

Inspector General Christi A. Grimm
Speech at RISE Conference in Colorado Spring, CO
OIG's Vantage on Medicare Advantage
Tuesday, March 7 from 9:15 - 10:00am

Good morning, everyone! It is great to be back in Colorado. My family is from Edgewater, a tiny, mile-wide town just west of Denver. It always feels good to be back out west, to see the Rocky Mountain landscape and the most beautiful sunsets imaginable.

Thank you to RISE. I appreciate the opportunity to speak about OIG's work in the Medicare Advantage space and connect with the plans, companies and vendors that work in Medicare Advantage.

This is my first time at the RISE conference, so I will start with brief context about the office I lead, the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services. At OIG, our mission focuses on protecting the over 100 programs that make up the HHS portfolio and the health and welfare of the people served by these programs.

To accomplish this, OIG's teams of evaluators and auditors provide independent and objective information to stakeholders and policymakers. And our criminal investigators identify and take swift action against fraud. We endeavor to ensure that program dollars are appropriately spent and that programs otherwise operate effectively, efficiently, and with integrity.

At OIG, we are relentlessly focused on getting results. To maximize the impact of each dollar Congress invests in us, we target our enforcement and oversight based on our assessment of risks. We look at:

- how much money is at stake,
- how vulnerable the affected populations are,
- and
- the scope of potential harm.

When I talk about what any OIG does, I always stress that OIGs do not run government programs or establish policy. OIG oversight and enforcement must be independent from the agencies it oversees in order to be credible. Our work is meant to be a roadmap for improving vulnerabilities in programs, programs like those administered by CMS. By virtue of our mission, we identify problems at programs. However, we make sizeable efforts to help industry understand and proactively comply with requirements.

While OIG serves a very different role than private plans, I see similarities between OIG's mission and that of many of your organizations. From viewing some of your missions, I see that PEOPLE are the through line. Most plans have missions that are centered on people, your enrollees, and improving their health. "Helping PEOPLE on their path to better HEALTH" "Keeping SENIORS HEALTHY and independent." Our missions are very

aligned in putting people and their health at the center of what we do.

Leading up to this talk, I have spent a lot of time reflecting on the mission of Medicare Advantage. It is timely to do so; after all, it is a milestone moment for the program. This year, 50% of Medicare enrollees are expected to sign up for Medicare Advantage. The program currently provides coverage for over 31 million seniors and people with disabilities. And private plans are available to 99 percent of Medicare enrollees across the country. Given the size and scope of Medicare Advantage, now is also an opportunity to reflect on risks in Medicare Advantage and how the plans, companies, and vendors that work in Medicare Advantage can mitigate them.

Today I have a dual message for you: first, the risks and effects of fraud, waste, and abuse in Medicare Advantage are significant. That includes alleged fraud and abuse by plans, vendors, and providers. The effects of this conduct have major consequences on the financial integrity of Medicare Advantage, as well as the program's and plans' reputations. Private plans must make improving compliance with Medicare Advantage requirements a priority.

Second, because criminals are increasingly targeting plans to steal from them, more coordination between plans and law enforcement is needed.

Today I will share concrete examples from OIG's work that demonstrate the seriousness of the risks we have found in

Medicare Advantage. Then I have 3 value propositions for why plans and others in managed care should take more action to combat fraud, waste, and abuse. Finally, I'll explain what OIG is doing and how our work can help inform your efforts.

OIG representatives have participated in this conference over the past few years, and we have folks here participating on a panel to provide greater detail about our growing body of managed care oversight and enforcement work. I am here for this conference to underscore my commitment toward ensuring that the Medicare Advantage program and plans effectively combat fraud, waste, and abuse. That is one of my top priorities. And I hope to persuade you that it should be a top priority of yours. Strengthening Medicare Advantage requires commitment and effective, coordinated action by both government and industry.

Looking back at the history of managed care, I'm not sure many would have predicted that the program would be serving nearly 50% of the Medicare population.

