

# How the Trump administration can crack down on Medicaid fraud

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# KEY FINDINGS

1

MORE THAN 10 PERCENT OF MEDICAID SPENDING IS IMPROPER—IN 2017 ALONE, IMPROPER SPENDING REACHED \$60 BILLION.



2

AUDITS REVEAL THAT ELIGIBILITY ERRORS DRIVE IMPROPER MEDICAID SPENDING.



3

PRECIOUS RESOURCES ARE BEING SPENT ON THOSE WHO NO LONGER QUALIFY FOR THE PROGRAM OR NEVER QUALIFIED IN THE FIRST PLACE.



4

OBAMA-ERA REGULATIONS HAVE STALLED STATE EFFORTS TO PRESERVE PROGRAM INTEGRITY FOR TOO LONG.



## BOTTOM LINE:

THE TRUMP ADMINISTRATION SHOULD REVERSE DAMAGING RULES TO PRESERVE MEDICAID PROGRAM INTEGRITY AND PROTECT RESOURCES FOR THE TRULY NEEDY.

## Overview

Waste, fraud, and abuse within Medicaid costs taxpayers billions of dollars and steals limited resources from the truly needy. In fact, federal auditors estimate that more than 10 percent of all Medicaid spending is improper.<sup>1-2</sup> Eligibility determination errors account for most improper payments made by the Medicaid programs.<sup>3</sup>

While the Medicaid program has struggled with program integrity issues for years, two Obama-era regulations made this problem even worse by limiting how frequently states can check eligibility for individuals on Medicaid and what type of information states can request to verify eligibility.<sup>4</sup> These regulations overturned longstanding policy at the Centers for Medicare and Medicaid Services (CMS), removed state flexibility, and created new gaps in program integrity. As policymakers consider steps to crack down on Medicaid fraud, reversing these two regulatory changes should be at the top of their list.

## Improper Medicaid spending is on the rise

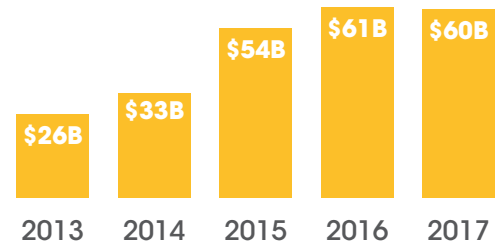
More than 10 percent of state and federal spending on Medicaid is improper, according to recent federal audits.<sup>5-6</sup> In 2017, improper Medicaid spending reached \$60 billion—more than double the \$26 billion improperly spent in 2013.<sup>7-9</sup> In some states, the error rates are even higher, reaching up to 46 percent for some types of errors.<sup>10</sup> **Every dollar spent on individuals who may no longer be eligible is a dollar that cannot fund services for the truly needy.**



**ELIGIBILITY ERRORS  
ACCOUNT FOR MOST  
IMPROPER MEDICAID  
PAYMENTS.**

## IMPROPER MEDICAID PAYMENTS HAVE MORE THAN DOUBLED SINCE 2013

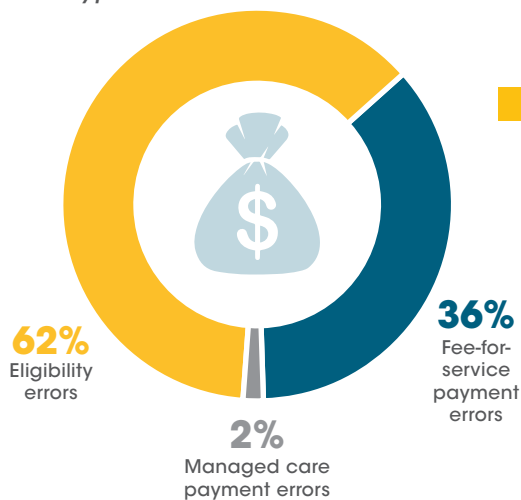
*Estimated cost of improper Medicaid payments, by fiscal year*



*Source: U.S. Department of Health and Human Services*

## ELIGIBILITY ERRORS CAUSE MOST IMPROPER PAYMENTS

Share of improper Medicaid payments in fiscal years 2010 through 2014, by error type



Source: U.S. Department of Health and Human Services

## Eligibility errors drive improper Medicaid spending

Although fraud prevention efforts traditionally focus on provider fraud, most improper payments are caused by eligibility errors. Between 2010 and 2014, eligibility errors were responsible for more than 62 percent of all improper payments in the Medicaid program.<sup>11-13</sup> In 2014, the Obama administration suspended eligibility reviews as part of the improper payment review process, leaving no data on eligibility errors in the years that followed.<sup>14</sup> Although the Obama administration halted reporting of eligibility errors, other types of payment errors have nearly doubled since 2014, suggesting that the amount of improper Medicaid spending could be even higher than reported.<sup>15</sup>

