

ELIGIBLE FOR WELFARE
UNTIL PROVEN OTHERWISE:

How hospital presumptive eligibility pours gasoline on the fire of Medicaid waste, fraud, and abuse

SEPTEMBER 21, 2020

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KEY FINDINGS

1



PRESUMPTIVE ELIGIBILITY WAS ORIGINALLY A STATE OPTION TO ALLOW ELIGIBLE PREGNANT WOMEN AND CHILDREN TO RECEIVE MEDICAID WHILE THEIR APPLICATIONS WERE PENDING.

2



OBAMACARE FORCED STATES TO ACCEPT HOSPITALS' PRESUMPTIVE ELIGIBILITY DETERMINATIONS FOR ALL ABLE-BODIED ADULTS.

3



OBAMA-ERA REGULATIONS HAVE LIMITED STATES' ABILITY TO COMBAT FRAUD IN THIS AREA.

4



AS A RESULT, 70 PERCENT OF THOSE DEEMED PRESUMPTIVELY ELIGIBLE ARE ULTIMATELY NOT APPROVED FOR MEDICAID THROUGH A FULL ELIGIBILITY CHECK.

5



TAXPAYERS CANNOT RECOUP HPE-RELATED IMPROPER SPENDING.

BOTTOM LINE:

THE TRUMP ADMINISTRATION HAS ALREADY TAKEN GREAT STRIDES TO PROTECT PROGRAM INTEGRITY AND CAN CONTINUE TO DO SO BY ENSURING THAT ABLE-BODIED ADULTS THAT ARE INELIGIBLE FOR MEDICAID ARE NOT STEALING FROM THE TRULY NEEDY.

Presumptive eligibility was intended to be a narrow state option

The Medicaid program is one of the nation's largest welfare programs, with more than 75 million enrollees and an annual price tag of \$639 billion in 2019.¹ The program was originally designed to include basic eligibility checks to ensure that only those actually eligible for the program receive benefits.

States are responsible for administering these eligibility checks and ensuring applicants are vetted properly. In 1986, Congress allowed states the option to provide temporary Medicaid coverage to eligible pregnant women while their applications were still pending.²⁻³ This option was expanded to include children in 1997 and women receiving breast or cervical cancer treatment in 2000.⁴⁻⁶ Under this process, states had the option to presume some applicants temporarily eligible for Medicaid based solely on "preliminary information," instead of the program's more robust eligibility requirements.⁷ Although the presumptive eligibility option had existed for decades for a narrow group of needy populations, few states chose to implement it. In 2011, for example, just 13 states were utilizing the presumptive eligibility option for children.⁸ One major reason states avoided the option was due to the significant challenges it poses to program integrity.

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**HOSPITAL
PRESUMPTIVE
ELIGIBILITY ALLOWS
HOSPITALS TO
DETERMINE IF
INDIVIDUALS ARE
ELIGIBLE FOR
MEDICAID**



ObamaCare expanded fraud by expanding presumptive eligibility

ObamaCare created a new path to waste, fraud, and abuse by expanding presumptive eligibility to a new class of able-bodied adults and forcing states to implement it.⁹⁻¹⁰ As a result, ObamaCare’s “hospital presumptive eligibility” (HPE) policy mandates that states allow hospitals—the largest recipients of Medicaid funding—to determine if individuals are eligible for Medicaid on the basis of self-reported income.

The process for enrolling an individual into temporary Medicaid coverage does not include any verification, or even the full slate of information that must typically be reported to receive Medicaid. In fact, hospitals do not even need to use a paper application—they can simply ask individuals their income and enroll them based on their verbal response.¹¹ Enrolling able-bodied adults into Medicaid based on self-reported information opened a brand-new door for welfare fraud.

Worse yet, Obama-era rules further tied states’ hands, prohibiting states from holding up hospitals’ eligibility determinations for verification of income, residency, or even citizenship.¹² Hospitals can even enroll individuals in Medicaid who are not receiving services, such as visiting family members or members of the community at large.¹³ Individuals remain eligible until they complete a full Medicaid application and receive an eligibility determination, or until the end of the next month following their initial enrollment.¹⁴

In addition, states can allow more than one instance of HPE. Minnesota, Illinois, and California, for example, allow individuals to be presumed eligible at least once every 12 months.¹⁵⁻¹⁷

Due to these changes mandated by ObamaCare, hospitals can now presume able-bodied adults eligible for the program based on their word alone, which qualifies them for up to two months of taxpayer-funded Medicaid benefits.

