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

Managed Care: Government Oversight and Enforcement Trends

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Senior Advisor
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Overview

- OIG – who we are
- OIG Priorities
- Challenges
- Data Issues
- Managed Care Oversight

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Who we are:

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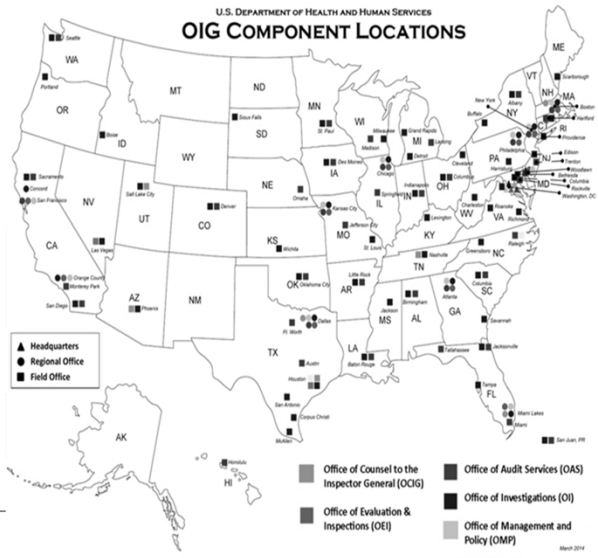
1,550+ employees



70+ offices

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What we do:

Audit **Evaluate** **Investigate** **Counsel**

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Office of Inspector General

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.

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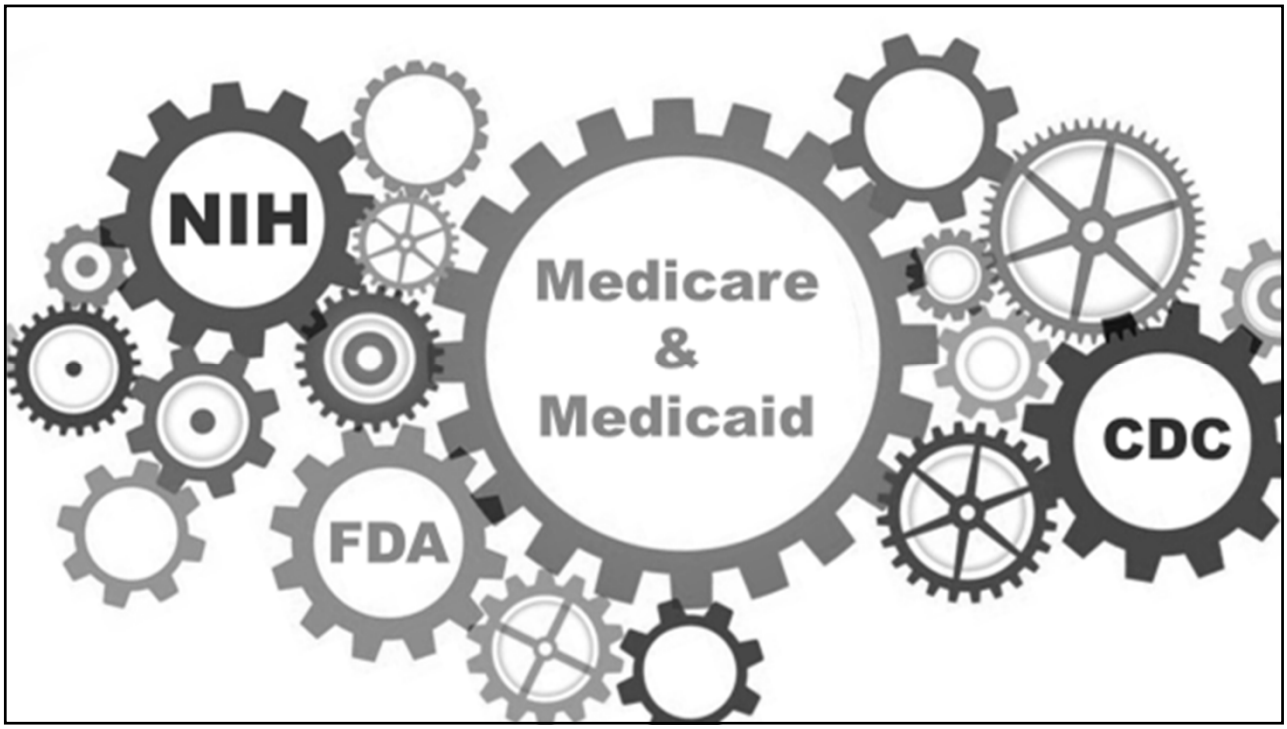

