

America's Largest Health Care Programs Are Full of Improper Payments

Policy choices have worsened the problem and auditing methods have downplayed it

By Joe Albanese and Brian Blase, PhD

Waste, fraud, and abuse in federal health care programs are perennial problems, and large payment errors are a sign of deeper program mismanagement. Recently released data shows over \$130 billion per year in improper payments, which are largely driven by unwise Medicaid policies and lax program integrity efforts. Questionable data collection practices mean that actual improper payments are likely much higher. This issue brief will summarize the new improper payments data, offer context from past data, and explain the policy decisions that have led to the significant rise in improper payments as well as limitations in measuring them.

Overview

On November 15, the Centers for Medicare and Medicaid Services (CMS) released its annual report on improper payments in federal health programs. Improper payments are those that do not meet program requirements and can result from a variety of problems, ranging from outright fraud to unintended documentation errors.¹ Improper payments do not encompass payments for low quality or unnecessary services. In the vast majority of cases, improper payments result in overpayment by the federal government.² Overall, this year's report shows that an enormous amount of money spent through federal health programs — roughly \$130 billion annually — does not comply with program rules.³

The tables and figures on the next page show the yearly improper payment rate and dollar amount by program.^{4,5} CMS's report contains improper payment rates for each of Medicare's three components:

KEY TAKEAWAYS

A new report estimates official improper payments made by federal health programs are about \$132 billion annually, although actual improper payments are likely far higher.

CMS data collection practices, including halting meaningful audits of state eligibility determinations for Medicaid and CHIP as well as "COVID-19 flexibilities" substantially underestimate official improper payments.

Improper payments in Medicaid have soared after the ACA's expansion of the program.

traditional fee-for-service (FFS), which is comprised of Parts A (hospital coverage) and B (physician coverage); Medicare Advantage (MA), which administers payment for services via private health plans; and Medicare Part D, which is the prescription drug program.

For Medicare, the analysis period for each report is roughly two years prior to the year the report was released. In the 2022 report, Medicare FFS data is from July 1, 2020, through June 30, 2021.⁶ Also, MA and Part D data is from calendar year 2020.^{7,8} For Medicaid and the Children's Health Insurance Program (CHIP), CMS audits one-third of states each year and reports improper payments as the average of the three most recent years.⁹

CMS Improper Payment Rates by Report Year

	2016	2017	2018	2019	2020*	2021*	2022*
Medicare							
Fee-for-Service	11.00%	9.51%	8.12%	7.25%	6.27%	6.26%	7.46%
Medicare Advantage	9.99%	8.31%	8.10%	7.87%	6.78%	10.28%	5.42%
Medicare Part D	3.41%	1.67%	1.66%	0.75%	1.15%	1.33%	1.54%
Medicaid	10.48%**	10.10%**	9.79%**	14.90%**	21.36%**	21.69%	15.62%
CHIP	7.99%**	8.64%**	8.57%**	15.83%**	27.00%**	31.84%	26.75%
Federal Exchange	N/A						0.62%

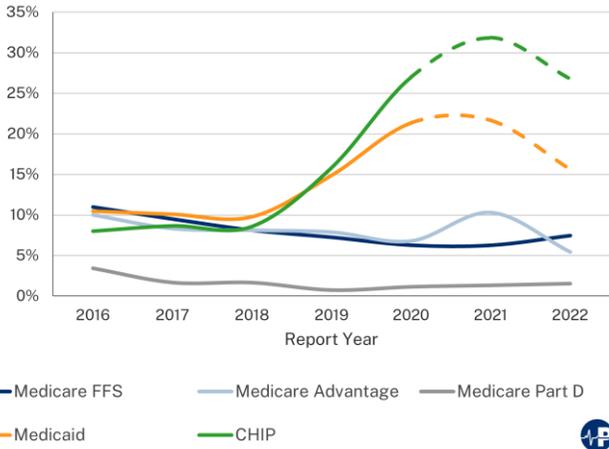
CMS Total Improper Payments by Report Year (Billions of Dollars)

	2016	2017	2018	2019	2020*	2021*	2022*
Medicare							
Fee-for-Service	\$41.08	\$36.21	\$31.62	\$28.91	\$25.74	\$25.03	\$31.46
Medicare Advantage	\$16.18	\$14.35	\$15.55	\$16.73	\$16.27	\$23.19	\$13.94
Medicare Part D	\$2.39	\$1.30	\$1.32	\$0.61	\$0.93	\$1.15	\$1.36
Medicaid	\$36.25**	\$36.73**	\$36.25**	\$57.36**	\$86.49**	\$98.72	\$80.57
CHIP	\$0.74**	\$1.24**	\$1.39**	\$2.74**	\$4.78**	\$5.37	\$4.30
Federal Exchange	N/A						\$0.26
Total	\$96.64	\$89.83	\$86.13	\$106.35	\$134.21	\$153.46	\$131.63

