U.S. Department of Health and Human Services
Office of Inspector General

RISE National 2023 - March 7, 2023

OIG's Vantage on Medicare Advantage

Christi A. Grimm
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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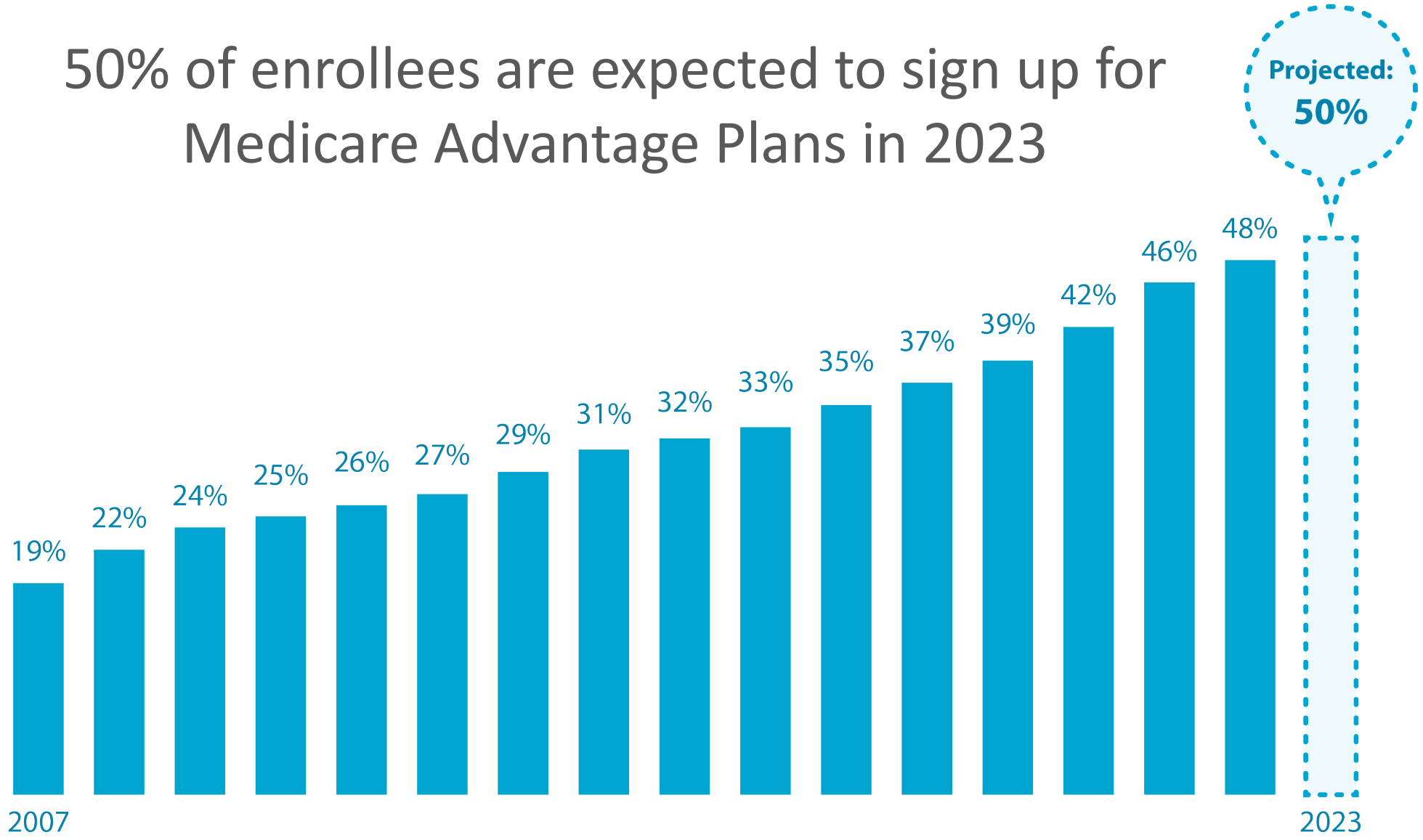
Insurance Company Mission Statements

