

Medicaid's True Improper Payments Double Those Reported by CMS

By Brian Blase, PhD, and Rachel Greszler

According to official government reports, Medicaid issued \$543 billion in improper payments from 2015 through 2024.¹ But that's only half of it. That \$543 billion includes only what the federal government audited, and the Obama and Biden administrations excluded eligibility checks in their audits of improper payments in Medicaid – the so-called PERM (Payment Error Rate Measurement) audits. We estimate that the true amount of improper payments in Medicaid is twice as high as reported.

In only two out of the past 10 years did audits by the Centers for Medicare and Medicaid Services (CMS) assess the accuracy and completeness of state eligibility reviews. In those two years that did include meaningful, complete audits of state Medicaid programs, improper payment rates exceeded 25 percent. Applying a 25 percent improper payment rate across the \$4.3 trillion of federal Medicaid spending between 2015 and 2024 yields roughly \$1.1 trillion in federal Medicaid improper payments over the past decade.²

This massive gap in measurement occurred because both the Obama administration and the Biden administration did not include reviews of state eligibility determinations in the PERM audits. This meant that CMS did not even check if the individuals that states enrolled in Medicaid – and on whose behalf payments were made – were even eligible for Medicaid. This resulted in hundreds of billions of dollars in improper payments not being counted as such. Importantly, these improper payments significantly benefitted health insurers, as most Medicaid enrollees are in managed care.

KEY TAKEAWAYS

Medicaid reported \$543 billion in improper payments or payment errors over the past decade, but that measure largely ignored eligibility checks, which are the biggest source of errors.

Using data from reviews that included eligibility checks, we estimate that Medicaid issued nearly \$1.1 trillion in improper payments over the past decade – doubling the officially reported number.

The President and Congress can save hundreds of billions of dollars in Medicaid spending over the next decade by reducing improper payments in the program.

The ACA caused the improper payment rate to quadruple by discouraging states from properly determining applicant eligibility before placing them on the program.

Medicaid is a means-tested welfare program, and to qualify for the program, people must meet income requirements and other criteria. These eligibility determinations became more important after the Medicaid expansion contained in the Affordable Care Act (ACA), because the ACA created a new category of able-bodied, working-age enrollees. The federal government typically reimburses states for between 50 percent and 75 percent of their costs for traditional Medicaid enrollees – which includes children, pregnant

Medicaid Improper Payments Likely Double The Reported Amount		
Obama and Biden Administrations' Halts on Eligibility Checks Led to Massive Underreporting of Improper Payments		
	Reported <i>based on partial or no eligibility checks</i>	Estimated <i>based on full eligibility checks</i>
2015	\$29,124,610,000	\$74,418,010,000
2016	\$36,253,250,000	\$86,493,430,000
2017	\$36,731,130,000	\$90,959,840,000
2018	\$36,249,700,000	\$92,597,750,000
2019	\$57,358,130,000	\$96,249,170,000
2020	\$86,487,380,000	\$101,224,790,000
2021	\$98,724,880,000	\$113,793,910,000
2022	\$80,573,030,000	\$128,953,380,000
2023	\$50,332,060,000	\$146,727,210,000
2024	\$31,099,130,000	\$152,708,340,000
TOTAL 2015-2024	\$542,933,300,000	\$1,084,125,830,000

Estimated amounts assume a 25% improper payment rate, based on improper payment rates of 26.2% and 27.5% in the 2019 and 2020 cycles when full audits were conducted.

SOURCE: PaymentAccuracy.gov (accessed December 20, 2024), and authors' estimates. The year represents the year of the CMS improper payment report. The year of the report corresponds to an improper payment rate that is a three-year average. For example, the 2020 report is the weighted average of the 2018 through 2020 PERM cycles, which would have occurred from July 1, 2016, through June 30, 2019.