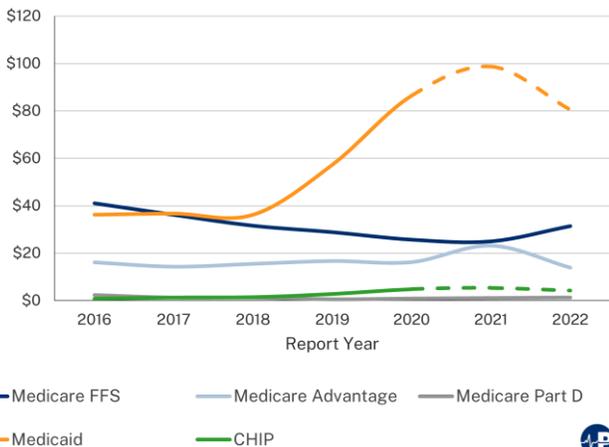
* CMS's "COVID-19 "flexibilities," such as the pause on improper payment activities between April and August 2020, impact the 2020 and 2021 reports for Medicare and CHIP, and the 2022 report for Medicare, Medicaid, and CHIP. Complications with using federal tax information to confirm state eligibility reviews affect the 2021 report for Medicaid and CHIP.

** CMS did not perform Medicaid and CHIP eligibility reviews from 2014 to 2017. Because of a time lag with the reports and since CMS audits these data from one third of the states each year and bases the report on a three-year average, the reported Medicaid and CHIP improper payment rates in the 2015-2020 reports are artificially low.

Historic Improper Payment Rates



Historic Improper Payments (Billions)



Note: The dashed lines represent significant methodological changes in the 2020, 2021, and 2022 reports. With respect to Medicaid and CHIP, CMS paused all improper payment activities during April through August 2020, continued to extend COVID-19 “flexibilities” on auditing related to eligibility in 2021, and did not assess eligibility in 2021 due to tax data complications.

Total estimated improper payments in this year’s report are \$132 billion across all reported programs. About 97 percent of the increase in improper payments since the 2018 report has been driven by higher reported misspending in Medicaid. A total of \$132 billion in improper payments is a decrease from the amounts reported in 2020 (\$134 billion) and 2021 (\$153 billion) —

years in which reported improper payments were exceptionally high—but this year’s reported improper payments total is still the third highest amount on record. As discussed below, all these estimates are much lower than actual improper payments, and this is especially true this year because of lax Medicaid and CHIP state eligibility audits.

Medicaid

Medicaid’s reported improper payment rate declined in the 2022 report to 15.6 percent, which is an artificially low figure due to CMS’s decision to reduce eligibility audits. Medicaid now provides coverage to about one in four Americans.¹⁰ Such rapid expansion and high rate of improper payments are indicators that taxpayers are suffering from poor government policy and program management.

A poorly run Medicaid program also harms the truly needy by misallocating resources.¹¹ The recent, drastic growth in improper payments has coincided with the Affordable Care Act’s (ACA’s) Medicaid expansion. Medicaid was originally designed to assist the most vulnerable Americans, such as low-income pregnant women, children, seniors, and individuals with disabilities. However, the ACA expanded Medicaid to able-bodied adults by enticing states with generous financial incentives. Much of the improper payment problem in Medicaid results from the enhanced federal reimbursement rate for the ACA expansion population. The enhanced reimbursement rate creates a significant incentive for states to enroll people under the expansion criteria even if those people would have been eligible to be enrolled under the prior criteria and thus at the lower reimbursement rate.

Indeed, the ACA’s Medicaid expansion not only diverts more resources from those most in need but also has produced much higher improper payments. In the two reporting years before the ACA’s Medicaid expansion took effect, Medicaid’s improper rate averaged about six percent. With the expansion, the improper payment rate increased substantially, reaching more than 20 percent in the 2020 and 2021 reports.¹² The main reason for the growth in Medicaid’s improper payments is that

states have failed to ensure people on the program are actually eligible. After conducting audits over a six-month period in 2014 and 2015, HHS's Office of the Inspector General estimated that just two states—California and New York—made at least \$1.7 billion in Medicaid improper payments to cover at least 1.6 million enrollees who were ineligible for the program (estimating at least \$4.3 billion more in spending on 3.9 million “potentially” ineligible enrollees, or those enrolled without a proper review of their information and may not have been eligible).¹³

