U.S. Department of Health and Human Services

Office of Inspector General

OIG's Oversight of Expanding Managed Care Programs

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January 29, 2024

Agenda

- Introduction to HHS-OIG
- HHS-OIG Strategic Plan for Oversight of Managed Care
- Enforcement
- Impact: Case Studies
- Resources and Guidance

Introduction to HHS OIG

Mission, Vision, Values

our MISSION	provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as the health and welfare of the people they serve
our VISION	drive positive change in HHS programs and in the lives of the people served by these programs
our VALUES	impact, innovation, and people-focus

What We Do

Audit

Evaluate

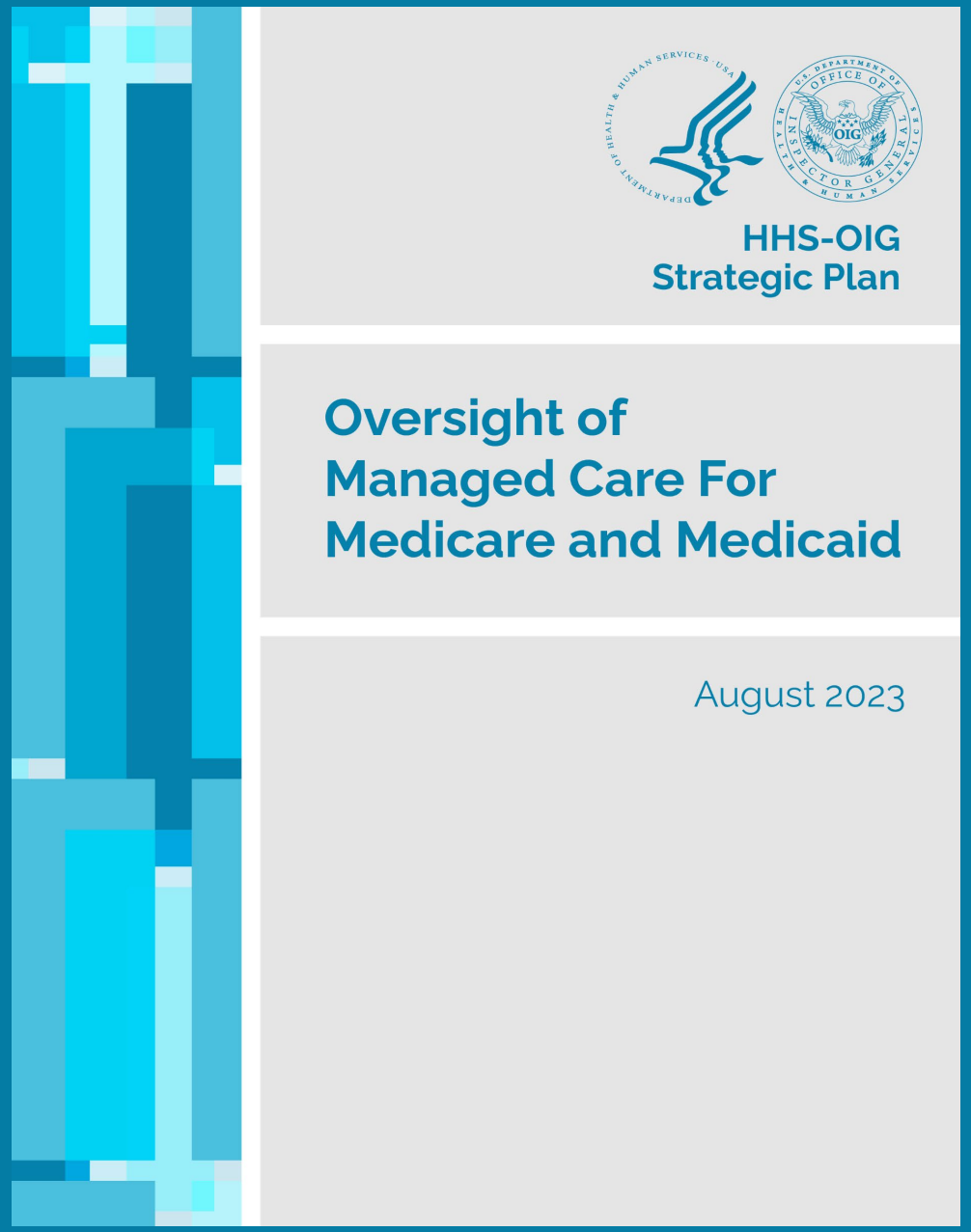
Investigate

Counsel

In FY 2023, OIG's team of nearly 1600 people:

