MEDICAID: THE REALITY

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Chairman Johnson, Ranking Member Merkley, and members of the Committee, thank you for hosting this important hearing. I am Jonathan Ingram, the Vice President of Policy and Research at the Foundation for Government Accountability (FGA).

FGA has worked with policymakers across the country for many years on ways to crack down on waste, fraud, and abuse in welfare programs. Nowhere is this fight more urgent than the nation's largest welfare program: Medicaid.

Overview

Medicaid enrollment and costs have spiraled out of control. In 2000, the Medicaid program had just 34 million enrollees and cost taxpayers $206 billion.[1] Since then, enrollment has nearly tripled and spending has increased nearly fivefold, reaching $964 billion in 2024.[2-4] Federal taxpayers have borne the brunt of this increased spending, with federal dollars covering almost 80 percent of the increase over the last decade.[5]

These vast increases in Medicaid enrollment and expenditures reflect a significant departure from the program's original intent to help the truly needy. ObamaCare expanded Medicaid to a new class of able-bodied adults, adding millions to the welfare rolls.[6-8] Today, there are 34 million able-bodied adults on the program, a fivefold increase since 2000.[9-11] Federal taxpayers now spend more to cover able-bodied adults through Medicaid than providing Medicaid to children, seniors, or individuals with disabilities.[12]

Despite several states declining to expand Medicaid under ObamaCare, nearly two-thirds of all able-bodied adults on the program are now enrolled through expansion.[13] Nearly 90 percent of those expansion enrollees are childless adults.[14] Worse yet, more than 62 percent of able-bodied adults on the program do not work at all.[15]

Higher enrollment and costs have directly translated into more opportunities for waste, fraud, and abuse.[16] Without reform, the program was on track for more than $2 trillion in improper payments over the next decade.[17]

Encouragingly, many of the reforms contained in the One Big Beautiful Bill Act (OBBB) have begun to address these systemic challenges. Commonsense work requirements, program integrity measures, and efforts to limit state financing gimmicks will help stem the widespread abuse in the Medicaid program. However, given the vast extent of waste, fraud, and abuse in Medicaid, policymakers must consider additional reforms to refocus the program on its core purpose and preserve resources for the truly needy.

At least one in five Medicaid dollars is spent improperly

Unfortunately, much of the increased spending in the Medicaid program over the last few decades has been driven by waste, fraud, and abuse. More than one in five Medicaid dollars is spent improperly, with virtually all improper payments driven by eligibility errors, administrative oversights, and outright fraud.[18] Eligibility errors alone account for more than 80 percent of all improper payments.[19]

The only two complete Medicaid audit cycles that included full eligibility checks found improper payment rates of more than 25 percent.[20] In some states, improper payments have exceeded 40 percent.[21] For example, immediately prior to the pandemic, Ohio and Connecticut each had improper payment rates of roughly 44 percent.[22] Prior to those years, the Obama administration excluded eligibility checks from federal audits entirely.[23-24]

Although the Trump administration restarted these eligibility reviews in 2019, they were largely suspended again during the Biden administration.[25] As the Government Accountability Office explained, the official improper payment rate was artificially lowered due to "flexibilities granted to states during the COVID-19 public health emergency," which allowed states and CMS to use "relaxed requirements" to hide "payments that would have previously been determined to be improper."[26] Even after the pandemic was over, the Biden administration continued to approve these flexibility waivers that artificially depressed improper payment rates.[27]

Furthermore, the managed care component of Medicaid improper payments is substantially understated. The federal audits capture whether or not states made correct capitation payments to managed care organizations, not whether those managed care organizations made appropriate payments to providers.[28]

As a result, the true extent of Medicaid improper payments is unknown. However, state and federal audits reveal widespread evidence of blatantly illegal instances of fraud as well as waste and abuse caused by bureaucrats' "legal" fraud-by-design schemes.