- 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



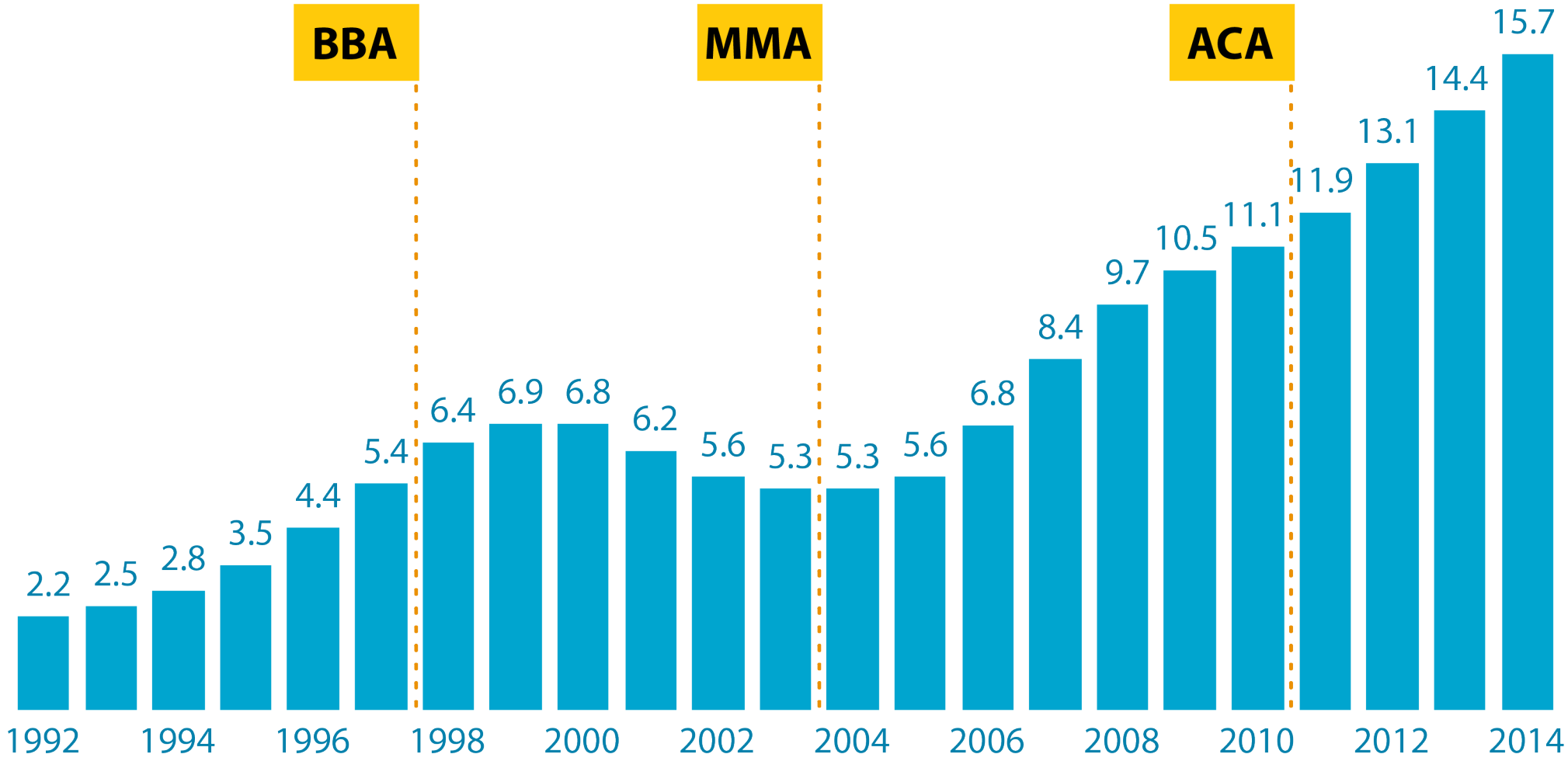
Kaiser Family Foundation: Medicare Advantage in 2022: Enrollment Update and Key Trends

