Grassley presses CMS on Medicare Advantage fraud

By Lisa Schencker | May 21, 2015

Sen. Chuck Grassley is pressing the CMS and the U.S. Justice Department to crack down on Medicare Advantage fraud—an issue that's spurring a growing number of lawsuits and could be costing the government billions.

The Iowa Republican, who leads the congressional Judiciary Committee, sent letters Tuesday to Andrew Slavitt, CMS' acting administrator, and U.S. Attorney General Loretta Lynch imploring them to take action. He cited government agency and news reports from The Center for Public Integrity outlining the issue.

The CMS pays plans within Medicare Advantage, a private insurance alternative to traditional Medicare, a certain amount of money each month based on members' risk scores, which reflect their health. Higher risk scores mean more money for plans. In recent years, HHS' Office of the Inspector General has said the model is being abused by some plans and providers. At least a few whistle-blower lawsuits have also been filed in federal court alleging inflation of risk scores to get more cash.

“With the reported increase in risk score gaming, and the monumental cost that the taxpayer will shoulder for such wrongdoing, it is imperative that (the) CMS implement safeguards to reduce risk score fraud, waste and abuse,” Grassley wrote.

The OIG estimated that in fiscal 2013 alone, Medicare made $11.8 billion in improper payments—$9.3 billion in overpayments and $2.6 billion in underpayments—because of errors related to risk adjustment.

Grassley wrote that if the reports of abuse are true, the CMS should increase auditing. He also asked the CMS and the Department of Justice to provide information on a number of questions including:

- What steps has the CMS taken to ensure insurance companies aren't fraudulently manipulating risk scores?
- Are the CMS and the Department of Justice working together to investigate risk score fraud?
- How many risk score audits has the CMS conducted each year, and how much of an overcharge did those audits find? How much of that overcharge was recovered?
- How much money does the CMS get each year to audit Medicare Advantage fraud, waste and abuse?

In auditing six Advantage plans for payments in 2007, the OIG found overpayments of more than $600 million because of risk scores that weren't properly supported by medical diagnoses. Those audit results were the last to be publicly released, according to the Center for Public

Integrity.

The plans, however, disputed the findings, blaming them on “statistically invalid methodology” used by the OIG, poor physician record-keeping and difficulty finding medical records because of the time lag between the diagnoses and the audits.

Whistle-blowers have already brought at least a few lawsuits against insurers alleging fraud, and more are thought to be in the pipeline. Lawsuits filed by whistle-blowers under the False Claims Act can be kept sealed or private, sometimes for years, before the Justice Department announces whether it will intervene in a case.

Brian Roark, a member at the law firm Bass Berry Sims in Nashville, said he expects the number of whistle-blower lawsuits over the issue to increase as the amount of money flowing through the Advantage program continues to grow. In successful False Claims cases, whistle-blowers are entitled to a percentage of whatever the government is able to recover.

Roark also said Grassley’s letters are likely to draw more public attention to the issue, though he cautioned that more lawsuits don’t necessarily equal more actual fraud.

“It likely just means the plaintiffs’ bar is pursuing more cases of this type,” Roark said. “I think as in any area in healthcare, there can potentially be bad actors or inappropriate risk score practices, but I certainly don’t think you can paint the industry with a broad brush, and I think for Medicare Advantage plans, what’s important for them is to have good compliance practices in place so they feel good about their risk scoring practices.”

Also, in February, health insurer Humana revealed in a regulatory filing that the U.S. Department of Justice had asked for information related to its risk-adjustment practices, related to but separate from an earlier whistle-blower case. Humana was not able to immediately provide comment Thursday, but said in the February filing, “We continue to cooperate with and voluntarily respond to the information requests from the Department of Justice and the U.S. attorney's office.”