Inspector General Christi A. Grimm
Speech at RISE Conference in Nashville, Tennessee
Cultivating Trust Through a Culture of Compliance
Monday, March 18 (8:40 a.m. to 9:20 a.m.)
Remarks as Prepared for Delivery

Good morning, Everyone! I am delighted to join you here in Nashville for what I know will be a terrific conference!

It is 8:30 in the morning. I can't expect folks to be fully awake and engaged at this hour, just 1 week after daylight savings, and the morning after St. Patrick's Day celebrations.

I thought we could start by playing an interactive game to warm things up. Are you ready?

This video clip was recently brought to my attention, maybe because I am a "Swiftie" at heart, and because I truly appreciate quality cookware. Have you seen it?

It looks like Taylor Swift, sounds like Taylor Swift, but is it Taylor Swift??? What do we think? Real or Fake?

It is fake! This is not Taylor Swift. This is a deep fake. Taylor Swift is no more selling Le Creuset cookware than I am here in Nashville to sing country songs, something I promise you I will not do.

Let's do another.

Here is George Clooney selling Nespresso. Or is it? What do you think? Real or Fake?

It is real... that is George Clooney selling Nespresso. Mr. Clooney has clearly spent a lot of time in Italy drinking fancy coffees…

Is this Oprah Winfrey selling weight loss gummies? What do we think? Real or fake?

It is a fake.

Last one—what about this? Is Tom Hanks selling dental services? Real or fake?

No—just another deep fake.

Deep fake videos like these are viewed tens of millions of times.

From a technology perspective, deep fakes are fascinating. They are also deeply worrisome.

Technology has delivered us to a place where something that appears entirely real is, in fact, often fake and undetectable to the public. Deep fakes may be the epitome of "what you see is not always what you get." You cannot trust what your eyes and ears are telling you.

In fact, in a world where deep fakes are possible, we must learn when to disbelieve what we see and hear. To avoid being fooled, we are called upon to sharpen our skepticism, to amplify doubt and ask more questions. It is harder to trust, and harder to earn trust.

The topic I want to reflect on with you this morning is cultivating trust. How building and valuing trust with diverse

stakeholders can help Medicare Advantage and other managed care plans—and their business partners—weather headwinds, and more safely navigate choppy waters.

Managed care is under the Government and public microscope. Since this conference last year, scrutiny of managed care business practices and the enrollee experience has intensified.

All too often there are critical gaps between the attractive promise of managed care to deliver cost-effective, high-quality, coordinated care—and how it operates in practice. We see this in important areas like prior authorization and risk adjustment. These gaps, if not closed, pose real risk, not just to patients, but also to managed care plans and the Medicare Advantage program.

If Medicare Advantage plans and their partners cannot turn promises into realities, then it begs the question whether managed care was a mirage in the first place. And they risk eroding hard-to-earn trust of important stakeholders like consumers, providers, regulators, policymakers, and investors.

So, I won't sell you cookware here today, but I do hope to sell you on this idea: managed care leaders must devote more attention to building trust.

There are stacks of books and articles on the topic of trust. Even the ancient philosophers pondered trust—what it is, how one obtains it, and how it is lost. Business schools teach the art and science of trust. These sources point to important values

that enhance trust, such as reliability, transparency, and accountability.

Common images about trust are telling: a handshake, a toddler leaping off the pool deck into a parent's arms, rock climbers pulling each other up the sheer face of a cliff. These images remind us that trust speaks to strong bonds between people.

What people perceive as trustworthy changes over time. Take bank architecture.

Architects design banks to convey security, confidence, trust. Historically, bank buildings were imposing, solid, often with grand classical columns. These edifices proclaimed: "Your money is safe here."

You could walk around almost any city or town and pick out the banks from their facades. Back in the day, if you were traveling in an unfamiliar town—even if you didn't speak the local language—you knew by looking at the buildings where to pop in to cash your American Express Traveler's check.

Remember those? The buildings, the Roman centurion you see here on the traveler's checks, they all projected "safety."

Even after those "Wild West" bank robberies stopped being grab and runs, bank design favored architectural styles that reassured people their money was safe.

Over time, bank design became sleeker, more transparent, with lots of glass, expansive open spaces, and fewer bars on teller windows.

