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HOW STATES CAN REFORM HEALTH CARE TODAY

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CHAPTER 2

Manage Effectively

Make Medicaid More Accountable

Jonathan Ingram

KEY TAKEAWAYS

- Medicaid was designed as a safety net for the truly needy, but, over time, the program has gotten further away from that purpose, leading to skyrocketing enrollment and costs.
- In 2020, more than one in four dollars spent on Medicaid was improper. Improper enrollment largely results from the failure of states to properly verify income, citizenship, residence, incarceration status, and even whether people are still alive.
- States can help preserve resources for the truly needy by ensuring those enrolled in the program are eligible, including better screening on the front end, more frequent postenrollment reviews, rolling back optional exemptions, and improving enforcement.
- States should also prepare for the end of the COVID-19 public health emergency by beginning to conduct eligibility reviews throughout the year and performing a financial analysis of whether the 6.2 percent increase in federal matching funds is outweighed by the increased state costs from covering so many ineligible enrollees.

PROBLEM

Medicaid was designed as a safety net for the truly needy, including seniors, individuals with disabilities, and low-income children, but, over time, the program has gotten further and further away from that purpose, leading to

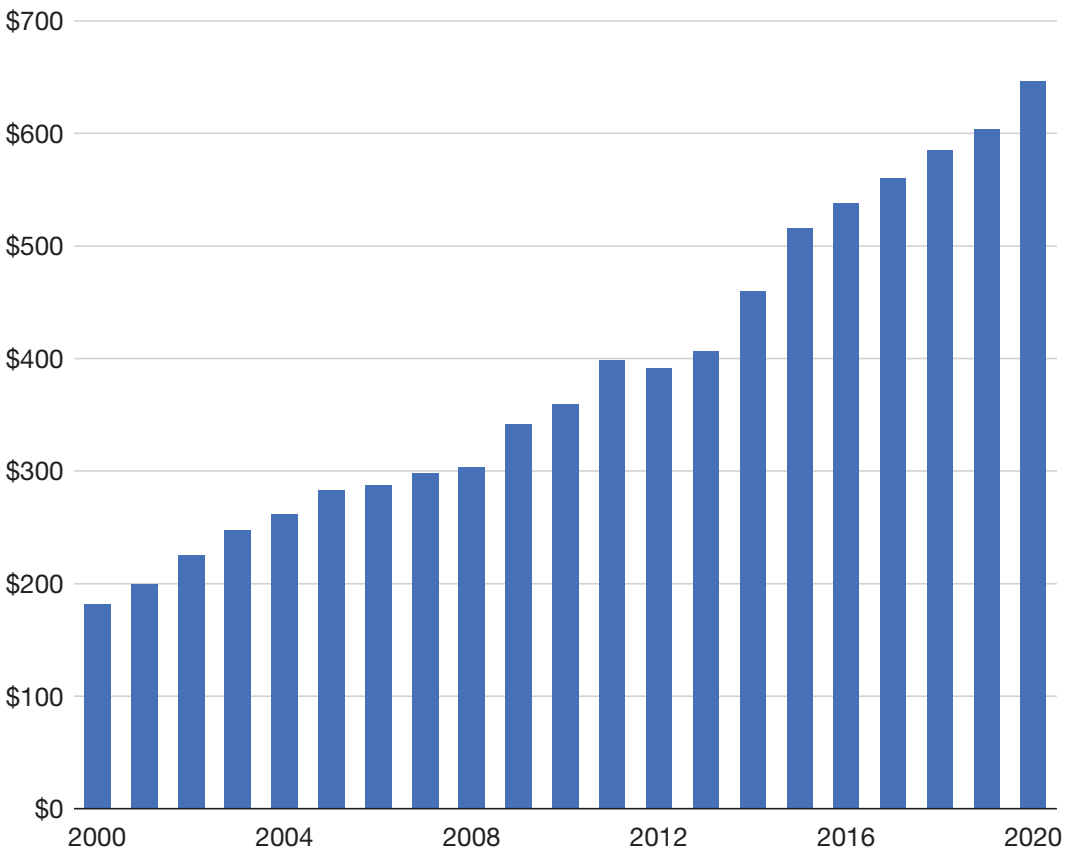

Figure 2.1 State and federal Medicaid spending by year (in billions). Medicaid spending has more than tripled since 2000.
Source: National Association of State Budget Officers.