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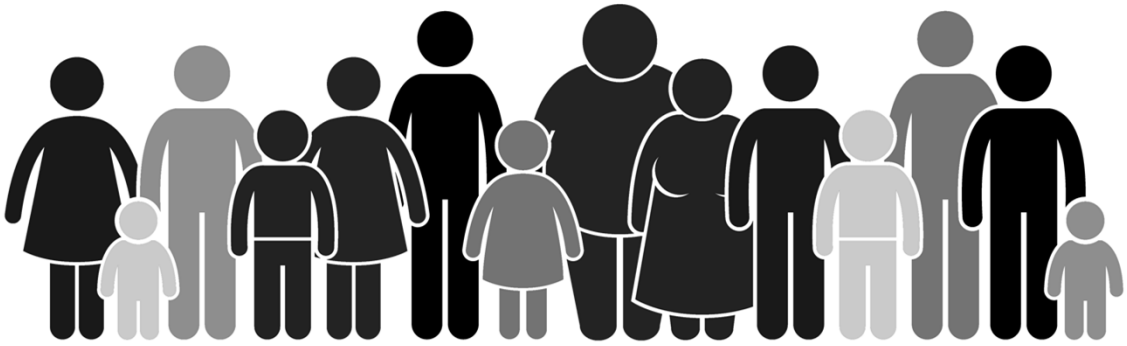
Medicare & Medicaid



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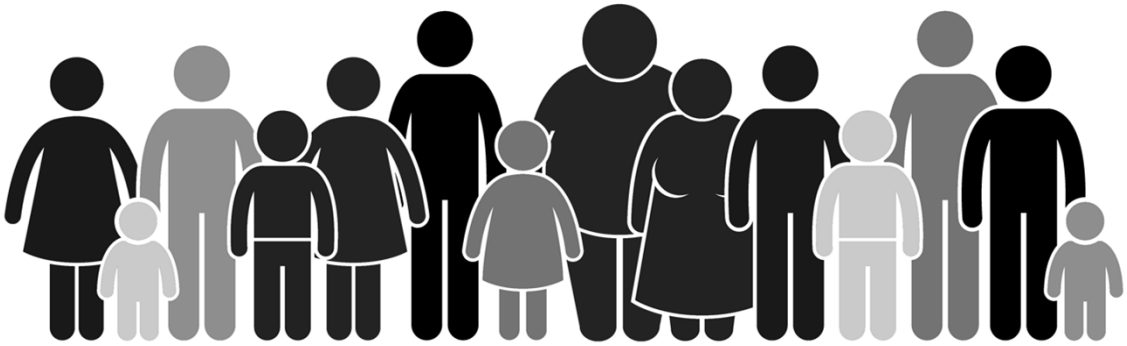
1 in 3

Americans



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Who we serve

Public

Industry

Congress

Department

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OIG By The Numbers

- Oversee the $1.3 trillion HHS budget
- $700M oversight per employee
- FY 18 OIG ROI = $4:$1

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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 FY19

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

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Desired Outcomes

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

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Identifying Risk Areas

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

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OIG-Identified Risks

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

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Opioids

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

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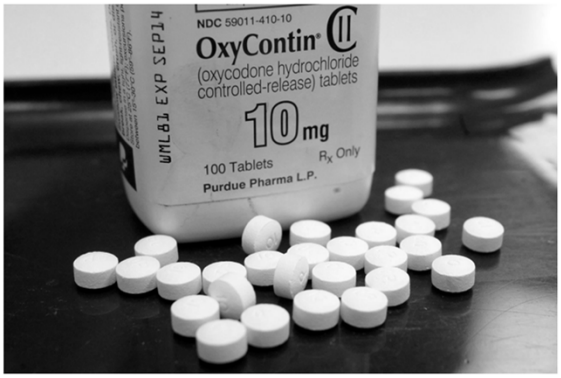
National Security