Architects designed banks to project a contemporary image of trust: that banks are modern enterprises with modern methods of safeguarding funds and serving customers. These edifices also proclaim: "You can trust us with your money."

Like banks, managed care plans must be trusted to handle what people value greatly: their health and well-being.

One way for managed care organizations to cultivate trust is through compliance. Acting—and being seen to act—with integrity is a concrete means of fortifying trust and projecting trustworthiness.

An organizational culture of compliance and an effective compliance program sound like a lot of corporate legal jargon. But compliance is fundamentally about trust. It is an organization being committed to doing the right thing, to fixing what has gone wrong, and to meeting the needs of its stakeholders. Compliance with the rules of the road signals: "Being trustworthy matters to us."

I hope to persuade you to seize important opportunities for decisive actions that bolster compliance with Medicare rules, create business value, and reduce reputational risk. You can act to close gaps between the promise of managed care and the reality that it sometimes under-delivers on that promise.

This morning, I will offer specific examples from OIG's work of known gaps and opportunities that managed care leaders have

for meaningful action. I will describe steps that OIG is taking to help strengthen managed care.

Last year at this conference, I urged managed care leaders and plans to intensify focus on program integrity risk and compliance.

I have returned this year to underscore my steadfast commitment to ensuring that the Medicare Advantage program delivers cost-effective, high-quality care for the millions of enrollees who rely on it. This remains one of my top priorities as Inspector General.

From its inception, managed care presented an attractive alternative to fragmented, fee-for-service, volume-driven health care. The vision was for well-coordinated health care that enhances patient outcomes and lowers costs.

Managed care gave seniors and people with disabilities more choices for coverage. Managed care could shift risk to plans, which could harness the know-how, technology, and business acumen of the private sector. Plans would keep reasonable profits.

Policymakers saw capitated payments as a driver to reduce wasteful spending, with risk adjustment as a backstop to ensure that high-cost patients would not bankrupt plans.

Managed care enrollees would receive high-quality, medically necessary care ordered by their doctors and have a better experience because their health care would be coordinated.

Enrollees would also benefit from lower out-of-pocket costs and supplemental benefits, in exchange for using a prescribed provider network and being subject to cost containment mechanisms like prior authorization and formularies.

Managed care has tremendous curb appeal—but only if it can be trusted to deliver on its promised outcomes. Unfortunately, in some important ways, Medicare Advantage falls short of its vision.

You know better than I the headwinds blowing at managed care. Plans are drawing increased scrutiny from Congress and regulators for problematic risk adjustment and prior authorization practices, including the use of artificial intelligence. The Centers for Medicare & Medicaid Services (CMS) is tightening regulations to compel improvements in plan operations. The number of fraud prosecutions involving managed care is up.

Stories about consumer dissatisfaction with Medicare Advantage abound. And…gains in Medicare Advantage enrollment may be slowing. Although many Medicare Advantage enrollees are satisfied with their plans, chatter around the "seniors' water cooler"—or perhaps the "decaffeinated tea urn"—is that Medicare Advantage plans deny medically necessary care, make patients jump through meaningless hoops, and put profits over patients.

Some patients walk into their doctors' waiting rooms and find warning signs about enrolling in Medicare Advantage.

Prospective enrollees study the marketing materials and the network directories, but their experience after enrollment often diverges from what those materials promised. The message some are conveying to their peers: "Steer clear of Medicare Advantage." That is not the word of mouth you are looking for.

Meanwhile, cybersecurity attacks and disruptions threaten plan operations.

A growing number of hospitals, health systems, and medical groups are voting with their feet and terminating contracts with Medicare Advantage plans.

For some managed care companies, unexpected utilization patterns have thrown off financial forecasts, raising questions for investors.

Some experts and longtime advocates for managed care have become so disillusioned that they express readiness to throw in the towel.

Which brings me back to the topic of trust. When faced with strong headwinds, trust can be the tailwind that helps a business stay the course.

As the saying goes, trust is hard to earn, easy to lose. Trust is fragile. Also, it is immensely powerful.

Trust is OIG's coin of the realm. Department officials, Congress, the health care industry, and the public expect OIG to produce independent oversight and enforcement that is data-driven,

objective, transparent, and impartial. Our stakeholders expect us to adhere rigorously to widely accepted professional standards. They listen to us because they trust us. Even if they don't agree with us.

