



## **HHS-OIG Strategic Plan**

# **Oversight of Managed Care For Medicare and Medicaid**

Revised March 2025



## *Our* **Mission**

To provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the people they serve.

## *Our* **Vision**

To drive positive change in HHS programs and in the lives of the people served by these programs.

## *Our* **Values**

To be impactful, innovative, and people-focused.

# Introduction

Due to the growth of managed care in terms of enrollees and expenditures and the significant differences between fee-for-service and managed care programs, OIG has developed a coordinated plan for managed care oversight. To align OIG's managed care work, this strategic plan establishes a specific framework for managed care to assess risks and potential OIG work to address those risks.

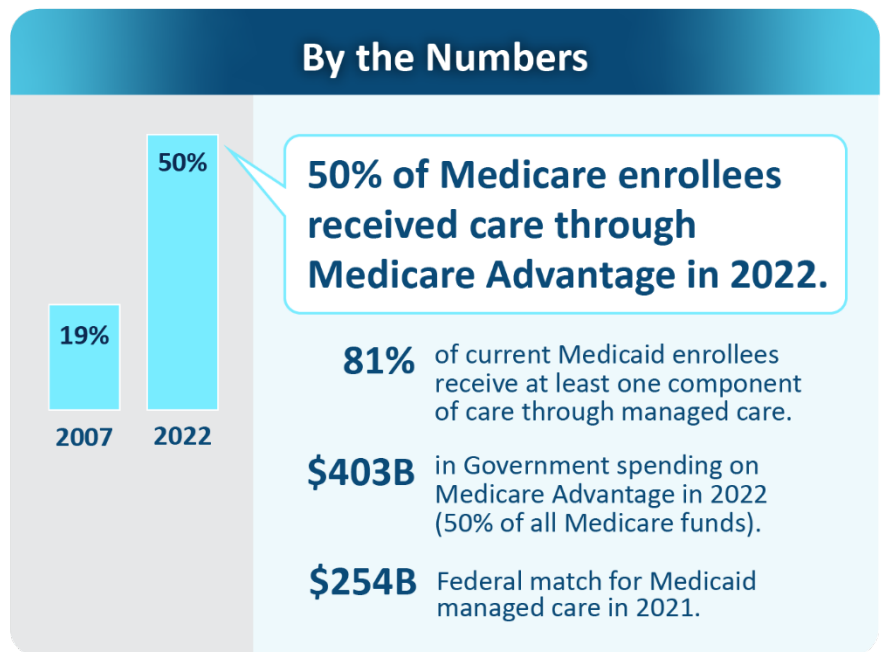
The strategy includes three underlying goals for OIG's managed care work: (1) promote access to care for people enrolled in managed care, (2) provide comprehensive financial oversight, and (3) promote data accuracy and encourage data-driven decisions.

Effective implementation of this strategy will require OIG to conduct rigorous oversight of managed care plans while also closely coordinating with the same plans to fight fraud, waste, and abuse. OIG must hold Medicare Advantage organizations (MAOs) and managed care organizations (MCOs) accountable. Focused oversight and enforcement targeting plan conduct can hold MAOs and MCOs accountable that game Federal health programs and encourage improved compliance across the industry.

At the same time, OIG must work closely with plans to address health fraud schemes that are increasingly shifting to managed care. OIG recognizes that partnering with plans is key to combating fraud that harms managed care plans, their enrollees, and the Medicare and Medicaid programs. Creating synergy between MAOs, MCOs, OIG and our law enforcement partners, CMS, and State Medicaid agencies is necessary to improve the prevention and detection of health care fraud under managed care.

Conducting oversight and closely coordinating with plans at the same time requires OIG to carefully perform this dual function. This strategic plan includes a practical tool that provides necessary context that OIG should consider when performing managed care work. The managed care life cycle, detailed below, describes the types of risks present across the different phases of managed care programs and how those risks can affect Medicare and Medicaid.

Managed care oversight and enforcement is among the most complex work that OIG performs. This strategic plan will help OIG navigate that complexity, address key risk areas, and improve partnerships.





# Managed Care Life Cycle

As a tool to provide comprehensive oversight, OIG developed the managed care life cycle. For purposes of oversight, the life cycle of a managed care plan is fourfold: plan establishment and contracting, enrollment, payment, and provision of services. Each stage of this life cycle raises different risks and vulnerabilities. Effective oversight and enforcement will address each stage of this life cycle and the associated risks. The managed care life cycle presents a framework in which different areas of risk and vulnerabilities may be evaluated.