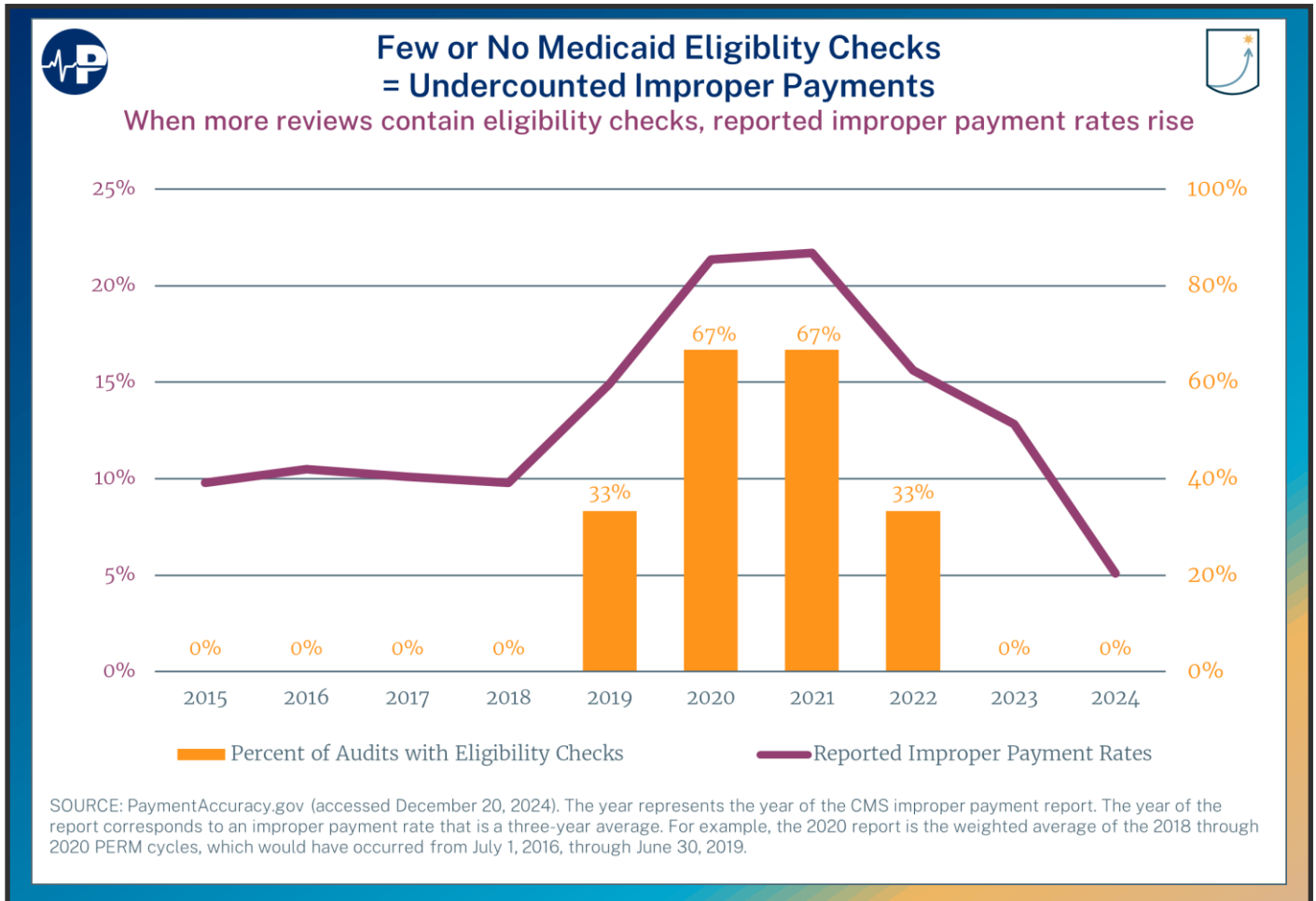
women, seniors, and individuals with disabilities. Under the expansion, the federal government reimburses states for 90 percent of their costs for able-bodied, working-age, generally childless enrollees.³ The expansion reimbursement rate was 100 percent from 2014 through 2016, before it gradually declined to 90 percent in 2020. In other words, states are provided a greater federal reimbursement percentage for enrolling non-traditional Medicaid recipients. This higher reimbursement rate for expansion enrollees creates an incentive for states to improperly classify traditional enrollees, as well as ineligible applicants, as expansion enrollees.