We also own our mistakes. If we get it wrong, we make the correction, and we are seen to make the correction. That matters too. What I know and convey to my team is that we can only be successful in carrying out our mission to protect the more than 100 HHS programs and the beneficiaries they serve if we and our work are trusted.

Myriad cautionary tales come to mind of catastrophic business consequences when trust breaks down. We recently excluded Elizabeth Holmes, founder, and former chief executive officer of biotech startup Theranos for 90 years. OIG's authority to exclude people and entities from participating in Federal health care programs exists precisely to ensure that those who are untrustworthy cannot treat Federal health program enrollees.

I suspect this audience is familiar with the Theranos story. I won't repeat the details here. But it bears pausing for a moment to notice that breakdowns in trust played a chief role in its downfall.

The company's blood testing technology delivered inaccurate and sometimes dangerous test results. This truth was concealed from consumers and providers. Investors, induced to provide millions in funding by Ms. Holmes' false claims, lost

confidence and suffered financial losses. And misleading claims about the Theranos product drew Government scrutiny.

Theranos lost the trust it had been given. Theranos' conduct had ripple effects and increased skepticism of investors, consumers, and regulators about future claims of bold innovation. This is lost ground that future innovators may need to make up.

Trust matters. Trust is more than a branding exercise. It requires commitment, persistence, and leadership to do the right thing. Medicare Advantage cannot live up to its promise through government action alone. Plans must act, too.

Persistent underperformance in meeting the goals and requirements of the Medicare Advantage program poses risk to business success and reputation. If underperformance veers into misconduct, the risks become even greater.

What should managed care leaders do? Championing an ethical corporate culture that values and practices compliance is an excellent starting point. Across the health care industry, we have seen that great strides in compliance are possible when there is will and leadership commitment.

Let me offer three specific examples of concerning shortfalls in Medicare managed care that jeopardize trust and present clear opportunities for managed care leaders to make improvements.

Said plainly, prior authorization is not working the way it should.

Our work has revealed basic breakdowns in prior authorization processes, resulting in improper denials of Medicare covered services.

In a review of Medicare Advantage plans, we found that more than 10 percent of prior authorization denials were for care requests that did, in fact, meet Medicare coverage rules. For example, a plan denied a request for a CT scan that was medically necessary to rule out a life-threatening aneurysm. The managed care plan denied the request because the patient did not have an x-ray first. Medicare, however, has no such requirement.

I think about being this patient and this patient's family. How infuriating it would be. How little trust I would have in my insurer and a health system in which this could happen. And how scared I would be to have my care for a life-threatening condition delayed.

When prior authorization misfires in this way, it risks being perceived as unfair, unreliable, and a crass mechanism to stint on patient care to goose up profits. The laudable purpose of prior authorization—to curb genuinely wasteful spending and low-value services so that plans can appropriately manage risk and lower costs—is lost.

Plans can do better. The ball is in your court. We have seen positive movement among plans. Several large managed care organizations announced that they have eliminated certain prior authorization requirements, in some cases reducing requirements for up to 20 percent of services. CMS has promulgated new rules to improve prior authorization. Ensuring compliance with these rules must be a priority.

If done right, prior authorization can be an important tool for risk-based plans to manage spending on health care and lower health care costs.

If done right, enrollees will get timely, medically necessary care that is covered by Medicare.

If plans improve prior authorization practices, plans will earn more trust from consumers, providers, and Government programs.

The gap between how risk adjustment should operate and how it currently operates seems to be widening, and at considerable cost to Medicare and Federal taxpayers.

Paying plans more to care for people with serious medical needs makes sense and preserves and expands access.

Our work shows, however, that plans often make claims based on potentially inaccurate diagnoses. In some cases, we see purposeful upcoding to obtain higher risk adjustment payments.

Our audits show that plans are consistently receiving substantial risk adjustment overpayments. CMS, the Government Accountability Office, the Medicare Payment Advisory Commission, and others have identified similar patterns, amplifying concern about the integrity of risk-adjustment payments.

Given this, the recent uptick in enforcement actions related to risk adjustment is not surprising. For example, in a well-publicized case, The Cigna Group agreed to pay $172 million to resolve allegations that it violated the False Claims Act by, among other things, submitting false diagnosis codes to increase its payments from Medicare.

