OBBBA Changes to Improper Payment Penalties Pose Risks to State Medicaid Programs

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Beginning October 1, 2029, the so-called "One Big Beautiful Bill Act" (OBBBA) makes the Medicaid Payment Error Rate Measurement (PERM) program significantly more punitive, expanding state liability for errors and mandating onerous monetary penalties.[1] Despite longstanding representations to the contrary by those hostile to Medicaid, PERM does not measure rates of fraud or abuse in Medicaid.[2] PERM's eligibility error measurements are better understood as an indicator of program complexity: States are more likely to have errors, such as with documentation, classified as improper payments when program rules and verification requirements are more complicated. Improper payments are simply payments that do not meet certain statutory or regulatory requirements; they are **not**, on their own, an indicator of the level of fraud, waste, or abuse in a state's Medicaid program.[3]

Nevertheless, the PERM program is undergoing its most significant changes in years. This OBBBA-generated PERM crackdown poses a great risk to state budgets and the services available to Medicaid enrollees, and the risks are compounded by OBBBA's complex changes to eligibility rules.[4] Under the new PERM requirements, states are at substantial risk of new penalties, and OBBBA's definitional changes in the PERM rules could make those penalties much more onerous. However, states have opportunities to make smart OBBBA implementation choices to limit their exposure while also minimizing erroneous coverage loss.

The History of the PERM Program Makes Its Purpose Clear

The PERM program was created as part of the Medicaid Eligibility Quality Control (MEQC) program to implement the requirements of the Improper Payments Information Act of 2002 (IPIA).[5] PERM was fully implemented in 2005, and it took its current form in 2017.[6] The PERM program conducts reviews in 3 "cycles," with 17 states reviewed per cycle.[7] The PERM program's goals are to identify "improper payments," understand what caused those payments, and use corrective action plans to reduce improper payments.[8] The PERM program does not exist to detect fraud, and the PERM rate is not synonymous with a fraud rate.[9]

PERM measures the rate of improper payments related to fee-for-service (FFS), managed care, and eligibility.[10] FFS claims undergo both a data processing review and a medical necessity determination.[11] The purpose of the data processing review is to "validate that the State processed the claim correctly," and the purpose of the medical necessity review is to "ensure documentation supports the claim billed, medical necessity, and coding accuracy."[12] For managed care payments, the PERM review looks for errors in the capitation payments made to managed care organizations (MCOs) (*i.e.*, whether any payments made to the MCOs were different than what CMS approved and what the state agency contractually must pay). [13] Finally, the eligibility review "universe" is defined by claims – "a universe of payments made."[14] Because PERM eligibility reviews are "tied directly to a paid claim," they generally assess whether a payment was correctly made on behalf of an eligible person.[15] If a state has both FFS and managed care payments, the audit will use samples from each "universe" of payments, estimate improper payment rates for each category, and weight them according to expenditure amount.[16]

Distinguishing Types of Payment Errors is Critical to Understanding PERM's Purpose

To better understand what PERM actually does, it is important to understand that waste, fraud, abuse, and improper payments are separate concepts with distinct definitions. This paper focuses on distinguishing improper payments and fraudulent payments. The following definitions from federal sources help delineate these terms:

Waste is the overuse or misuse of certain services in a way that results in excessive cost to the program.[17] Waste, as a concept, lacks the intentional element of fraud and abuse, instead describing payment inefficiencies.[18] An example of waste is 2 providers ordering the same test for a patient because they are not communicating with each other.[19]

Fraud is an "intentional deception or misrepresentation" made for the purpose of gaining "some unauthorized benefit" from Medicaid.[20] Examples of fraud include signing false ambulance run sheets to bill Medicaid for ambulance trips that did not happen; billing for diagnostic tests that were not medically necessary, not ordered by a medical provider, and "not provided as represented"; and using enrollees' information without their knowledge to make false claims for durable medical equipment (DME).[21]

Abuse refers to "provider practices that are inconsistent with sound fiscal, business, or medical practices" **and** which "result in an unnecessary cost" to Medicaid, or enrollee practices resulting in unnecessary costs to Medicaid.[22] An example of abuse would be a provider who

"bends the rules" through practices like "upcoding" – submitting claims for more complex, expensive services than were actually delivered to reap a higher reimbursement.[23]

Erroneous payments are payments on behalf of ineligible people and overpayments to eligible individuals and families, also known as "monetary loss errors."[24]

Improper payments, on the other hand, are simply payments that do not meet certain statutory, regulatory, or other program requirements.[25]

The Nature of PERM Improper Payments

Medicaid is an intricate, multifaceted program with strict recordkeeping and documentation requirements and complex processes for determining eligibility.[26] Additionally, many states experience issues that compound Medicaid's inherent complexity. Outdated or dysfunctional computer systems, a lack of funding, and staffing shortages can all be exacerbating factors.[27] To that end, most "improper" payments are related to a lack of documentation, such as missing paperwork or a step in the eligibility determination process that was not correctly documented, preventing reviewers from determining whether a payment was correctly made on behalf of an eligible individual, but not indicating that the person was ineligible or the payment should not have been made. [28]

As an example, an improper payment may occur when an eligibility worker correctly verifies an enrollee's eligibility, but fails to save the documentation used for verification.[29] For PERM purposes, payments on behalf of that enrollee would still be considered "improper" even though the worker correctly found them eligible, simply because the appropriate documentation is not present in the file upon review. In fiscal year 2025, the overwhelming majority of improper payments were attributable to documentation issues or minor administrative mistakes – more than 74 percent.[30]

PERM is Effective at What it Does, But its Intended Purpose is Limited

Understanding the risks that OBBBA's changes pose to states requires an understanding of what PERM does and does not do. PERM has a specific purpose, and it fulfills that purpose well. OBBBA's PERM changes seek to turn the measurement into something it is not, creating an arbitrary standard that states must meet or face considerable penalties.

The PERM Rate Alone is Not an Indicator of the Amount of Fraud, Waste, or Abuse in Medicaid

PERM is largely a measure of documentation errors. No more, no less. It may well be the case that a person whose eligibility was not supported by documentation upon review was in fact eligible and payments on their behalf were made appropriately, but that research simply does not exist. The PERM inquiry ends with the identification of the improper payment and an analysis of its root cause (*i.e.*, insufficient documentation).[31] It does not include an assessment of whether the enrollee would actually have been eligible if correct documentation was included. As such, the PERM rate is more an indicator of "potential problem areas" than it is a conclusion about fraud or any other malfeasance. [32] In other words, it may signify that the eligibility worker did not "show their work," but it does not conclusively prove that the end result (*i.e.*, a finding of eligibility) was wrong.