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



OxyContin, the prescription opioid painkiller, made by Purdue Pharma. (Toby Talbot/AP)

By Sari Horwitz
June 28

The Justice Department charged more than 600 peopl
professionals, with making $2 billion in false billings i
was the nation's largest ever health care fraud takedow

The cases are connected to the nation's ongoing drug c
2016, Sessions said. About two-thirds of the overdose

"It is the deadliest drug epidemic in the history of this
have never seen anything like it. Some of our most tru
vulnerable people suffering from addiction, and they s

Of those arrested, 162 defendants, including 76 doctor
distributing opioids and other dangerous narcotics.

"Many of these fraudsters have stolen tax dollars, and
Sessions said. "One doctor allegedly defrauded Medica
2.2 million unnecessary dosages of drugs like oxycodo
charged more than 400 people across the country with
about $1.3 billion in false billings, including for the pr

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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

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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

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Home and Community Based Services

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

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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,
  4. challenges facilities faced in ensuring children's safety.

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Managed Care

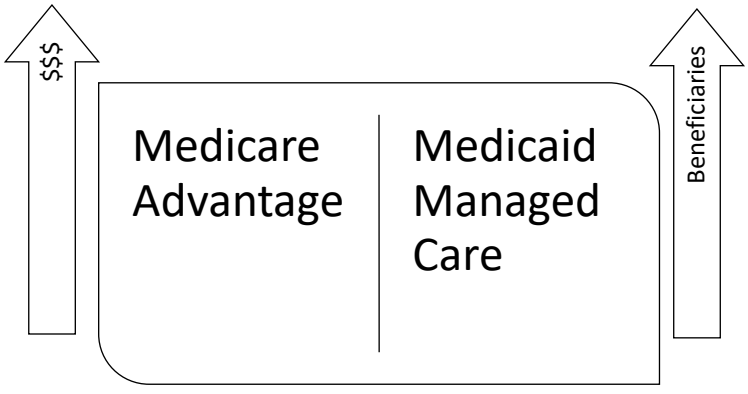

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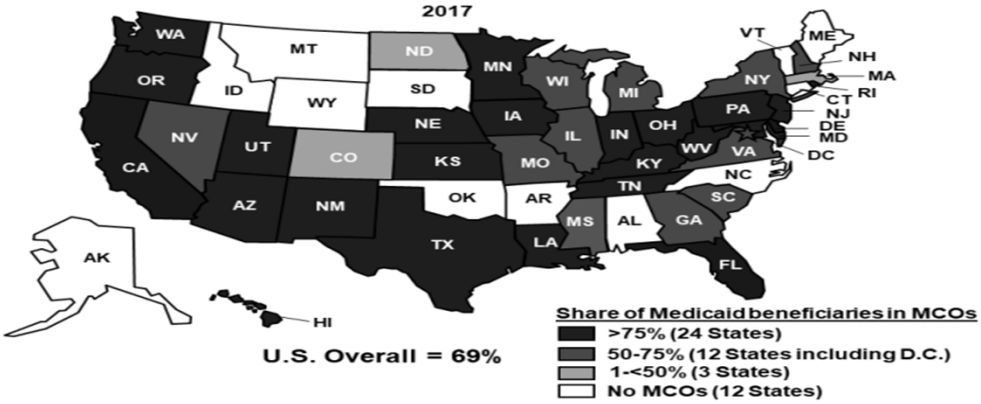
Figure 2
In most states with comprehensive MCOs, at least 75% of beneficiaries are enrolled in one.



SOURCE: Medicaid Managed Care Enrollment Reports, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 2019.

