Combatting Fraud, Waste, and Abuse in Managed Care

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Overview

- OIG – who we are
- Managed Care Top Management Challenge
- Risk Areas and OIG Action
- Compliance Guidance
- Program Integrity in Medicaid MCO Rule
- Coordination with Key Stakeholders

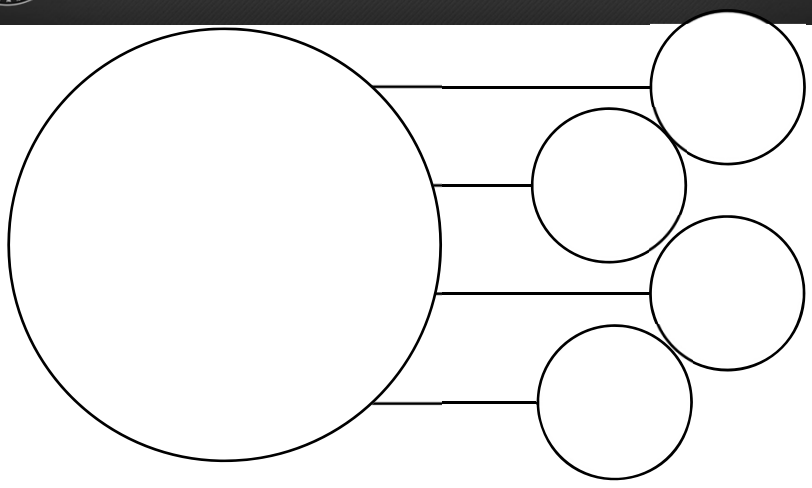
OIG Mission

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.

Values: To be relevant, impactful, customer focused, and innovative

OIG Components



OIG Locations

1,550+ employees

70+ offices

OIG's Unique Role

- Identify
- Educate
- Enforce

Managed Care: Top Management Challenge

Managed Care: Top Management Challenge

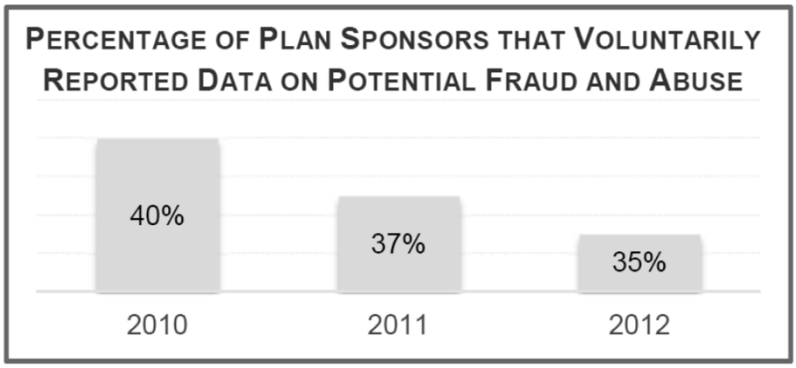
1) Combatting fraud, waste, and abuse by health care providers billing managed care plans

2) Ensuring integrity and compliance by managed care plans and Part D sponsors.

Risk Area: Fraud by Providers

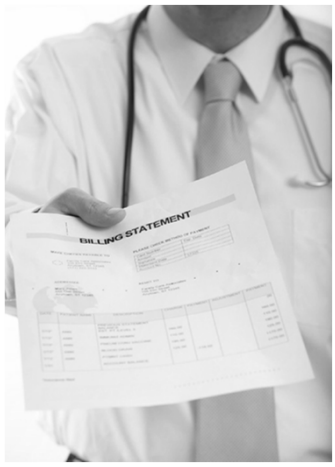
- Challenges to oversight
- Shared program integrity obligations
  - CMS, plans, States, and contractors
- Detection of suspected provider fraud varies widely

Risk Area: Fraud by Providers



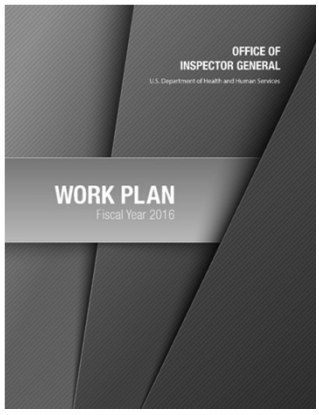
Risk Area: Fraud by Providers

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



Work Plan Items: Providers

- Medicaid MCO identification of fraud and abuse by network providers
- Integrity of MA encounter data
- 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

- Billing Fraud
  - Coordination with MEDICS, MCOs, CMS, States, and other government partner
- 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 Area: Plans

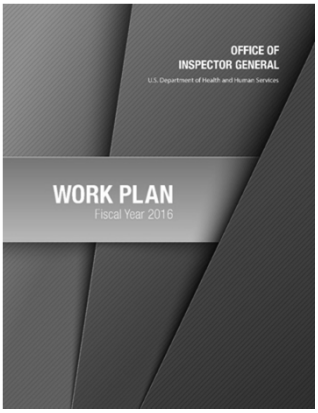
- Ensuring integrity and compliance by managed care plans and Part D sponsors
- Incentives to maximize capitated payments while minimizing costs
- Risk to beneficiaries and HHS funds

Risk Areas: Plans

- Risk adjustment fraud
- Capitated payments made for ineligible beneficiaries
  - Deceased
  - No longer in the plan

Work Plan Items: Plans

- 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 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
- City of New York
  - improper Medicaid MCO payments

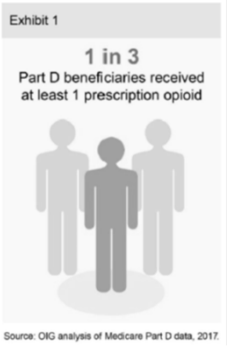
Risk Area: Quality of Care

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

Risk Area: Quality of Care

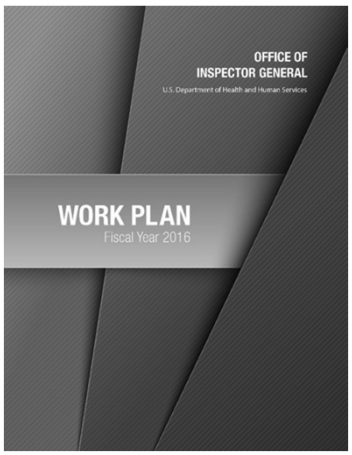
Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing

- 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



Compliance Resources

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

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
- Core component
- 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
- Core component
- 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

Questions?