In any case, Medicaid is a popular, cost-effective program with "negligible" rates of enrollee fraud.[33] Nonetheless, those who oppose the Medicaid program often misrepresent the PERM rate as a fraud rate in an attempt to create a false narrative surrounding Medicaid.[34] That argument distorts the nature of the PERM program and it overstates the ease of identifying fraudulent spending.[35]

> **An example of PERM rate distortion:** A 2022 report from the Foundation for Government Accountability asserted that more than 20 percent of Medicaid dollars were spent improperly, claiming that "eligibility errors" constituted "more than 80 percent of improper payments" in fiscal year 2020 and concluding that this figure showed that "countless individuals [were] receiving Medicaid benefits for which they [were] not eligible."[36] This report based its conclusion on fiscal year 2020 PERM data, which showed that 66.4 percent of improper payments were eligibility-related, 33.4 percent were FFS-related, and 0.1 percent were managed care-related.[37] But during the review year, more than 41 percent of eligibility-related improper payments were based on insufficient documentation to determine eligibility.[38] Conversely, just 3.3 percent of improper payments were made on behalf of people who were confirmed ineligible.[39] In other words, a much higher percentage of eligibility-related improper payments in fiscal year 2020 were improper because there was not sufficient documentation to show that they were **not** improper, not because they were made on behalf of people who should not have been furnished Medicaid services.[40]

Medicaid has an array of monitoring mechanisms **other than PERM** to ensure program quality and efficacy, including fraud detection. For instance, all states are required by law to have a Medicaid Fraud Control Unit (MFCU).[41] The MFCUs are effective at combating provider fraud – in fiscal year 2025, for every dollar spent to operate the MFCUs, they recovered $4.64.[42] The federal government and states rely on the Transformed Medicaid Statistical Information System (T-MSIS), along with other resources, to "detect unusual billing patterns, outliers, and service anomalies" for fraud prevention and early detection.[43] States vest their Medicaid agencies with broad authority to perform program integrity activities; some maintain entire divisions of their Medicaid agencies dedicated solely to preserving program integrity.[44] PERM, on the other hand, does not track or guard against fraud, waste, or abuse because that is not its design.

Moreover, the casual observer typically cannot distinguish between fraud, waste, abuse, and unintentional mistakes.[45] Identifying whether an improper payment is a simple mistake or something more requires an investigation, and the final determination as to whether it is fraudulent must be accomplished through an adjudicative process.[46] Exaggerated reports of Medicaid fraud based on misrepresentations of the PERM rate are misleading because the PERM rate on its own simply does not provide sufficient information to permit a conclusion about the prevalence of fraudulent payments.

PERM is Not a Safeguard or a Protective Measure

PERM is also not a measure of how well Medicaid serves applicants and enrollees in that it does not track erroneous denials, terminations, or reductions in coverage. This is an ongoing deficiency in Medicaid program integrity efforts writ large – they do not meaningfully hold states to account when they fail to provide eligible people with needed health coverage.[47] But these kinds of errors create significant harm to applicants and enrollees.[48] Even short periods without coverage, such as those that occur when people "churn" off and on Medicaid because of procedural errors, are associated with increased emergency room usage and hospitalization.[49] Churn also reinforces existing health disparities caused by structural racism, as Black and Latinx people are more at risk of losing coverage due to churn.[50]

The harms of churn are not limited to enrollees; states also experience negative effects related to churn. Enrollees who are covered for 12 full months generally have lower costs per month ($371) than enrollees who were only enrolled for 6 months ($583) or 3 months ($799), in part because disruptions in coverage may cause people to go without primary and preventive care, leading to increased use of more expensive, higher-acuity care once they re-enroll in Medicaid.[51] Churn also increases administrative spending for states, providers, and managed care organizations.[52] If anything, the inefficiencies and costs associated with failing to provide

care – including higher utilization of more expensive services, increased costs associated with gaps in coverage, and the additional burden of churn – are where the real waste lies in Medicaid.[53]

Moreover, many Medicaid enrollees who are improperly terminated never re-enroll, despite remaining eligible.[54] And since most Medicaid-eligible adults have Medicaid as their only source of health insurance, they then become uninsured.[55] Uninsurance has enormous health and financial consequences. Uninsured people are significantly more likely to accrue medical debt, to be hospitalized for chronic conditions, and to die from health complications.[56] People who enroll in another type of health coverage after being disenrolled from Medicaid still experience barriers to accessing care, with most reporting that their new coverage is worse in terms of cost.[57]

Yet, CMS oversight largely ignores these kinds of harms. Only the Medicaid Eligibility Quality Control (MEQC) program tracks erroneous coverage terminations and denials – but the sample size is small, and CMS does not impose financial penalties on states based on their MEQC results.[58] As such, it is more an informative measure than it is a corrective one.

OBBBA's PERM Changes Threaten State Budgets

Incoming federal changes pose a substantial risk to state budgets in at least 3 significant ways:

- OBBBA eliminates the "good faith waiver," a policy that permitted the Secretary to waive penalties for states with error rates over 3 percent.[59] This policy gave states space to work on bringing down their error rates without the threat of losing millions of federal dollars hanging over their heads. But because OBBBA eliminates the good faith waiver, states will now have to repay the federal portion of any errors over the 3 percent threshold.

- OBBBA makes payments that are improper based on a lack of documentation subject to recovery, whereas recovery was previously limited only to overpayments and payments made on behalf of a confirmed ineligible person.[60] This means the penalty will be far tougher than it was before, exposing states to significantly more financial liability.

- OBBBA makes considerable additional eligibility changes, which will place states at additional risk of errors and potentially further increase penalties.