Another problem is hospital presumptive eligibility, an expedited Medicaid enrollment process that permits hospitals to enroll people into Medicaid based on only a few questions about income and household size, and without verification of their answers. People receive temporary Medicaid coverage pending a review. The Foundation for Government Accountability found that in 2018, 70 percent of people deemed eligible by hospitals were eventually determined ineligible or did not ultimately have their information verified.⁴

Despite the new expansion population and a greater-than-ever need to assess whether states properly determine Medicaid eligibility, the Obama administration halted eligibility reviews for the 2015 through 2018 cycles,⁵ and the Biden administration halted meaningful eligibility reviews for the 2021 through 2024 cycles.

To estimate improper payment rates, CMS does a PERM audit for one-third of the states each year. For all states to be represented, the national improper payment rate reported by CMS is the weighted average of the PERM audits over the previous three years. The only two cycles in which states conducted full improper payment audits, including eligibility determinations, were 2019 and 2020. In those cycles, the improper payment rates among the states CMS measured were 26.2 percent and 27.5 percent, respectively.⁶

The reported year for the cycle is for audits conducted during the previous July 1 through June 30 period. So, the 2019 cycle was for audits conducted from July 1, 2017, through June 30, 2018. The improper payment rate reported by CMS in their 2019 report would be for



the 2017 through 2019 cycles, covering audits conducted between July 1, 2015, through June 30, 2018.

In 2021, CMS again made the decision, using state COVID flexibilities as its justification, to stop meaningfully assessing eligibility in the annual PERM audits.⁷ Through the 2024 PERM audits, CMS had not resumed real reviews of states' eligibility determinations. Consequently, none of the three-year average improper payment rates reported in the government's official payment accuracy database over the past decade incorporates complete measures of eligibility errors. Most of the reports assume no or virtually no eligibility errors. The figure shows how CMS's official Medicaid improper payment rate is largely a function of the percentage of PERM audits that assessed the accuracy of state eligibility

determinations. The official improper payment rate soared during the years when eligibility assessments were part of the official improper payment rates.

Obama's Halt on Medicaid Eligibility Reviews Covered Up Glaring Problems

The ACA's Medicaid expansion — the largest expansion in the program's history — took effect in 2014. Given the higher federal reimbursement rate of state spending on expansion enrollees, eligibility reviews became more important at that point than at any other time in Medicaid's history. Yet President Obama stopped the PERM audits from reviewing state eligibility determinations for the cycles from 2015 to 2018, likely

because such audits may have conflicted with his attempts to build public support for the law. When PERM audits resumed assessing state eligibility determinations in the 2019 cycle, the amount of reported improper payments jumped by 60 percent — from \$38 billion to \$60 billion — even though CMS had reviewed eligibility in only one-third of the states.⁸ The improper payment rate for the one-third of states represented in the 2019 cycle was 26.2 percent.

CMS's 2019 improper payment report documented high eligibility errors, which it attributed to states maintaining insufficient documentation to substantiate that income and other information was appropriately verified, failures to conduct timely and appropriate annual redeterminations, and claiming beneficiaries under incorrect eligibility categories that provide a higher federal matching rate than was appropriate. Eligibility errors of this nature are particularly concerning as it can indicate that individuals are allowed to remain enrolled in the program during times in which they do not qualify, potentially diverting limited resources that could otherwise be invested in better serving vulnerable populations.⁹

The improper payment rate was actually higher for the third of states in the 2020 PERM audit cycle — up to 27.5 percent. CMS's 2020 improper payment report stated that states' eligibility determination errors were caused by states' failure to verify even basic data such as income and their failure to comply with eligibility redetermination requirements.¹⁰

Other audits and studies similarly found significant problems during this period. For example, an audit by the inspector general of the U.S. Department of Health and Human Services (HHS) found that more than half of sampled enrollees in California's Medicaid program were either improperly enrolled or potentially improperly enrolled, meaning that they were placed on the program without their eligibility being determined.¹¹ In a 2019 study, Blase and Yelowitz found that there are some areas, such as New York City and Los Angeles,

where the problem appears so large that it suggests purposeful and fraudulent abuse on the part of local officials and the medical industry to enroll ineligible individuals in the program.