The ebbs and flows of Medicare managed care stretch back to the original Medicare Act in 1965. Congress included "Group Practice Prepayment Plans" to deliver health care for a defined population. By 1968, however, only 6 such plans were operating.

Over the next twenty years, managed care would struggle to gain traction in Medicare. By 1991, about 90 managed care

plans covered about one and a half million Medicare enrollees. Roughly 4% of Medicare.

The 1990s were a turning point for managed care. By 1995, 50% of all Americans receiving employer sponsored health insurance were enrolled with managed care plans. This renewed popularity and the problem of continued cost growth in Medicare led Congress to turn to managed care as a solution. In 1997, Congress established the modern version of Medicare Advantage, known then as Medicare + Choice.

Just a year prior, Congress also recognized the need to root out fraud, waste, and abuse more aggressively in Medicare and Medicaid and enacted HIPAA. Although well-known for its privacy provisions, HIPAA established new funding and authorities for the government to fight health care fraud. And it directed Federal law enforcement to coordinate with health plans for the purpose of fighting fraud across the health care industry.

At the time, many believed that managed care would be less susceptible to the types of fraud, waste, and abuse that were pervasive in fee-for-service. With fixed, capitated payments, the thinking went that plans would be appropriately incentivized to address fraud. Through risk-based payments, plans would take on the task of preventing fraud, along with managing costs and patient care to protect their bottom lines. And Medicare + Choice included other features, such as risk adjustment payments. Features that – it was believed – would

align plans' financial success with the goals of the program, like ensuring access for Medicare enrollees regardless of their health status.

Under HIPAA, Congress established very broad anti-kickback statute safe harbors for managed care. This was telling; Congress viewed managed care as a lower-risk program than fee-for-service Medicare. OIG's rule implementing the safe harbors echoed this sentiment. It stated that managed care plans "presented little or no risk of overutilization or increased costs to the Federal health care programs." At the time, this lower risk was attributed to the managed care payment structure – the fixed, capitated payment – and regulatory constraints.

Over the many years I have served in government, I have heard similar predictions for managed care, especially related to oversight and to OIG's work. I've heard things like - "Oversight is not necessary for managed care." "Shifting the financial risk to plans will incentivize good behavior and push the plans to root out fraud and waste." Unfortunately, time and experience have proved these predictions wrong.

Today, we have abundant evidence that fraud, waste, and abuse in Medicare Advantage are more serious problems than the early prognosticators had hoped. For example, we are seeing increased risks of health care fraud, gaming of program incentives, and improper payments. These issues can affect

Medicare's ability to serve current enrollees and impair the long-term sustainability of the program itself.

Let me offer specific examples from OIG's work that demonstrate the scope and breadth of Medicare Advantage risks on our radar.

First is the real and persistent risk of HC fraud. Health care fraud affects every payor in the United States; government, private plans, and everything in between. We know that fraud does not disappear because a private insurance company pays the claims instead of CMS. We are concerned about fraud committed by providers, suppliers, and others against plans.

In 2019, after Operation Brace Yourself, a major law enforcement operation that shut down a BILLION-DOLLAR medical brace scheme, we saw how quickly fraud can jump from fee-for-service to Medicare managed care. After the law enforcement action, Medicare fee-for-service claims for orthotic braces dropped by 9 percent. Shortly after that, claims in Medicare Advantage for the same types of braces increased by 22 percent. This migratory effect with fraud was not years later, but weeks later. Once the criminals found out about the takedown, they switched to targeting plans.

In one case, husband and wife owners of a medical equipment company were fraudulently billing Medicare Part B for orthotic braces. Our enforcement action dried up that well, hindering their original scheme. Did they stop? No. They opened a new

company at the same address and started billing Medicare Advantage plans instead.

We know from experience that fraudsters pay close attention to industry trends and – most importantly – to where the money is. The risk of provider-level fraud will increase as program enrollment continues to grow.