The potential negative impacts of these changes and the associated risk of funding loss are not limited to states' Medicaid budgets. Medicaid is often the largest or among the largest line items in state budgets, **and** Medicaid funding is the single largest source of federal dollars to the states – so Medicaid cuts have a ripple effect on state budgets.[61] The loss of federal funds means less cash flow into state economies, impacting economic activity far beyond the health care sector.[62] OBBBA's Medicaid cuts in particular are estimated to result in the loss of tens of thousands of jobs and broader economic contraction at the state level.[63] Medicaid funding cuts can even negatively affect states' credit ratings.[64]

Medicaid funding cuts also shift costs that would ordinarily be covered in large part by the federal government to state and local entities. As an example: Medicaid financing for school-based services is a key funding stream for school districts, but in the absence of federal dollars, the cost of providing those services can shift to the district.[65] Coverage loss related to funding cuts results in hospitals providing more uncompensated care, the cost of which is often absorbed by state and local governments.[66] These cost shifts can also impact other government services. For instance, increased state health care spending associated with reduced federal funding risks cutting into state spending on higher education; in turn, colleges and universities may raise tuition, eliminate certain programs, and limit student services.[67]

In all, the effects of the potential funding loss that comes with OBBBA's changes to PERM will reverberate across state economies, with impacts extending far beyond the health care sector. Employment rates, consumer spending, states' creditworthiness, and access to other government services all stand to be affected.

Elimination of the Good Faith Waiver Creates a Formidable Compliance Standard

Before OBBBA, if a state's improper eligibility-related payments exceeded 3 percent, the state risked losing all federal funding related to such errors above that threshold. HHS historically had the authority to waive such penalties, and there is no record of HHS initiating recoveries based on PERM findings.[68] However, beginning October 1, 2029, OBBBA effectively eliminates this "good faith waiver," instead requiring HHS to assess financial penalties in states with error rates higher than 3 percent.[69]

Data shows that 12 states had error rates exceeding 3 percent during their most recent PERM audits.[70] While some states, such as Michigan and Indiana, are only slightly over the 3 percent threshold, other states have considerably higher error rates. South Carolina had an error rate of 8.7 percent at its last audit, and Alaska has the highest error rate in the country at 9.5 percent.[71]

State	Eligibility-Related Payment Error Rate (Percent)	Projected Eligibility-Related Improper Payments (Rounded)	Total Projected Eligibility Expenditures (Rounded)	Year Measured (PERM Cycle)
Alaska[72]	9.5	$191 million	$2 billion	FY 2024 (Cycle 3)
South Carolina[73]	8.7	$466.5 million	$5.3 billion	FY 2023 (Cycle 2)
Rhode Island[74]	7.9	$170.6 million	$2.2 billion	FY 2023 (Cycle 2)
Delaware[75]	6.1	$148 million	$2.4 billion	FY 2025 (Cycle 1)
California[76]	5.9	$4.5 billion	$75.5 billion	FY 2023 (Cycle 2)
Massachusetts[77]	5.1	$661.2 million	$13 billion	FY 2023 (Cycle 2)
New Jersey[78]	4.1	$560.2 million	$13.6 billion	FY 2023 (Cycle 2)
Florida[79]	3.9	$829 million	$21.4 billion	FY 2024 (Cycle 3)
Maryland[80]	3.4	$326.9 million	$9.5 billion	FY 2023 (Cycle 2)
Tennessee[81]	3.4	$313.2 million	$9.2 billion	FY 2023 (Cycle 2)
Michigan[82]	3.2	$601 million	$18.7 billion	FY 2025 (Cycle 1)
Indiana[83]	3.1	$419.8 million	$13.7 billion	FY 2024 (Cycle 3)

But state-level error rates do not tell the full story of overall state performance.[84] As a threshold matter, it is difficult to meaningfully compare how different states administer their Medicaid programs.[85] In general, states have considerable flexibility in developing their Medicaid programs within broad federal parameters.[86] While PERM's purpose is not to compare states against one another, it is still the case that different states running different Medicaid programs may have different improper payment rates for reasons that have very little, if anything, to do with fraud, waste, or abuse. For example, a 2024 analysis concluded that a primary driver of the difference in Alaska's and Washington state's overall improper payment rate (not just eligibility) was the difference in the states' delivery systems.* Washington's

* To be clear, OBBBA's PERM changes **only** apply to eligibility-related improper payments, and **not** managed care or FFS improper payments. This example is provided solely to illustrate how benign structural differences in states' Medicaid programs can impact improper payment rates.

Medicaid program is managed care, whereas Alaska's is fee-for-service, and managed care claims are evaluated using a different methodology than fee-for-service claims.[87]

This is not to say that it is *per se* inappropriate to hold states to a certain standard of accuracy. Maintaining program integrity is important, and PERM has been a key tool for improving states' administration of their Medicaid programs.[88] However, holding 51 vastly different Medicaid programs to a single standard and attaching extremely draconian penalties to that standard ignores a basic fact about improper payment rates: They primarily reflect how different states managing different programs fare when carrying out exceptionally complex administrative processes within a constantly shifting landscape of rules, requirements, and available resources.[89] The previous flexibility given to the Secretary in deciding whether to impose penalties worked well in this respect, giving states breathing room to address administrative and other non-fraud related issues that may have contributed to an increase in improper payment rates. OBBBA's new standard disregards the importance of this flexibility, instead imposing significant penalties based on a flawed premise.[90]

Additionally, the cyclical nature of PERM means that certain states may have lower rates of improper payments than other states based solely on when their PERM review comes up. For instance, eligibility-related improper payment rates were extremely high for states reviewed in 2021 (Cycle 3), which was those states' first PERM cycle following the reintegration of the eligibility component: 14 of the 17 states reviewed had eligibility improper payment rates over 3 percent, and of those 14 states, 7 were over 10 percent, 3 were over 20 percent, and 2 were over 30 percent.[91] However, eligibility-related improper payment rates decreased substantially when the Cycle 3 states were reviewed again in 2024: 16 of the 17 states' improper payment rates had decreased, and only 3 states exceeded the 3 percent threshold.[92] Conversely, error rates in 2022 – Cycle 1 states' second PERM cycle following reintegration of the eligibility component – were much lower.[93]

The risks of a rigid standard: Hawaii had an eligibility improper payment rate of 37.6 percent in 2021.[94] When Hawaii was reviewed again in 2024, the state's eligibility improper payment rate had decreased to just 1.2 percent.[95] Thus, based on the available data, Hawaii's 2021 eligibility improper payment rate appears to be an outlier – but the new OBBBA rules make no allowance for such outlier years. Had the new OBBBA recoupment requirements been in place, the impact on Hawaii's Medicaid budget would have been disastrous: The state would have been subject to a penalty of more than $278 million.[96] Hawaii's total state Medicaid spending in FY 2021 was about $890 million, meaning this recoupment would have been equivalent to about 31 percent of Hawaii's state Medicaid spending.[97]