State and federal audits reveal countless examples of Medicaid fraud

State and federal audits confirm the magnitude of the Medicaid fraud crisis: Medicaid has enrolled dead people, prisoners, illegal aliens, criminals using stolen or fake identities, and millions of other ineligible individuals.[29] Federal auditors found nearly 4.4 million ineligible and potentially ineligible enrollees on Medicaid in California alone.[30] In Ohio, auditors determined that 62 percent of the state's expansion population was ineligible or potentially ineligible.[31] New York experienced similar results, as auditors concluded that more than one million Medicaid enrollees were either ineligible or potentially ineligible.[32] Audits performed in other states have flagged hundreds of thousands of ineligible and potentially ineligible enrollees.[33] In a four-state review performed by the Office of the

Inspector General, auditors estimated that roughly one-third of those states' combined 17.5 million Medicaid enrollees were ineligible or potentially ineligible.[34]

Audits have also identified tens of thousands of enrollees who were enrolled more than once in the same state—with some individuals having as many as seven open Medicaid cases at one time.[35] Auditors also found hundreds of thousands of individuals who were enrolled in multiple states.[36-37] A federal review of 47 states' Medicaid programs found every single reviewed state had enrollees who were also on other states' programs at the same time.[38] In some cases, individuals were enrolled in as many as nine states' Medicaid programs at the same time.[39] In 2025, CMS identified as many as 2.8 million individuals enrolled in two or more Medicaid managed care or ObamaCare exchange plans.[40]

In many cases, duplicate enrollment may result from identity fraud by illegal aliens or others.[41] In Arkansas, more than 20,000 enrollees were reported to have "high-risk identities," including some with stolen or fraudulent Social Security numbers (SSNs).[42] Similarly, in New Jersey, auditors discovered more than 18,000 enrollees with fake or duplicative SSNs.[43] Making matters worse, auditors have uncovered hundreds of millions of dollars in Medicaid funding spent on deceased individuals, including individuals who had died as early as 1981.[44-45] In some cases, audits identified millions of dollars spent on enrollees who had moved out of state, or never lived in the state at all.[46]

Fortunately, OBBB begins to crack down on some of this fraud by requiring states to share data with CMS to prevent duplicate enrollment, checking enrollees against death records, and instituting real penalties for eligibility errors above a certain threshold.[47-50]

Bureaucrats' fraud-by-design schemes are driving ineligible enrollment

Much of the Medicaid fraud crisis was caused by fraud-by-design schemes: policies intentionally designed by state and federal bureaucrats to maximize enrollment at all costs.

These policies have "legalized" fraud by dismantling eligibility verification infrastructure, reducing eligibility review frequency, adopting "passive" redetermination processes, and adopting self-attestation as the default eligibility standard.[51-52] Many states currently accept applicants' self-attestation for a variety of information, including income, household size, household composition, residency, and more.[53] Nearly all states accept self-attestation for household composition despite having access to tax return information and other relevant sources, more than 40 states accept self-attestation of residency, and more than a dozen states accept self-attestation of income to some degree.[54]

Once accepting this information, states may not verify it until months later and sometimes not at all. A Louisiana audit, for example, found tens of thousands of ineligible individuals 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.[55] Similarly, New Jersey auditors identified thousands of enrollees with unreported six-figure incomes, including some earning as much as $4.2 million per year.[56]

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.[57] New Jersey auditors identified a number of cases where individuals did not report changes as legally required, including individuals with wages nearly 15 times the eligibility threshold.[58]

This is particularly worrisome, given that 69 percent of Medicaid cases recently renewed were done through this passive or "ex parte" basis, and federal regulations require states to redetermine eligibility through this process first.[59-60] In some states, virtually all recent renewals were conducted through this passive process. In North Carolina, for example, more than 99.5 percent of the state's 2.2 million recent renewals were conducted completely passively.[61]

State bureaucrats are already attempting to undermine the new work requirements adopted in OBBB through this same fraud-by-design scheme.[62] Left-wing advocacy groups are preparing states to create new loopholes and gimmicks to exempt as many able-bodied adults from Medicaid work requirements as possible, primarily through eliminating verification through self-attestation.[63] Officials from at least 30 states recently announced that they would accept enrollees' self-attestation of medically frail status for exemption purposes if allowed by CMS.[64] Several states also initiated litigation against CMS for an interim final rule that would somewhat limit their ability to use self-attestation for work requirement exemptions or compliance.[65]

Bureaucrats have also designed welfare expansions through "presumptive" eligibility determinations—a process whereby Medicaid allows hospitals to make temporary eligibility determinations before eligibility is verified by state agencies.[66 - 67] 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.[68] Data from state Medicaid agencies reveals that such improper payments could be even higher, with just 30 percent of individuals that hospitals determine "presumptively eligible" ultimately determined eligible for Medicaid by the state.[69] This legalized fraudulent spending is never recouped.[70]