skyrocketing enrollment and costs. State and federal spending on Medicaid has more than tripled since 2000 (see Figure 2.1), with able-bodied adults the fastest growing enrollment group, both before, but especially after, the Affordable Care Act (ACA) expanded eligibility to a new class of able-bodied adults.[1–3]

Between 2013 and 2018, able-bodied adult enrollment nearly doubled, while enrollment in the rest of the Medicaid program grew by just 2 percent.[4] In states that opted into the ACA expansion, more than twice as many able-bodied adults signed up for the program as states expected, with a much higher cost—nearly double the cost per person—than federal officials projected.[5–6]

In California, for example, state officials expected just 910,000 able-bodied adults would sign up for expansion by 2020.[7] The state shattered those projections in less than a month.[8] In 2021, more than 4.2 million

able-bodied adults in California were enrolled in Medicaid expansion, costing taxpayers billions of dollars more than anticipated.[9–10] In fact, Medicaid expansion has cost significantly more than expected in every expansion state with available data.[11]

Medicaid also plays a large role in why Americans are generally underprepared for long-term care, as the program has largely supplanted the private long-term care insurance market for upper- and middle-class families.[12] Long-term care costs now represent nearly a third of states' entire Medicaid budgets, with these costs making up more than half of all Medicaid expenditures in some states.[13] Eligibility expansions, increased income and asset exemptions, and sophisticated "Medicaid planning" techniques have ensured that virtually anyone who chooses can become eligible for Medicaid long-term care benefits, including millionaires.[14]

As Medicaid enrollment and costs have continued to spiral out of control, and as accountability for the program has eroded, states have increasingly struggled to manage it effectively. More than one in four dollars spent on Medicaid today is improper.[15] Before the ACA was implemented, improper payments accounted for 6–8 percent of Medicaid spending.[16]

While provider fraud often makes the headlines, the reality is that roughly 80 percent of improper payments are tied directly to eligibility errors (see Figure 2.2).[17] Unfortunately, the Obama administration suspended its review of states' eligibility determinations in 2014, which stayed on pause until the Trump administration restarted it in 2018 (and as reflected in a 2019 report).[18]

In New York, for example, federal auditors projected that more than one million ineligible and potentially ineligible enrollees were in the program.[19–20] Nearly 100,000 ineligible or potentially ineligible expansion enrollees were estimated in Colorado, and more than 100,000 potentially ineligible enrollees were estimated in Kentucky.[21–23] In Ohio, a federal audit concluded that nearly 300,000 of the state's 481,000 expansion enrollees were ineligible or potentially ineligible, and federal auditors estimated nearly 1.2 million ineligible enrollees and another 3.2 million potentially ineligible enrollees in California's Medicaid program.[24–26]

Improper enrollment largely results from the failure of states to properly verify income, citizenship, residence, incarceration status, and even whether people are still alive. Some individuals have multiple enrollments in the same state or across states. Applicants may submit false information and fail to update key information, such as a large income change. Many individuals are