Relatedly, states may sometimes experience periods of difficulty wherein their improper payment rate is above the 3 percent threshold for any number of reasons unrelated to fraud or other malfeasance. For instance, when Alaska's review cycle came up in 2024, the state had recently faced pressure from at least 3 lawsuits over its delays in processing Medicaid, SNAP, and Adult Public Assistance (cash assistance for older adults and adults who are blind or have other disabilities) cases.[98] Taken together, this information, along with news reports regarding staffing shortages and other internal issues, suggests that Alaska was experiencing overall difficulties in administering its safety net programs, and these difficulties were likely reflected in the state's high eligibility improper payment rate.

In sum, there are numerous factors – largely unrelated to fraud, waste, or abuse – that contribute to a state's improper payment rate. OBBBA's elimination of the good faith waiver completely disregards the nuance of state error rates and the factors that contribute to them, and instead imposes a strict standard carrying severe penalties on all states, with no consideration for legitimate, non-fraud-related reasons why a state's error rate may be above the 3 percent threshold in a given cycle. In short, state-level error rates should not be used to justify punishing states with onerous monetary penalties. Such financial penalties ultimately harm states' ability to improve their programs and to provide needed services to their residents.

Definitional Changes Pose Risks to States and Make it Harder to Find Real Fraud

OBBBA also significantly changes how PERM measures improper payments by amending the definition of erroneous payments at 42 U.S.C. § 1396b(u)(1)(D) to include payments where there is "insufficient information" available to confirm eligibility.[99] Prior to OBBBA's changes,

improper payments and erroneous payments were related but distinct concepts.[100] In general, **improper** payments were those lacking documentation, whereas **erroneous** payments were previously limited to payments on behalf of ineligible people and overpayments to eligible individuals and families (also known as "monetary loss errors").[101] Improper payments are much more common than erroneous payments. Between fiscal years 2021 and 2025, more than 72 percent of all eligibility-related improper payments fell into just 3 categories:

1) Eligibility could not be confirmed because an eligibility determination was "not conducted as required";

2) Eligibility could not be confirmed because an eligibility element was not verified or documentation was not collected at the time of the eligibility determination; or

3) Eligibility could not be confirmed because documentation supporting the eligibility determination was not maintained.[102]

To be clear, these payments were not necessarily made on behalf of people who were incorrectly enrolled in Medicaid or who should not have received services. These findings only show that reviewers could not confirm that a payment was correctly made on behalf of an eligible enrollee due to a lack of documentation.

Erroneous payments as they were defined prior to OBBBA are comparatively far less common. During the same time period, just 4 percent of payments were **confirmed** to have been made on behalf of ineligible people, and an additional 2.8 percent were made on behalf of people who were eligible but enrolled in the wrong program (*i.e.*, Medicaid vs. CHIP) or the wrong eligibility category (*i.e.*, a parent or caretaker relative who would have been eligible for Medicaid even without expansion was incorrectly enrolled in expansion).[103] Although erroneous payments are payments that technically should not have been made, they do not necessarily indicate the presence of fraud, waste, or abuse.

Changing the definition of "erroneous payments" to encompass payments that are improper due to documentation issues poses a risk of artificially inflating states' error rates, and, in turn, increases the risk of additional penalties, as payments with insufficient documentation make up the vast majority of improper payments.[104] This definitional change also risks making PERM data far less useful by obscuring **actual** errors, making it more difficult for states to understand where they can improve their performance to reduce errors in the future. **Actual** erroneous payments – overpayments and payments on behalf of ineligible people – make up a significantly smaller portion of payment errors. Merging these distinct payment types will cause states' erroneous payment rates to skyrocket despite there being no material change in

their performance. Further, because these definitional changes and the elimination of the good faith waiver take effect at the same time, states will not have any opportunity to adjust to the "new normal" of expanded erroneous payments: More types of payments will be subject to repayment at the same time that recoupment for errors over 3 percent will become mandatory.[105] Practically, this means states will have no opportunity to gather information about their error rates and make needed policy changes before they become subject to OBBBA's formidable financial penalties.

These changes will also likely make it harder to identify possible fraud by obscuring the prevalence of more "relevant" improper payments. PERM measures specific types of improper payments in a specific way, and it is a useful measurement in helping states improve the administration of their Medicaid programs.[106] OBBBA's changes to the definition of "improper payment" effectively eliminate this important metric of state performance, instead lumping the varied landscape of improper payments into the category of "erroneous payments."[107] This change skews the numbers to feed critics' narratives about fraud in Medicaid while also making it more challenging for states to get a clear picture of their performance and how they can improve it. Attempting to identify fraud under these new rules will be like looking for the proverbial needle in the haystack – but it gets harder to find the needle as the haystack grows.

Other OBBBA Changes Will Compound Risks and Negative Impacts

Even under the best of circumstances, reducing improper payments is no simple task. Legislative mandates for improper payment reduction have long been in effect, and progress has certainly been made.[108] But there are still structural barriers that hinder further progress toward reducing improper payments. For one thing, many federal programs are "more complicated than necessary," with conflicting legislative requirements and discrepancies in eligibility criteria contributing to error rates.[109] These programs are also often multilayered in a way that increases the potential for errors, with many actors handling funds, making eligibility determinations, and holding other responsibilities for day-to-day program management.[110] Additionally, steps to reduce improper payments like risk assessments and implementing new internal controls can be costly. [111] Finally, reducing error rates is a continuous process and not something that is "done" once the error rate falls to a certain level.[112] As such, a state's error rate is not a problem that can be fixed overnight – no matter how punitive Congress decides to be.

At this point, states are not operating under the best of circumstances. OBBBA's changes to the PERM eligibility component will have a synergistic effect with other OBBBA Medicaid

eligibility changes, further compounding the risk of payment errors and exposing states to onerous penalties and further budget reductions.