Bureaucrats have also created an on-ramp to federal welfare programs for illegal aliens, despite statutory restrictions.[71] Under federal regulations, states must enroll individuals in Medicaid for a "reasonable opportunity period" of at least 90 days while it attempts to verify satisfactory

immigration status.[72] This has allowed illegal aliens to enroll in the program, despite clear federal prohibitions, and remain on the program for months or even years at a time while states ostensibly attempt to verify their status after enrollment.[73-74] Roughly 70 percent of these "temporary" cases now extend beyond the 90-day federal standard.[75] In some states, enrollees have remained in this "temporary" Medicaid coverage for as long as 16 years without ever having their citizenship or immigration status verified.[76]

This Medicaid on-ramp was supercharged under the Biden administration, with the number of illegal aliens enrolled in the program through this loophole skyrocketing by more than 400 percent—even before the Biden administration finalized new regulations to block states from limiting its use.[77]

Bureaucrats have also begun importing eligibility errors from other welfare programs into Medicaid.[78] In 2013, for example, the Obama administration issued guidance encouraging states to bypass important eligibility verification steps by enrolling individuals into Medicaid based on their food stamp eligibility.[79] CMS directed states to use this method to seek out and enroll ineligible individuals—all in the name of administrative efficiency.[80-81] At the time, CMS was already aware that many of these individuals are "income-ineligible for Medicaid," yet guided states to "facilitate their renewal, without requiring them to complete a new application."[82] Although this strategy was initially meant to be temporary due to massive enrollment surges associated with ObamaCare expansion, the Obama administration made it a permanent option for states in 2015.[83-84]

This guidance encouraged states to adopt integrated eligibility approaches that use a single point of entry for multiple welfare programs. Not only does this increase Medicaid enrollment, but it also increases the likelihood of errors: If a state makes an initial incorrect determination when enrolling an individual in food stamps, this mistake is imported directly into Medicaid automatically without independent verification.[85-86] The more welfare programs that states integrate in this way, the higher the risk and cost of fraud.[87]

A network of advocacy organizations, funded in part by tens of millions of dollars in federal grants, has promoted these "One Door" integrated eligibility systems that consolidate enrollment across multiple welfare programs into a single process.[88] Eligibility errors in one program propagate automatically across all integrated programs, meaning a single act of fraud or misrepresentation cascades through Medicaid, food stamps, housing, and childcare subsidies simultaneously.[89]

The predictable result: millions of ineligible individuals on the program and billions in improper payments. Until policymakers limit the widespread use of self-attestation and other fraud by design schemes, this crisis will persist.

Bureaucrats' fraud-by-design schemes are driving provider fraud

Bureaucrats' fraud-by-design schemes have not only led to millions of ineligible enrollees on the Medicaid program, they have paved the way for rampant provider fraud through lax verification of providers and continuing to pay providers long after learning of credible allegations of fraud.

Federal law requires all participating Medicaid providers to undergo revalidation of their enrollment at regular intervals.[90] States have frequently failed to comply with those requirements, conducting revalidation on extended timelines, performing pro forma reviews, or failing to remove providers who no longer meet enrollment standards.[91-94] More than 14 percent of states' total fee-for-service Medicaid spending improperly flows to unenrolled providers, unlicensed providers, providers that have not been appropriately screened, and providers with missing information.[95-98]

Data from state Medicaid agencies further reveals how poorly states have followed these federal requirements. Illinois, for example, did not revalidate a single provider between March 2021 and February 2024.[99] According to state officials, nearly 142,000 providers have not been revalidated within the last five years, with some providers having gone nearly a decade since their last revalidation.[100] In some states, providers have gone as long as 17 years without revalidation.[101]

CMS recently forced Minnesota to revalidate nearly 6,000 providers in 13 high-risk service categories.[102] The results are astounding: more than 62 percent of those providers were disenrolled after failing background checks, site visits, or refusing to provide accurate and complete information.[103]

Even when they receive credible allegations of fraud, states often forgo enforcement. Under federal law, state Medicaid agencies must suspend all payments to a provider upon determining there is a credible allegation of fraud with a pending investigation.[104]

