Managed Care: Government Oversight and Enforcement Trends

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Overview

• OIG – who we are
• OIG Priorities
• Challenges
• Data Issues
• Managed Care Oversight
Who we are:

![Image](image_url)

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

1,550+ employees

70+ offices

![Map](map_url)

- U.S. Department of Health and Human Services
- Office of Inspector General (OIG)
- OIG Component Locations
- 1,550+ employees
- 70+ offices
What we do:

Audit  Evaluate  Investigate  Counsel

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.
Medicare & Medicaid

Image of gears with logos of NIH, FDA, CDC, and text reading Medicare & Medicaid.
1 in 3 Americans

Who we serve

Public  Industry  Congress  Department
OIG By The Numbers

• Oversee the $1.3 trillion HHS budget
• $700M oversight per employee
• FY 18 OIG ROI = $4:$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
OIG by the Numbers FY19

- Expected recoveries of +$5 billion
- 809 criminal actions
- 695 civil actions
- 2,640 exclusions
- +200 Audits and Evaluations
- 341 recommendations implemented by HHS

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
More than 600 charged in nation’s largest health care fraud investigation

The Justice Department charged more than 600 people, including 62 doctors, with fraudulently billing the government

More than 600 people, including 62 doctors, were charged in the biggest health care fraud case in U.S. history, the department announced Wednesday.

The investigation, dubbed Operation Corrupt Care, involved bills totaling more than $2 billion, according to the department.

The case is the largest in the department’s health care fraud unit’s history, the department said.

The investigation was led by the department’s health care fraud division, which works with local law enforcement agencies and the Federal Bureau of Investigation.

The investigation began in 2010, and the department charged 19 people in the case in June.

The charges include criminal attempts to defraud Medicare and Medicaid, which are jointly funded by the federal and state governments.

US Department of Health and Human Services
Office of Inspector General

Opioids

Resources:

• Using Data Analysis to Calculate Opioid Levels and Identify Patients at Risk of Misuse or Overdose

• State-specific factsheets: oversight of opioid prescribing and monitoring of opioid use
Opioids

• CMS Informational Bulletin (Aug 2019)
  • Outlines key provisions that Medicaid MCOs must implement to curb opioid abuse.
  • Drug review utilization standards
  • Prospective reviews of drug utilization

Home and Community Based Services

• Home Health
• Hospice
• Group Homes
• Personal Care Services
Unaccompanied Alien Children

• OIG responded quickly, dedicating an unprecedented level of resources to conduct large, multifaceted reviews.
• 4 products have been issued as of September 2019
• Additional work the OIG has underway focuses on:
  1. Challenges HHS and facilities faced in reuniting separated children with their parents
  2. Physical security of facilities,
  3. Cybersecurity to protect sensitive data,

Managed Care

Medicare Advantage | Medicaid Managed Care

Beneficiaries
Medicare Advantage is the fastest growing part of Medicare (2015-2018)

- **Part B**: $36,048,496
- **Part C**: $18,752,285
- **Part D**: $41,744,215

### Medicaid Managed Care Expenditures

- **2007**: $100,000
- **2008**: $200,000
- **2009**: $300,000
- **2010**: $400,000
- **2011**: $500,000
- **2012**: $600,000
- **2013**: $700,000
- **2014**: $800,000
- **2015**: $900,000
- **2016**: $1,000,000
- **2017**: $1,100,000
- **2018**: $1,200,000

### Medicaid Expenditures

- **2007**: $27,000
- **2008**: $28,000
- **2009**: $29,000
- **2010**: $30,000
- **2011**: $31,000
- **2012**: $32,000
- **2013**: $33,000
- **2014**: $34,000
- **2015**: $35,000
- **2016**: $36,000
- **2017**: $37,000
- **2018**: $38,000
Why do we care?

- **Beneficiary Harm**
- Fraud in one program often means fraud in another program
- Fraud in Managed Care can increase taxpayer costs
- Federal Government has the enforcement tools: criminal, civil, administrative
Quality

Access to Care

Dallas Morning News

Des Moines Register

Care denied:
How Iowa's Medicaid maze is trapping sick and elderly patients in endless appeals

STORY BY JASON CLAYWORTH
PHOTOS AND WORK OF JAMIE ROBLES
DEVELOPMENT BY ANDREW EATON
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.

Access to Care

Examples of OIG’s Ongoing Work:

- Overturned Denials in Medicaid Managed Care
- Inappropriate Denial of Services and Payments in Medicare Advantage
- Medicaid Managed Care Organization Denials
  - OIG is reviewing whether a Pennsylvania MCO complied with Federal requirements for denying medical procedures, drug prescriptions, and dental procedures that required prior authorization.
Access to Care

• Network Adequacy

• Workforce

• Support services

Access to Care

• Medicaid Access Rule

• Executive Order on Protecting and Improving Medicare for Our Nation’s Seniors
  • Improving Access Through Network Adequacy
Federal Funds

What is the Government Paying For?