KFF

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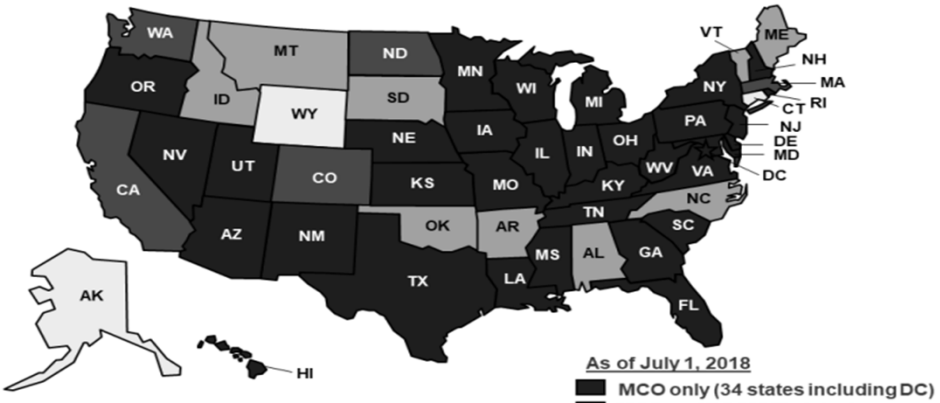
Figure 1
As of July 2018, 39 states used capitated managed care models to deliver services in Medicaid.



NOTES: CA has a small PCCM program operating in LA County for individuals with HIV. SC uses PCCM authority to operate a small, children's care management program and is not counted here as a PCCM.
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2018.

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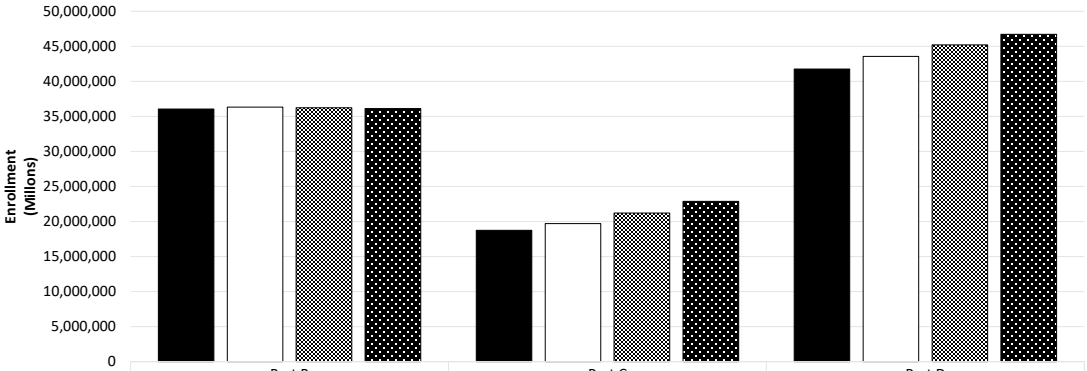
Medicare Advantage is the fastest growing part of Medicare (2015-2018)



	Part B	Part C	Part D
2015	36,048,496	18,752,285	41,744,215
2016	36,327,111	19,696,459	43,562,550
2017	36,223,759	21,202,204	45,188,022
2018	36,110,894	22,864,150	46,711,427

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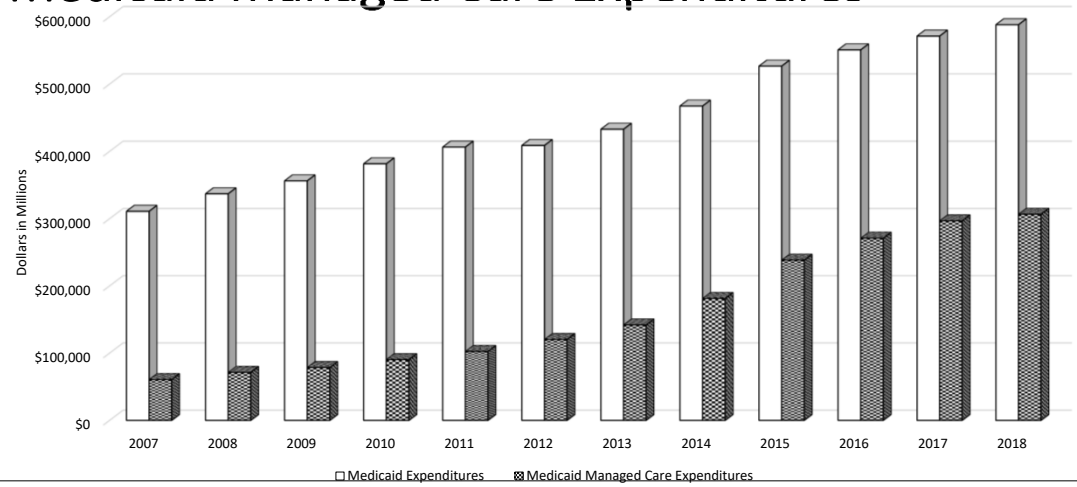
Medicaid Managed Care Expenditures