Allegations are considered "credible" long before proven beyond a reasonable doubt; states must treat allegations as credible if they "have indicia of reliability," meaning that there are "signs, indications or circumstances that seem to point to the existence of fraud."[105-106]

This is one of the most powerful program integrity tools available and one of the most underused. Federal audits have uncovered that states routinely fail to suspend payments even when clear fraud indicators are present.[107] New York, for example, issued "good cause" waivers to allow nearly 96 percent of providers with credible allegations of fraud to continue receiving Medicaid payments.[108] Likewise, Massachusetts suspended payments for fewer than 10 percent of providers with credible allegations of fraud levied against them.[109]

With little enforcement by the states, it is no surprise that provider fraud has skyrocketed in recent years.

Medicaid money laundering has become widespread

If bureaucrats' fraud-by-design schemes were not bad enough, states have engaged in other types of "legal" fraud, primarily through Medicaid money laundering—the deliberate use of financing gimmicks to shift state costs on to federal taxpayers.[110]

Provider taxes are one of the most well-known examples of Medicaid money laundering, with nearly every state taking advantage of this gimmick.[111] Under provider tax arrangements, hospitals and other providers are charged a tax or fee by the state, which is used to fund the "state share" of Medicaid spending to those same providers.[112]

Over the years, states have used provider taxes to boost their effective federal matching rate by an average of 5.4 points—and by as much as 12 points in some states—beyond what they are legally entitled to.[113] For some supplemental payment programs within Medicaid, the provider tax scheme lets states raise their effective matching rate by a whopping 32 percentage points.[114] To put this in perspective, a 5.4 point increase in the federal matching rate equates to roughly $50 billion in state costs shifted onto federal taxpayers every year.[115] This explosion in money laundering is readily apparent in the share of non-general fund state spending on Medicaid, which has increased by an astonishing 70 percent since 2018 alone.[116]

In recent years, states have gotten even more creative with their money laundering schemes. California and New York, for example, pioneered massive new "taxes" on Medicaid managed care plans.[117] Despite a federal requirement that such taxes be uniform, California structured its managed care tax to collect roughly $12.7 billion per year from Medicaid plans, compared to just $27 million from commercial plans.[118] New York's managed care tax followed a similar pattern: $2.7 billion per year collected from Medicaid plans, compared to just $76 million per year from commercial plans.[119] Because the entire cost of these taxes are built into the capitated rates paid to Medicaid managed care companies, this effectively serves as a direct tax on the federal government.[120]

States then use this "state share" to draw down even more federal funding from the Medicaid program. As a result, the taxed providers and plans receive back what they paid in taxes, while state policymakers generate a nearly endless stream of revenue from federal taxpayers.[121] State officials have readily admitted that these provider tax schemes are used to increase Medicaid spending "without risk of the state needing to contribute" and "solely to offset General Fund spending" on Medicaid.[122]

These schemes are most glaring for ObamaCare expansion enrollees, where states often use the proceeds from money laundering to shift the entire cost of expansion onto federal taxpayers.[123] States can also use the proceeds to fund special projects for which federal funding is specifically prohibited, such as coverage for illegal aliens.[124]

These money laundering schemes have been further augmented by other schemes, such as state-directed payments. These payment schemes, largely financed through provider tax money laundering schemes, enable states to direct managed care companies to pay politically connected providers excessively high supplemental payments.[125] But unlike other types of supplemental payments, state-directed payments were not subject to a cap at Medicare rates.[126]

Under President Biden, CMS finalized a rule authorizing states to use state-directed payments to increase provider rates to the average commercial rate—roughly 2.5 times higher than typical Medicare rates.[127] It is no surprise that from 2020 to 2024, SDPs more than quadrupled.[128]

Encouragingly, OBBB implemented both limitations on provider taxes and state-directed payments. OBBB closed the loophole that allowed states to tax Medicaid managed care plans at highly inflated rates to maximize revenue.[129] OBBB also barred any new or increased provider taxes and phased down the "safe harbor" threshold for existing provider taxes from six percent of net patient revenue to 3.5 percent of net patient revenue in Medicaid expansion states.[130] OBBB also capped new state-directed payments at Medicare rates in expansion states and 10 percent above Medicare rates in non-expansion states, while phasing down existing state-directed payments until reaching those new thresholds.[131] CMS is now taking the initial regulatory steps to implement these policies.[132-134]

