

RESEARCH SUMMARY

Medicaid Enrollment under the Affordable Care Act: Getting the Eligibility Rules Right

Before passage of the Affordable Care Act (ACA), Medicaid covered individuals with disabilities, lower-income seniors, pregnant women, and lower-income children along with their adult caretakers. The ACA opened program eligibility to working-age, able-bodied adults with incomes up to 138 percent of the federal poverty level. It also set much higher federal reimbursement rates for state expenditures on the new enrollees so that the federal government covers nearly the entire cost.

In their new study, “[The ACA’s Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments](#),” Brian C. Blase and Aaron Yelowitz find evidence that enrollment has been much higher than expected in states that adopted the expansion, that significant errors and problems permeate state eligibility determinations for Medicaid, and that many program enrollees are ineligible. States are responsible for monitoring who enrolls in Medicaid, but the federal government foots most of the bill. Given the structure of the ACA Medicaid expansion, states have little, if any, incentive to spend wisely or to strictly follow enrollment guidelines.

The financing structure for the Medicaid expansion presents states with incentives to classify individuals—both those already eligible for Medicaid under previous criteria and those formerly ineligible for Medicaid—as newly eligible. Additionally, healthcare interest groups in the states, such as hospitals and insurers offering Medicaid managed care, generally benefit from maximizing Medicaid enrollment, particularly at the elevated rate. As these groups have significant political power in state capitols and most of the money is flowing from the federal government, the lack of program integrity from states is not surprising. The problematic incentives facing states necessitate competent and vigorous federal oversight of the program, which unfortunately has not occurred to date because the Obama administration actually canceled Medicaid eligibility reviews from fiscal years 2014 through 2017 and the Trump administration has pursued other priorities in the program.

THE MEDICAID FINANCIAL STRUCTURE IS BROKEN

Evidence suggests there has been significant dysfunction and problems with Medicaid enrollment after the ACA:

- Audits by the Department of Health and Human Services and several states have found a broken process, with eligibility rules routinely ignored and many ineligible and potentially ineligible individuals enrolled in Medicaid. In particular, audits in California, Colorado, Kentucky, and New York have shown large numbers of both ineligible and potentially ineligible Medicaid enrollees.
- A new Centers for Medicare and Medicaid Services (CMS) audit shows significant errors in how states are reviewing and determining eligibility, with an improper payment rate likely in excess of 20 percent.
- State audits in Louisiana and Oregon have shown a broken eligibility process, with large numbers of ineligible or potentially ineligible enrollees.

- Substantially more working-age adults with incomes above 138 percent of the federal poverty line, particularly those who do not otherwise meet Medicaid eligibility criteria, are enrolled in Medicaid.

STATES ARE NOT PROPERLY SCREENING FOR MEDICAID ELIGIBILITY

Audits by the Office of the Inspector General (OIG) at the Department of Health and Human Services found many shortcomings with states' Medicaid eligibility processes, including the following:

- Failing to maintain proper documentation
- Not properly verifying income eligibility
- Misclassifying individuals into the newly eligible category
- Failing to properly verify citizenship

Correcting these problems would protect federal taxpayers and ensure that states are contributing their lawful required amount for Medicaid enrollees. For example, the OIG estimates that New York made federal Medicaid payments of more than \$520 million on behalf of almost 400,000 ineligible beneficiaries during its six-month audit period. Fixing these problems would also ensure that resources are being used to provide services and care for the people that Medicaid was originally intended to serve.

Addressing these shortcomings would also create fairness between the states. The nine states with the largest percentage point change in Medicaid enrollment of adults with income above 138 percent of the federal poverty level (New Mexico, California, Kentucky, Rhode Island, West Virginia, Oregon, Washington, Arkansas, and Colorado) all experienced a more than doubling of the percentage of this group enrolled in Medicaid. There are some areas, such as New York City and Los Angeles, where the problem is so egregious that it may be a sign of purposeful abuse of the program rules and potentially of fraud.

A few Medicaid expansion states, such as Delaware, Hawaii, Indiana, Iowa, and New Hampshire, appeared to do a reasonable job of avoiding improper Medicaid enrollment.

FOUR KEY RECOMMENDATIONS

- 1) Congress should reform Medicaid financing so that states have better incentives to obtain value from program expenditures, by making fixed payments to states rather than open-ended reimbursements and by equalizing the reimbursement rate between traditional Medicaid populations and the expansion group.
- 2) CMS (on behalf of federal taxpayers) should recover costs that have been improperly claimed.
- 3) CMS should target states and regions with particularly egregious abuses of the system for immediate eligibility redeterminations.
- 4) The Congressional Budget Office should evaluate why initial cost estimates were so inaccurate and work to more accurately model the Medicaid expansion going forward.