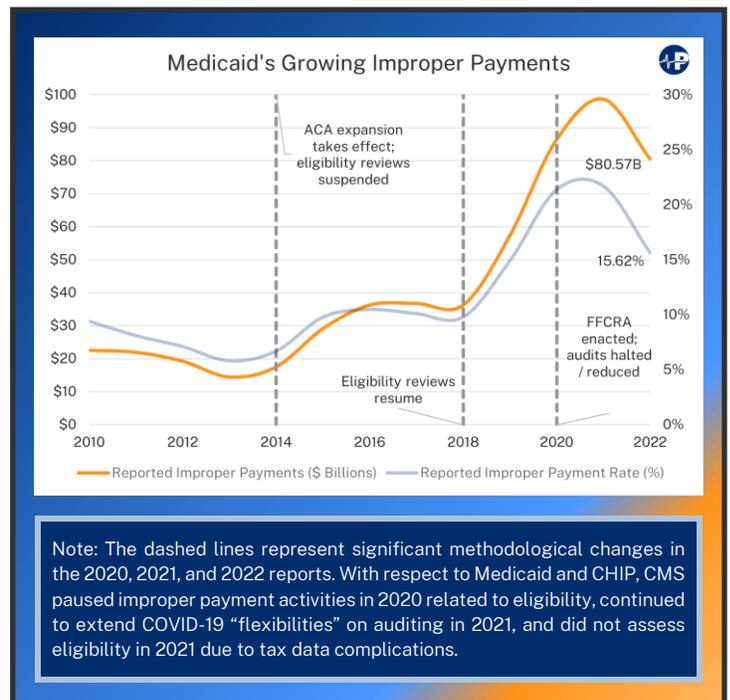
Since the ACA expansion, CMS has failed to adequately track this rise in misspending on ineligible enrollees. CMS stopped eligibility reviews as part of its overall audits from 2014 to 2017, so the reported Medicaid payments for those years (found in the 2015 through 2020 reports) do not reflect true improper payment estimates. When it restarted eligibility reviews in 2018, there was a huge increase in reported improper payments (from a \$36 billion in the 2018 report to \$57 billion in the 2019 report), even though only one-third of states had eligibility reviews accounted for in the 2019 report. The 2020 report showed a further surge in Medicaid improper payments (up to \$86 billion) as a second third of the states were reviewed for eligibility. Those states, like the first third reviewed, consistently failed to properly determine eligibility for the program. The 2021 report did not fully assess eligibility in the final third of states, citing complications with using federal tax information for income verification.¹⁴ 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.¹⁵ In short, even this report, which excuses significant problems and does not include meaningful eligibility audits, indicates a high improper payment rate.

The ACA expansion created high improper payments in Medicaid, but the policy response to COVID-19 has only exacerbated it. The enactment of the Families First Coronavirus Response Act (FFCRA) in March 2020 increased federal financial support of Medicaid so long as states did not update their eligibility requirements or remove ineligible people from the program until the public health emergency ends.¹⁶ CBO estimated in June 2022 that over one in six Medicaid enrollees—nearly 13 million people—are ineligible for the program but remain enrolled due to these policies.¹⁷ The Urban Institute's estimate of ineligible Medicaid enrollees is 16 million people as of the end of September 2022.¹⁸ Because CMS suspended or reduced its activities for collecting improper payment data due to the COVID-19 pandemic, recent reports have undercounted Medicaid and CHIP errors.¹⁹

CHIP

CHIP's improper payment rate has also risen substantially since the 2019 report. In reporting year



2021, nearly a third of program payments were improper (this too is almost certainly an undercount for many of the same reasons described above). In the 2022 report, official improper payments declined to one quarter of program payments. CHIP's total loss of dollars is less than other programs' losses because of its smaller overall size.

Medicare

In the most recent report, improper Medicare payments slightly increased for FFS and Part D, while decreasing in MA. These fluctuations come after CMS changed how it calculates its error estimates for MA. Specifically, in the prior year, CMS began to focus its calculations on a subset of the MA expenses most at risk for diagnostic error. As a result of this measurement change, the 2021 report estimated an inflated improper payment rate.²⁰ While Part D improper payment rates are consistently and significantly lower than the rest of Medicare, rates for FFS and MA are typically within two percentage points of each other. Reporting year 2022 is the first since 2016 in which FFS improper payment rates have increased. FFS improper payment rates have generally declined since 2016, as have MA's improper payment rates. However, CMS's pause on improper payment activities in 2020 also likely undercounts the Medicare improper payment rates reported in the 2021 and 2022 reports.