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Quality	• Network Adequacy • Denials • Appeals
Federal $	• Fraud • RADV • Rates
Data	• Security • Adequacy • Compliance

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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

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Quality

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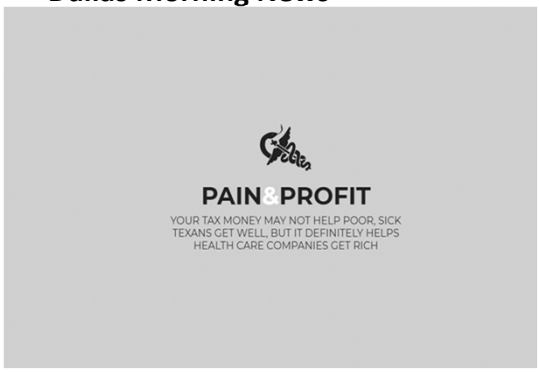
Access to Care

Dallas Morning News



Des Moines Register

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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.

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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.

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Access to Care

- Network Adequacy
- Workforce
- Support services

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Access to Care

- Medicaid Access Rule
- Executive Order on Protecting and Improving Medicare for Our Nation's Seniors
  - Improving Access Through Network Adequacy

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Federal Funds

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What is the Government Paying For?

- Healthcare items and services for beneficiaries
- Not fraud, waste and abuse by plans and providers

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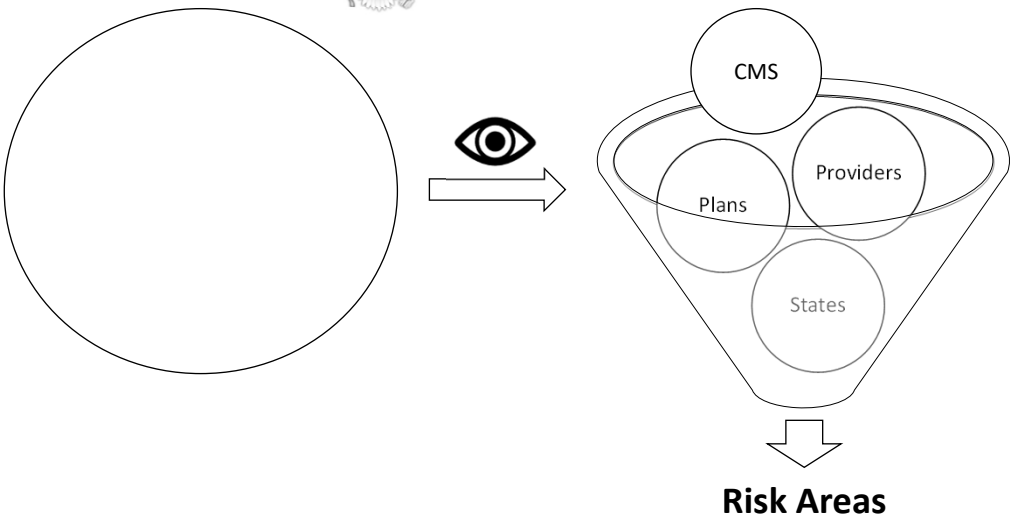

Risk Areas

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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

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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

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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

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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

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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

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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.