- Issued **169** reports
- Executed **707** criminal actions and **746** civil actions
- Excluded **2,112** individuals and entities from federal health care programs
- Identified nearly **$3.45 billion** in expected audit and investigative recoveries

HHS-OIG Strategic Plan for Oversight of Managed Care

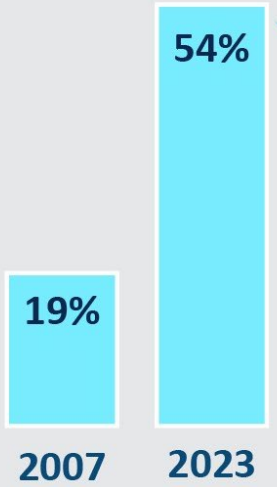


Why We Care

- Harm to beneficiaries
- Fraud in one program often means fraud in another program
- Fraud in Medicare Advantage can increase taxpayer costs
- Federal government has criminal, civil, and administrative tools

Growth in Managed Care

By the Numbers



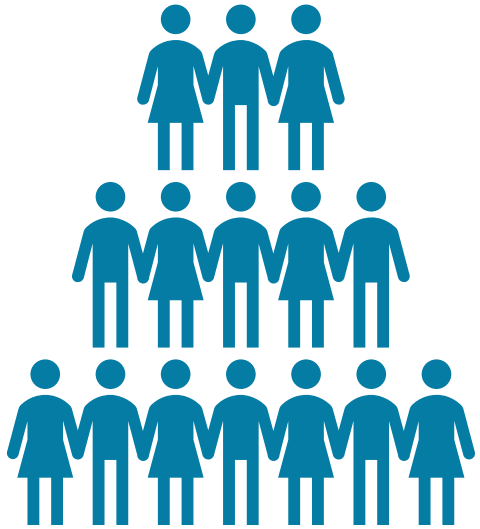
54% of Medicare enrollees received care through Medicare Advantage in 2023.

81% of current Medicaid enrollees receive at least one component of care through managed care.

$454B in estimated Government spending on Medicare Advantage in 2023.

$254B Federal match for Medicaid managed care in 2021.

Expanding Oversight of Managed Care



OIG priority due to rapid growth in managed care programs

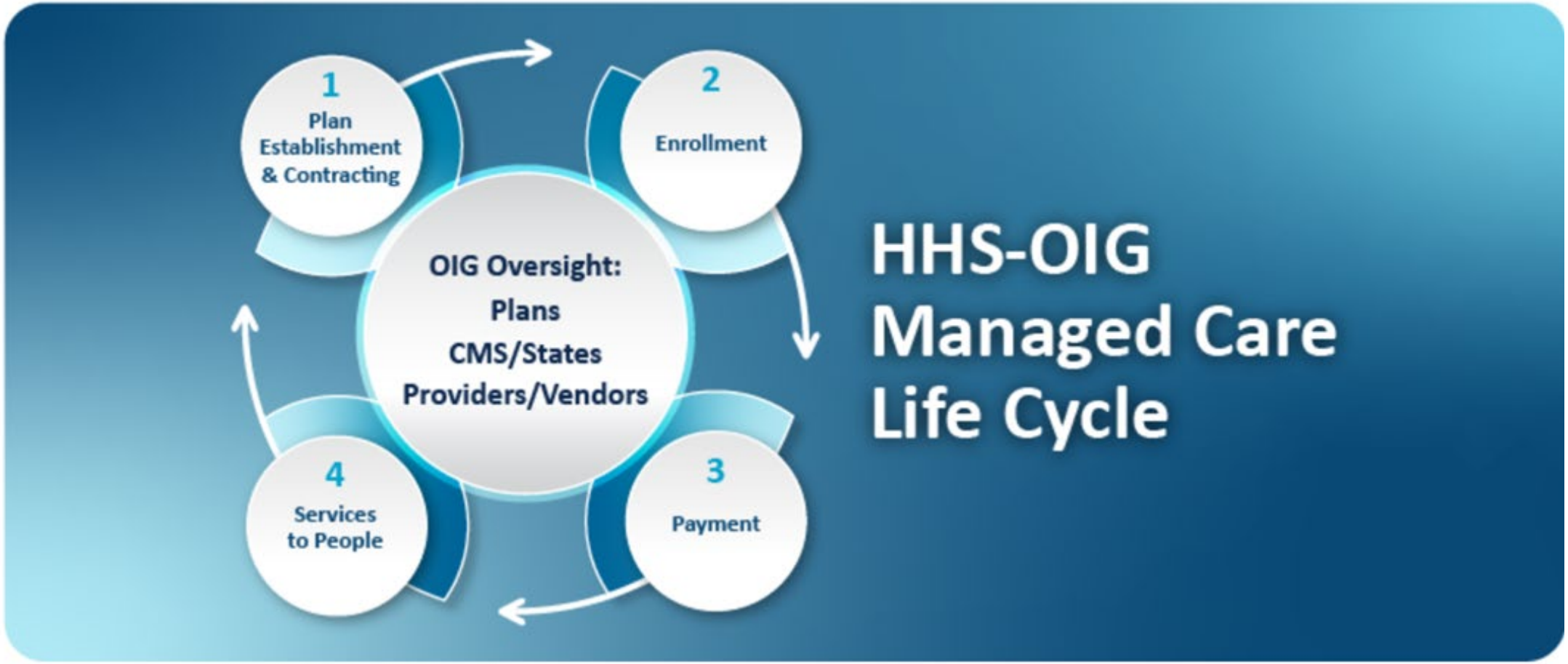
OIG aims for comprehensive oversight as managed care programs grow

