoveries of +$3.43 billion
- 764 criminal actions
- 813 civil actions
- 2,712 exclusions
- $66M in Civil Monetary Penalties and assessments
Desired Outcomes

• Healthier People
• Lower Costs
• Better Care
• More Efficient System

Identifying Risk Areas

• Program Vulnerabilities
• Data Analytics
• Hotline, Qui Tams, Tips
• OIG Collaboration
OIG-Identified Risks

- HHS Top Management Challenges
- Work Plan
- Semi-Annual Report, HCFAC Report
- Audits, Evaluations, Investigative Results
- Website – oig.hhs.gov
Opioids

- OIG Role
- HHS Program Improvement
- Identify and Hold Wrongdoers Accountable
- Share/Collaborate with Partners

Opioid Use in Medicare Part D in 2017

Almost **460,000** Part D beneficiaries received high amounts of opioids

About **71,000** Beneficiaries are at serious risk of opioid misuse or overdose
Opioid-Related Exclusions

587 excluded

Since the 2017 takedown, the HHS Office of Inspector General’s Exclusions Program issued notices to 587 health care providers, including doctors, nurses, pharmacy employees and other individuals who were convicted of health care fraud, patient abuse or neglect, or illegal activity tied to opioids.

Top 5 States with Exclusions

Exclusions by Occupation

U.S. Department of Health and Human Services Office of Inspector General

Exclusions from June 2017-May 2019

Nurses 402
Doctors 87
Pharmacy Services 40

Opioids

Toolkit:

Using Data Analysis To Calculate Opioid Levels and Identify Patients At Risk of Misuse or Overdose
Home and Community Based Services

- Home Health
- Hospice
- Group Homes
- Personal Care Services

Home Health

- Vulnerable Area
  - Medical Necessity
  - Kickbacks
- OIG Multi-Disciplinary Approach
- OCIG Industry Outreach
- Focus on Geographic Hot Spots
Hospice

Portfolio:
Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity

Joint Report

U.S. Department of Health and Human Services
Office of Inspector General,
Administration for Community Living, and
Office for Civil Rights

Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight

January 2018
Personal Care Services

• MFCU focus
  – 38% of MFCU indictments involve PCS providers or attendants
• Beneficiary abuse and neglect
• Financial fraud

Managed Care:
Top Management Challenge
Managed Care: Top Management Challenge

Ensuring Value and Integrity in Managed Care:
• Combatting provider fraud and abuse
• Fostering compliance by managed care organizations

Managed Care: Top Management Challenge

What needs to be done:
• Ensure comprehensive data
• Identify fraud and abuse
• Make referrals to law enforcement
• Ensure access to care
• Enhance oversight of MCO contracts
Risk Area: Fraud by Providers

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

Risk Area: Fraud by Providers

<table>
<thead>
<tr>
<th>Percentage of Plan Sponsors that Voluntarily Reported Data on Potential Fraud and Abuse</th>
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<tr>
<td>40%</td>
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<tr>
<td>37%</td>
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<tr>
<td>35%</td>
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<tr>
<td>2010</td>
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<td>2011</td>
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<td>2012</td>
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Risk Area: Fraud by Providers

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

- Lack of complete data

OIG Report: Weaknesses Exist in Medicaid MCO’s Efforts to Identify Fraud and Abuse

- Medicaid MCO identification of fraud and abuse by network providers

- Some MCOs identified and referred only a few providers suspected of fraud or abuse

- Not all MCOs used proactive data analysis

- MCO did not inform states of action taken against providers suspected of fraud
MCOs did not always identify and recover overpayments (dollars in millions)

Overpayments associated with fraud or abuse
$57.8 identified, $12.5 recovered

Overpayments not associated with fraud or abuse
$831.4 identified, $561.4 recovered

MCOs took corrective actions but did not always report these actions to the State.

Prepayment/Postpayment Review
MCOs reported all actions
MCOs did not report all actions

Provider Education

Suspension of Payment

Corrective Action Plan
MCOs sometimes terminated suspected providers but did not always notify the State.