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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

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Freedom Health CIA (May 2017)

- Provider Network Review:
  - Network Adequacy
  - New contract
  - Expanded Service Area Contracts
- Diagnosis Coding Review
  - Filtering logic
  - 100 member sample

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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

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Data

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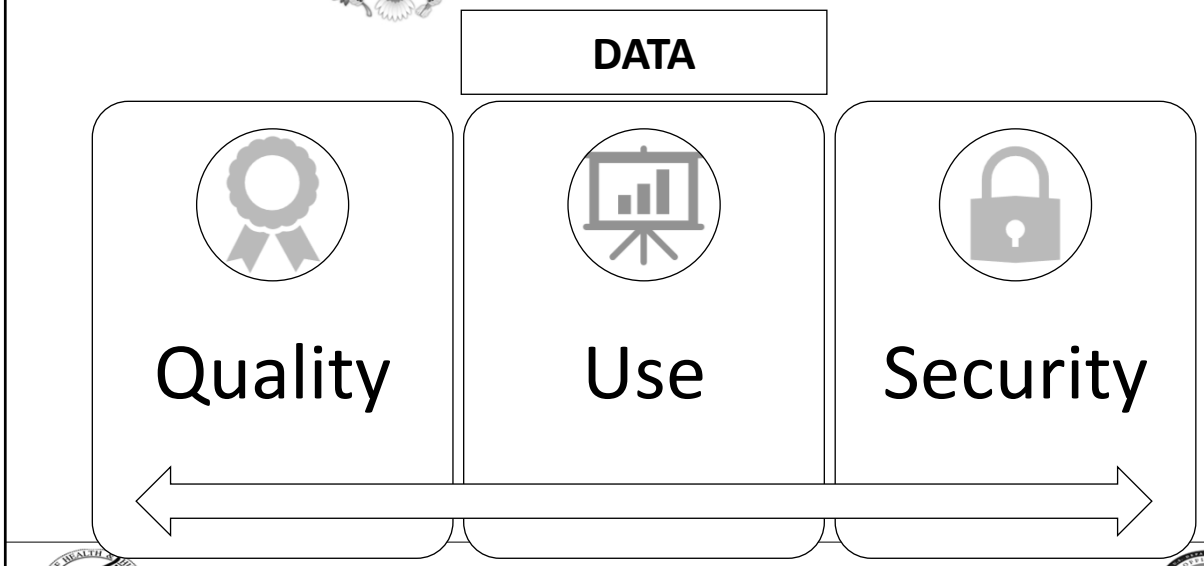

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Quality of Encounter Data

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

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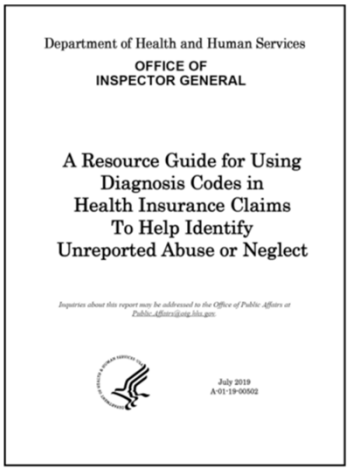
Using Data to Protect Patients

- 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


Department of Health and Human Services
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A Resource Guide for Using
Diagnosis Codes in
Health Insurance Claims
To Help Identify
Unreported Abuse or Neglect

July 2019
A-01-19-00502

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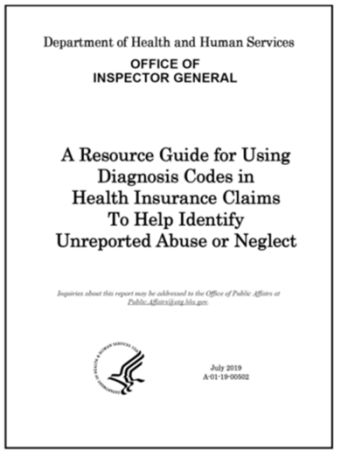
Using Data to Protect Patients

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 patters of abuse or neglect
4) Instances providers did not comply with mandatory reporting requirements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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

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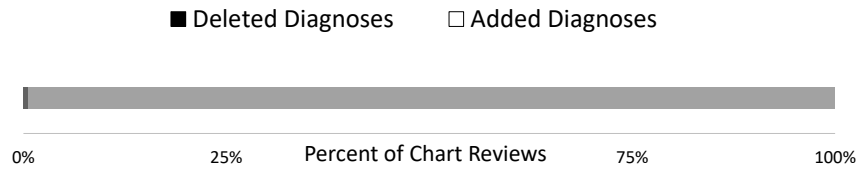
OIG Report: Using MA encounter data to identify vulnerabilities