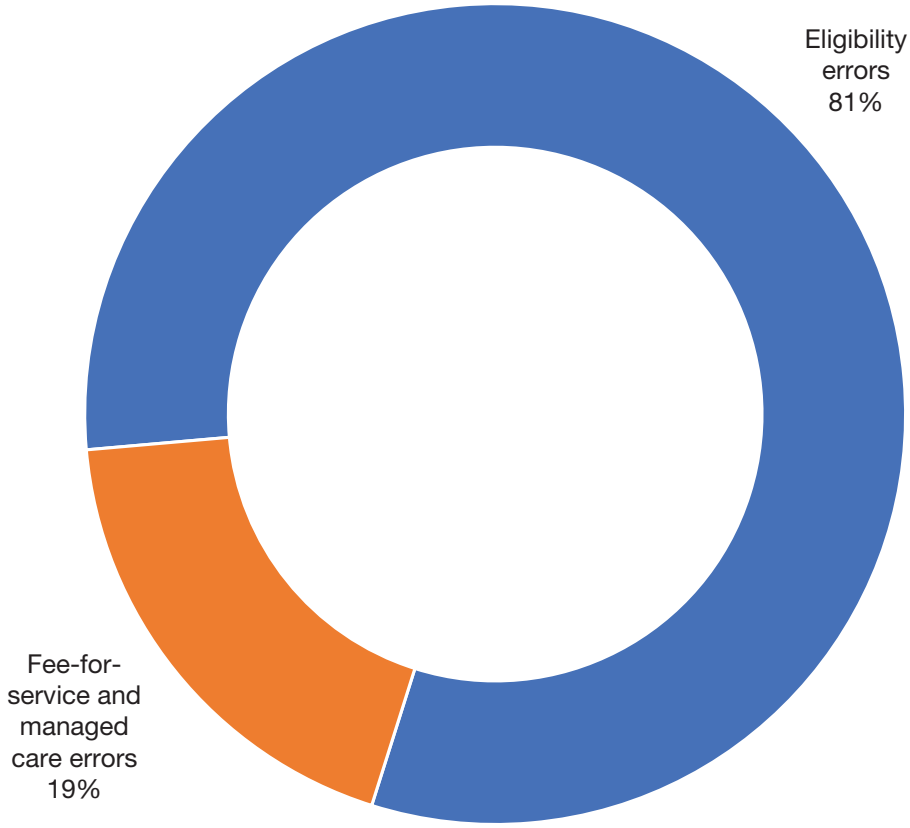

Figure 2.2 Source of improper Medicaid payments in 2020 PERM cycle. Eligibility errors cause most improper Medicaid payments.

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

incorrectly determined eligible by HealthCare.gov, hospitals, or other providers using presumptive eligibility. Because managed care companies receive a flat monthly premium for every enrollee—regardless of whether the enrollee is actually eligible—the incentives align with improper enrollment. While some hope that managed care could reduce Medicaid's cost growth, it could make costs spiral even further out of control. For example, some amount of state payments to insurers are for individuals who have died, moved out of state, are otherwise ineligible, or who utilize little, if any, health services.

Self-Attestation

One of the biggest program integrity issues in Medicaid is the acceptance of self-attested information. Many states accept applicants' attestation for a

variety of information, including income, household size, household composition, and more. For example, all states accept self-attestation for household composition despite having access to tax return information and other relevant sources, 45 states accept self-attestation of residency, and at least 15 states accept self-attestation of income to some degree.[27] Once accepting this information, states may not verify it until months later and sometimes not at all.[28] A Louisiana audit, for example, found tens of thousands of ineligible individuals who were allowed to enroll in the program because the state did not verify self-attested information on household size, composition, or certain types of income.[29] New Jersey auditors identified thousands of enrollees with unreported six-figure incomes, including some earning as much as $4.2 million per year.[30] In Minnesota, at least 15 percent of enrollees misreported their incomes to the Medicaid agency, with the average enrollee having nearly $21,000 in underreported income.[31] Several of these cases included individuals who self-attested to no income but who had income far above the eligibility limits.[32]

Unreported Changes in Circumstances

Although individuals are legally required to report changes in their circumstances that may affect eligibility, few do. An Illinois audit of the state's passive redetermination processes discovered that more than 93 percent of all eligibility errors resulted from enrollees reporting incorrect information or failing to report changes in their income, household composition, and more.[33] New Jersey auditors identified a number of cases where individuals did not report changes as legally required, including one individual who had wages of nearly $250,000—nearly 15 times the eligibility threshold.[34]

Presumptive Eligibility

A growing Medicaid program integrity problem involves "presumptive" eligibility determinations—a process whereby Medicaid programs pay for expenses incurred by individuals before eligibility is verified. In a 2019 audit, the U.S. Department of Health and Human Services estimated that roughly 43 percent of sampled spending on presumptively eligible enrollees was improper.[35] Data from state Medicaid agencies reveals that such improper payments could be higher.[36]

The problem may be growing worse since the ACA allowed hospitals to make presumptive eligibility determinations for all able-bodied adults regardless of whether states prefer to limit hospitals' ability to deem people eligible for Medicaid. Hospitals do not have incentives to ensure that people meet eligibility requirements, and they have done a poor job of assessing applicant eligibility before enrollment. Data provided by state Medicaid agencies reveals that just 30 percent of individuals that hospitals determined "presumptively eligible" were ultimately determined eligible for Medicaid by the state.[37] In California, for example, nearly 500,000 individuals were determined presumptively eligible by hospitals between April 2019 and March 2021, but the state enrolled only 155,000 after completing full eligibility reviews.[38] Under federal regulations, states also have no way to recoup their share of this improper spending.[39]