## Plan Establishment and Contracting

OIG will focus on activities that occur when the plan is first established or when the contract is renewed. CMS enters into contracts with and makes monthly payments to MAOs to provide coverage to people enrolled in the program. In Medicaid, States operate and fund the program in partnership with the Federal Government. States contract with MCOs to make services available to people enrolled in Medicaid. Both Medicare and Medicaid have operational requirements for plans, such as financial solvency and providing an adequate network. 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 enrollees.

Focus areas may include review of contracts with the State or CMS, plan benefit design, establishment of plan service area, as well as accuracy and integrity of plan bids.

## Enrollment

OIG will focus on processes related to enrolling people in plans. To attract enrollees, some MAOs engage in aggressive marketing programs through direct contact with enrollees and media campaigns. In some cases, tactics are used that violate marketing guidelines, such as providing incorrect information, which may put people at risk. Enrollment is also the point at which eligibility and other information (e.g., demographics) is transmitted to the Government; incorrect information will result in incorrect payment.

Focus areas may include marketing, agent or broker activities, eligibility determinations, and accuracy and use of enrollment data.

## Payment

OIG will focus on the payments made by CMS and the States to plans, as well as plan payments to providers. The Federal Government's financial risk is primarily associated with capitation payments to plans, including those based on risk adjustment. Risk adjustment provides higher payments to plans for individuals who are sicker, with the goal of accurately paying plans to provide services to their enrollees and prevent cherry-picking. However, there is a risk that plans will misreport the health status of their enrollees to make them appear sicker to receive a higher payment.

Plan payments to providers could also be improper and at risk for fraud, waste, and abuse. Although costs associated with improper payments from plans to providers may not pose direct financial risk to the Government, these costs could be passed along to Medicare and Medicaid in future years if not identified and corrected.

Focus areas may include components such as risk adjustment, payment accuracy, medical loss ratio, and the value-based care or other alternative payment mechanisms used by plans, States, and CMS under the managed care programs. OIG will also continue to investigate the overlap in providers engaging in fraud in fee-for-service Medicare and Medicaid that are also providing services in managed care networks.

## Services to People

OIG will focus on whether enrollees have adequate access to high-quality services. Managed care plans have different incentives based on the capitation payment. Plans may impose barriers that prevent enrollees from accessing services to reduce plan medical costs and increase revenue. Although program safeguards, such as medical loss ratios, are intended to curb these behaviors, the risks and potential impact on enrollees are high, warranting additional oversight. Additionally, managed care arrangements also have flexibility to provide nontraditional benefits, such as gym memberships. These benefits are often funded through a different financial mechanism than the base payment and actual utilization may not be transparent.

Focus areas may include network adequacy, ineligible or untrustworthy providers, coverage determinations, whether enrollees are receiving care that meets clinical guidelines, and fraud schemes that cross multiple plans and/or Federal health care programs.



# Goals and Objectives

Through its oversight and enforcement, OIG seeks to ensure that managed care provides value as measured by the financial impact to the Federal Government and the quality of care for people in the programs. To address the risks associated with each stage of the managed care plan life cycle, OIG has three strategic goals: (1) promote access to care for people enrolled in managed care, (2) provide comprehensive financial oversight, and (3) promote data accuracy and encourage data-driven decisions.

## 1. Promote access to care for people enrolled in managed care

OIG is committed to protecting Medicare and Medicaid enrollees. People enrolled in managed care should have access to safe, effective, and equitable care. They should be able to access effective services in a timely and efficient manner. Health care quality has an impact on the services-to-people portion of the managed care life cycle. It also has an impact on payment, enrollment, plan establishment, and contracting.

### Objective A

**Ensure that managed care plans provide enrollees with access to health care services, including mental health services.**

Access to services is the foundational principle for care; without the ability to access providers, enrollees will not receive the care they need. Access encompasses not only physical proximity but also timeliness of care. Harmful delays in care can result from wait times to get an appointment and lengthy prior authorization processes.

### Objective B

**Ensure that care provided to people enrolled in managed care is safe and effective.**

People enrolled in managed care should receive services that are safe and effective. At a minimum, the care they receive should not harm them. It should also meet established quality standards. Mechanisms, such as quality bonus payments, incentivize plans, creating a nexus between quality of care and payment. Care should also promote the ability of enrollees to reach the highest level of health.

#### Examples of OIG's work in this area

OIG has been working on access to behavioral health and is [conducting a cross-program behavioral health study](#) that will examine the ratio of providers to people enrolled, ability of providers to accept new patients and schedule appointments, and network adequacy.

[OIG examined prior authorization requests in Medicare Advantage](#) and found that in 13 percent of cases, plans denied services that met Medicare coverage rules. OIG found that certain Medicaid MCOs denied one out of every eight requests for the prior authorization of services, and that States had limited oversight of MCO prior authorization denials.