• Healthcare items and services for beneficiaries
• Not fraud, waste and abuse by plans and providers
Risk Areas

• MA Risk Adjustment Data
• Medicaid payments for deceased or incarcerated benes
• Medicaid payments to ineligible providers
• Part D Sponsor compliance with remuneration reporting requirements
Improper Payments, Medicaid

- Medicaid capitated made on behalf of dead beneficiaries
- Medicaid capitated payments made on behalf of incarcerated individuals
- Medicaid payments made to terminated or ineligible providers
Rates

• Federal share of MCO recoveries
• State recoupment when MCO profits exceeded contract-established limits
• Failed to consider FMAPs associated with the ACA expansion population or specific programs like family planning

OIG Report: Essence Healthcare, Inc. – Targeted RADV

• Targeted RADV – focused on specific diagnostic codes
• 75 of 218 enrollee years had unsupported diagnosis codes
• $158,904 in identified overpayments
• Cause: Policies and procedures to detect and correct noncompliance were ineffective
OIG Report: MA Payments from Chart Reviews

• CMS bases payment to MAOs on diagnoses from two data systems: Risk Adjustment Processing System and Encounter Data System (EDS)
• OIG reviewed diagnoses from EDS from 2016
• Focused on diagnoses that resulted from chart reviews, which are from MAOs’ retrospective reviews of medical records
• Findings:
  • MAOs use chart reviews to add, not delete, diagnoses
  • MAOs received approx. $6.7 billion in risk adjustment payments in 2017 from chart review records
  • $2.6 billion of the chart review payments did not link to specific services

OIG Study: Health Risk Assessments in Part C

• Nationwide Review: Financial Impact of Health Risk Assessment on Risk Scores in Medicare Advantage
• Goal: determine the extent to which diagnoses solely generated by health risk assessments were associated with higher risk scores and higher MA payments.
Part C Risk Adjustment – Fraud Enforcement

• United States has filed suit and has settled civil cases against both providers and plans
  • Sutter Health
  • UnitedHealth Group Inc.
  • Beaver Medical Group, L.P.
  • DaVita Medical Holdings, LLC
  • Freedom Health, Inc.
  • Wellcare

Freedom Health CIA (May 2017)

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

• Diagnosis Coding Review
  • Filtering logic
  • 100 member sample
Identification of provider FWA

- MAOs and Medicaid MCOs fail to identify and address provider FWA
- MEDIC’s Effectiveness is also limited
  - OIG studied the MEDIC’s Part C and D benefit integrity activities from 2012-2017 and released a report in July 2018:
    - Finding the MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness
    - Recommended that CMS require plan sponsors to report fraud and abuse incidents and the actions taken to address them
    - Recommended that CMS provide the MEDIC with centralized access to all Part C encounter data

Data
Quality of Encounter Data

OIG examined the quality of the data used in managed care.

- OIG issued a report in January 2018, “Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed”
  - Many errors in data
  - Small percent of MAOs responsible for most of the errors
  - CMS made many data corrections
- OIG’s work plan items:
  - Quality of Medicaid Encounter Data
Using Data to Protect Patients

• Data can be used to identify critical incidents
• Health insurance claims can be used to identify beneficiaries that are the victims of abuse or neglect.
• Guide for public and private sector partners

Develop unique processes for analyzing claims data to identify:
1) Unreported instances of abuse or neglect
2) Beneficiaries that require immediate intervention
3) Providers exhibiting patterns of abuse or neglect
4) Instances providers did not comply with mandatory reporting requirements
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

OIG Report: Using MA encounter data to identify vulnerabilities

Findings: MAOs almost always used chart reviews as a tool to **add**, rather than to **delete**, diagnoses for risk adjustment, resulting in increased payments to MAOs

- [□] Deleted Diagnoses    - [■] Added Diagnoses

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<th>Percent of Chart Reviews</th>
<th>0%</th>
<th>25%</th>
<th>50%</th>
<th>75%</th>
<th>100%</th>
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Managed Care Landscape

Litigation
Executive Order
State Innovation

Regulations
Industry Changes
CMS Guidance

Laws
Shifting Landscape

• Medicare Executive Order

• Medicare Parts C and D rules

• Medicaid MCO NPRM

Regulatory Updates

Medicare Executive Order (Oct. 3, 2019)
• Propose changes to Medicare 1/1/2021 and annually to combat fraud, waste and abuse
• Direct public and private resources towards detecting and preventing f/w/a, including use of artificial intelligence
Regulatory Updates

• CMS issued Parts C and D rules
  • Risk adjustment (proposed)
  • Preclusion
  • Telehealth

Medicaid Managed Care 2018 Rulemaking to ease administrative burden and streamline major 2016 regs
  • Develop Quality Rating System for plans
  • MLR standards
  • Prohibition on retroactive risk-sharing
  • Setting capitation rates
  • Network adequacy standards
Conclusion

• OIG is focused on oversight and enforcement in Managed Care:
  • *Quality* – more Americans than ever rely on Managed Care,
  • *Federal $* – ensure the financial integrity of HHS programs,
  • *Data* – leverage data to identify risk areas

Stay Connected

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