Here is another example. The former director of Medicare risk adjustment analytics at HealthSun Health Plans was charged with orchestrating a multimillion-dollar scheme to submit false and fraudulent information about chronic ailments that plan enrollees did not actually have. An alleged motivation? Increasing company profits and this director's own compensation.

Of interest to this audience, the Department of Justice (DOJ) declined prosecution of the company. Why? DOJ considered factors such as the company's prompt voluntary self-disclosure, cooperation, and remediation. HealthSun agreed to repay about $53 million in overpayments. And the former director awaits Federal criminal trial.

Unless plans do more to prevent fraud, upcoding, and erroneous diagnoses codes for risk adjustment, plans can fully expect more oversight, regulation, and enforcement.

Plans have an opportunity—and a responsibility—to implement better processes and practices so that risk adjustment does what it was meant to do: compensate for legitimate costs of treating sicker patients.

A concrete step that managed care plans can take is to use the methodology from OIG's risk-adjustment audits to pinpoint problems in your own data. In December, we published a toolkit to help plans do just that. The toolkit is a practical springboard for plans to initiate measures to prevent, detect, and correct errors.

Fraudsters are stealing money from Medicare Advantage plans.

Although many honest vendors serve Medicare Advantage plans and enrollees, fraud committed by providers, suppliers, and others against plans is pervasive.

Just as we are committed to ensuring that Medicare Advantage plans follow the rules, we are equally committed to ensuring that Medicare Advantage plans and enrollees are not victims of fraud.

We know from experience that fraudsters pay close attention to industry trends and—most importantly—to where the money is. With more than half of Medicare beneficiaries

enrolled in Medicare Advantage, managed care is where the money is. Fraudsters follow the money.

One area worth paying attention to is fraud by durable medical equipment (DME) suppliers. DME fraud includes everything from use of stolen billing numbers, to billing for unnecessary or phantom supplies, to kickbacks. Increasingly, DME fraud is perpetrated on a national scale by using sophisticated technology like telemedicine platforms and aggressive marketing software.

Although DME fraud has been a longstanding problem in traditional Medicare, we have seen DME fraud schemes migrate to Medicare Advantage. Managed care is where the money is.

We are seeing large increases in DME billing in Medicare Advantage, and these increases are cause for concern. If the increases result from fraud, both plans and the Medicare Advantage program are harmed.

One example: Operation Brace Yourself was a major law enforcement operation that shut down a billion-dollar medical brace scheme in traditional Medicare. We saw a nearly instantaneous migration of claims for orthotic braces to managed care. Within weeks, traditional Medicare claims for the braces dropped by 9 percent. Claims for the same types of braces billed to Medicare Advantage increased by 22 percent.

In one case, our enforcement shut down fraud by a DME supplier billing Medicare Part B for orthotic braces. The fraudster opened a new company at the same address and started billing Medicare Advantage plans instead.

The criminals switched tactics to target plans. Evidently, they perceived less risk of being detected. When one door shut, the criminals looked for another, less-well-guarded door.

One emerging risk area involves DME suppliers that do not participate in traditional Medicare. There are thousands of DME suppliers that bill only Medicare Advantage.

Although there is not a requirement that DME suppliers enroll in traditional Medicare, the lack of enrollment means that these suppliers have not been vetted through Medicare's enrollment screening process. Thus, as plans contract with DME suppliers, it is worth asking very fundamental questions: Do you know with whom who you are doing business? Do you have policies and procedures in place to screen for risky suppliers?

Fraud schemes orchestrated by DME suppliers can be difficult for plans to detect. The reason is because individual plans have visibility into only a slice of the overall fraud scheme—the part that is being billed to them.

This is where public-private partnership can make a significant difference. Our Office of Investigations is working closely with plans and other law enforcement partners to detect and stop

fraud. Unlike individual plans, we can better see the full picture, including billings to multiple plans.

I am pleased to report that the collaboration launched last year between special investigative units at managed care plans and OIG's investigators has gained traction. Plans are stepping up their engagement with health care fraud working groups. As a result, we are seeing an increase in fraud referrals from managed care plans.

