Crush Medicaid Fraud By Trusting Americans More, Not Less

To bring Medicaid fraud into the light, stop pushing honest care into the shadows.

Reinier Schuur and Colleen Smith

The federal government has escalated its war on Medicaid fraud from a warning to an outright fiscal assault. Following a 30-day ultimatum to governors by the Center for Medicare and Medicaid Services (CMS) Administrator Dr. Mehmet Oz, the administration proved it was not bluffing: on May 13, officials announced an unprecedented $1.3 billion freeze on federal Medicaid funds for California, claiming the state has failed to take fraud seriously.

But while past administrations and state regulators have certainly failed to safeguard the program's integrity, the current administration's aggressive retaliation reveals that they, too, fundamentally misunderstand how to fix it.

The administration proposes to replace the slow "pay-and-chase" approach (where payments are sent out first and potential fraud cases are investigated later) with a quicker, more proactive "stop-and-cop" approach: stopping suspicious payments first and asking questions later. Artificial Intelligence (AI) will also be used as part of this strategy. Dr. Oz has tried to reassure concerned parties that CMS's Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) will quickly restore payments to providers who can prove they are not fraudulent. But with a program as big as Medicaid, CRUSH will be slow or even fail to restore payments to some legitimate providers. *This is not owning the issue of Medicaid fraud.*

Both approaches treat fraud as an enforcement issue, differing only in whether they prioritize patients' access to care or Medicaid's long-term integrity. But Medicaid fraud is not just an issue of going after rule-breakers, as big a problem as they are. This is an occasion to revisit the very rules of Medicaid itself. When we do that, we can see how Medicaid's rules have effectively criminalized honest providers, driving them out of the program, and disempowered Medicaid patients, making them vulnerable to fraudsters.

Consider, for example, the ambiguous Medicaid rules in many states that effectively prohibit providers, whether or not enrolled in Medicaid, from accepting cash payments from Medicaid patients. Providers accepting such cash, even from willing patients, can be found guilty

of fraud even if they were unaware that the patient was on Medicaid. To avoid the risk of inadvertent fraud allegations (which carry fines and removal from participation in Medicare and Medicaid), most Medicaid-enrolled providers refrain from engaging in cash-pay practices altogether. But such parallel practice would enable many providers to remain in Medicaid by offsetting its low reimbursement rates. Doctors in many other countries (the UK and Singapore, for example) regularly engage in this parallel practice.

But in America, the fear of fraud accusations is enough to drive many providers out of Medicaid when they cannot make ends meet. And worse, with fewer doctors enrolled in Medicaid, patients are left without healthcare options, because they're effectively prohibited from paying cash to non-enrolled providers (who might, for example, be in their geographic area). While it may seem counterintuitive that it might be to the benefit of low-income individuals to be able to pay out of pocket when they could receive free care, the ban on parallel practice means that many Medicaid patients have free care on paper but no access to care in practice, since so many providers have already left the program. America stands alone amongst other nations in prohibiting publicly insured patients from accessing the private system.

Thus, the exodus of providers from Medicaid is matched by a systemic disempowerment of its patients. Medicaid patients have virtually no control over how their healthcare dollars are spent and therefore have little incentive, let alone the proper means, to act as a check on billing accuracy or unnecessary care. This lack of agency doesn't just limit their choices; it makes them uniquely vulnerable to fraudsters. When a patient is treated as a passive recipient of a government benefit rather than an active consumer of healthcare, they become the perfect cover for scammers who bill for phantom services that the patient never sees and has no reason or inclination to verify.

Yes, the administration must pursue those who loot public funds. But the administration can't 'CRUSH' its way out of a fraud-ridden program if the existing rules already crush those who follow them, and worse, reward those who use loopholes to game the system. We must stop crushing honest providers and their patients with rules that make them less free than their peers in other nations to provide and receive care. Before we settle on our fraud enforcement strategy, we need to 'decriminalize-and-deputize' providers and patients by giving them more choice and responsibility over how healthcare dollars are spent. We need to make it easier for honest

providers to deliver care to their patients. Fraud enforcement is secondary to such reforms. To create a more honest *system*, we need to trust Americans more, not less.

CMS, federal, and state governments can focus on two specific reforms to begin moving the arrow toward a system that rewards integrity in financial transactions, rather than dishonesty.

First, states should clarify guidance surrounding parallel practice. The guidelines must make it clear that with informed consent, Medicaid beneficiaries may choose to pay cash. They must also allow individual providers to link their Medicaid enrollment to their practice location. This will allow physicians who primarily practice outside the Medicaid system to participate more broadly in the workforce.

Second, payment models should be placed more directly in patients' hands, rather than the government's. This will remove the incentive for providers (or their billing staff) to massage charts, gently upcode, or overprescribe — as patients will be less willing to pay out of pocket for extra or unnecessary care, and providers will be reluctant to take advantage of patients, whom they are working to help. But when the government underpays providers at baseline, they are forced to eke out every possible dime from wealthy third-party payers, which is more about survival than scamming. One easy way to move toward patient-centered payment models is to expand HSAs, which can be self-funded by patients, employer-funded, or government-funded based on need. No AI algorithm or CMS bureaucrat can match the vigilance of a patient with the power to choose where their healthcare dollars go.

There's a need for good enforcement with any large program. So yes, let's do a better job of that. But if we really want to get to the root of what would help Medicaid be a more functional system, let's also give patients and providers the freedom they need to make it work honestly.

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Declaration of Conflicting Interests

The author has declared no potential conflicts of interest with respect to the research, authorship, or publication of this article.