Biden Reinstated Irresponsible Halt on Medicaid Eligibility Reviews

Despite CMS's reports showing massive improper payments when it halted eligibility determinations as part of the PERM audits, President Biden's CMS essentially followed the same policy as President Obama's CMS and ceased meaningful eligibility reviews with the PERM audits for the 2021 to 2024 cycles.

Medicaid enrollment increased substantially during this time period because of provisions of the Families First Coronavirus Response Act and the extension of the public health emergency by President Biden. The act contained a provision to increase federal financial support of Medicaid so long as states did not update their eligibility requirements or remove ineligible people from the program until the end of the public health emergency. By the time President Biden declared an end to the public health emergency, according to one estimate, there were nearly 20 million ineligible enrollees on Medicaid.¹²

As a result of the federal policy that kept ineligible enrollees on Medicaid and the failure of PERM audits to include eligibility determination reviews, the PERM audits conducted since 2021 are meaningless in determining Medicaid's improper payment rates. The most recent CMS report is the most meaningless, because none of the annual PERM audits that make up the average amount included eligibility verification.

Policy Solutions to Reduce Improper Payments

The ACA's expansion of Medicaid caused the improper payment rate in the program to quadruple. The improper payment rate went from 6 percent before the ACA expansion of the program took effect in 2014 to

over 25 percent in the two cycles fully audited in 2019 and 2020.

The continuous coverage provisions of the COVID-19 public health emergency further exacerbated improper payments, which included payments going to insurers for millions of enrollees who had other coverage. A consequence of the spending explosion—alongside a blatant lack of accountability—has been a surge of improper payments, which we estimate at nearly \$1.1 trillion over the past decade.

Improper payments violate the Medicaid program's purpose of providing efficient and effective care to those eligible by costing taxpayers far more than necessary to provide health coverage to low-income Americans. Because states pay only a small fraction of Medicaid costs, they have little incentive to reduce improper payments, and in some cases—such as misclassifying enrollees as expansion-eligible Medicaid recipients—they actually make money by issuing improper payments.

Federal policymakers have a duty to protect the integrity of the Medicaid program for truly eligible Medicaid beneficiaries, as well as for the hard-working Americans who finance the program. There are steps that Congress and the administration can take to reduce improper Medicaid payments.

Require more frequent reviews of eligibility and conduct complete audits of state programs, including reviews of their eligibility determinations.

As the number one reason for improper Medicaid payments is eligibility errors, federal policymakers should require states to conduct more frequent eligibility redeterminations for existing Medicaid enrollees, assessing eligibility for most enrollees every six months.¹³ Federal policymakers should also take a close look at hospital presumptive eligibility and consider whether improvements can be made to reduce incentives for hospitals to enroll ineligible applicants into the program. In addition, federal policymakers should require PERM audits to assess state eligibility determinations when measuring Medicaid improper payment rates.

Apply the law and end permissive exemptions from accountability in improper payments.

The Medicaid statute specifies that if a state's erroneous payments based on eligibility errors exceed 3 percent, "then the [HHS] Secretary shall make no payment" for the excess erroneous payment.¹⁴ Despite the fact that most states have true improper payment rates many times that level, HHS has never withheld funds under that requirement. Congress should require HHS to apply the law—without granting permissive exemptions—and not let massive state improper payment rates exist without consequence.

Make accountability automatic by incorporating improper payment rates into the Federal Medicaid Assistance Percentage (FMAP) or charging states the full fare for their excessive improper payments.

If states exceed a reasonable rate of improper Medicaid payments, Congress should require CMS to reduce their FMAPs. By doing so, states, which are responsible for managing the programs, would bear the cost of their errors and failure to ensure that only eligible people are enrolled in the program—not federal taxpayers. Currently, states do not have a strong incentive to reduce their improper payments, because the federal government picks up most of the tab. Many states even scheme with providers to use Medicaid to pay for non-health-related budget items.¹⁵ Congress could properly incentivize a state to reduce improper payments by prospectively reducing its FMAP based on its improper payment rate for the previous year.

