Medicaid Wastes Billions Despite Warnings

By James Swann

Bloomberg Law

- Medicaid made $36.7 billion in improper payments in FY 2017
- Program doesn't comply with federal law on improper payments

The Medicaid program continues to waste billions of dollars a year by failing to eliminate improper payments to states despite government recommendations to do so.

Medicaid's long-standing problem with enrolling providers has emerged as one of the chief culprits of the wasteful spending, along with correctly identifying providers.

The improper spending stands to keep growing as states expand their Medicaid programs under Obamacare provisions, adding to government losses.

The program has perennially been classified as high-risk by the Government Accountability Office and has seen its improper payment rate increase the last three fiscal years.

Medicaid failed to comply with a federal law requiring the elimination and recovery of improper payments for FY 2017, a government watchdog said May 15. The Improper Payments Information Act requires federal programs to meet improper payment reduction targets and to ensure that programs have improper payment rates below 10 percent.

An estimated 10.1. percent of all Medicaid payments—$36.7 billion—were deemed improper in FY 2017, according to data from the Centers for Medicare & Medicaid Services.

Improper payments to states for health-care services provided through their own Medicaid programs can be tied to outright fraud or be the result of unintentional errors. The CMS didn't respond to a request for comment on the Medicaid improper payment rate.

The main causes for the improper payments were problems with the states' implementation of provider enrollment requirements and identification of the providing practitioner's information, the Health and Human Services Office of Inspector General report said.

"It seems like the identified issues with provider enrollment are much more easily fixable than medical necessity or outright fraud, and provider enrollment has been a priority with CMS, but first they need to figure out what they should do to fix the problem," Judith Waltz, a health-care attorney with Foley & Lardner LLP in San Francisco, told Bloomberg Law.

Overall, however, the report is likely to have little impact, Ellyn Sternfield, an attorney with Mintz, Levin,Cohn, Ferris, Glovsky and Popeo PC in Washington, told Bloomberg Law.

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"CMS will submit a plan to correct the deficiencies identified, and nothing else will happen," Sternfield, a former director of the Oregon Department of Justice's Medicaid Fraud Control Unit, told Bloomberg Law.

Meeting improper payment rate goals is always going to be elusive, but the CMS is likely to emphasize its exploration of alternatives to Medicaid fee-for-service as part of any plan to address the problems, Sternfield said. A chief alternative is Medicaid managed care plans.

Provider Enrollment

Most of the provider enrollment requirements date back to the Affordable Care Act, and states have had many years to get an appropriate system in place, Waltz said.

"As it is now, each state has to set up its own enrollment system, which takes resources from the state that may not be fully supported with federal funds," Waltz, a former assistant regional counsel for the HHS, said.

The CMS at one point was considering creating a one-stop shop for Medicaid provider enrollment that would have allowed all the state programs to use a single federal enrollment process, Waltz said.

"For reasons that aren't clear to me, CMS gave up on that idea, but that might be one way to address what seems to be a continuing problem already several years in existence," Waltz said.

The Medicaid program did come very close to lowering the improper payment rate below 10 percent, Waltz said, and it's important to remember that Medicaid is not one program but rather a collection of individual state programs that each have their own requirements.

Medicare Contractors

The report also criticized Medicare for not expanding a fraud and abuse program to the Medicare Advantage program. The ACA mandated the expansion, but a contract has yet to awarded.

Waltz said the CMS may have had a hard time identifying the scope of work for the Medicare Part C Recovery Audit Contractor program, which was created by the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments to health-care providers, including defining what an overpayment is in the managed care world.

The RACs are tasked with identifying and recovering misspent Medicare funds and are paid on a contingency fee basis.

"The RACs were so unpopular, maybe CMS has just decided to abandon the idea and just do its own audits," Waltz said.

The problem with RAC expansion is likely part of the overall controversy with the program across all of Medicare, Sternfield said. These controversies have led to a multi-year backlog of administrative appeals of RAC audits and are the subject of ongoing litigation, Sternfield said.

"CMS probably is reluctant to launch a new RAC program in Part C without redressing the current issues with RAC operations," Sternfield said.

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