Medicaid Payment Oversight Found Lacking

By James Swann

Bloomberg Law

- CMS isn't conducting adequate oversight of Medicaid managed care payments
- Overpayments and unallowable costs aren't being measured, raising program risks

Medicaid is boosting the risk of fraud and abuse by failing to account for millions of dollars in improper payments it's making to Medicaid managed care organizations, a government watchdog says.

Failing to catch improper payments means MCOs are getting paid more than they deserve and jeopardizes the financial health of the Medicaid program.

Medicaid is supposed to assess the accuracy of payments made to MCOs, but 10 recent state and federal audits and investigations uncovered roughly $68 million in overpayments and unallowable costs that weren't accounted for, according to a June 6 Government Accountability Office report. The report said the Centers for Medicare & Medicaid Services should consider revising the way it measures improper Medicaid payments and should take any other necessary steps to reduce risks.

State Medicaid agencies contract with private companies to provide Medicaid services to beneficiaries. The MCOs receive a set payment per-beneficiary, per month—also known as a capitated payment—from state Medicaid agencies.

The CMS strongly supports efforts to improve Medicaid program integrity and agreed with the GAO that better information on improper payments can reduce risks, an agency spokesperson told Bloomberg Law. The agency is working with states to strengthen Medicaid managed care spending oversight, the spokesperson said.

The report's finding aren't surprising considering the history of light regulation for Medicaid managed care plans, Ellyn Sternfield, an attorney with Mintz, Levin, Cohn, Ferris, Glovsky and Popeo PC in Washington, told Bloomberg Law.

In the early days of Medicaid managed care there was little in the way of regulation, as most states viewed managed care as an option that would enable them to reduce their administrative costs by delegating oversight to the MCOs, Sternfield, a former director of the Oregon Department of Justice's Medicaid Fraud Control Unit, said.

It was only after 2007 that the CMS instituted program integrity reviews for Medicaid managed-care plans, Sternfield said.

"As a prosecutor, my earliest Medicaid managed care cases involved the types of cases highlighted by the report, including capitation payments that went to providers that were ineligible or were for services that weren't eligible for reimbursement," Sternfield said.

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In one case, the lack of regulatory requirements for the Medicaid managed care plan meant the case couldn't even be prosecuted, Sternfield said. The report's recommendations make sense when factoring in the history of Medicaid managed care plan regulation, but implementation will be a challenge for the CMS due to the lack of standardization of state Medicaid reporting, Sternfield said.

Managed Care Growth

Medicaid managed care accounts for nearly 50 percent of all Medicaid payments—$171 billion as of fiscal year 2017, according to the Medicaid and CHIP Payment and Access Commission. The overall program had a 10.1 percent error rate in 2017, meaning that $36.7 billion in payments were deemed improper out of the total $363.8 billion, according to the CMS.

Out of 78.5 million Medicaid enrollees in 2016, 67.5 percent were enrolled in managed care plans, and the top five MCOs—Centene, Anthem, United Healthcare, Amerigroup, and Wellcare—accounted for 39 percent of all Medicaid managed-care enrollees, according to MACPAC.

The CMS needs to update the way it measures payments so it can reduce the level of Medicaid improper payments, Rep. Greg Walden (R-Ore.) said in a June 6 statement. Walden and Rep. Fred Upton (R-Mich.) requested the GAO report.

Program integrity regulations governing Medicaid managed care plans are already robust, Jeff M. Myers, president and CEO of Medicaid Health Plans of America, told Bloomberg Law, referring to the report's call for strengthening program integrity.

MHPA represents Medicaid managed care plans.

Hard to Assess

The report goes a long way toward encapsulating how hard it is to assess Medicaid managed-care performance, Judith Waltz, a health-care attorney with Foley & Lardner LLP in San Francisco, told Bloomberg Law.

For example, the Medicaid payment error rate measurement (PERM) doesn't measure whether the paid-for services were medically necessary, actually provided, accurately billed, or whether the MCO costs are allowable and appropriate, Waltz, a former assistant regional counsel for the Department of Health and Human Services, said.

The whole idea of managed care is that it allows a plan to operate with some freedom as to the services it covers and how the services are delivered, Waltz said. Capitated payments are designed to reflect average costs, but encourage flexibility and creativity in an MCO, Waltz said.

The CMS should shy away from applying a nationwide standard to assess Medicaid MCOs, Waltz said, as the plans differ from state to state and address specific state needs.

Instead of a single standard, the CMS should make state provisions on how to repay overpayments more accessible by posting them on the Medicaid website, Waltz said.

In addition, the report is too critical of Medicaid managed care programs and is trying to impose a fee-for-service methodology without understanding how different managed care really is and how each state program is unique, Waltz said.