**Work Plan Items: Providers**

- State Compliance with MCO Provider Enrollment Requirements
- 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
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

Enforcement: Providers

• HealthCare Partners Holdings LLC, doing business as DaVita Medical Holdings LLC (DaVita)
  – October 2018 $270 million settlement to resolve its False Claims Act liability for providing inaccurate information that caused Medicare Advantage Plans to receive inflated Medicare payments
  – DaVita operated a medical service organization and contracted with MAOs in various states to provide care to the MAOs’ enrolled Medicare beneficiaries
Enforcement: Providers

- **Billing Fraud**
  - Coordination with MEDICS, MCOs, CMS, States, and other government partners

- **Unlicensed NJ Dentist**
  Agrees to Pay $1.1 Million and 50-year voluntary exclusion

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
Risk Areas for Plans

- Stinting on care: improper denials of care/payment
- Risk adjustment fraud
- Data security vulnerabilities
- Improper cap payments
  - Per-bene rate
  - Deceased
  - No longer in the plan

OIG Report: MA Appeal Outcomes Raise Concerns About Service Denials

- MAOs overturned 75% of their own denials during 2014-2016
- High volume of overturned denials raises concerns that that some beneficiaries were denied services and payments that should have been provided.
- Beneficiaries rarely use appeals process – only 1% of denials were appealed in 2014-2016
- OIG recommends CMS enhance oversight of MAO contracts, address inappropriate denials, provide beneficiaries with clear information about serious violations by MAOs.
OIG Report: Data Security Vulnerabilities

- OIG identified data security vulnerabilities at two Arizona Medicaid MCOs
- Disparate treatment of data security at the state and MCOs
- Increased risk to Medicaid patient data
- OIG recommendations
  - CMS conduct documented risk assessment
  - Inform all State agencies of the cybersecurity vulnerabilities identified

Work Plan Items: Plans

- Inappropriate Denial of Service and Payment in Medicare Advantage
- Review of MCO’s use of Medicaid funds to provide services
- Managed care payments made for dead beneficiaries
Work Plan Items: Plans

- Risk Adjustment Data – Part C
  - Audits of risk adjustment data
  - Study: Financial Impact of Health Risk Assessments and Chart Reviews on Risk Scores in Medicare Advantage
- Part D Sponsor compliance with remuneration reporting requirements

Enforcement: Plans

- United Litigation
  - Risk adjustment fraud
- Freedom Health Settlement
  - Wide ranging Part C fraud
  - Resolved with CIA, Part C reviews
- Centers Plan for Healthy Living
  - improper enrollment of individuals into long term care plan who were not eligible for the plan.
Risk Adjustment in Part C

- Courts are weighing in
  - United States District Court in DC vacated CMS’s overpayment regulation in Sept. 2018
  - Governing statute remains unaffected
- CMS issued proposed rule October 26, 2018
  - Would update Part C and D regulations
  - Addresses CMS RADV audits
- CMS announced FFS Adjuster study results on October 26, 2018

Risk Area: Quality of Care

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

Work Plan Items: Quality of Care

- Availability of Behavioral Health Services in Medicaid MCOs
- Denials by Part C and D plans
- Health-Care-Acquired Conditions in Medicaid MCOs
Compliance Resources

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

Seven Fundamental Elements
1. Written policies and procedures
2. Compliance professionals
3. Effective training
4. Effective communication
5. Internal monitoring
6. Enforcement of standards
7. Prompt response
Freedom Health (May 2017): Notable Elements of the CIA

- Provider Network Review:
  - Network Adequacy
  - New contract
  - Expanded Service Area Contracts

- Diagnosis Coding Review
  - Filtering logic
  - 100 member sample

Advisory Opinion

- Requestor is a Medicaid MCO, wants to provide network providers with incentive payments for providing EPSDT services to existing enrollees
- This arrangement is protected under the eligible managed care organizations safe harbor, 42 C.F.R. 1001.952(t)
- Incentive payments are payments to provide or arrange for health care services
Program Integrity in Medicaid Managed Care Regulation

Medicaid MCO Regulation

Program Integrity in the MCO contract

- 42 C.F.R. 438.608
- Robust, effective compliance program
- Applies to subcontractors
Medicaid MCO Regulation

Provider Screening and Enrollment

• 42 C.F.R. 438.608(b)

• Network providers required to be enrolled in Medicaid

• Applies to subcontractors

Medicaid MCO Regulation

Treatment of Overpayment Recoveries

• 42 C.F.R. 438.608

• Must be addressed in contract

• States have a lot of flexibility
Medicaid MCO Regulation

Partnering with States

• Strong partnership between plans and states

• Payment suspension

• Coordination with law enforcement

Maximizing Fraud Fighting Impact

• National Health Care Anti-Fraud Association

• Healthcare Fraud Prevention Partnership

• Managed care plan SIU
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