OIG identifies areas of risk throughout managed care programs

Strategic Plan

- Articulates OIG's vision for comprehensive oversight of Medicare and Medicaid managed care
- Outlines OIG's goals for its managed care work
- Serves a tool for evaluating greatest areas of risk and focusing resources
- Creates synergy in work across the organization

Evaluating Risk and Focusing on Oversight



Strategic Plan Goals

01

Promote Access to High Quality Care

02

Provide Comprehensive Financial Oversight

03

Promote Data Accuracy and Data Driven Decisions

01

Promote Access to High Quality Care

Goal 1: Completed Work

Prior Authorizations	• Denial Rates and Access to Medically Necessary Care • State Specific Audits: New York, Iowa, Pennsylvania
Behavioral Health	• Availability of Services for Medicaid Managed Care • Telehealth Implementation and Oversight
Quality and Payment Nexus	• Payment for Preventable Conditions • Health and Safety Risks in Medicaid Long Term Care Plans

Goal 1: Work Plan Items

- Medicaid Managed Care Organizations' Denials
- Medicaid Telehealth Expansion During COVID-19
- Cross Program Behavioral Health Study
- States' and MCOs' Compliance With Mental Health Parity Requirements
- Strategies To Improve Access to Maternal Health Care in Medicaid Managed Care

02

Provide Comprehensive Financial Oversight

Goal 2 Work Areas

1. **Medicare Advantage**
2. Medicaid Managed Care

Goal 2: Completed Evaluations of Health Risk Assessments and Chart Reviews

- Three evaluations estimated $9.2 billion in MA risk-adjusted payments for diagnoses that have no other record of services
  - Disproportionately driven by a small number of Medicare Advantage companies
- OIG is updating this information for 2022

Goal 2: Risk Adjustment Data Validation Audits

Compliance Audit of Diagnoses Submitted by MAOs (RADV-like)	Compliance Audit of Specific Diagnosis Codes (Targeted)
• Sample across plan and review all diagnoses for selected beneficiaries • 200 enrollees selected per plan; over 1,500 HCCs	• Target high-risk diagnoses with a greater probability for error; specific scenarios or mis-keyed • 200+ enrollee years sampled per plan

Targeted Audit Results to Date

26 audit reports issued

Over $209 million in overpayments identified

72% of HCCs not validated in Targeted Audits

Contract RADV Audit Results to Date

6 audit reports issued

Over $375 million in overpayments identified

9% of HCCs not validated in Targeted Audits

Medicare Advantage Risk Adjustment Data Validation Final Rule (CMS-4185-F2)