Summary

Medicaid spending has grown exponentially, with the federal government paying for the entirety of the growth in spending. With that growth have come new problems and an explosion in improper payments.¹⁶ Official government reports cite \$543 billion in improper Medicaid payments over the past decade, but in only two of the past 10 years did the government meaningfully measure improper payments. Based on the two years of meaningful measurements, we

estimate nearly \$1.1 trillion in improper Medicaid payments over the decade from 2015 through 2024 – or double the amount of improper payments reported by CMS.

Many changes are necessary to improve Medicaid and protect the integrity of taxpayers' spending on it.¹⁷ Cracking down on improper payments is a necessary first step that could provide hundreds of billions of dollars in Medicaid savings for federal taxpayers. Those savings would come primarily from requiring states to properly assess Medicaid eligibility and holding them accountable by requiring them to pay a higher share of costs when they fail to protect the integrity of federal taxpayers' dollars.

About the Authors

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¹ Office of Management and Budget, "Payment Accuracy," Annual Improper Payments Datasets, <https://www.paymentaccuracy.gov/payment-accuracy-the-numbers/>.

² Authors' calculations; Office of Management and Budget, "Payment Accuracy."

³ In many states, pervasive state financing gimmicks mean that states do not pay any of the cost of the expansion population. In these cases, the state share of the expansion population is paid with provider and insurer contributions, which are then used to obtain nine times as much money as the contribution, which fuels higher Medicaid payments to those providers using federal dollars.

⁴ Jonathan Bain, "Eligible for Welfare Until Proven Otherwise: How hospital presumptive eligibility pours gasoline on the fire of Medicaid waste, fraud, and abuse," Foundation of Government Accountability, September 2020, <https://thefga.org/research/hospital-presumptive-eligibility/>.

⁵ The 2015 cycle corresponds to reviews from July 1, 2013, through June 30, 2014. The other cycles have this same time frame.

⁶ CMS, *2021 Medicaid and CHIP Supplemental Improper Payment Data*, Table 2A, November 2021, <https://www.cms.gov/files/document/2021-medicaid-chip-supplemental-improper-payment-data.pdf-1>.

⁷ The 2021 report did not fully assess eligibility in the final third of states, citing complications with using federal tax information for income verification. Despite this, Medicaid improper payments still rose to \$99 billion in that report. Other shortcomings in CMS's error measurement stem from the COVID-19 pandemic. CMS paused all its improper payment activities from April to August 2020. The most recent report again cited "COVID-19 flexibilities," such as postponed

eligibility determinations, as a factor in its lower reported improper payments rate in the third of states reviewed this year. In short, even this report – which excuses significant problems and does not include meaningful eligibility reviews – indicates a high improper payment rate.

⁸ Brian Blase and Joe Albanese, "America's Largest Health Care Programs Are Full of Improper Payments," Paragon Health Institute, December 5, 2022, <https://paragoninstitute.org/medicaid/americas-largest-health-care-programs-are-full-of-improper-payments/>.

⁹ Blase and Albanese, "America's Largest Health Care Programs Are Full of Improper Payments."

¹⁰ CMS, "2020 Estimated Improper Payment Rates for Centers for Medicare and Medicaid Services (CMS) Programs," press release, November 16, 2020, <https://www.cms.gov/newsroom/fact-sheets/2020-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs>.

¹¹ HHS, Office of Inspector General, *California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements*, December 2018, <https://oig.hhs.gov/oas/reports/region9/91702002.pdf>.

¹² Blase and Albanese, "America's Largest Health Care Programs Are Full of Improper Payments."

¹³ Eligibility determinations for seniors and people with disabilities can be done every year.

¹⁴ 42 U.S.C. § 1396b(u).

¹⁵ Brian Blase, "The Importance of the Medicaid Fiscal Accountability Rule," *Health Affairs Forefront*, April 7, 2020, <https://www.healthaffairs.org/content/forefront/importance-medicaid-fiscal-accountability-rule>.

¹⁶ Brian Blase and Drew Gonshorowski, "Medicaid Financing Reform: Stopping Discrimination Against the Most Vulnerable and Reducing

Bias Favoring Wealthy States," Paragon Health Institute, July 2024,
<https://paragoninstitute.org/medicaid/medicaid-financing-reform-stopping-discrimination-against-the-most-vulnerable-and-reducing-bias-favoring-wealthy-states/>.