Payments for the Deceased, Nonresidents, and Prisoners

State and federal audits have uncovered hundreds of millions of dollars in Medicaid funding spent on deceased individuals.[40–54] In California, nearly a third of deceased individuals still enrolled in the program had been dead for more than a year.[55] Audits have also uncovered millions spent on individuals who had moved out of state or who may never have lived in the state in the first place. Missouri and Minnesota auditors identified thousands of Medicaid enrollees with out-of-state addresses.[56–57] In Arkansas, nearly 43,000 out-of-state enrollees were discovered in the program.[58] To make matters worse, nearly 7,000 of those enrollees had no record of ever having lived in the state.[59]

States have also discovered individuals enrolled in Medicaid while in state or federal prison, even though federal law generally prohibits states from using Medicaid funds to pay for inmates' medical care. In Missouri, for example, the Medicaid program paid managed care companies millions of dollars to cover individuals who were incarcerated and unable to utilize Medicaid services.[60] Similarly, Arkansas auditors identified more than 1,000 prisoners enrolled in Medicaid, many of whom were not expected to be released for five or more years.[61]

Double Enrollment

State and federal audits have also identified tens of thousands of individuals who enrolled multiple times in the same state.[62–69] In some cases,

individuals had as many as seven different open Medicaid cases.[70] States then paid managed care companies multiple capitated premiums for the same individuals, costing taxpayers millions of dollars.[71–76]

High-Risk Identities

In many cases, duplicate enrollment may result from identity fraud. In Arkansas, auditors discovered more than 20,000 enrollees with high-risk identities.[77] These included individuals with stolen or fraudulent Social Security numbers linked to multiple people.[78] A similar audit in New Jersey identified more than 18,000 enrollees with fake or duplicate Social Security numbers.[79]

Faulty Exchange Determinations

Some states are adopting eligibility mistakes made by the federal government. States have the option to either assess the eligibility of individuals who have applied for coverage through HealthCare.gov or simply accept its determinations. Auditors have found a number of cases where HealthCare.gov's determinations were incorrect and where even cursory reviews of state data would have prevented eligibility errors.[80] States have reported thousands of cases of incorrect Medicaid determinations by HealthCare.gov.[81]

The Problematic Maintenance of Effort

States have been hamstrung in their abilities to address program integrity during the COVID-19 pandemic. As part of the Families First Coronavirus Response Act (FFCRA), states can increase federal taxpayers' share of traditional Medicaid funding by an additional 6.2 percent.[82] In order to receive these funds, however, states must agree not to make changes to the eligibility or enrollment process and not remove ineligible enrollees.[83] States frequently report that 30 percent or more of cases reviewed at their annual redetermination are no longer eligible, meaning states are paying for millions of enrollees nationwide who are no longer eligible or who may never have been eligible.[84]

In California, for example, Medicaid enrollment has spiked by more than 1.2 million people—nearly 10 percent—since March 2020, but a state enrollment review revealed that the entire *net* increase in enrollment was caused by federal rules prohibiting the state from removing people who were no longer

eligible. [85–86] Likewise, Arizona's Medicaid enrollment has increased by nearly 360,000, but Medicaid officials indicate that as many as 300,000 current enrollees are ineligible.[87]

Harming the Truly Needy

Nearly 820,000 individuals nationwide are on waiting lists for home- and community-based services and support.[88] The average wait time for individuals with intellectual or developmental disabilities—who make up the vast majority of those waiting for needed services—is nearly six years.[89] In some states, the average wait can be as long as 14 years.[90] Since the ACA's Medicaid expansion began, at least 22,000 individuals on Medicaid waiting lists have died.[91]

Crowding Out Other State Priorities

Medicaid is the largest and the fastest-growing program in state budgets and is crowding out funding for other priorities (see Figure 2.3). In 2000,

