Lawmakers to Grade New Medicaid Anti-Fraud Strategy

By James Swann

Bloomberg Law

- Senate hearing will focus on CMS efforts to curb Medicaid fraud
- CMS rolled out new Medicaid anti-fraud strategy in June

Lawmakers are set to grill the head of Medicare and Medicaid on her recently rolled-out strategy to curb Medicaid fraud and abuse.

The Centers for Medicare & Medicaid Services Administrator Seema Verma will testify Aug. 21 before the Senate Governmental Affairs and Homeland Security Committee on her agency's work in deterring Medicaid fraud and preventing overpayments to physicians making claims to the program.

The hearing follows up on a June report from Republicans on the committee that was highly critical of existing Medicaid anti-fraud efforts.

Medicaid fraud and abuse have been a growing focus of lawmakers on both sides of the aisle and have factored into the overall debate about the future of Medicaid. Medicaid overpayments have grown from $14.4 billion in 2013 to $37 billion in 2017, a 157 percent increase, according to the CMS.

Republicans have said making Medicaid a block grant program could reduce the opportunity for fraud and abuse while Democrats argue that Medicaid's current funding mechanism needs to be maintained. Block grants would provide a fixed amount of funding for state Medicaid programs that would be less likely to be wasted or abused, Republicans say. Democrats say the current system, in which the federal government matches state funding, is the only way to ensure access to care for patients.

Verma didn't appear at a June committee hearing on Medicaid fraud. A May letter from Chairman Ron Johnson (R-Wis.) and the committee's ranking Democrat, Claire McCaskill (D-Mo.), said her presence was necessary and indicated that the committee might be forced to compel her testimony.

The hearing is also likely to focus on the role of Medicaid managed care plans, Ellyn Sternfield, an attorney with Mintz, Levin, Cohn, Ferris, Glovsky and Popeo PC in Washington, told Bloomberg Law.

The overwhelming majority of states now use Medicaid managed care plans and it's logical that they would be the focus of fraud and abuse oversight questions, Sternfield said.

Medicaid Managed Care

States have been moving to Medicaid managed care plans as a way to reduce the costs of providing care and lower administrative costs including fighting fraud and abuse, but this can be a tough

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balancing act, Sternfield, a former director of the Oregon Department of Justice's Medicaid Fraud Control Unit, said.

State Medicaid programs have the federally imposed obligation to provide beneficiaries with adequate access to services, as well safeguard the program from fraud and abuse, and meeting those competing requirements has proved difficult for states and for Medicaid managed care plans, Sternfield said.

The Trump administration has called for giving more flexibility to state Medicaid programs, including letting them limit or restrict the provision of services through beneficiary work requirements.

"If CMS indeed is lessening the emphasis on the need for states to ensure patient access to necessary medical care in Medicaid managed care plans, will they increase the requirements for the state to monitor for fraud and abuse?" Sternfield asked.

It remains to be seen whether the CMS takes a similar hands-off approach on Medicaid fraud and abuse oversight and leaves it up to the states, Sternfield said.

Pressure of Medicaid

There's a growing amount of pressure on the CMS to increase the focus on Medicaid fraud, Judith Waltz, a health-care attorney with Foley & Lardner LLP in San Francisco, told Bloomberg Law.

The Affordable Care Act added a number of anti-fraud tools that have been slowly implemented, but there has been little federal leadership, Waltz said.

Verma has been active in reforming Medicaid through ideas like work requirements, and a focus on fraud would fit in with the agency's focus on cutting costs in the program, Waltz said.

"There's apparently a fair amount of beneficiary fraud in enrollment and stolen identities that seems like it could be relatively easy to address," Waltz said.

Tackling Medicaid managed care plan fraud is more difficult and requires a thorough review of Medicaid records to pinpoint fraud, Waltz said.

It's especially hard to get a handle on provider fraud against Medicaid managed care plans because many plans basically pay providers on a fee-for-service basis, Waltz said.

The same issues that hit Medicare FFS can affect Medicaid managed care, such as billing for unnecessary services and upcoding charges, Waltz said. Upcoding occurs when a physician bills Medicaid for a more expensive procedure than what was actually performed.

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