To crack down on provider and supplier fraud, we are working with our law enforcement partners and engaging with plans' special investigative units. We aim to increase referrals of potential fraud from the plans that are on the frontlines to spot it. We share data and get leads from CMS and other programs. And we spot and work to close gaps in data that can hinder prevention and rapid detection of fraud, making it harder to remedy problems that occur.

Beyond provider and supplier fraud, we are concerned about trends we are seeing and whether this potentially indicates that private plans are defrauding Medicare. We routinely get referrals and complaints from whistleblowers and others. That includes organization insiders who see fraud risks or unethical conduct and may be frustrated or disillusioned by plans' failure to address them. Insider referrals have led to several significant settlements with plans and others. Settlements that resolved allegations of plans acting intentionally to get larger risk adjustment payments. Or allegations of plans ignoring results and never acting on their own audits and other internal information on potential fraud. Holding industry accountable is

one fundamental way to strengthen Medicare Advantage. Across the health care industry, we are holding companies and individuals accountable for misconduct.

Next is the risk of gaming. At OIG, we examine how programs are designed and whether they achieve their goals, like cost-effectiveness and quality of care. We identify the potential program risks that result in undesirable behavior, like upcoding, stinting on care, or misreporting of data. Our work consistently shows that program risks in Medicare can have huge impacts leading to improper payments costing hundreds of millions of dollars and imposing barriers to enrollees receiving necessary care.

Risk adjustment in Medicare Advantage is an example of how oversight of well-intentioned policy helps ensure the policy works as intended. There is no doubt that risk adjustment is important to the success of the program. It is designed to compensate plans for the increased cost of treating older and sicker beneficiaries and thus to discourage plans from preferential enrollment of healthier individuals. Paying plans more to care for people with serious medical needs preserves and expands access.

Nevertheless, our work has demonstrated there are significant problems with risk adjustment. The program is designed to compensate for sicker patients but has had few ways to effectively assess whether plans are legitimately caring for a sicker population or are just upcoding diagnoses. OIG's work

has shown the potential risk of inadequate care for plan enrollees – in other words, that plans could be stinting on care.

If enrollees with more expensive care needs are not getting treatment commensurate with their diagnoses, then risk adjustment is not fulfilling its purpose.

A 2021 OIG report examined practices by plans and vendors to identify diagnoses for enrollees through health risk assessments and chart reviews. Both are allowable practices that are often helpful for plans and patients. However, our report raises serious questions about diagnoses that plans identified thru these practices and needed care that enrollees might not be receiving. Medicare Advantage enrollees may have significant unmet needs based on the diagnoses recorded by plans. We found that Medicare Advantage companies received over nine billion dollars in risk adjustment payments in one year for serious medical conditions that only appeared from assessments or chart reviews.

20 Medicare Advantage companies accounted for five billion of that amount. Again, risk adjustment is an important tool to ensure private plans are compensated appropriately for the patients they serve. However, when we see patterns that indicate patients may not be getting treatment for serious medical conditions, it raises the question of whether risk adjustment is working to preserve and expand access to care or whether the diagnoses are accurate.

For example, when we narrowed the lens to look at those 20 companies that received such a big proportion of risk adjustment payments, we saw something interesting. These 20 companies received over half a billion dollars in risk adjustment payments for patients that plans diagnosed with serious mental illness, such as major depressive, bipolar, and paranoid disorders. Yet, no service records showed those same enrollees received treatment for these serious conditions. The same applies for other serious illness and disease you see on the slide. This is a troubling gap for these patients. Or, if the diagnoses do not reflect unmet needs, then equally troubling is the accuracy of the diagnoses and why they were reported in the first place.

Relatedly, in a 2020 report, we found that plan vendors or partners that conduct in-home assessments contribute to questionable diagnoses. The top 8 vendors or partners accounted for 89 percent of the diagnoses that had no associated service record. This is a lucrative practice. The same 8 entities generated over a billion dollars in risk-adjustment payments that went to about 50 plans owned by one parent company. Again, this trend raises questions about how best to ensure that patients with legitimate needs are getting care or whether the diagnoses submitted were accurate.