Documentation problems—such as failing to submit medical records along with billing records—are the most common form of improper Medicare payment.²¹ In FFS, such problems could lead to a failure to demonstrate that a service was medically necessary; in MA, it may mean that a patient's diagnosis could not be confirmed for risk adjustment payments.²²

One factor that sets MA and Part D apart from FFS is that their private plans can deploy more tools to control utilization, such as prior authorization requirements. While some have decried such requirements as barriers to access of care for beneficiaries, policymakers should be careful not to impose unnecessary obstacles

on their use because they serve as a deterrent to waste, abuse, and improper utilization.

Importantly, Medicare is the U.S.'s largest single health care program and the second largest federal program with an estimated \$846 billion in Fiscal Year 2023 spending.²³ Therefore, even with lower error rates than Medicaid and CHIP, the Medicare program's sheer size indicates that improper payments should remain an important concern for policymakers.

Taking Improper Payments Seriously

Unfortunately, improving program integrity is much harder when federal officials do not even acknowledge the severity of the problem. Rather than conducting appropriate audits, CMS has instead touted findings in its first year of reporting data from the federal ACA exchanges, while pointing out that the FFS improper payment rate remains under the 10 percent mark.

CMS has also taken pains to point out that improper payments are not necessarily fraud or abuse. However, the Justice Department has uncovered billions of dollars in fraud in recent years.^{24,25} Fraud related to COVID-19 response efforts has become more salient.²⁶ Thus, it is reasonable to suspect that fraud has increased along with other types of improper payments over the past few years. Although improper payments do not account for utilization of care that is of little value or that may be harmful to patients, improper payment rates of this magnitude demonstrate some combination of a poor program design as well as government failure to properly manage America's largest federal health care programs.

Conclusion

This year's improper payments data might be most charitably summed up as "less bad than last year's," but this is too generous given CMS's shortcomings in measurement and data collection. Even taking these numbers at face value, enormous errors and misspending permeate Medicaid and CHIP. Yet, as discussed above, the reported improper payment rates for Medicaid and CHIP are much lower than reality

because of how CMS largely failed to conduct meaningful eligibility reviews over the past two years.

Overall, as the federal role in the American health care system has increased, so too have waste, fraud, abuse, and erroneous payments. The tens of millions of Americans who rely on these programs, as well as taxpayers, deserve better than this enormous mismanagement and careless spending. As massive federal deficits and the impending insolvency of Medicare's Part A trust fund present increasingly urgent concerns, change is needed more than ever. Policymakers should reform government health

programs in ways that expand patient control of the dollars as patients would then have incentives to ensure higher value expenditures. And the political leadership in charge of managing these programs must prioritize program integrity efforts.

About the Authors

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¹ "Fiscal Year 2022 Improper Payments Fact Sheet," *Centers for Medicare and Medicaid Services*, November 15, 2022, <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2022-improper-payments-fact-sheet>.

² See table 2. In reporting year (RY) 2022, underpayments accounted for less than 3 percent of improper payments for Medicare FFS and Part D, about 9 percent for Medicare Advantage, and less than 0.5 percent for Medicaid and CHIP. See: "Agency Financial Report: Fiscal Year 2022," *Department of Health and Human Services*, Accessed December 1, 2022, <https://www.hhs.gov/sites/default/files/fy-2022-hhs-agency-financial-report.pdf>.

³ *Ibid.* Table 2 shows overpayments of \$129.2 billion for Medicare, Medicaid, and CHIP, versus \$2.4 billion in underpayments in RY 2022.

⁴ "Improper Payments Measurement Programs," *Centers for Medicare and Medicaid Services*, Last Modified December 1, 2021, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs>.

⁵ *Ibid.*

⁶ "Comprehensive Error Rate Testing (CERT)," *Centers for Medicare and Medicaid Services*, Last Modified November 10, 2022, <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/improper-payment-measurement-programs/cert>.

⁷ "Part C Improper Payment Measure (Part C IPM) Fiscal Year 2022 (FY 2022) Payment Error Rate Results," *Centers for Medicare and Medicaid Services*, Accessed December 1, 2022, <https://www.cms.gov/files/document/fy-2022-medicare-part-c-error-rate-findings-and-results.pdf-0>.

⁸ "Part D Improper Payment Measurement (Part D IPM) Fiscal Year 2022 (FY2022 Error Rates Results)," *Centers for Medicare and Medicaid Services*, Accessed December 1, 2022, <https://www.cms.gov/files/document/fy2022-medicare-part-d-error-rate-findings-and-results.pdf>.

⁹ "PERM Error Rate Findings and Reports," *Centers for Medicare and Medicaid Services*, Last Modified November 15, 2022, <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicaid-and-chip-compliance/perm/permerrorratefindingsandreport>.