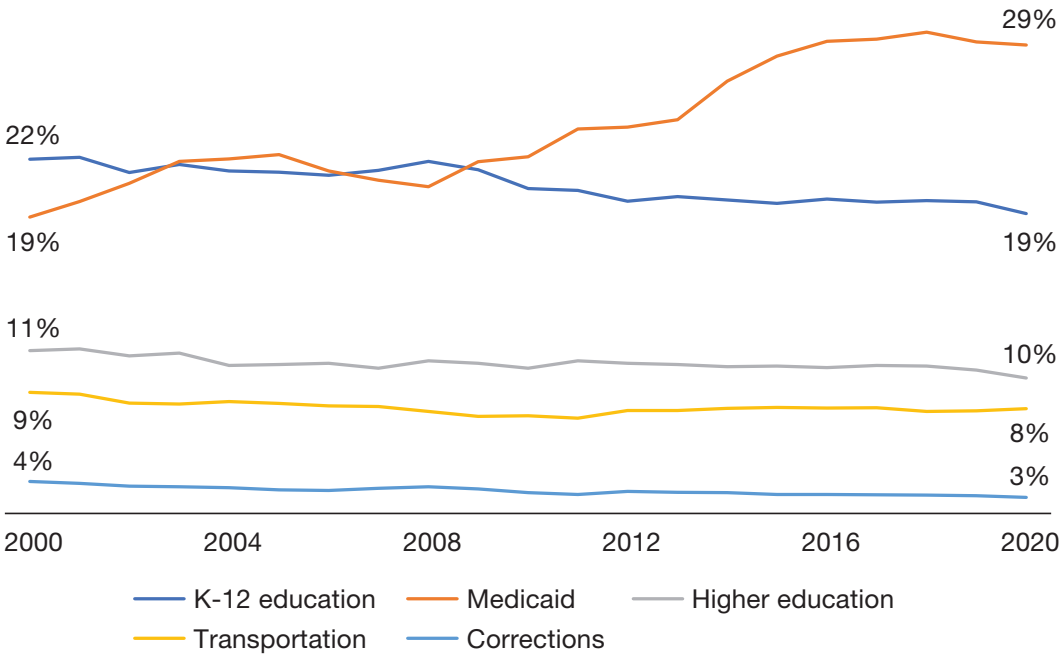

Figure 2.3 Medicaid's share of total state budgets by year, showing that it is consuming more and more of states' budgets.

Source: National Association of State Budget Officers.

Medicaid spending accounted for roughly one in five dollars in states' budgets.[92] By 2020, that figure had reached nearly one in three.[93] In some states, Medicaid consumes nearly 40 percent of the state budget.[94] Because Medicaid spending is growing nearly three times as fast as state tax revenues, more and more funding must be diverted from other areas, such as education, infrastructure, and public safety.[95–96]

PROPOSAL—GREATER ACCOUNTABILITY IN MEDICAID

While Washington policies push Medicaid further and further from its core purpose, states can improve the program for those who truly need it and be better stewards of taxpayer dollars. This starts with ensuring that those enrolled in the program are eligible. States can take action now, regardless of federal government policy.

Prepare for the End of the COVID-19 Emergency

In response to the Maintenance of Effort (MOE) restrictions imposed by FFCRA, many states stopped conducting eligibility reviews altogether. When the government declares the public health emergency over, these states will face a massive backlog of overdue redeterminations. States should begin to prepare now by commencing eligibility reviews throughout the year. For those states that have paused redeterminations, that means restarting the reviews immediately. This will ensure that states are prepared to remove ineligible enrollees as soon as the emergency ends. As part of that preparation, states should also conduct a financial analysis of whether the 6.2 percent increase in federal matching funds is outweighed by the increased state costs from being unable to remove ineligible enrollees, as the number of ineligible enrollees will continue to grow throughout the declared public health emergency. As states prepare for these changes, they should ensure better verification on the front end, increase data matching processes on an ongoing basis, roll back optional exemptions, and improve enforcement.

Audit of the Medicaid Program

States should also conduct a full-scale audit of the Medicaid program, including eligibility verification processes, utilization rates, managed care rates,

duration of individuals enrolled through retroactive or presumptive eligibility, and more. These audits are justified by the high, pre-COVID, improper payment rate in the program, as well as the dramatic program changes that have occurred during the public health emergency. The audits should provide valuable information for states as they seek to introduce reforms into their programs.

Better Verification on the Front End

States must perform better initial verification of Medicaid eligibility. Instead of accepting self-attestation for income, household size, and household composition or only conducting postenrollment verification months later, states should once again verify this information before enrolling applicants. States already have access to a variety of data that can help verify eligibility, including employers' quarterly wage reports, state tax filings, and commercial databases already in use for other purposes. Medicaid agencies should set up data-sharing arrangements with other state agencies to begin using this data.

States should also stop accepting eligibility determinations from HealthCare.gov, as the federal exchange lacks important data that states maintain and has a history of significant errors. Instead, they should assess the eligibility of applicants submitted through HealthCare.gov, just as they do all other applications.