- **Work requirements** will place a colossal burden on states, requiring them to make complex changes to eligibility systems, modify public-facing portals and materials, implement new eligibility rules, recruit additional eligibility workers, train their agency workforce to apply the rules **properly** (*i.e.*, in a way that ensures eligible people retain their coverage), and engage in outreach to impacted individuals.[113] And those changes are only the beginning, as states will have the added burdens of verifying work requirement compliance or identifying and verifying exemptions.[114] Requiring eligibility workers to follow more rules to process eligibility information on a more frequent basis creates additional space for errors.[115] Work requirements are also expensive to administer, which will compound the effect on state budgets.[116]

- **6-month redeterminations** will substantially increase administrative burden for states.[117] As with work requirements, eligibility workers will have to handle and review more information at greater frequency while managing the additional work of OBBBA's other eligibility changes, increasing the risk of errors.[118]

- **Limitations on retroactive eligibility** will narrow the universe of claims that are payable under the new rules, creating an increased risk of additional payment errors.[119] Pre-OBBBA, new Medicaid enrollees could access up to 3 months of coverage prior to the month of application, as long as they fulfilled all other eligibility requirements.[120] OBBBA reduces the maximum retroactive coverage period to 1 month for expansion enrollees and 2 months for all other enrollees.[121]

- **Increased address checks** will also require additional modifications to policies and systems, as well as create increased burden on eligibility workers. States already do not make significant use of the Public Assistance Reporting Information System (PARIS) to check for duplicate Medicaid enrollment due to technology issues and limited staff capacity.[122] Moreover, even when PARIS **does** return reports of duplicate enrollment, states often choose not to pursue recovery of those improper payments because it is not cost-effective to do so.[123] OBBBA does nothing to address these structural issues. Instead, it imposes additional requirements on a strained workforce, increasing the risk of errors.

Implementing OBBBA's complex changes to state Medicaid systems risks further increasing error rates. The COVID-19 Public Health Emergency unwinding ("PHE unwinding" or "unwinding") exposed the weaknesses in these systems, with devastating results for many

enrollees.[124] Call center performance was problematic in many states and severely impeded individuals attempting to obtain or retain their coverage.[125] In some cases, enrollees waited 20 minutes or more before their calls were answered, and call abandonment rates were as high as 49 percent.[126] Dysfunctional online portals and "incomprehensible" notices made it difficult for enrollees to submit eligibility information or even understand what they needed to submit.[127] And while states have made strides in improving their systems since the height of the unwinding, it is also the case that implementing OBBBA's substantial Medicaid changes on the exceedingly short timeframe that Congress has allowed will be an exceptionally heavy lift that will create additional room for error.[128]

Other significant Medicaid changes and disruptions have had a similar effect on payment error rates. For instance, during implementation of the Affordable Care Act (ACA), state noncompliance with new requirements governing provider enrollment and documentation of claims caused an uptick in FFS-related payment errors that increased the overall improper payment rate.[129] A primary driver of state noncompliance (which contributed to an increase in improper payment rates) was the slow adoption of systems changes needed to adhere to these requirements.[130] Although OBBBA's Medicaid changes are primarily related to eligibility for applicants and enrollees, they are similar to the ACA changes in that they are complex and will require significant systems changes. However, the OBBBA changes differ from the ACA changes in a significant way: The ACA changes were implemented over the course of 8 years, with ongoing rulemaking throughout that period.[131] States had time and space to implement the ACA's many provisions and reforms.[132] Perhaps more importantly, states were not necessarily under threat of substantial monetary penalties while working to implement a complex new set of rules and requirements.[133] And, more generally, changes to Medicaid similar in scale to OBBBA's have been implemented on a much less accelerated timeline: The COVID-19 continuous enrollment condition ended March 31, 2023, but CMS released the first relevant State Health Official (SHO) letter on December 22, 2020 and provided additional guidance and training throughout 2021 and 2022.[134] The 2024 Eligibility and Enrollment Final Rule phased in compliance requirements over a 3-year timeline.[135]

On the other hand, OBBBA's changes will begin to take effect less than 18 months from the time the law was enacted.[136] Certain changes have been given an even more truncated timeline. An Interim Final Rule (IFR) governing implementation of work requirements was released on June 1, 2026 and took effect on July 31, 2026.[137] OBBBA requires that all states implement work requirements by January 1, 2027, leaving only 5 months between the effective date of the IFR and the beginning of work requirements.[138] However, outreach to potentially impacted enrollees must begin well before January. States must begin outreach at least 3 months prior to the first month that enrollees must demonstrate compliance, meaning that states with a 1-month lookback period must begin outreach by September 1, 2026 at the

latest.[139] States with longer lookback periods must initiate outreach even earlier; states electing 3-month lookback periods should have started outreach July 1, 2026 at the absolute latest – before the IFR even took effect.[140] This leaves states with vanishingly little time to adjust to these new policies before having to implement them.

Previous significant changes to PERM have also had a similar effect on improper payments: The eligibility error rate ballooned in fiscal years 2019 through 2021 due to the reintegration of the PERM eligibility component following its suspension between fiscal years 2015 and 2018, as well as significant changes in how the eligibility error rate was measured.[141] And, because PERM reviews occur on cycles, states whose review cycles align with significant program changes can potentially be at higher risk of error than states reviewed in later cycles, which have more time to adjust. This effect is illustrated by the eligibility improper payment rates in 2021 as compared to 2022, as discussed above.[142]

Other non-Medicaid OBBBA changes will also compound the complexity facing states in a unique way. Specifically, changes to the Supplemental Nutrition Assistance Program (SNAP or food assistance) will pose additional challenges in decreasing improper payment rates: OBBBA imposes new penalties on states based on their SNAP error rates, further squeezes state budgets by decreasing federal match for administrative costs, and expands SNAP work requirements.[143] States are making major changes to policies and systems in order to comply with the new requirements, including devoting additional funds to updating benefits systems, establishing additional eligibility restrictions, and imposing onerous penalties on certain agency staff in an attempt to bring SNAP error rates below OBBBA's 6 percent threshold.[144] Nevertheless, early rollout of the new SNAP work requirements has been "chaotic," and the changes are already straining state resources.[145]

Further, many states use the same staff for SNAP and Medicaid, making it even more difficult to improve error rates due to the degree of changes to both programs.[146] Plus, state social services agencies are already chronically understaffed, and they have faced mass exoduses of staff in recent years following the PHE unwinding and again as OBBBA's changes have begun to take effect.[147] There are therefore fewer people to manage these systems through these changes, further increasing the risk of additional improper payments.[148]

OBBBA's PERM Changes Pose a Significant Risk to Medicaid Coverage

The elimination of the good faith waiver means that states **will** be penalized for any improper payment amount over the 3 percent threshold, because OBBBA eliminates HHS's authority to exercise discretion in imposing PERM penalties. Practically, this means states will have to pay

back the federal portion of whatever that figure is. And, because OBBBA also expands the definition of "erroneous payments" (or "monetary loss errors") to include payments without sufficient documentation, states will now be liable for substantially more money than they would have been with "just" the elimination of the good-faith waiver.

