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The Valued Voice

Vol. 67, Issue 34 Thursday, August 31, 2023

U.S. OIG Reveals Strategic Plan for Oversight of Medicare and Medicaid Managed Care

"Insurance companies must be held accountable if they game the system."

The U.S. Office of the Inspector General released a new strategic plan, outlining its intent for "rigorous" oversight of Medicare Advantage Organizations (MAOs) and Medicaid managed care organizations (MCOs), saying it must hold these plans accountable.

"Insurance companies must be held accountable if they game the system," according to the introductory message from Inspector General Christi A. Grimm. "The Centers for Medicare & Medicaid Services (CMS), the states and managed care plans must have appropriate controls to ensure that payments to plans are accurate and that managed care works as intended," said Grimm.

OIG's goals are to promote access to care, provide financial oversight and promote data-driven decisions. It outlines several objectives under each of these goals, including ensuring that managed care plans provide access to care in a timely manner and avoid lengthy prior authorization processes. OIG also indicates plans should meet established quality standards.

OIG emphasizes that it will be a balance to holding plans accountable while also working with them to help detect and address provider fraud. OIG intends to strengthen the ties with law enforcement agencies, the health plans, CMS, and state Medicaid agencies to improve provider fraud prevention and detection. At the same time, OIG believes its strategy to target specific health plan activities can hold the health plans accountable and improve health plan compliance.

OIG's strategy is to target specific risks in four different phases of the managed care "life cycle." These include the initial contracting phase, enrollment, payment to providers and access to high-quality health care services.

When a contract with a plan is first established or renewed, OIG will review plan benefit design, service area and the accuracy and integrity of plan operational requirements such as financial solvency and network adequacy. "If plans provide inaccurate information related to these requirements, or if plans do not adhere to the contract, there is risk that the plan should not be operating or is not providing adequate care for its enrollees," the strategic plan notes.

OIG will also target inappropriate marketing practices, and for the enrollment phase of the life cycle, OIG indicates it will focus on areas such as agent or broker activities, eligibility determinations and enrollment data.

As for payments to providers, the federal and state governments typically provide capitation payments to MAOs and MCOs, and thus payments to providers do not pose a direct financial risk to them. However, OIG indicates it is concerned about risk adjustment payments and that plans might game the system by making enrollees appear sicker than they are to receive a higher risk adjustment payment.

Finally, OIG's strategic plan recognizes that due to the capitation payment arrangement, "Plans may impose barriers that prevent enrollees from accessing services to reduce plan medical costs and increase revenue." OIG intends to address this concern by looking into coverage determinations and whether enrollees are receiving care that meets clinical guidelines. OIG will also review "ineligible or untrustworthy providers" as well as fraud schemes that may cross multiple plans and/or multiple federal health care programs.

OIG has also released a public webpage that will include information about its monitoring and enforcement activities.

"More than half of Medicare enrollees and more than 80% of Medicaid enrollees are covered by managed care plans. The American people deserve to know that the insurance companies receiving more than $700 billion annually in taxpayer funds are delivering efficient, effective, high-quality care," according to Grimm.

Some members of Congress are also starting to take notice of this troubling trend. Congressman Frank Pallone (D-NJ), ranking member of the House Energy & Commerce Committee, announced an inquiry into the high rates of prior authorization denials on Aug. 17.

"I'm deeply troubled by reports that Medicaid managed care plans denied an average of one out of every eight requests for treatment, more than double the rate of service denials in Medicare Advantage," said Pallone. "I will be contacting each of these health insurance companies directly for additional information and questions regarding their prior authorization practices. It is essential that these state contracted plans are upholding their responsibility to patients and their families," he added.

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