When Medicare Advantage was initially rolled out, many believed that risk-based, capitated payments in managed care would limit the financial risk to Medicare. However, the

accuracy of risk adjustment payments raises important questions about how much financial risk the government still bears under Medicare Advantage. And whether plans are complying with program rules when they claim risk adjustment payments.

OIG's audit work has demonstrated that some of the largest insurance companies and their plans across different markets have consistently received risk adjustment overpayments. Across 17 OIG audits issued since 2019, we could not find support for 69% of diagnoses used for risk adjustment and identified a total of over one hundred million dollars in overpayments made by Medicare to plans. CMS, GAO, and others have identified similar patterns, highlighting concern about the integrity of risk adjustment payments.

Again, we understand how important risk adjustment is to the overall success of the program. With billions of dollars in risk adjustment payments each year, it is mission critical work for us to ensure these payments are accurate both for the program and for the wellness of beneficiaries.

OIG's work and recommendations support CMS' recent risk adjustment validation rule. The rule supports stronger oversight of Medicare Advantage plans and recovery of misspent taxpayer funds. Enhanced oversight will help ensure that plans are taking steps to reduce improper payments and to improve the financial integrity of the program.

Other OIG work highlights how incentives under capitation payments to reduce costs can result in plans' inappropriately impeding beneficiaries' access to care. An April 2022 report looking at prior authorization revealed several basic breakdowns at plans that lead to improper denials of Medicare covered services. We found that 13% of prior authorization denials were for care requests that in fact did meet Medicare coverage rules. Similarly, 18% of payment denials were inappropriate and should have been paid. One common breakdown involved plans requesting unnecessary or duplicative documentation. This practice led to unnecessary delays in care. We are currently conducting work to assess similar issues in Medicaid managed care.

The bottom line is that the risks of fraud, waste, and abuse are real and significant. Now, let me provide you with three value propositions explaining why plans should prioritize actions to address these risks.

ONE Healthy compliance is smart business. First, plans have a stake in the Medicare Advantage program achieving its goals of delivering equitable, comprehensive, person-centered care that is sustainable and affordable. F, W, &A can impede those goals and jeopardize the future success of the program and, relatedly, the plans.

The health of many companies that operate managed care plans is closely tied to the health of the Medicare Advantage program. They go hand in glove. Analyses of public earning

reports highlight that several large insurance companies receive over 75% of their revenue from Medicare and Medicaid. And some are even higher than that. Smart and proactive compliance is just smart business practice.

The stakes are high for companies that receive a significant portion of their revenue from taxpayers. When risks become actual, costly problems, those problems can threaten the success of the plans, and the Medicare Advantage program.

It has happened before. In the mid-1980's, Medicare's largest HMO in the country – International Medical Centers in Florida – was shut down due to systemic fraud and corruption. I'll pause a second for you to read this quote from the article. OIG, the FBI, and DOJ found widespread issues at the plan, including intentionally dropping sick patients to avoid costs, impeding access, and a litany of other serious allegations. The unscrupulous conduct of this one company marred the reputation of Medicare managed care for a decade. The case was cited often in resistance to growing the managed care model in Medicare until well into the 1990s.

While this may be a particularly egregious example, it demonstrates that the behavior of one plan can affect the trust that Congress, taxpayers, and potential enrollees have in managed care as a care model. Prioritizing actions that detect and mitigate fraud, waste, and abuse can help improve and preserve the reputation of the Medicare Advantage program and the plans that participate in it.

Proactively addressing fraud, waste, and abuse within plans can lead to greater efficiency, better customer service for enrollees, improved public perception, and better plan ratings. Making data more complete and consistent can help identify fraud and provide more clarity about other plan operations. Savings captured by preventing problems can be redirected to improved services for enrollees. And for the attorneys in the crowd, it can also reduce the risk of relator, or qui tam lawsuits, that can have serious reputational, financial, and legal consequences. Effective risk reduction creates a feedback loop that makes the Medicare Advantage program even more attractive for future enrollees, policymakers, Congress, shareholders, and investors. Again, it's just smart business practice.