I commend you and your plans for these important efforts to help us help you. And we can continue to help. OIG has a proven track record of success in finding and stopping DME and other forms of fraud in traditional Medicare. With collaboration from plans, we can be similarly successful in curbing fraud that harms Medicare Advantage plans and the Medicare program.

Managed care leaders have tremendous opportunities to earn trust and reduce business risk. They can take meaningful actions to improve Medicare Advantage in the three areas I have just described.

Making meaningful progress in these areas would help ensure that Medicare Advantage delivers on its promise of well managed care and costs. And it would be good business for plans.

With more than half of Medicare beneficiaries enrolled in managed care plans and annual expenditures of more than

$450 billion in scarce taxpayer funds—enough to fund more than 160 trips to the moon—the stakes are high. As long as significant gaps exist between the vision for managed care and current reality on the ground, plans and their business partners can expect continued scrutiny and mounting distrust.

Many aspects of the problems I've described are fixable. As managed care leaders, you have the agency and power to fix them. Resolute action would go a long way toward fortifying trust.

The health of many of your companies is tied to the health of the Medicare Advantage program. By which I mean both the financial health of the program and how enrollees fare in the program.

Prioritizing actions to enhance compliance can help improve and preserve the reputation of the Medicare Advantage program and Medicare Advantage plans.

As for reputation, to a large extent plans are in it together. We are all familiar with the proverb about bad apples tainting the whole barrel. Unscrupulous conduct by one plan can diminish the trust that Congress, taxpayers, providers, and potential enrollees have in managed care as a worthy insurance model. Trustworthy conduct by plans can help tip the scale in the other direction.

So, what is OIG doing to support the vision for managed care?

In addition to aggressively holding wrongdoers accountable, it is a core value of mine that OIG provide insights, tools, and support for those who want to do the right thing. I know that for Medicare Advantage to be successful, plans need to be successful, too.

Let me highlight three ways that we are working to help managed care succeed.

First, we are prioritizing managed care and executing on a new strategic plan for oversight with three clear goals: promoting access to care for managed care enrollees, providing comprehensive financial oversight, and promoting data accuracy and data-driven decisions. I encourage you to read our strategic plan; it is a roadmap to where we are going.

Second, we are continuing to collaborate with plans and our law enforcement partners to crack down on fraud that targets plans. Your partnership is crucial to identifying where fraud is happening.

Third, we are providing compliance tools, such as the toolkit for high-risk diagnosis codes.

Last year, we issued an updated General Compliance Program Guidance. It contains important information for compliance officers, as well as for company leaders and boards of directors.

We anticipate issuing updated compliance guidance specific to managed care later this year. We are developing this resource with input from a wide range of managed care stakeholders. I

want to thank RISE for helping us get the word out and all those who have provided input thus far.

When we meet again in several years, I hope our conversation will be about all that was done by plans and the Government to close the gap between managed care as it is today in 2024 and managed care as it should be. I hope that we are talking about:

- how patients, payers, and policymakers trust managed care to deliver high-value, cost-effective, patient-centered care;
- how managed care plans are excelling at managing costs by reigning in wasteful spending, curating high-value care, and reducing administrative burden; and
- how profits in managed care derive from delivering an outstanding product to patients and payers.

And I hope that oversight of managed care is no longer a topmost priority for the OIG.

Medicare Advantage plans have a clear choice between perpetuating a problem-riddled system or building a better future for health care and for millions of seniors and people with disabilities.

Plans have a tremendous opportunity to bring the best thinking and promising innovations to the difficult problem of lowering costs and improving health.

This is a call to service. And a call for trust. Trust that plan benefits will be there when patients need them. Trust that plans will be good stewards of taxpayer dollars. And trust that plans and their business partners will prioritize compliance and follow the rules.

By bringing together key industry players and providing a platform to share important learnings, RISE is well positioned to promote trust in managed care and propel a robust culture of compliance. The agenda for this conference makes clear that RISE has its finger on the pulse of the most compelling issues, with important sessions on risk adjustment, quality, cybersecurity, and more.

Thank you for your time this morning. I appreciate the invitation to share my thoughts with you. I hope you will have an opportunity to attend the panel of OIG's top subject matter experts later this morning. They will dive more deeply into our managed care work. I wish you a great stay in Nashville and a successful conference.