Medicaid Improper Payments: Frequently Asked Questions

1. Why do Medicaid improper payments matter to children and families?

Medicaid's job is to pay providers for health care services that children and families need. If it doesn't do its job, children and families may not get the services they need. One of many measures of how well Medicaid is doing its job is improper payments. It's designed to identify errors that states have made in paying providers so that the states can fix them going forward. Unfortunately, opponents of Medicaid misuse the results to undermine support for the program. Understanding what improper payment rates are—and are not—is the best way to fight these attacks.

2. What is a Medicaid improper payment?

It's any payment that a state Medicaid program makes to a provider or to a managed care organization (MCO) that "should not have been made or that was made in an incorrect amount, including an overpayment or underpayment." As we'll see, this formal definition covers a lot of ground, including administrative deficiencies like missing information on a claims form. Lack of complete documentation doesn't necessarily mean that the payment made for the service was erroneous.

3. Are Medicaid improper payments the same as fraud?

No. Unfortunately, there are providers that defraud government programs, including Medicaid; you can read all about them here. And if the Medicaid program is defrauded by a provider, then the payment made to that provider is clearly improper. But most Medicaid payments considered to be improper—89% of the total in the most recent Annual Financial Report—are not the result of fraud. They are payments for which the state Medicaid agencies do not have sufficient information to document the payment (an eligibility determination was missing, the provider receiving the payment was not properly enrolled, etc.).

4. Is an improper payment money that the government has actually lost?

In some cases. For example, in the same report, actual monetary losses—"when CMS has sufficient information to determine that the Medicaid payment should not have occurred or should have been made in a different amount"—were estimated at 11% of total improper payments. The reasons for the losses include that the beneficiary was ineligible and that the provider was not enrolled.

5. So why are they called improper payments? It's so confusing.

You've got that right. People who want to take Medicaid down use it to suggest that the program is losing money hand over fist and is riddled with fraud. But "improper payments" is a term that the federal government, for better or for worse, has been using for many years and is likely to continue to do so. It's right there in the Payment Integity Information Act of 2019: federal agencies are required to identify, report, and reduce "improper payments." So that's the term CMS uses to measure how accurate Medicare and Medicaid payments are.

6. Why does the federal government measure them?

The federal government runs lots of programs that are critical to the well-being of children and families and people with disabilities and the elderly. Some of these, like Medicare and Medicaid, affect tens of millions of beneficiaries and spend hundreds of billions of dollars. For obvious reasons, the federal government needs to be a good steward. Among other things, that means limiting the amount of errors the programs make in paying providers and managed care plans. To reduce the number of mistakes the programs make, they have to know what mistakes they are making. Once they know that, they can figure out how to avoid making them going forward.

7. What is the current Medicaid improper payment rate?

The national Medicaid improper payment rate in 2021 was 21.69%. This translates into estimated improper payments of $98.7 billion. By way of comparison, the national CHIP improper payment rate in 2021 was 31.84%, which translates into estimated improper payments of $5.37 billion (CHIP is a much smaller program than Medicaid). You can find that national rates for each year going back to 2010 here.

8. Why are national Medicaid improper payment rates so high?

As explained in question #2, it's not because of waste, fraud, and abuse in the program. Mostly it's because state Medicaid agencies (or their contractors) do not have adequate documentation for the claims that they pay, including documentation of the eligibility of the beneficiary to receive the service or the provider to be paid for delivering the service. Medicaid is complicated, which makes it more likely that mistakes will occur, and they do.

9. What is the Medicaid improper payment rate for my state?

Late in 2021 CMS for the first time posted state-specific improper payment rates for 33 states and the District of Columbia. The rates for AK, AZ, DC, FL, HI, IN, IA, LA, ME, MS, MT, NV NY, OR, SD, TX and WA are here (Table S35). The rates for AK, CT, DE, ID, IL, KS, MI, MN, MO, NM, ND, OH, OK, PA, VA, WI, and WY are here (Table S24). CMS has not posted data for the remaining 17 states (AL, CA, CO, GA, KY, MD, MA, NE, NH, NJ, NC, RI, SC, TN, UT, VT, and WV).

10. How are improper payment rates calculated in Medicaid?

This is where things get very complicated very quickly. Here are the basics.

The measurement of Medicaid improper payments is done by CMS. They call this their Payment Error Rate Measurement (PERM) program. CMS uses a contractor to review a statistically valid sample of paid claims in 17 state Medicaid programs each year to determine whether they were improperly paid (see question #1). Each group of 17 states is known as a "cycle" and is sampled once every three years. CMS combines the results of the three most recent cycles into a 3-year "rolling" national rate. For example, the national rate for 2021 (see question 6) is based on reporting years 2019 (cycle 1 states), 2020 (cycle 2 states), and 2021(cycle 3 states).

For the wonks: the PERM calculation process is explained in this slide deck. Detailed reports on the types of errors and the causes of those errors for each year since 2014 are found here.

11. How can my state lower the number of improper payments it makes?

At the end of a measurement cycle, CMS notifies each of the 17 states in the cycle of the payment errors that its contractor has found. The states are required to develop and submit a Corrective Action Plan (CAP) to reduce improper payments going forward. Because state Medicaid programs vary so greatly in their structure and administration, the sources of payment error, and the solutions, will vary as well. CMS does not publish CAPs, but they would be the starting point for lowering improper payments in a state.