## 2. Provide comprehensive financial oversight

In 2022, the Federal Government spent more than \$650 billion on Medicare and Medicaid managed care programs. The payment mechanisms in managed care are complex and multifaceted, requiring robust surveillance. Oversight is needed to safeguard taxpayers dollars and to promote a culture of compliance in the managed care industry. Financial oversight is critical across all aspects of the managed care life cycle. OIG must oversee plans to ensure that they are held accountable for the large amount of taxpayer funds they receive and, at the same time, work with plans to combat health care fraud targeting Medicare Advantage and Medicaid managed care.

### Objective A

#### **Ensure that payments to Medicare Advantage and Medicaid plans are accurate.**

Incentives in managed care are different than those in fee-for-service systems. OIG's work looks at various aspects of these payments to identify areas of potential risk and focuses on risk-adjusted capitated payments as well as the documentation and diagnosis submission patterns behind them. OIG has also highlighted concerns that Medicare Advantage plans' use of certain tools to increase the risk-adjustment payments they receive presents payment integrity risks.

As managed care has grown in enrollment and complexity, plan compliance functions generally have not kept pace. Additional compliance focus is needed to ensure that plans can detect and mitigate improper payments. OIG work will provide insights and guidance with the goal of improving managed care plan compliance. When necessary, OIG will continue to investigate allegations of plans defrauding Medicare and Medicaid managed care. OIG's work on this topic will continue and expand to other areas of payment that are at risk.

### Objective B

#### **Identify and prevent fraud in managed care plans.**

OIG's work to combat health care fraud protects enrollees and holds wrongdoers accountable. OIG knows from experience that fraudsters pay close attention to industry trends and—most importantly—to where the money is. The risk of provider-level fraud against plans has increased as managed care enrollment has grown over the past several years.

To address growing fraud under Medicare Advantage and Medicaid managed care, OIG is expanding its engagement with plans and their special investigation units, in coordination with our Federal and State law enforcement partners. This work focuses on enhancing plan capabilities to prevent and detect fraud because plans are on the front lines to spot it. Improved collaboration with plans will increase referrals of potential fraud to law enforcement and help close gaps in managed care operations that can hinder response to fraud against plans.

#### **Examples of current and completed work**

OIG has conducted audits of health plans to validate risk-adjusted payments made by CMS. As of August 2023, OIG has identified approximately \$377 million in potential overpayments. [OIG has also examined the use of chart review and health risk assessments to increase risk scores.](#)

In Medicaid, OIG has undertaken a [series of evaluations focused on oversight and integrity of managed care plans' reported medical loss ratios](#), a critical tool for ensuring that managed care plans are directing appropriate levels of funds toward patient care.

### 3. Promote data accuracy and encourage data-driven decisions

Data accuracy safeguards program dollars and quality of care. Data should be accurate, timely, and complete. Without accurate data, payments will not be correct and resources may not be appropriately directed. Data accuracy and data-driven decision making are critical to all areas of the managed care life cycle.

#### Objective A

##### **Ensure that data are accurate.**

When information is not accurate, correct payment is at risk and oversight and monitoring become difficult. It is critical that States, CMS, and plans have accurate data to effectively administer the program and ensure compliance. Data are also a powerful tool to examine health care quality issues.

#### Objective B

##### **Encourage timely collection of complete data.**

Incomplete data can result in inaccurate payment and make program analysis difficult. Areas of risk evolve and change and can be best addressed by data that are timely and complete. Furthermore, analysis of robust, near real-time data allows for identification of emerging risks.

##### **Examples of current and completed work**

OIG's audits of Medicaid enrollment data found that States made approximately \$1 billion per year in questionable payments for concurrent enrollment in two different States or concurrent enrollment in two different MCOs, and more than \$170 million in payments after death of enrollees.

OIG reported that [the lack of provider identifiers on Medicare Advantage encounter data](#) prevented their ability to provide robust oversight.

OIG has consistently identified deficiencies in the Transformed Medicaid Statistical Information System (T-MSIS) data, including in its managed care data. OIG will continue to examine data issues, in both Medicare and Medicaid managed care, especially regarding collecting more robust data that will give critical insights into the programs.





# About the Office of Inspector General

OIG's mission, as mandated by P.L. No. 95-452, as amended, is to protect the integrity of HHS programs, as well as the health and welfare of the people served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## Office of Audit Services (OAS)

OAS provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## Office of Evaluation and Inspections (OEI)

OEI conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## Office of Investigations (OI)

OI conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and enrollees. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## Office of Counsel to the Inspector General (OCIG)

OCIG provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations.

OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

### **OIG Public Hotline (for reporting fraud):**

**Website:** <https://oig.hhs.gov/fraud/report-fraud/>

**Phone:** (800) 447-8477

**TTY (for hearing impaired):** (800) 377-4950

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