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



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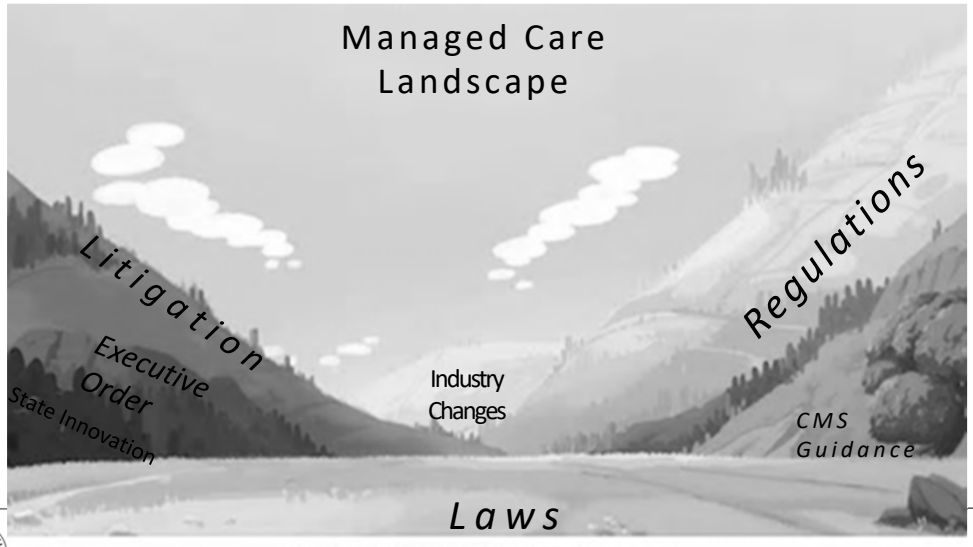

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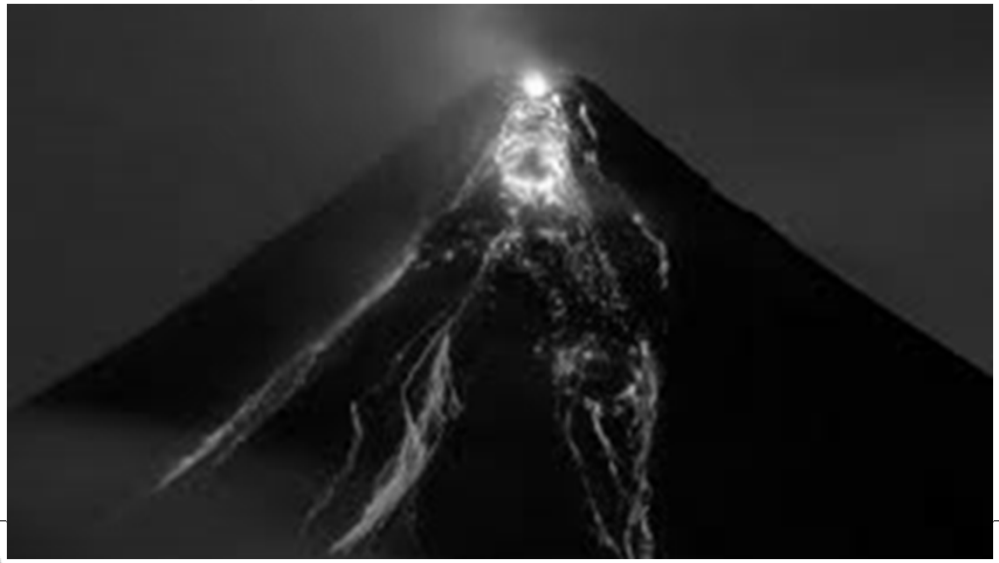

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Shifting Landscape

- Medicare Executive Order
- Medicare Parts C and D rules
- Medicaid MCO NPRM

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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

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Regulatory Updates

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

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Regulatory Updates

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

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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

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Stay Connected

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