> **The impact at work:** HHS estimates that Alaska made $191 million in improper eligibility-related payments in fiscal year 2024, constituting an improper payment rate of 9.5 percent. [149] Importantly, Alaska had no "monetary loss errors" in fiscal year 2024; the entirety of the state's improper payments were insufficient documentation errors.[150] But OBBBA's changes would require HHS to initiate recovery of the federal portion of improper payments over the 3 percent threshold, and the law's definitional changes mean Alaska's insufficient documentation improper payments would be included in that figure. Under OBBBA's new requirements, Alaska would be responsible for repaying about $65.7 million – nearly equivalent to all FY 2024 state spending on dental services, personal care services, home health and hospice services, Federally Qualified Health Centers (FQHCs), non-emergency medical transportation (NEMT), Alaska's 1915(k) Community First Choice program, targeted case management, and laboratory/radiological services combined.[151]

States with higher federal medical assistance percentages (FMAP or federal match) will also suffer disproportionately. Compare Maryland and Tennessee, both of which were reviewed in 2023 (PERM Cycle 2): Both states had similar figures for improper payments and projected expenditures, and they had identical error rates.[152] But Tennessee's FMAP is significantly higher than Maryland's (66.10 percent vs. 50 percent in fiscal year 2023).[153] Had repayment been required, as it will be under OBBBA, Tennessee would stand to lose significantly more money than Maryland, despite the 2 states being generally similarly situated for PERM error rate purposes, other than their federal match percentages.[†]

[†] References throughout to federal match percentages are based on "regular" FMAP rates, which are set by a statutory formula. ALISON MITCHELL, CONG. RESEARCH SERV., R43487, MEDICAID'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) 1 (2025), https://www.congress.gov/crs-product/R43847. There are exceptions to the regular FMAP rate for "certain states, situations, populations, providers, and services." *Id.*

Fiscal Year 2023 PERM Data[154]	Maryland[‡]	Tennessee
Improper payments (eligibility)	$326,900,000	$313,200,000
Projected expenditures	$9,543,600,000	$9,167,000,000
Improper payment rate	3.4 percent	3.4 percent
Percent over 3 percent threshold	0.4 percent	0.4 percent
Penalty amount	$38,174,400	$36,668,000
FMAP (fiscal year 2023)	50 percent	66.10 percent
Federal recoupment (based on FMAP)	**$19,087,200**	**$24,237,548**

These risks come as states are already struggling to fill the gaps OBBBA has left in their budgets. The overall loss to state budgets as a result of OBBBA's Medicaid changes alone is estimated at $679 billion through 2034, with work requirements and 6-month redeterminations being responsible for more than half of that figure.[155] Other OBBBA changes to certain programs will compound the effect on state budgets. The new SNAP error rate penalties alone will result in estimated costs to states of between $5.5 million (North Dakota) and $1.8 billion (California), on top of an average of $67 million per state in additional administrative spending.[156] Overall, cuts in federal funding for SNAP are estimated to total $186 billion over a decade.[157]

Some states are predicting substantial revenue losses in the coming years due to OBBBA's tax changes, as well. For example, Oregon has predicted losses of $888 million by the end of 2027, Virginia has predicted losses of nearly $1.1 billion by the end of fiscal year 2028, and Nebraska estimates a reduction in state tax revenue of around $406 million by the end of fiscal year 2029.[158] Colorado is experiencing a "fiscal crisis" brought on by the tax changes, with losses of over $1 billion in fiscal year 2025 alone leading the state to cut funding for community colleges, clean drinking water initiatives, and small business development programs.[159]

In response to the massive blow OBBBA has dealt to state budgets, states are ushering in a new era of "Medicaid austerity," where they are considering and pursuing service cuts, additional eligibility restrictions, and attempts to chip away at Medicaid expansion.[160] Versions of this story played out during the 2002 economic downturn and again during the Great Recession of 2008. States considered and made heavy cuts in 2002 and 2003, but a temporary

[‡] Maryland also had a 0.2 percent monetary loss error rate, but the impact of that figure has not been calculated here since it is under the 3 percent recovery threshold. Tennessee did not have any monetary loss errors.

FMAP increase for fiscal year 2004 helped stem the bleeding.[161] And even with the American Reinvestment and Recovery Act (ARRA)'s temporary FMAP increase in 2009, states still made a wide variety of cuts that were not prohibited by ARRA's Maintenance of Effort provision, such as eliminating optional services, erecting new barriers to enrollment, and freezing or reducing provider reimbursement rates.[162] But those periods of economic distress, caused by external economic forces, were temporary, and the federal government worked to support states through them.[163] Conversely, through OBBBA, the federal government has cut an estimated $1 trillion from Medicaid while also limiting states' financing options through restrictions on provider taxes and state-directed payments (SDPs).[164]

However, there is still much states can do to reduce their exposure to errors, conserve resources, and promote enrollment and coverage retention for eligible people.

