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These results support more investments in Medicaid program integrity, not harmful policies designed to restrict enrollment of people who are eligible for the program.

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THREE WAYS REPUBLICANS DISTORT MEDICAID DATA

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MAJORITY STAFF

This document has not been reviewed and approved by the Democratic Caucus of the Budget Committee and may not necessarily reflect the views of all members.

Yesterday, the Department of Health and Human Services (HHS) released new data on Medicaid improper payments. A Medicaid payment is considered "improper" when anything about it is inconsistent with state or federal policies: it could be that the amount was wrong, or that a piece of documentation was missing, or that the state made a procedural mistake. Nearly all of the time, Medicaid improper payments fall into the third category. Unfortunately, this critical distinction is omitted when Republicans try to use the data to justify their attempts to cut the Medicaid program or make it harder for eligible people to enroll.

The House Budget Committee is committed to ensuring tax dollars are spent properly and in accordance with the law. Democrats have long supported bipartisan measures to protect taxpayer dollars, including the Inspector General Act of 1978, the Government Performance and Results Act of 1993, and special provisions for health care anti-fraud funding in Congressional budget resolutions (as well as the Budget Control Act of 2011). These efforts recognize that promoting efficiency and accuracy, while reaching all eligible people with the help they need, is vital to any government program.

The Payment Error Rate Management (PERM) Program is one of the tools the federal government uses to identify program integrity issues and correct them in the Medicaid program. Medicaid is a large, complex program that provides health insurance to nearly 69 million people – or roughly one in five Americans. It has become an even more important lifeline during the COVID-19 pandemic and resulting economic crisis, as newly unemployed Americans seek health coverage after losing their employer-sponsored insurance.

This paper summarizes **three key facts** about Medicaid improper payments and debunks common Republican attacks:

FACT #1: IMPROPER PAYMENTS AND FRAUD ARE NOT THE SAME THING.

FACT #2: MOST IMPROPER PAYMENTS OCCUR BECAUSE STATES OR PROVIDERS DID NOT FOLLOW RULES AND ARE NOT THE FAULT OF MEDICAID BENEFICIARIES.

FACT #3: THE PAYMENT ERROR RATE MANAGEMENT (PERM) PROGRAM'S ELIGIBILITY MEASUREMENT CAPTURES ONLY A PIECE OF THE ELIGIBILITY PICTURE.

FACT 1: IMPROPER PAYMENTS AND FRAUD ARE NOT THE SAME THING.

Many people incorrectly assume that an improper payment means that waste, fraud, or abuse occurred. However, an improper payment does not necessarily mean that the payment was fraudulent or should not have been made; it simply means that the payment did not meet all requirements. Usually it means that there was not enough documentation to support the claim, or that the state did not follow a rule along the way.

In fact, only a small fraction (just 9 percent in FY 2020) of Medicaid improper payments reflect "known monetary loss," meaning that upon review, it turns out that the federal government should not have made that payment in the first place. The data makes clear that, contrary to Republican claims, actual fraud in Medicaid is quite rare. HHS reported that only 3 percent of improper payments were deemed improper because the beneficiary was ineligible for the program or service provided, and some of those cases may represent accidental errors made by patients or providers rather than intentional fraud. Other payments might be considered improper because there was insufficient information to determine eligibility, for example, as was the case with 41 percent of Medicaid improper payments in FY 2020. But if the missing information had been included in those claims, they may have been payable.