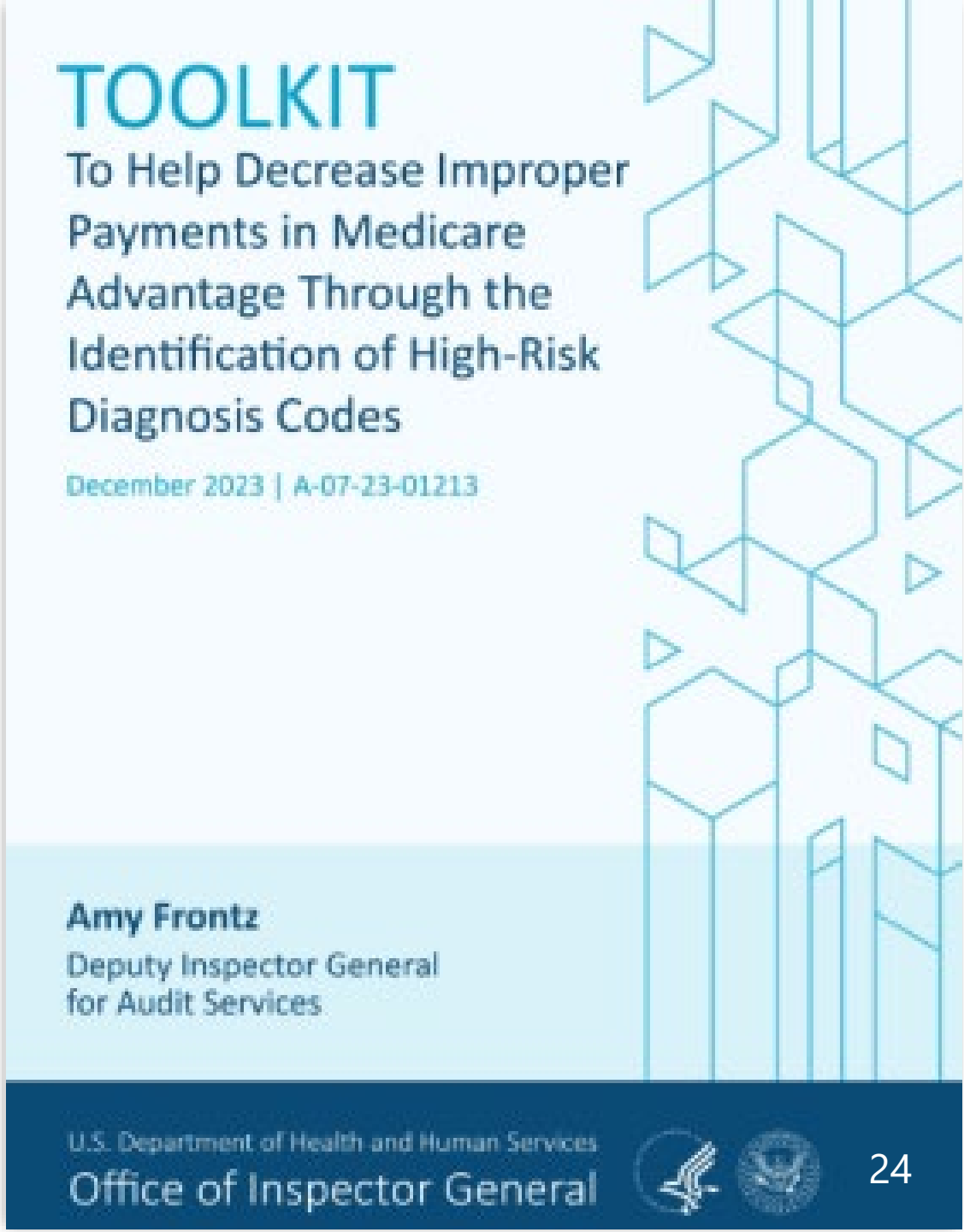
Two main provisions:

- Extrapolation to begin with payment year 2018
- CMS will not apply an adjustment factor (FFS adjuster)

Impact to OIG audits in progress

OIG High-Risk Diagnosis Code Toolkit

- Provides information on high-risk diagnosis codes in Targeted audits
- Detailed description and steps on how plans can identify these codes



Goal 2: Risk Adjustment Work Plan Items

- Audits of At-Risk Diagnoses
  - Continuation of Targeted Audits
  - Nationwide Audits
- Health Risk Assessments and Chart Reviews
  - Health Risk Assessment Submission Update
  - Health Risk Assessment Audit
  - Unlinked Chart Reviews

Goal 2 Work Areas

1. Medicare Advantage

2. Medicaid Managed Care

Goal 2: Completed Work on Enrollee Level Payments

Payments for Deceased Enrollees

- 14 States identified over $249 million; $172 million Federal share in unallowable payments
- 11 States have since refunded over $125 million of identified overpayments