States Can and Should Limit Burden to Limit Their Exposure to Errors

Programs like Medicaid, with their complicated rules and abundance of moving parts, are inherently complex.[165] "Political contests" over these programs' existence and scope compound their complexity and result in a shifting landscape of criteria governing eligibility and benefit levels.[166] Increasing administrative burden to hinder program uptake is a way of "policymaking by other means" – erecting barriers to thwart eligible people from accessing services.[167]

Administrative Easing Improves Agency Performance and Promotes Access to Services for Eligible People

Reducing these burdens is critical for several reasons. First, simplifying systems limits agency exposure to errors.[168] For example, after Michigan radically simplified its integrated benefits application, eligibility workers were able to reduce the time they spent correcting client errors by 75 percent.[169] The same holds true across a variety of federal programs. One study found that SNAP households that were required only to do simplified reporting were about 12 percent less likely to receive benefits in error than "traditional reporting" households, for whom the burden of proving continued eligibility was higher.[170] The "near-zero" error rate in the Social Security retirement program has been attributed to its low burden level.[171] Conversely, in the context of unemployment insurance, error rates were found to be greater where programs had more complex eligibility requirements and processes for determining benefit amounts.[172] Similarly, the Earned Income Tax Credit (EITC)'s high rate of improper payments is widely attributed to the intricacy of the rules governing eligibility for the credit.[173] Simplifying eligibility rules also, in general, does not result in ineligible people incorrectly being determined eligible for a program.[174] In fact, the inverse is true: More complicated eligibility

rules and processes are directly associated with lower rates of program uptake among eligible people.[175]

Not only does simplifying the system reduce the risk of errors, but doing so also limits strain on states and conserves valuable resources. For instance, states that eliminated the Medicaid asset test for families in the late 1990s and early 2000s reaped the benefits of simplified systems. [176] Worker productivity improved, implementing new automated eligibility systems was easier, and administrative cost savings were significant.[177] States also saw no increase in error rates as a result of eliminating the asset test.[178] Broader simplification efforts similarly benefit states: When Oregon reduced the size of its Medicaid application by nearly 80 percent, the time required to complete enrollment fell from 22 days to 3 days and the state was able to save more than $28,000 per month in overtime pay for eligibility workers.[179]

In addition to having a positive impact on error rates, reducing administrative burden ensures services are appropriately furnished to eligible people. Increased administrative burden is strongly associated with lower take-up among people who would be otherwise eligible for a program, and it impacts coverage retention for eligible people already on the program.[180] When Arkansas first implemented work requirements in 2018, the majority of the 18,000-plus people who lost Medicaid coverage were either meeting or exempt from the requirements; they lost coverage due to reporting difficulties and a lack of information about the requirements.[181] Administrative burdens in Medicaid home- and community-based services (HCBS) programs often serve to ration access to care for eligible people, either directly or indirectly.[182] And although most adults remain eligible for Medicaid from year to year, procedural terminations due to paperwork issues and barriers to completing the renewal process are exceedingly common.[183]

Finally, limiting administrative burden makes programs more equitable. Administrative burdens "do not fall equally" on all people, leading to unequal barriers to access and "disproportionate underutilization" of important programs and services.[184] Because administrative burdens are unequally distributed, they have the effect of reinforcing inequities and disparities.[185] For instance, administrative burdens are often felt much more sharply by people living in rural communities than by people living in metropolitan or "urban" areas due to structural issues like a lack of access to broadband internet, the difficulty of potentially having to travel long distances to a Medicaid office to submit paperwork, and office hours that do not accommodate the needs of all community members.[186] For all of these reasons, it is in states' best interest to keep policies and procedures simple and reduce burden to the maximum extent possible.

States Can Take Steps Now to Mitigate Improper Payment Impacts

Some increased complexity is, unfortunately, inevitable under OBBBA. But states can still minimize the impact of OBBBA's eligibility changes on their improper payment rates by electing less-restrictive policy options like shorter lookback periods for work requirements compliance, and limiting the frequency of compliance reviews and reverification of exceptions and exclusions.[187] States should also accept self-reported information from applicants and enrollees wherever possible. Self-declaration is already widely permitted in Medicaid eligibility determinations: States may accept self-declaration for all eligibility factors other than citizenship and immigration status.[188] Moreover, self-reported information is largely reliable, and it is also auditable with appropriate uses of data matching, preserving program integrity while also reducing the burden on applicants, enrollees, and states of having to produce and manage documentation.[189] In turn, this reduces the potential for documentation-related errors to impact states' error rates. One survey found that pairing self-reporting of income and assets with automated verification was generally associated with error rates of 3 percent or lower when verification was performed prior to an eligibility determination.[190]

A note on automation: It may help lighten the load, but it is not a cure-all. Technology can be helpful in reducing administrative burdens if its scope is reasonably limited to a narrow purpose, but it has its own limitations and risks.[191] Crucially, technology can sometimes make things worse – it can easily create additional opportunities for worker error or other problems, harming enrollees at great speed and scale in ways that states find difficult to control or fix.[192] It is critical to recognize these risks and limitations and to be realistic about what technology can achieve without assuming that tech tools can substitute for an efficient, straightforward eligibility system or sufficiently prop up an eligibility system that is otherwise dysfunctional due to its complexity.

In short, cutting through the red tape is good for everyone. It limits the probability of errors, it preserves state resources, and it facilitates take-up of services by eligible people who otherwise may be foreclosed from accessing services by onerous requirements for proving eligibility.

Conclusion

The current narrative surrounding Medicaid fraud, waste, and abuse is nothing more than a product of antipathy, often racialized, toward the social safety net.[193] Fraud by Medicaid enrollees is minimal, and Medicaid is overall a cost-effective, efficient program. Nevertheless, exaggerated reports of fraud, mismanagement, and program "bloat" have become a pretext

for program cuts and part of a narrative attempting to diminish support for Medicaid and similar programs. Efforts sold as combating fraud, waste, and abuse are really just ways of weaponizing red tape to withhold Medicaid coverage from eligible people. PERM eligibility data in particular has been dishonestly wielded as a cudgel – represented as something it is not in an attempt to justify unpopular program cuts under the guise of addressing fraud, waste, and abuse through additional penalties and administrative burdens. To be sure, OBBBA makes an already-complex system significantly more complicated. Because of that, errors will happen. But these errors as identified by PERM are still largely documentation errors, not indicators of ineligible people on the program. Additionally, smart implementation choices will limit states' exposure to errors and help eligible people obtain and keep their Medicaid coverage.