¹⁰ CMS's July 2022 data shows Medicaid enrollment of 82.8 million. See: "Medicaid and CHIP Enrollment Trend Snapshot," *Centers for Medicare and Medicaid Services*, Accessed December 1, 2022,

<https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html>. The U.S. Bureau of Economic Analysis estimated the overall U.S. population for that month at 333.1 million. See: US Bureau of Economic Analysis, "Federal Reserve Economic Data: Population," *Federal Reserve Bank of St. Louis*, Accessed December 1, 2022, <https://fred.stlouisfed.org/series/POPTHM>.
¹¹ Brian Blase, "Managed Care in Medicaid: Need for Oversight, Accountability, and Reform," *Paragon Health Institute*, October 13, 2022, <https://paragoninstitute.org/wp-content/uploads/2022/10/20221012-Managed-Care-in-Medicaid-Need-for-Oversight-Accountability-and-Reform-FOR-DISTRIBUTION-V2.pdf>.

¹² "PERM Error Rate Findings and Reports."

¹³ See tables 5, 6, 9, and 10 (Table 6 provides estimates on "potentially ineligible beneficiaries" but does not include New York). See: Office of the Inspector General, "Prior Audits of Medicaid Eligibility Determinations in Four States Identified Millions of Beneficiaries who did not or may not have met Eligibility Requirements," *Department of Health and Human Services*, February 2022, <https://oig.hhs.gov/oas/reports/region2/22001018.pdf>.

¹⁴ "2021 Medicaid and CHIP Supplemental Improper Payment Data," *Centers for Medicare and Medicaid Services*, November 2021, <https://www.cms.gov/files/document/2021-medicaid-chip-supplemental-improper-payment-data.pdf-1>.

¹⁵ "Financial Report Fiscal Year 2022," *Centers for Medicare and Medicaid Services*, November 2022, <https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2022.pdf>.

¹⁶ Joel Zinberg and Gary Alexander, "A Permanent Pandemic Means a Huge Medicaid Expansion," *Wall Street Journal*, June 12, 2022, <https://www.wsj.com/articles/permanent-pandemic-means-medicaid-expansion-rolls-remove-health-care-public-health-emergency-covid-biden-welfare-government-spending-11655057229>.

¹⁷ "Federal Subsidies for Health Insurance Coverage for People Under 65: 2022 to 2032," *Congressional Budget Office*, June 2022, <https://www.cbo.gov/system/files?file=2022-06/57962-health-insurance-subsidies.pdf>.

¹⁸ Matthew Buettgens and Andrew Green, "What will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency? Updated Projections of Medicaid Coverage and Costs," *Urban Institute*, March 9, 2022, <https://www.urban.org/research/publication/what-will-happen->

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¹⁹ "Payment Error Rate Measurement (PERM) Program Medicaid Improper Payment Rates," *Centers for Medicare and Medicaid Services*, Last Modified November 2022,

<https://www.cms.gov/files/document/2022-perm-medicaid-improper-payment-rates.pdf>.

²⁰ "Financial Report: Fiscal Year 2021," *Centers for Medicare and Medicaid Services*, November 2021,

<https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf>.

²¹ "Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments," *Government Accountability Office*, March 2019, <https://www.gao.gov/assets/gao-19-277.pdf>.

²² "Fiscal Year 2022 Improper Payments Fact Sheet."

²³ See table S-4. See: "Budget of the US Government: Fiscal Year 2023," *White House Office of Management and Budget*, March 28,

2022, https://www.whitehouse.gov/wp-content/uploads/2022/03/budget_fy2023.pdf.

²⁴ "National Health Care Fraud and Opioid Takedown Results in Charges Against 345 Defendants Responsible for More than \$6 Billion in Alleged Fraud Losses: Largest Health Care Fraud and Opioid Enforcement Action in Department of Justice History," *US Department of Justice*, September 30, 2020,

<https://www.justice.gov/opa/pr/national-health-care-fraud-and-opioid-takedown-results-charges-against-345-defendant>.

²⁵ "Justice Department Charges Dozens for \$1.2 Billion in Health Care Fraud: Nationwide Coordinated Law Enforcement Action to Combat Telemedicine, Clinical Laboratory, and Durable Medical Equipment Fraud," *US Department of Justice*, July 20, 2022,

<https://www.justice.gov/opa/pr/justice-department-charges-dozens-12-billion-health-care-fraud>.

²⁶ Jonathan Green et al., "CARES Act Fraud Tracker," *Arnold and Porter*, Last Modified November 22, 2022,

<https://www.arnoldporter.com/en/general/cares-act-fraud-tracker>.