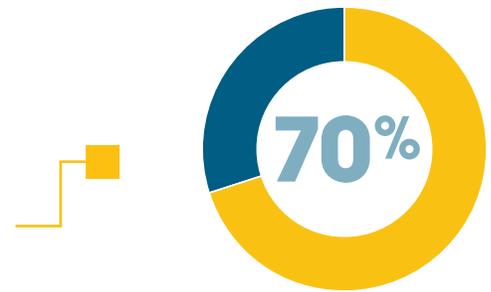
Hospital presumptive eligibility results in massive Medicaid fraud

The Medicaid program has long been plagued by waste, fraud, and abuse.¹⁸⁻²⁰ In 2019, taxpayers paid out nearly \$100 billion in improper Medicaid payments, including more than \$57 billion at the federal level.²¹ Among the states audited in 2019, more than 26 percent of Medicaid spending was improper.²² The single largest cause: eligibility errors, which accounted for nearly 80 percent of all improper Medicaid spending in those states.²³ In a program already fraught with waste, fraud, and abuse, the HPE policy only makes the situation worse.

New data provided by state Medicaid agencies show just how big of a threat to program integrity the HPE policy poses. In 2018, just 30 percent of individuals deemed “presumptively eligible” by hospitals were verified and enrolled into Medicaid.²⁴ A staggering 70 percent were found ineligible or never even completed an application.²⁵

In some states, the situation is even worse. In California, for example, just 23 percent of individuals granted presumptive eligibility by hospitals were enrolled and verified as eligible.²⁶ That means nearly four out of every five people hospitals claimed were eligible for Medicaid were ineligible or never actually applied.²⁷

In 2015, Indiana expanded its HPE policies to allow federally qualified health centers, local health departments, and other locations to also make eligibility determinations.²⁸ The results have not been pretty. Just 25 percent of individuals determined “presumptively eligible” by hospitals and other providers are ultimately eligible and enrolled in the program, despite the fact that the vast majority of them complete applications.²⁹⁻³⁰



**IN 2018, 70 PERCENT
WERE FOUND
INELIGIBLE OR NEVER
COMPLETED AN
APPLICATION**




With fraud running rampant in a program that was already susceptible to improper payments, stronger performance standards are needed to combat these issues.



Federal rules help perpetuate hospital presumptive eligibility fraud

Federal regulations suggest two primary performance standards for states' HPE policies. First, those deemed presumptively eligible should complete a full Medicaid application before the end of their HPE period.³¹ This would allow states to quickly and efficiently verify eligibility. Second, states should hold hospitals accountable for those found ineligible.³²

But these performance standards are mere suggestions, not requirements. Indeed, federal rules only require that states enforce performance standards if they implement them.³³ CMS has justified the lack of standards by stating that states are best equipped to evaluate these situations and thus need additional flexibility.³⁴ But with fraud running rampant in a program that was already susceptible to improper payments, stronger performance standards are needed to combat these issues.

Worse yet, federal rules make it difficult for states to disqualify poorly performing hospitals from participating in the program. Even when states identify hospitals improperly enrolling individuals through HPE, they must provide those hospitals with additional training, and take other corrective action steps prior to suspending their ability to improperly enroll people in the program.³⁵

These Obama-era rules have made performance standards unclear or virtually non-existent. For many states, the only required performance standard is ensuring hospitals assist individuals in completing their Medicaid application.

State profiles: HPE performance standards



CALIFORNIA

Performance standards: Maintain records of employee trainings related to HPE and maintain records of HPE applications.

Actual performance: 23 percent of HPE enrollees determined eligible for Medicaid.



NEW HAMPSHIRE

Performance standards: Ensure 75 percent of HPE enrollees submit Medicaid applications.

Actual performance: 33 percent of HPE enrollees determined eligible for Medicaid.



WEST VIRGINIA

Performance standards: Ensure 75 percent of HPE enrollees submit Medicaid applications. Ensure half of those who submit applications are actually eligible.

Actual performance: 35 percent of HPE enrollees determined eligible for Medicaid.

Taxpayers cannot recoup HPE-related improper spending

The fiscal impact of so many ineligible enrollees draining Medicaid resources is significant. Every HPE enrollee eventually determined ineligible represents up to two months of improper Medicaid spending, siphoning away resources from the truly needy. Making matters worse, many states allow these individuals another period of HPE eligibility the following year, and even more often in some states.³⁶ Despite the obvious potential for fraud, these taxpayer resources cannot be recouped.