Duplicate Payments

- Payments for enrollees concurrently enrolled in a Medicaid Managed Care program in two States; nationwide $190 million identified for a two-month period
- Enrollees assigned more than one identification number; identified over $28 million in Federal funds paid incorrectly

Goal 2: Completed Work on Plan Payments Issues

State Refunds to Federal Government

- Refunds that should have been made for services provided by Indian Health Services Facilities
- Refunds that should have been issued from MCO recoveries

Medical Loss Ratio

- MCOs are required to spend 85% of revenue on patient care
- *CMS Has Opportunities To Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratio*

Initiative to Increase Medicaid MCO Fraud Referrals

- Initial evaluation identified need to increase referrals
- OIG has embarked on a series of work:
  - Medicaid Managed Care Plans' Focus on Fraud Referrals
  - State Medicaid Agencies' Perspectives of Managed Care Plans' Referral of Fraud
- Medicaid Fraud Control Unit Oversight
- Partnering

Goal 2: Medicaid Managed Care Work Plan Items

- Medicaid Managed Care Plans' Focus on Fraud Referrals
- Concurrent Eligibility and Payments for Deceased Enrollees
- Managed Long Term Care Reimbursements
- Oversight of Federal Medical Loss Ratio Requirements
- Joint Work With State Agencies
- Achieved Savings Rebate Program-Offset of Rebates on CMS-64

03

Promote Data Accuracy and Encourage Data Driven Decisions

Goal 3: Completed Work

Encounter Data

- Data including Denied Claims and Ordering Provider Identifiers are not required, inhibiting program oversight and integrity efforts

Medicaid Data

- Incomplete and inaccurate date on payments to providers, including T-MSIS data and incomplete State data on amount plans paid, allowed, and billed
- Evaluations of Universal Program Integrity Contractor (UPIC)

Goal 3: Work Plan Items

- Medicare Advantage Organizations' Efforts To Reduce Racial and Ethnic Health Disparities
  - Evaluate actions MAOs a have taken to reduce disparities, including use of available data
- Race and Ethnicity Data for Medicaid Beneficiaries
  - Evaluate completeness and accuracy of T-MSIS data

Civil and Criminal Enforcement Actions

Enforcement Examples

Martin's Point Healthcare Inc.

- False Claims Act
- Chart Review
- Settlement of $22,485,000 in July 2023

Health Sun: Former Executive

- October 2023 criminal indictment
- Charge against former Director of Risk Adjustment Analytics for alleged falsely submitted risk adjustment information

Impact: Case Studies

Prior Authorization in MA

Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Needed Care (OIG Report, April 2022)

- 13% of prior authorization denials were for services that met Medicare coverage rules

> ***Case D472: MAO restricted follow up MRIs based on the size of the beneficiary's lesion, a restriction that is not included in Medicare coverage rules. Eight months after a beneficiary was discovered to have an adrenal lesion of 1.5 cm in size, an MAO denied a request for a follow-up MRI (estimated cost $300).***

Increased Attention on Prior Authorization

HOMELAND SECURITY & GOVERNMENTAL AFFAIRS

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PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

EXAMINING HEALTH CARE DENIALS AND DELAYS IN MEDICARE ADVANTAGE

Date: May 17, 2023

Time: 2:00pm

Location: SD-562, Dirksen Senate Office Building

OIG found that Medicaid MCOs had an overall prior authorization denial rate of 12.5%–more than 2 times higher than the Medicare Advantage rate (Figure 1). In 2019, the Medicaid MCOs included in the OIG review requested over 17 million prior authorizations. Jul 27, 2023

KFF
https://www.kff.org › policy-watch › new-oig-report-exa...

New OIG Report Examines Prior Authorization Denials ... - KFF

"Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans"
117th Congress (2021-2022)

HOUSE COMMITTEE HEARING Hide Overview ✕

Committee:	House Energy and Commerce
Subcommittee:	House Energy and Commerce Subcommittee on Oversight and Investigations
Related Items:	Data will display when it becomes available.
Date:	06/28/2022 (11:00 AM Local Time)
Location:	2123 Rayburn House Office Building, Washington, D.C.