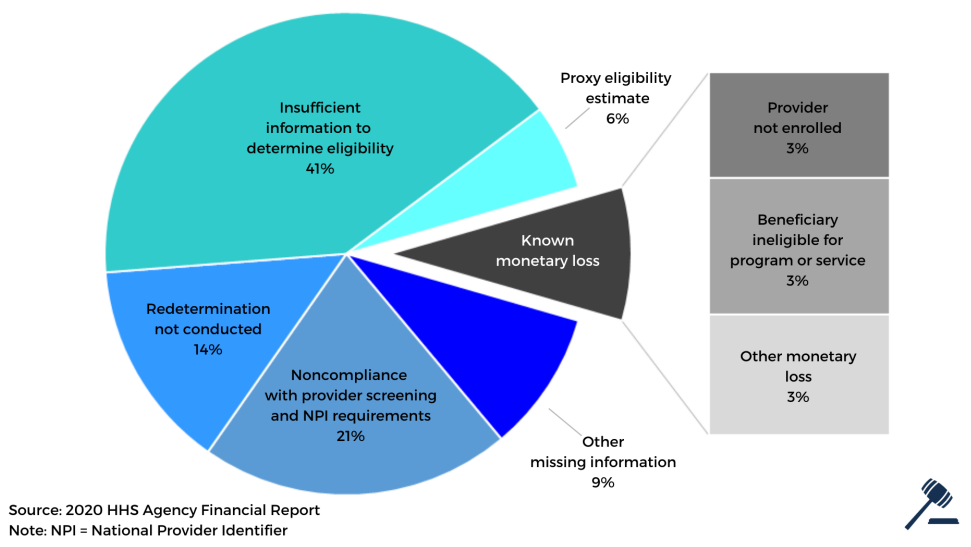
What is PERM?

Federal law requires agencies to estimate the amount of improper payments for certain programs. HHS measures improper payments in Medicaid and the Children's Health Insurance Program (CHIP) through the **Payment Error Rate Management** (PERM) program. PERM samples Medicaid and CHIP claims from 17 states each year, which means that each state is sampled once every three years.

Claims are reviewed to ensure that they followed all appropriate state and federal rules, and that they are supported by necessary documentation. The FY 2020 HHS Agency Financial Report contains the most recent available data, and it includes claims from FY 2019 for 17 states, FY 2018 for 17 states, and FY 2017 for 17 states. Supplemental data is available here.

Less than 10 Percent of Improper Payments are Monetary Loss to the Government

FY 2020 Medicaid Improper Payments by Type of Error



Source: 2020 HHS Agency Financial Report
Note: NPI = National Provider Identifier

FACT 2: MOST IMPROPER PAYMENTS OCCUR BECAUSE STATES OR PROVIDERS DID NOT FOLLOW RULES AND ARE NOT THE FAULT OF MEDICAID BENEFICIARIES.

Each state administers its own Medicaid program, but each is required to follow federal statutes, regulations, and guidance. Many of those federal requirements help ensure the program's integrity, such as by making sure all providers go through risk-based screening periodically and attach a National Provider Identifier to each claim. Some states have not fully updated their information technology (IT) systems to incorporate these changes, as they have only been in effect for the last few years.

This technical issue has had a major effect on the Medicaid improper payment rate: more than one-fifth of all Medicaid improper payments are due to state noncompliance with these provider screening and enrollment rules. But if all states had updated their IT systems and screened providers often enough, those claims might have been considered "proper."

Other examples of improper payments include situations where an eligibility worker neglected to fully document the sources used to verify income, or where the state incorrectly enrolled a beneficiary in fee-for-service rather than managed care, or when the state failed to conduct an eligibility redetermination on time.

It is important that states and providers follow federal program integrity laws, and the Centers for Medicare and Medicaid Services (CMS) is working with states to get their systems up to speed. But Medicaid patients have nothing to do with these errors, and Republican efforts to conflate provider enrollment issues with beneficiary fraud are disingenuous and harmful.

FACT 3: THE PAYMENT ERROR RATE MANAGEMENT (PERM) PROGRAM'S ELIGIBILITY MEASUREMENT CAPTURES ONLY A PIECE OF THE ELIGIBILITY PICTURE.

The Medicaid improper payment rate has three parts. The first component examines fee-for-service claims paid to providers, and the second component looks at capitation payments to managed care organizations. The third component assesses whether states adhere to all applicable Medicaid rules when determining eligibility. That analysis is done by selecting a sample of beneficiaries and reviewing their documentation to ensure they were truly eligible for Medicaid during that time. Based on the most recent supplemental data, approximately one in five cases revealed noncompliance with at least one eligibility requirement. Again, noncompliance does not necessarily mean a beneficiary is truly ineligible – in many cases it might just mean a piece of paperwork is missing or incomplete. States with high rates of eligibility errors should work on reducing those rates by addressing the root causes of the errors.

