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OIG’s Vantage on Medicare Advantage

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HHS Inspector General
HHS-OIG Mission Statement

To 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.
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Insurance Company Mission Statements
• Help people on their path to better health.
• To help people achieve lifelong wellbeing.
• Keeping Seniors Healthy and Independent.
50% of enrollees are expected to sign up for Medicare Advantage Plans in 2023.
A Dual Message
What will I discuss today?

- Historical landscape of managed care
- Managed care risks identified by OIG work
- Three value propositions for plans
- What OIG is doing to address managed care risks
Total Medicare Advantage Enrollment, 1992–2014 (in millions)

Kaiser Family Foundation: Total Medicare Advantage Enrollment, 1992-2014
[Managed care plans] presented little or no risk of overutilization or increased costs to the Federal health care programs, given applicable payment arrangements and regulatory oversight.

– OIG negotiated rulemaking
Federal Register, Vol. 64, No. 223, 1999
Medicare Advantage has a marketing problem

Private Medicare Plans See Scrutiny

Medicare Advantage Plans Keep Big Firms at Bay

‘The Cash Monster Was Insatiable’: How Insurers Exploited Medicare for Billions

By next year, half of Medicare beneficiaries will have a private Medicare Advantage plan. Most large insurers in the program have been accused in court of fraud.
The Real and Persistent Risk of Health Care Fraud
Medicare Fee-For-Service claims for orthotic braces

Medicare Advantage claims for orthotic braces

9% down

22% up

OPERATION BRACE YOURSELF
LAW ENFORCEMENT ACTION

WITHIN WEEKS

Medicare Fee-For-Service

Medicare Advantage
The Risk of Gaming
OIG Work: Risk Adjustment in Medicare Advantage
<table>
<thead>
<tr>
<th>Disease</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular Disease</td>
<td>$610M</td>
</tr>
<tr>
<td>Major Depressive, Bipolar, and Paranoid Disorders</td>
<td>$533M</td>
</tr>
<tr>
<td>Diabetes With Chronic Complications</td>
<td>$390M</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>$349M</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>$339M</td>
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<tr>
<td>Congestive Heart Failure</td>
<td>$309M</td>
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<tr>
<td>Rheumatoid Arthritis and Inflammatory</td>
<td>$196M</td>
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<tr>
<td>Connective Tissue Disease</td>
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<tr>
<td>Myasthenia Gravis/Myoneural Disorders/Guillain–Barré Syndrome/Inflammatory and Toxic Neuropathy</td>
<td>$156M</td>
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<tr>
<td>Drug/Alcohol Dependence</td>
<td>$135M</td>
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<tr>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>$122M</td>
</tr>
<tr>
<td>Protein–Calorie Malnutrition</td>
<td>$118M</td>
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<tr>
<td>Specified Heart Arrhythmias</td>
<td>$112M</td>
</tr>
</tbody>
</table>

$533 million for major depressive, bipolar, and paranoid disorders: No evidence of treatment

$390 million for diabetes with chronic conditions: No evidence of treatment

$122 million for metastatic cancer and leukemia: No evidence of treatment

OIG Report: OEI-03-17-00474
Eight companies conducted 89% of the in-home health risk assessments containing diagnoses that resulted in risk-adjustment payments, but these diagnoses were not reported on any other encounter record for the beneficiaries.
• 17 HHS-OIG audits since 2019
• No support for nearly 69% of diagnoses used for risk adjustment
• $113 million in overpayments made by Medicare to plans
Report examined payment denials issued by 15 of the largest MAOs and found:

- Some prior authorization requests that MAOs denied met Medicare coverage rules.
- Some payment denials were inappropriate and should have been paid.
- Some plans requested unnecessary or duplicative documentation.

This practice led to unnecessary delays in care.
Healthy compliance is smart business
Government officials say IMC's collapse is an exception to the general success of their policy, and that the elderly have little to fear from Medicare HMOs. Yet their plans to expand the use of private health plans in Medicare have already run into trouble in Congress because of the IMC debacle.

—Michael Abramowitz, Washington Post
Medicare Advantage is under increased scrutiny: Preparing for and embracing oversight will pay dividends
Fraud affects all plans: Fight sophisticated fraud by collaborating with law enforcement
Multi-State Shell Company Scam

$109 million in fraudulent Medicare Part C claims

The scammer manufactured and submitted false and fraudulent Medicare claims by instructing his employees to establish shell companies in more than a dozen different states.
What is OIG doing about it?
Holding wrongdoers accountable
Promoting access to high-quality care
Providing comprehensive financial oversight
Improved integrity and fiscal sustainability will allow private plans and Medicare to better serve more than 31 million seniors and people with disabilities, today and into the future.
RESOURCES

- Health Care Fraud Self-Disclosure Portal
  https://oig.hhs.gov/compliance/self-disclosure-info/self-disclosure-protocol/

- HHS-OIG Work Plan
  https://oig.hhs.gov/reports-and-publications/workplan/

- Compliance Resource Portal
  https://oig.hhs.gov/compliance/