TWO Medicare Advantage is under increasing scrutiny. Second with growth in Medicare Advantage, comes more scrutiny of plans. So my second value proposition is that it will pay dividends to prepare for and embrace oversight – not just our oversight, but self-policing. The kind of internal oversight that you can do.

We know OIG's oversight is not always popular with the health care industry. No one wakes up looking forward to an OIG audit. Or getting a subpoena from an OIG investigator.

The natural inclination is to want less oversight. Not necessarily for any malicious or nefarious reason. Instead, it is an understandable reaction to overflowing inboxes and the

immense complexity of health care. All of us deal with tough decisions that often have enormous ramifications. Defending those hard decisions by downplaying the need for and value of oversight is understandable. But downplaying the value of oversight – whether internal or external – carries organizational risk and missed opportunities.

Plans can demonstrate that they take problems seriously through proactive self-policing and responding effectively to the problems unearthed. Companies and others that dismiss problems uncovered by oversight often find themselves defending their actions later in other forums, such as in relator lawsuits.

Across health care, we have seen increasingly sophisticated compliance programs that proactively find problems so that companies can fix them. Those companies also use OIG's self-disclosure protocol to rectify problems and avoid future legal entanglements. In fact, most self-disclosures OIG receives are from health care providers, but plans can use this option too.

For decades compliance officials in health care companies have looked to OIG's oversight as a roadmap for avoiding problems at their own companies and you (plans) can too! For example, OIG reports have found data gaps at plans related to denied claims, and identifiers for ordering and referring providers. These are the kinds of data that plans should have and that you can improve. Much can be learned from our audits, evaluations, investigations, advisory opinions, and legal actions

about emerging risk areas. Our work plan, which we update monthly, tells you what issues have our attention. We know from roundtable discussions with industry that our methodologies are often instructive for companies seeking to identify potential vulnerabilities internally.

And I can tell you with great certainty that you will see us expanding our oversight of Medicare Advantage in the coming months and years. Now is truly the time to embrace the benefits of proactive, effective compliance actions and oversight.

THREE, because fraud schemes are increasingly sophisticated, there is tremendous value in collaboration among plans and with law enforcement to stop fraud.

In recent years, the scale and extent of damages from health care fraud schemes have increased. Criminal organizations have adapted their schemes with changing times. They are aware of the weak spots in Medicare and at specific plans. Consequently, health care fraud spreads quickly. By manipulating technology, criminals can activate a scheme in all 50 states with speed and relative ease.

For example, in one recent case, a foreign national living in Florida illicitly obtained a provider's billing number. They used that number and Medicare patient data purchased from corrupt call centers to submit more than one hundred million dollars in fraudulent claims for medical braces to plans. As plans would identify a suspicious claim or send a request for

records to the provider, the perpetrators would shut down one shell company and then open a new one in a different state and target different plans. Action by OIG and our law enforcement partners shut this scheme down.

So be aware of risks. And recognize that if fraud is left undetected and unaddressed at one plan, that fraud scheme will likely have a contagion effect and is likely to spread to other plans. One plan's health or lack thereof affects the broader population of plans, and each plan has tremendous potential to protect the larger community. And when fraud is detected, please refer it to law enforcement. We can aid in identifying broader trends before they can metastasize and take enforcement action to hold wrongdoers accountable.

Also take a look at lines of communication with other plans and with law enforcement and take steps to improve them. Promising communication models include having plans' investigative units hold regular meetings with Federal and state law enforcement. Good communication can and does detect and stop fraud early.

Promoting efficiency and effectiveness of HHS programs is baked into the mission of HHS OIG; we want Medicare Advantage to be successful. OIG's work helps ensure that the program works as intended for Medicare enrollees and for taxpayers. For that to happen, Medicare Advantage plans must be successful at ensuring their enrollees receive high-quality health care services that are cost-effective.