ObamaCare expansion's match rate encourages Medicaid fraud

ObamaCare's perverse funding formula encourages and enables fraud. For traditional Medicaid populations—like children, seniors, and individuals with disabilities—federal Medicaid matching funds are set based on states' per capita income, with rates currently ranging from 50 percent to 77 percent.[135-136] Higher-income states receive a lower match rate, while lower-income states receive higher rates, though some jurisdictions like Washington, D.C. receive an artificially high rate set in statute.[137-138]

ObamaCare's Medicaid expansion, however, is fixed at 90 percent for this new class of able-bodied adults.[139] This means that federal taxpayers provide $9 for every dollar states spend on able-bodied, childless adults, but on average provide only $1.39 for every dollar states spend on severely disabled individuals or frail low-income seniors.[140]

This creates a perverse incentive for states looking to constrain rapidly growing Medicaid costs. A state seeking $1 million in state-funded Medicaid savings would need to reduce total Medicaid costs

by roughly $2.4 million if they targeted traditional enrollees like seniors or individuals with disabilities.[141] But if policymakers sought to find the same state savings among able-bodied adults in the ObamaCare expansion, they would need to reduce total Medicaid costs by $10 million.[142]

The funding formula also creates no incentive for states to stop fraud committed by ObamaCare expansion enrollees or providers serving those enrollees. This is especially true in states that use provider taxes or other financing gimmicks to render the state match for expansion effectively zero. States have treated ObamaCare expansion as an economic stimulus to draw down "free" federal dollars and shift existing costs onto federal taxpayers.[143-146] Under this view, every dollar of fraud financed through ObamaCare expansion creates an economic "multiplier effect" that generates even more economic activity and state revenues. As such, many bureaucrats view investigating and stopping fraud in this eligibility category as budgetary malpractice. It should come as no surprise that Medicaid expansion spending is roughly 32 percent more likely to be improper than other types of Medicaid spending.[147]

If that were not bad enough, ObamaCare's perverse funding formula also encourages state officials to commit fraud themselves. State bureaucrats have defaulted to categorizing enrollees into ObamaCare expansion, even when they qualify under a different eligibility category, in order to claim ObamaCare's enhanced matching funds.[148]

Under federal law, ObamaCare's enhanced funding is only available to individuals who are not eligible under a different eligibility category.[149] But numerous states have improperly claimed "savings" by shifting existing enrollees into ObamaCare expansion.[150-151] Some states even instruct those conducting eligibility determinations to evaluate eligibility under ObamaCare expansion before evaluating eligibility under other pathways, routing as many enrollees through the expansion as possible to maximize federal dollars.[152]

Policymakers can close loopholes to limit waste, fraud, and abuse—illegal or otherwise

Medicaid waste, fraud, and abuse is omnipresent. With sky-high improper payment rates and frightening levels of fraud found in state-level audits, the Medicaid program has become a magnet for erroneous expenditures.

Unfortunately, far too much of this does not fall in the category of just bad-actor providers or foreign scam artists. In many cases, the responsibility lies squarely at the feet of bureaucrats creating and promoting a fraud-by-design framework. These bureaucrats have designed a system that not only permits fraud to run rampant, but rewards it. Whether intentional or not, these policy decisions have created the broken status quo today that has left the Medicaid program in shambles.

Thankfully, Congress has an opportunity to close the door to waste, fraud, and abuse by:

- Prohibiting self-attestation for key eligibility factors;
- Requiring identity verification and frequent post-enrollment cross-checks;
- Mandating more frequent eligibility reviews for all able-bodied adults;
- Implementing more frequent and more robust provider revalidation standards;
- Verifying immigration status prior to Medicaid enrollment;
- Expanding work requirements to all able-bodied adults without young children;
- Further limiting states' ability to use Medicaid money laundering schemes;
- Unwinding ObamaCare's perverse funding preference for able-bodied adults;
- Holding hospitals accountable for incorrect presumptive eligibility determinations;
- And much more.

Through these and other commonsense Medicaid reforms, policymakers can refocus Medicaid into a sustainable program that puts the truly needy first, rejects the fraud-by-design mantra, and holds bad actors accountable instead of letting them flourish with taxpayer dollars.

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