States should improve their performance benchmarks for hospitals and other providers that incorrectly determine someone is presumptively eligible for Medicaid. Maine, for example, instituted a commonsense "three strikes" policy for presumptive eligibility.[97] Under this policy, all hospitals making presumptive eligibility determinations in Maine were given extensive training on the determination process.[98] After the first strike—where a hospital incorrectly determined an individual was presumptively eligible—the Medicaid agency sent a notice explaining which standards the hospital failed to meet and warned that a second incorrect determination would require additional training.[99] After the second strike, the agency sent another notice and warned that the third strike would result in the hospital no longer being authorized to perform presumptive eligibility determinations.[100] After the third strike, the agency sent a notice of which standards were not met and confirmed that the hospital could no longer make presumptive eligibility determinations.[101]

More Ongoing Reviews

Most states only perform eligibility reviews once per year, even though many, if not most, individuals experience life changes, such as finding a new job, a change in salary, moving to a new state, getting married, or even death, during the year. States already receive reports from employers when they make new hires as well as receiving quarterly wage reports. The Medicaid agency should be crosschecking this data as it receives it, ensuring that it knows when enrollees' circumstances change, rather than waiting a year to check.

States also maintain death records for their residents and have access to federal and commercial death registry data. The Medicaid agency should be reviewing this data monthly, removing dead enrollees from the program to avoid paying managed care companies for individuals who are dead.

States also have access to a variety of data to ensure that those in the program still reside in their state. More active participation and use of data-sharing arrangements with other states—such as the Public Assistance Reporting Information System and the National Accuracy Clearinghouse—would provide additional notice when enrollees apply for benefits in other states, but data sharing between welfare programs would improve program integrity even more. For those Medicaid enrollees also receiving food stamps or cash welfare, states could review monthly out-of-state food stamp transactions to identify individuals who have likely moved out of state.

States must then do a full eligibility redetermination when changes in enrollees' circumstances suggest the enrollee is no longer eligible. Collectively, these reforms have produced hundreds of millions of dollars in savings, their administrative costs have been accommodated within existing resources, and the potential savings far exceed implementation costs.[102–104]

Roll Back Optional Exemptions and Improve Enforcement

States should also take action to minimize the ease with which relatively affluent people can have their long-term care expenses paid by Medicaid. For example, under federal law, states must exempt up to $603,000 in home equity from their resource limits when determining eligibility for Medicaid long-term care, but states can extend that exemption beyond the federal minimum, and many have done so. [105–106] In most states that have extended

the exemption, individuals can exempt up to $906,000 in home equity from the asset limits.[107] In some states, such as California, applicants can exempt an unlimited amount of home equity.[108] In order to preserve resources for the truly needy, states should immediately return to the federal standards for home equity exemptions for all new long-term care applicants, as Illinois did in 2012.[109] While additional changes are needed at the federal level to return the program to its intended purpose, this will help states begin charting that path.[110]

States should also improve enforcement of their estate recovery efforts. Although federal law requires that states recover Medicaid enrollees' long-term care costs from their estates, there is wide variation in the kinds of costs states try to recoup and even whether states try to recover funds at all.[111] When states fail to meaningfully engage in estate recovery, heirs can receive large inheritances while taxpayers are left covering those expenses.

CONCLUSION

Irrespective of federal policy and whether states adopted the ACA Medicaid expansion, states should responsibly manage their Medicaid programs. With a federal Medicaid improper payment rate above 25 percent, there is a lot of work to do. Unfortunately, many of the institutions that are financially benefiting from these improper payments or benefit politically from higher welfare enrollment are likely to oppose commonsense program oversight and accountability, but Medicaid does not exist to funnel unlawful payments to hospitals and insurance companies, where funds meant for the truly needy are instead siphoned away through waste, fraud, and abuse.

ABOUT THE AUTHOR

Jonathan Ingram is vice president of policy and research at the Foundation for Government Accountability (FGA), where he leads a team that develops and advances policy solutions to help millions of people achieve the American Dream. Prior to joining FGA, he served as the director of health policy and pension reform at the Illinois Policy Institute and as editor-in-chief at the *Journal of Legal Medicine*. He holds a BA in history and English, an executive MBA, and a JD. His passion for reducing dependency resulted in Illinois governor Bruce Rauner appointing him to serve on the Illinois Health Facilities and Services Review Board in 2016. He has

testified before numerous state legislative committees, and his research and commentary has earned coverage from the *Wall Street Journal*, the *Chicago Tribune*, *Crain's Chicago Business*, *Forbes*, *USA Today*, and Fox News, among other media outlets.

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