For our Medicare Advantage work, OIG is focused on **fighting fraud**, **promoting access to high quality care**, and **providing comprehensive financial oversight**.

Holding wrongdoers accountable: Preventing and mitigating fraud benefits patients, Medicare, and plans. I am committed to taking swift action against those who defraud Medicare Advantage. That includes fraud by plans, or fraud committed by providers or others against plans, enrollees, and the program. But OIG cannot fight fraud alone.

Our valuable partnership with plans' investigative units and compliance officials is key to combatting fraud that harms plans, enrollees, and the Medicare Advantage program.

In January of this year, OIG hosted a summit focused on fraud in Medicare Advantage. We brought together plan representatives and members of OIG, DOJ, FBI, CMS, and CMS' contractors. We planted the seeds for sustainable engagement with plans by providing information on what to expect when working with prosecutors and investigators. That included tips for making actionable referrals and the need to ensure timely access to data for law enforcement.

We want to build on the success of the summit to foster increased communication between plans and with law enforcement in order to improve our collective fraud-fighting abilities.

Promoting access to high-quality care. People enrolled in managed care should have access to safe, appropriate, and equitable care. And we see efforts in plans to make that happen. That includes adopting value-based care models with their providers, figuring out how to address social determinants of health for their enrollees, and deploying technologies to better connect and coordinate care.

OIG is ramping up work to oversee whether plans are meeting program requirements in the delivery of care. We will examine issues like network adequacy and benefit design. And we will continue work examining prior authorization and payment denials. We are currently conducting work assessing plan actions to reduce racial and ethnic disparities in access to care, quality of care, and health outcomes. We hope you will find this work instructive as you consider this crucial issue in your companies.

Providing comprehensive financial oversight: OIG's work to ensure the financial integrity of Medicare Advantage will continue to examine risk adjustment. We want to see how program changes affect payment accuracy, such as increased use of encounter data in risk adjustment. We are planning work examining other financial issues, including bonus payments and medical-loss ratios.

OIG is also planning to review payments made by plans to providers and vendors. As the healthcare environment has become more complex, we recognize plans have outsourced

some functions to vendors and contractors. Assessing how vendor and contractor payments and performance affect the financial integrity of Medicare Advantage is increasingly important.

Finally – I would be remiss in not pointing out how critically important it is to have complete, accurate, and timely data. Improving data within Medicare Advantage is essential to all of the efforts mentioned this morning. We will continue to focus on data integrity in our work.

Let me end where I began. OIG's mission and the mission of plans center around the health and welfare of the individuals served by Medicare. This morning, I asked you to focus on two objectives to further our missions: prioritizing compliance within your plan and improving coordination with law enforcement to fight fraud.

I recognize these objectives may sound good in a talk but may seem removed from the daily realities of operating large, complex insurance plans. So, I want to conclude by leaving you with a practical way of thinking about this concept. I heard this explained elsewhere and it resonated with me.

If you want to know whether your company has effectively prioritized ways to address fraud, waste, or abuse, think about an individual employee. That employee faces an ethical dilemma that forces them to make a choice. Has your company informed, trained, and empowered that employee to make the right choice? Are they empowered to make the choice that is

consistent with your mission? And in times when that employee makes the wrong choice, does your company have the right capabilities to detect it, to fix it, and to ensure others don't do the same?

When you are back at work later this week or next, I hope you take time to reflect on this milestone moment for Medicare Advantage and what it means for your plan or company going forward. To assess what else can be done to better serve your enrollees and fulfill your very important missions. I hope I have persuaded you that being proactive by prioritizing actions to address F,W,A is a necessary and value-added element of plan and vendor operations.

Improved integrity and fiscal sustainability will allow private plans and Medicare to better serve over 31 million seniors and people with disabilities, today and well into the future.

Thank you and enjoy the rest of your conference.