It is also important to note what the eligibility component of PERM leaves out, however. Millions of Americans who did not apply for the program because they did not know about it or were discouraged from applying because of red tape, excessive paperwork, stigma, or other factors are excluded from the calculation. According to the Congressional Budget Office, 30 million Americans were uninsured in 2019 – but 5.1 million of them were likely eligible for Medicaid. If all states had expanded Medicaid under the ACA, an additional 3.2 million uninsured Americans would be eligible for Medicaid. These estimates rely on data collected before the pandemic and are likely even higher now given the economic downturn and its effects on the number of Americans with employer-sponsored insurance.

CMS should take a broader view of eligibility program integrity and improve its capacity to identify people who were eligible for, but not enrolled in, Medicaid.

This could include encouraging states to eliminate barriers to coverage such as excessive paperwork, burdensome enrollment requirements, and harmful policies such as work requirements, premiums, and lock-out periods that discourage otherwise eligible people from enrolling. During the COVID-19 pandemic, CMS should work with states to prioritize enrolling unemployed and uninsured Americans; once the public health emergency ends, states should return their focus to addressing the root causes of eligibility errors.

THESE RESULTS SUPPORT MORE INVESTMENTS IN MEDICAID PROGRAM INTEGRITY, NOT HARMFUL POLICIES DESIGNED TO RESTRICT ENROLLMENT OF PEOPLE WHO ARE ELIGIBLE FOR THE PROGRAM.

One week before the FY 2019 improper payment data was released publicly, CMS Administrator Seema Verma – who was found responsible for abusing millions of dollars of taxpayer funds – called the results "deeply concerning." She used it to justify plans for a proposed rule that would likely substantially tighten Medicaid eligibility requirements, which would almost certainly make it harder for eligible people to enroll. While CMS appears to have delayed the proposed rule in light of the COVID-19 pandemic, it could resurface at any time.

Instead, CMS should focus on helping states improve state systems and processes. Over one-fifth of all Medicaid improper payments are due to state noncompliance with provider screening and enrollment rules, but the reasons for state noncompliance are complex, according to a recent report from the Government Accountability Office. CMS should focus on identifying specific reasons for state noncompliance in all 50 states and addressing them.

In addition, CMS should explore metrics that more accurately evaluate improper payments in managed care. Currently, CMS looks at the capitation payments states make to managed care organizations but does not examine payments from managed care organizations to providers. For that reason, the improper payment rate for managed care claims is incomplete, because CMS is only evaluating part of the equation. As the number of Medicaid enrollees in managed care increases, getting an accurate picture will only become more important.

Finally, these results reinforce the importance of investments in program integrity. Through the Medicaid Integrity Program, CMS works with states to reduce improper payments and fraud, waste, and abuse. In 2018, these efforts resulted in a federal savings of $1.3 billion in Medicaid and CHIP. A related initiative, the Health Care Fraud and Abuse Control (HCFAC) program, is under the joint direction of HHS and the Department of Justice and coordinates federal, state, and local law enforcement activities targeting fraud, waste, and abuse in Medicare and Medicaid. Every dollar invested in HCFAC returns about $4.20 in federal taxpayer dollars. The Budget Committee has long supported HCFAC through provisions in Congressional budget resolutions allowing overall discretionary funding levels to be adjusted upward by set amounts to accommodate additional HCFAC investments. The Budget Control Act of 2011, which set statutory caps on discretionary spending through 2021, adopted this principle as well by including HCFAC cap adjustments.

House Budget Committee Democrats are committed to ensuring that Medicaid and CHIP dollars are spent properly and in accordance with the law. Improving program integrity efforts in Medicaid and CHIP will strengthen the programs for the more than 75 million people who rely on them.