Recent audits have revealed significant problems with state efforts to ensure those receiving benefits are actually eligible. These audits uncovered individuals still enrolled in Medicaid long after their deaths.<sup>16-24</sup> In some cases, individuals who died as far back as 1981 were still enrolled in the program three decades later.<sup>25</sup> In other states, audits revealed individuals enrolled in the program with out-of-state addresses, including some who had no record of ever having lived in the state.<sup>26</sup> In multiple states, Medicaid made payments to managed care organizations multiple times for cases with the same Social Security number.<sup>27-30</sup> In some instances, the same Social Security number was used in seven or more open cases.<sup>31</sup> In other states, audits identified thousands of enrollees with high-risk identities, including individuals committing identity fraud or using fake Social Security numbers.<sup>32</sup>

**1981**

**IN SOME CASES, INDIVIDUALS WHO DIED AS FAR BACK AS 1981 WERE STILL ENROLLED IN THE PROGRAM THREE DECADES LATER.**

Undoubtedly, some of these errors slipped through because states were not performing eligibility reviews as required by law.<sup>33-35</sup> In some states, up to 20 percent of Medicaid cases were overdue for annual eligibility reviews.<sup>36</sup> The delays for those annual reviews ranged up to more than five years.<sup>37</sup>

In other cases, errors stemmed from states relying too heavily on enrollees to report changes that affected their eligibility. One audit, for example, found up to 34 percent of randomly-selected case files had eligibility errors.<sup>38</sup> More than 93 percent of those errors were the result of enrollees reporting incorrect or incomplete information, or not reporting information at all.<sup>39</sup> But in each of those cases, the state renewed the individual’s eligibility in the program, even when the state had access to information indicating they were no longer eligible.<sup>40</sup>

These eligibility and fraud issues can have significant impacts on state and federal budgets. In California, federal auditors identified more than 366,000 ineligible individuals.<sup>41</sup> Additionally, another 79,000 individuals who were potentially ineligible were enrolled in the program.<sup>42</sup> In New York, auditors found more than 47,000 ineligible beneficiaries.<sup>43</sup> In Kentucky, up to eight percent of Medicaid enrollees—nearly 105,000 individuals—were potentially ineligible for the benefits they were receiving.<sup>44-46</sup> These reports provide a glimpse of the billions of dollars in resources being spent on those who no longer qualify for the program or perhaps never qualified in the first place.

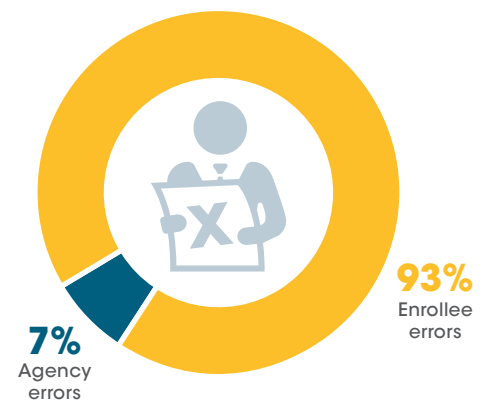
## Obama-era rules undermine program integrity

If these problems were not bad enough, states that want to protect program integrity have been stalled by Obama-era rules. Before 2014, states were required to redetermine Medicaid eligibility at least every 12 months, with the option to check eligibility more frequently.<sup>47</sup>

But in 2014, the Obama administration implemented new regulations that required states to check eligibility no more frequently than once every 12 months.<sup>48-49</sup> This made the previous minimum requirement the new maximum. This regulatory change was adopted alongside other changes related to ObamaCare, but with no basis in statute.<sup>50-51</sup> The regulation also significantly limits what kind of additional information states can request, even if a state receives information that suggests a change in circumstances affecting eligibility.<sup>52</sup> Ultimately, the current regulation crowds out resources for the truly needy as states spend funds on individuals who may no longer be eligible for the program.

### STATES CANNOT RELY ON ENROLLEES TO SELF-REPORT CHANGES

Share of eligibility errors in passive redetermination cases in Illinois, by error source



Source: Illinois Department of Healthcare and Family Services



OBAMA-ERA REGULATORY CHANGES MADE THE PREVIOUS MINIMUM THE NEW MAXIMUM.

WHEN THE CURRENT  
REGULATION WAS  
IMPLEMENTED IT:



**OVERTURNED  
LONGSTANDING  
POLICY**



**REMOVED STATE  
FLEXIBILITY**



**CREATED LARGER  
GAPS IN PROGRAM  
INTEGRITY**

## Protecting program integrity should be a top priority

Life changes frequently. Marriages and deaths occur, jobs change, income fluctuates, and life's happenings do not occur on an annual schedule—making more frequent checks a necessity. The revised regulation made it increasingly more difficult for states to capture these changed circumstances. Every dollar spent on individuals no longer eligible for Medicaid is a dollar that is unavailable to fund services for the truly needy, including poor children, seniors, and individuals with disabilities.

The current regulation overturned longstanding policy, removed state flexibility, and created larger gaps in program integrity. If reversed, states would be given the flexibility to seek additional information on applicants and enrollees. This would empower states to protect program integrity, eliminate passive renewal requirements, and allow for more active redetermination processes.

In April 2018, President Trump signed Executive Order 13828.<sup>53</sup> This order directs federal officials to review existing regulations and sub-regulatory guidance to, among other things, increase program integrity and protect resources for the truly needy.<sup>54</sup> As policymakers consider steps to fulfill the requirements of that order, reversing Obama-era regulations that undermine program integrity should be at the top of their list.

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