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

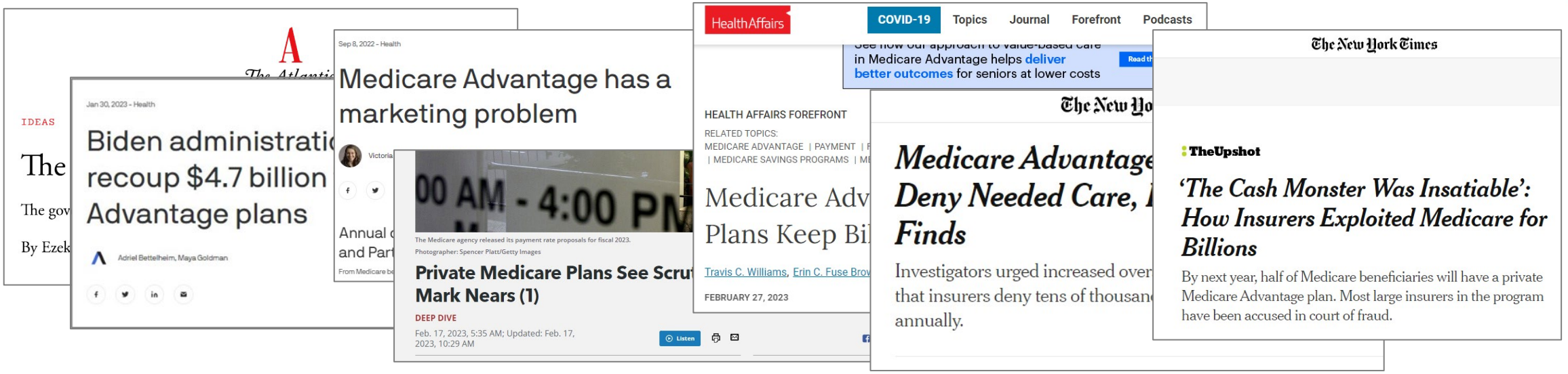
Total Medicare Advantage Enrollment, 1992–2014 (in millions)



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


IDEAS
Jan 30, 2023 - Health
Biden administrati
recoup $4.7 billion
Advantage plans
Adriel Bettelheim, Maya Goldman
Sep 8, 2022 - Health
Medicare Advantage has a
marketing problem
00 AM - 4:00 PM
The Medicare agency released its payment rate proposals for fiscal 2023.
Photographer: Spencer Platt/Getty Images
Private Medicare Plans See Scru
Mark Nears (1)
DEEP DIVE
Feb. 17, 2023, 5:35 AM; Updated: Feb. 17, 2023, 10:29 AM
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in Medicare Advantage helps deliver
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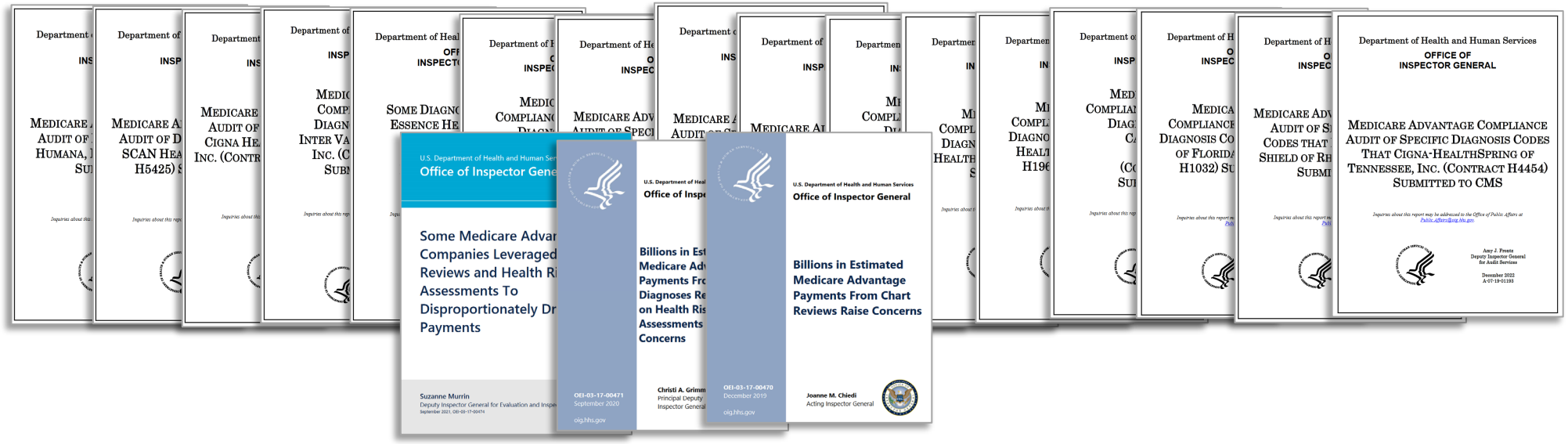
The New Yo
Medicare Advantage
Deny Needed Care,
Finds
Investigators urged increased over
that insurers deny tens of thousan
annually.
The New York Times
TheUpshot
'The Cash Monster Was Insatiable':
How Insurers Exploited Medicare for
Billions
By next year, half of Medicare beneficiaries will have a private Medicare Advantage plan. Most large insurers in the program have been accused in court of fraud.


Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL
MEDICARE ADVANTAGE COMPLIANCE AUDIT OF SPECIFIC DIAGNOSIS CODES THAT CIGNA-HEALTHSPRING OF TENNESSEE, INC. (CONTRACT H4454) SUBMITTED TO CMS
U.S. Department of Health and Human Services
Office of Inspector General
Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns
Joanne M. Chiedi
Acting Inspector General
OEI-03-17-00470
December 2019
oig.hhs.gov
Some Medicare Advar
Companies Leveraged
Reviews and Health Ri
Assessments To
Disproportionately Dr
Payments
Suzanne Murrin
Deputy Inspector General for Evaluation and Inspe
OEI-03-17-00471
September 2020
oig.hhs.gov

The Real and Persistent Risk of Health Care Fraud

OPERATION BRACE YOURSELF
LAW ENFORCEMENT ACTION

Medicare Fee-For-Service

9% ↓

Medicare Fee-For-Service claims for orthotic braces

WITHIN WEEKS

Medicare Advantage

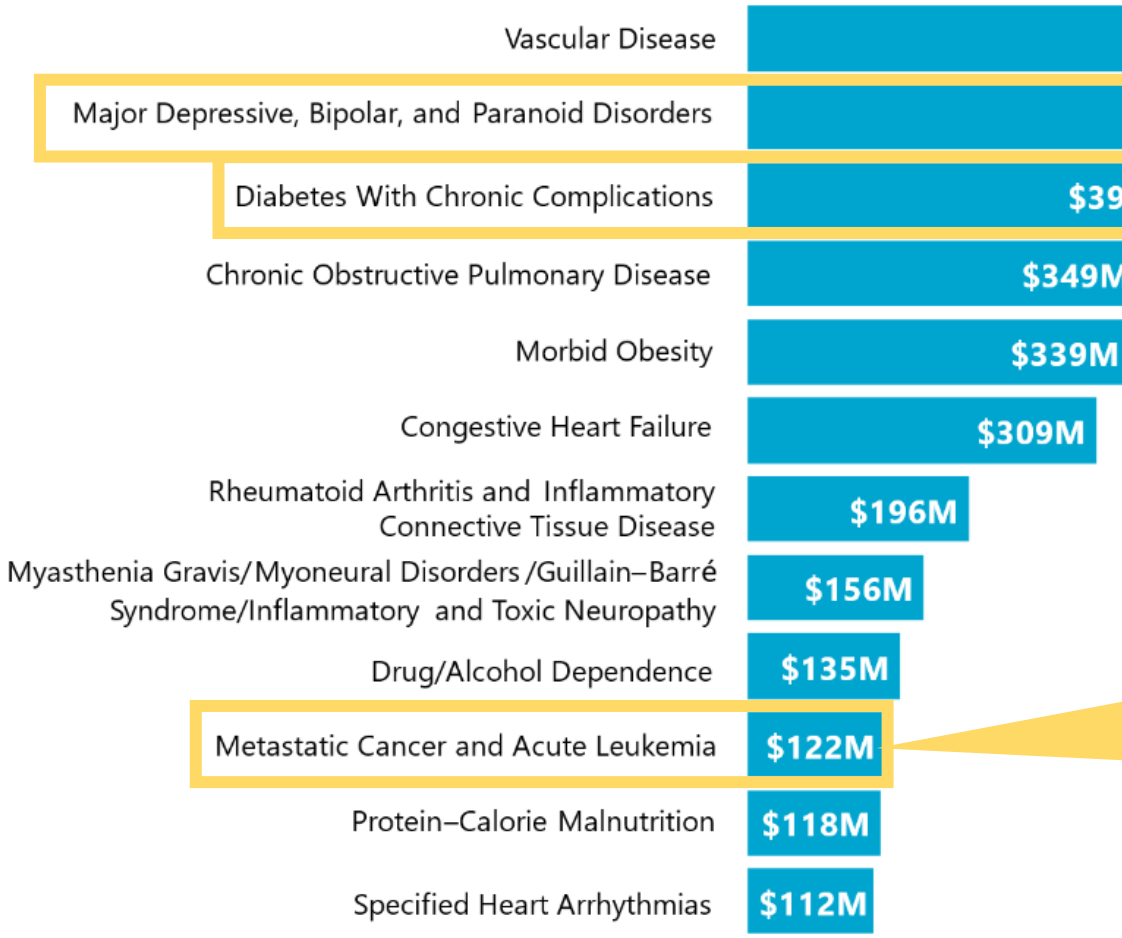
22% ↑

Medicare Advantage claims for orthotic braces

The Risk of Gaming

OIG Work: Risk Adjustment in Medicare Advantage

20 Companies | $5 Billion | No Evidence of Treatment



$533 million for **major depressive, bipolar,** and **paranoid disorders**:

No evidence of treatment

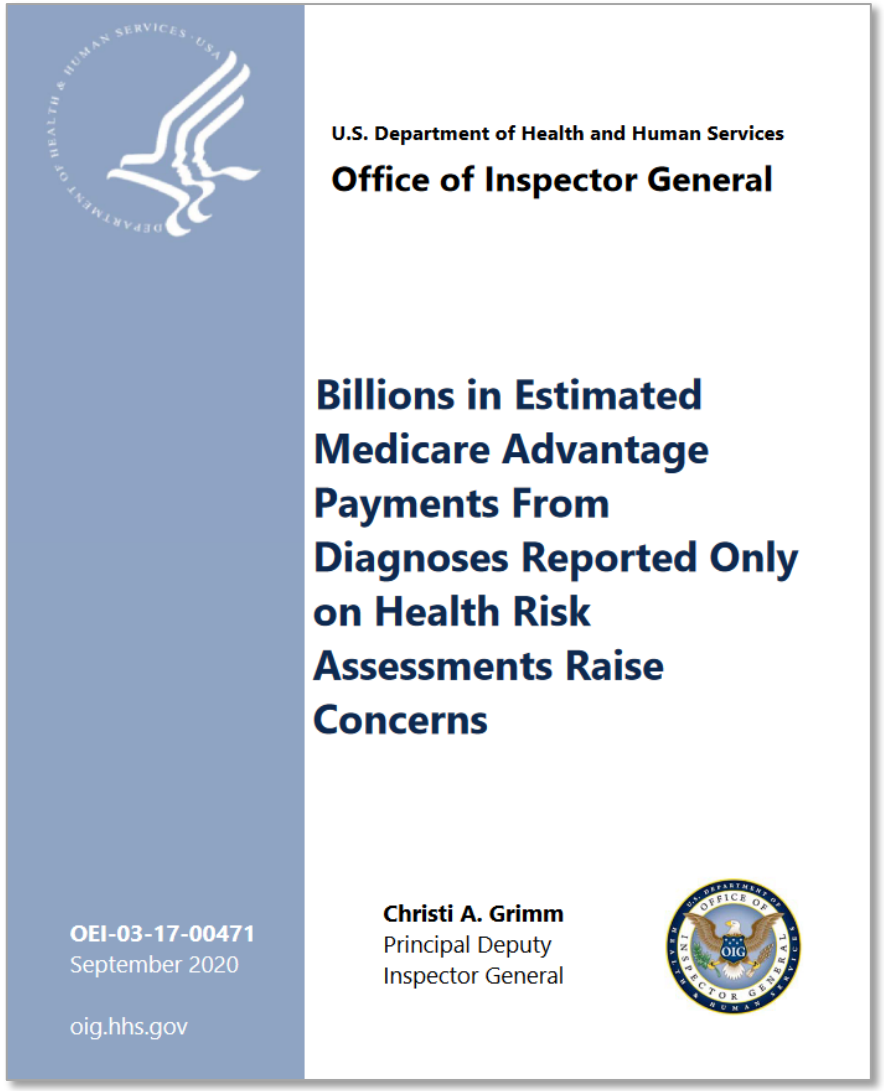
$390 million for **diabetes with chronic conditions**:

No evidence of treatment

$122 million for **metastatic cancer** and **leukemia**:

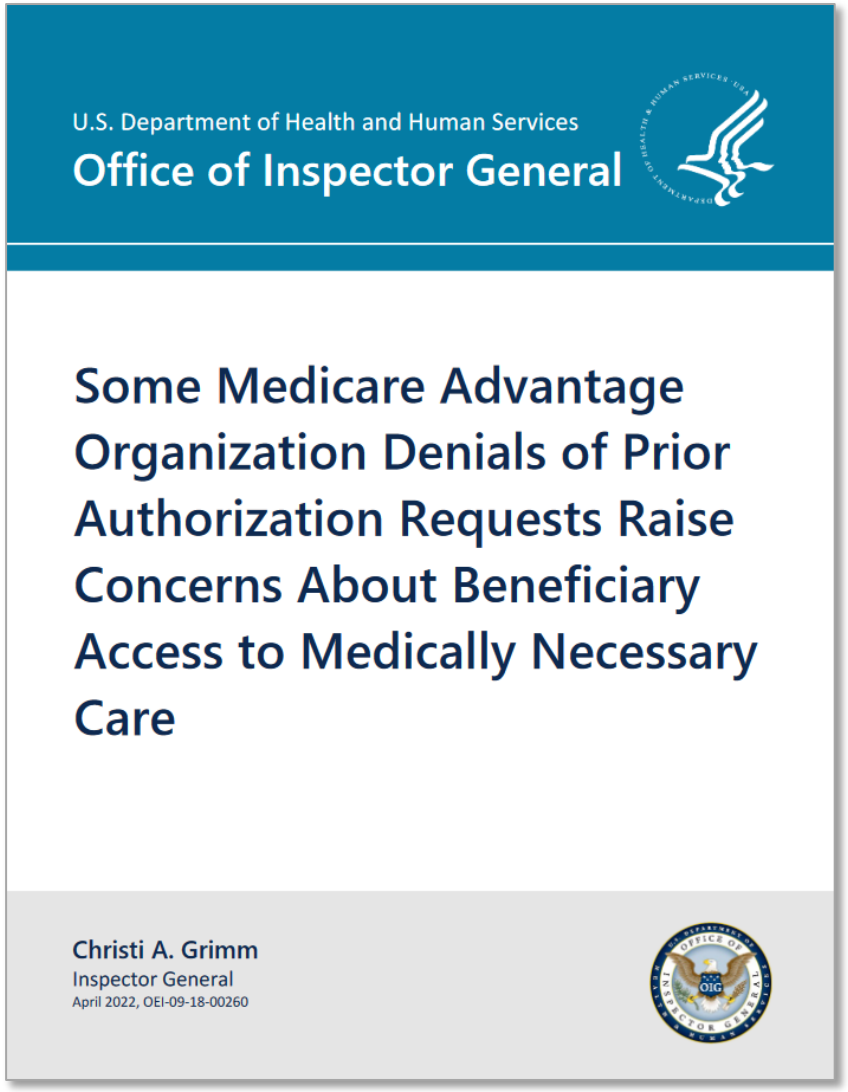
No evidence of treatment

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

The Washington Post

Collapse of a Health Plan

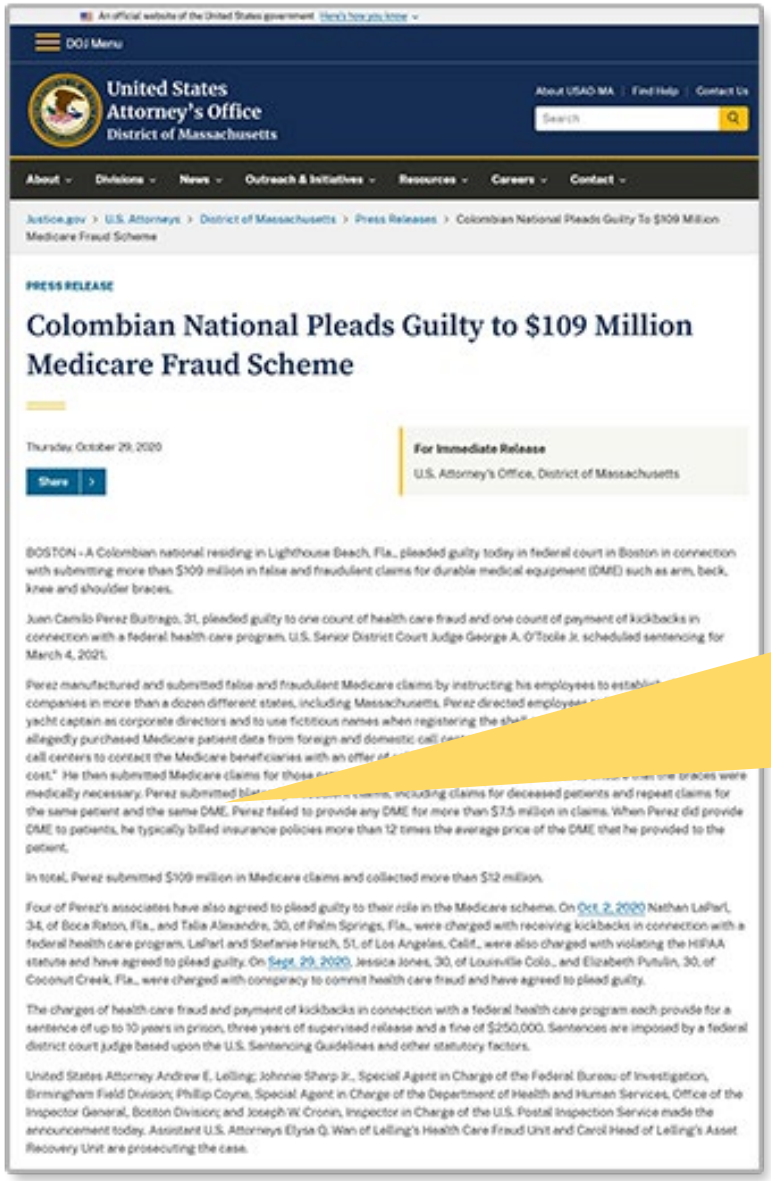
June 23, 1987

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



United States Attorney's Office
District of Massachusetts

PRESS RELEASE

Colombian National Pleads Guilty to $109 Million Medicare Fraud Scheme

Thursday, October 29, 2020

For Immediate Release
U.S. Attorney's Office, District of Massachusetts

BOSTON - A Colombian national residing in Lighthouse Beach, Fla., pleaded guilty today in federal court in Boston in connection with submitting more than $109 million in false and fraudulent claims for durable medical equipment (DME) such as arm, back, knee and shoulder braces.

Juan Camilo Perez Bustrago, 31, pleaded guilty to one count of health care fraud and one count of payment of kickbacks in connection with a federal health care program. U.S. Senior District Court Judge George A. O'Toole Jr. scheduled sentencing for March 4, 2021.

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/

THANK YOU!

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