H.R.3173 - Improving Seniors' Timely Access to Care Act of 2021
117th Congress (2021-2022)

BILL Hide Overview ✕

Sponsor:	Rep. DelBene, Suzan K. [D-WA-1] (Introduced 05/13/2021)
Committees:	House - Ways and Means; Energy and Commerce
Latest Action:	Senate - 09/15/2022 Received in the Senate. (All Actions)
Tracker:	Introduced ➤ Passed House

Healthcare Finance News

OIG: Prior authorization denials raise concerns about Medicaid Advantage

The Office of Inspector General has released a report examining prior authorization patterns from seven managed care companies,...

Jul 24, 2023

Federal News Network

The Health and Human Services inspector general takes on a $400B program

Managed care. It's a substantial part of the gigantic Medicare program. The Centers for Medicaid and Medicare Services figures half of...

Sep 19, 2023

Strengthening Enrollee Protections

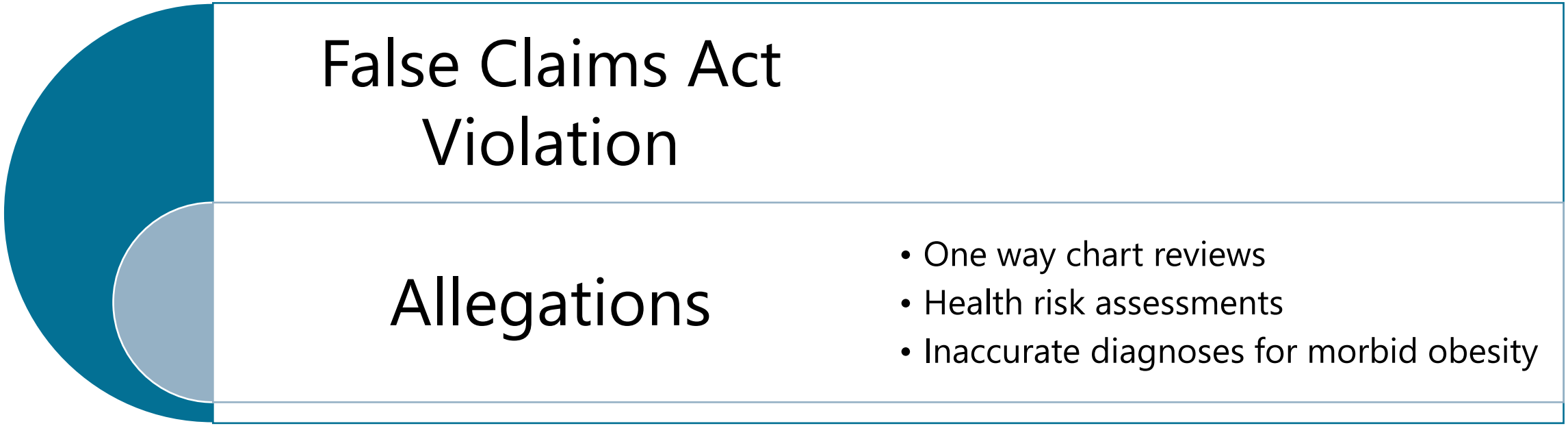
Regulation Issued

MAOs must comply with Traditional Medicare coverage requirements and tightened restrictions on when MAOs can use internal clinical criteria.

Industry Increases Access

Several large MA insurers eliminated prior authorization requirements, in some case for up to 20% of services.

Case Against Cigna



"Medicare Advantage plans that submit false information to increase payments from CMS show blatant disregard for the integrity of these vital federal health care funds."
- Christian J. Schrank, Deputy Inspector General for Investigations

How We Tackled This Case

Broad and deep expertise in MA

Work related to risk adjustment payment integrity issues raised in this case

- Health Risk Assessments and Chart Reviews
- Risk Adjustment Payment Diagnoses

Collaborated with Department of Justice

- Auditors, Attorneys, Evaluators, Investigators

Cigna Settlement

- Cigna paid over $172 million to resolve allegations
- Corporate Integrity Agreement:
  - Chief Compliance Office directly reports to CEO
  - Certification of Compliance Measures by Board of Directors
  - Annual Risk Assessments and Monitoring
  - Independent Review Organization

Resources and Guidance

Toolkits

- Analyzing Telehealth Claims to Assess Program Integrity Risks
- A Resource Guide for Using Medicare's Enrollment Race and Ethnicity Data
- Risk Adjustment High-Risk Diagnosis Toolkit

General Compliance Program Guidance

U.S. Department of Health & Human Services

Office of Inspector General

Thank You!

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