Typically, when a Medicaid provider or applicant commits fraud, or even unintentionally wastes Medicaid funds, the state and federal government have options available to recoup the wasted tax dollars.³⁷ This provides at least some protection for both the Medicaid budget and taxpayers.

But HPE-related improper payments are treated differently. In fact, **states and the federal government are forbidden from collecting overpayments from the hospitals, even when they incorrectly enroll ineligible individuals into temporary Medicaid.**³⁸

“There is no recoupment for Medicaid services provided during a PE period resulting from erroneous determinations made by qualified entities.”

—U.S. Department of Health and Human Services

This loophole creates terrible incentives for hospitals. When coupled with lax performance standards and spotty oversight, immunity from repayment gives hospitals perverse incentives to determine all HPE applicants eligible, even if it is clear they are not. In these cases, hospitals have no financial liability, and in a worst-case scenario, may fall into “corrective action” status in the few states who implemented performance standards. Indeed, these hospitals are actually rewarded for bad behavior—instead of potentially covering the cost of treatment for these patients, they are bailed out by taxpayers.



**IMPROPER
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Three steps to protect Medicaid from HPE fraud right now

States and the Trump administration can take three major steps to protect Medicaid from HPE fraud. First, end HPE for able-bodied adults. Second, establish real performance standards for hospitals making HPE determinations and remove hospitals who fail to meet them. Finally, recoup lost funds for ineligible HPE enrollees.

1. END HPE FOR ABLE-BODIED ADULTS

★ **State action: Request a waiver to end HPE for able-bodied adults**

🏛️ **Federal action: Approve and encourage waivers to end HPE for able-bodied adults**

Presumptive eligibility was intended to be an optional, narrow policy for targeted groups of eligible enrollees. States should seek federal permission to return the program to its intended purpose and exclude able-bodied adults from HPE policies. Several states, including Illinois, Maine, and Utah, have already sought waivers for this policy.³⁹⁻⁴¹ The Trump administration should immediately approve these requests and encourage other states to submit similar waivers.

SEVERAL STATES HAVE ALREADY SOUGHT WAIVERS TO CRACK DOWN ON HPE ABUSE



STEPS TO PROTECT MEDICAID FROM HPE FRAUD

1



END HPE FOR ABLE-BODIED ADULTS

2



ESTABLISH PERFORMANCE STANDARDS

3



RECOUP LOST FUNDS

2. ESTABLISH PERFORMANCE STANDARDS



State action: Implement a “three strikes” performance standard



Federal action: Require states to implement performance standards

States’ HPE performance standards often have little to do with performance, if they exist at all. In many cases, the standards simply require hospitals to ensure some portion of HPE enrollees file Medicaid applications at a future date. But some states have developed strong program integrity protections for their HPE programs.

Under the leadership of then-Commissioner Mary Mayhew, Maine’s Department of Health and Human Services implemented a “three strikes” policy for hospitals. Hospitals were required to ensure the agency received notice of each HPE determination within five days, that a full Medicaid application for each HPE enrollee was received by the end of the HPE period, and that each HPE enrollee was ultimately determined eligible for Medicaid.⁴² Hospitals who failed to meet this standard were required to have staff attend the Medicaid agency’s mandatory training on HPE for the first two occurrences.⁴³ If a hospital failed to meet this standard a third time, they were permanently removed from the HPE program.⁴⁴

States should adopt this type of strong protection for program integrity and implement real performance standards for the HPE program. Likewise, given the massive amount of improper HPE determinations nationwide, the Trump administration should require that all states adopt such standards.

3. RECOUP LOST FUNDS

★ **State action:** Request a waiver to recoup lost funds

🏛️ **Federal action:** Issue new guidance to allow states to recoup lost funds and approve related waivers

Under current guidance, states may not recoup funds from improper HPE determinations. States should seek federal permission to recoup funds spent on HPE-related fraud from hospitals and other providers making improper HPE determinations. The Trump administration should immediately approve these waiver requests and issue new guidance making it easier for states to protect program integrity by recouping such funds.

ObamaCare opened the door even wider to fraud in the Medicaid program. The Trump administration has already taken great strides to protect program integrity and can continue to do so by ensuring that able-bodied adults who are ineligible for Medicaid are not stealing from the truly needy.

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