ENDNOTES

[1] Pub. L. No. 119-21, § 71106, 139 Stat. 295 (2025) [hereinafter "OBBBA"].
[2] *See, e.g.*, Hayden Dublois & Jonathan Ingram, *Ineligible Medicaid Enrollees Are Costing Taxpayers Billions*, Found. for Gov't Accountability (Jan. 23, 2022), https://web.archive.org/web/20220317061610/https:/thefga.org/paper/ineligible-medicaid-enrollees-costing-taxpayers-billions/ (contending that all improper payments are evidence of program "bloat" and mismanagement, yet acknowledging that program integrity measures show that improper payments occur for a variety of reasons and are not universally attributable to ineligibility or fraud); Brian Blase, *Medicaid is hemorrhaging $100B on Americans ineligible for the program*, N.Y. POST (Nov. 28, 2020), https://nypost.com/2020/11/28/medicaid-hemorrhaging-100b-on-americans-ineligible-for-the-program/ (broadly construing PERM eligibility data as showing that all eligibility-related improper payments were made on behalf of ineligible people when the data generally does not prove ineligibility).
[3] CMS, *Payment Error Rate Measurement (PERM)* (Mar. 12, 2026), https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm (definition of "improper payment"); *see also, e.g.*, HHS, *Department of Health and Human Services Agency Financial Report: Fiscal Accountability for a Healthy America* 156 (2026), https://www.hhs.gov/sites/default/files/fy-2025-hhs-agency-financial-report.pdf ("Missing or insufficient documentation accounts for the most significant portion of improper payments . . .").
[4] *See, e.g.*, Steph Quinn, *Missouri lawmakers weigh $294M price tag to carry out new federal Medicaid rules*, MO. INDEP. (Mar. 5, 2026), https://missouriindependent.com/2026/03/05/missouri-lawmakers-weigh-294m-price-tag-to-carry-out-new-federal-medicaid-rules/ (discussing a potential federal clawback of $1.2 billion starting in October 2029 based on prior error rates and expenses related to implementing OBBBA requirements).
[5] 82 Fed. Reg. 31158, 31158 (Jul. 5, 2017). IPIA was later amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA). *Id*. The Payment Integrity Information Act of 2019 (PIIA) broadly replaced IPIA, IPERA, and IPERIA. *See* Payment Integrity Information Act of 2019, Pub. L. No. 116-117, 134 Stat. 113 (2020) [hereinafter "PIIA"] (codified at 31 U.S.C. §§ 3301, 3321, 3351-58, 3562(a)).
[6] 82 Fed. Reg. at 31160.

[7] Medicaid & CHIP Access & Payment Comm'n (MACPAC), *Payment Error Rate Measurement (PERM)* (Mar. 9, 2020), https://www.macpac.gov/subtopic/payment-error-rate-measurement-perm/ [hereinafter "MACPAC PERM Overview"].
[8] Andy Schneider, *Medicaid Fraud: The Improper Use of Improper Payments*, Georgetown Univ. Ctr. for Children & Families (Mar. 13, 2025), https://ccf.georgetown.edu/2025/03/13/medicaid-fraud-the-improper-use-of-improper-payments/ [hereinafter "The Improper Use of Improper Payments"].
[9] *See* S. REP. NO. 107-333, at 1 (2002), *as reprinted in* 2002 U.S.C.C.A.N. 1459, 1460 (noting that IPIA's purpose was to require that federal agencies "estimate annually the amount of underpayments and overpayments" made by programs identified as "vulnerable to improper payments," and stating that improper payments "include any payments to ineligible recipients, payments for an ineligible service, duplicate payments, payments for services not received, and payments that do not account for credit for applicable discounts"); *see also, e.g.*, Kamryn Perry et al., *Understanding Medicaid's Payment Error Rate Measurement (PERM) Program and Changes Under H.R. 1*, Bipartisan Policy Ctr. (Apr. 8, 2026), https://bipartisanpolicy.org/article/understanding-medicaids-payment-error-rate-measurement-perm-program-and-changes-under-h-r-1/ (PERM is "a key federal mechanism CMS uses to estimate states' payments that do not meet statutory, regulatory, or administrative requirements in Medicaid and CHIP" and, "[i]mportantly," these payments "do not necessarily constitute fraud . . ."); U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-107487, MEDICARE AND MEDICAID: ADDITIONAL ACTIONS NEEDED TO ENHANCE PROGRAM INTEGRITY AND SAVE BILLIONS 8 (2024), https://www.gao.gov/assets/gao-24-107487.pdf ("[t]he improper payment estimation process agencies use is not designed to detect or measure the amount of fraud that may exist"); OFF. OF MGMT. & BUDGET, APPENDIX C TO CIRCULAR NO. A-123, REQUIREMENTS FOR EFFECTIVE ESTIMATION AND REMEDIATION OF IMPROPER PAYMENTS 28 (2014), *available at* https://obamawhitehouse.archives.gov/sites/default/files/omb/memoranda/2015/m-15-02.pdf (noting that fraudulent activity is just 1 potential root cause of improper payments).
[10] *See* MACPAC PERM Overview, *supra* note 7. This paper focuses primarily on eligibility-related improper payments, which CMS started reviewing again during the 2019 PERM cycle.
[11] HHS, Office Inspector Gen. ("OIG"), *The Centers for Medicare & Medicaid Services' Review Contractors Generally Conducted Medicaid Fee-for-Service Claim Reviews for Selected States Under the Payment Error Rate Measurement Program in Accordance with State and Federal Requirements* 3 (2022), https://oig.hhs.gov/documents/audit/7387/A-04-21-00132-Complete%20Report.pdf.
[12] *Id.*

[13] *See* HHS, Office Inspector Gen. ("OIG") *The Centers for Medicare & Medicaid Services' Review Contractor Did Not Document Medicaid Managed Care Payment Review Determinations Made Under the Payment Error Rate Measurement Program* 2 (2022), https://oig.hhs.gov/documents/audit/7404/A-04-21-09003-Complete%20Report.pdf.
[14] 82 Fed. Reg. at 31171.
[15] When CMS overhauled the PERM program in 2017, it specifically declined to focus on eligibility reviews "that potentially could not be tied to payments," such as those "conducted on beneficiaries that did not receive any services," in order to better align with IPERIA requirements and reduce state burden. *Id*.
[16] *See* MACPAC PERM Overview, *supra* note 7.
[17] Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Program Integrity* (Mar. 30, 2018), https://www.macpac.gov/subtopic/program-integrity/ [hereinafter "MACPAC Program Integrity Overview"].
[18] CMS, *Medicare Fraud & Abuse: Prevent, Detect, Report* 6 (2026), https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/fraud-abuse-mln4649244.pdf.
[19] *Why Did They Do It That Way? Program Integrity*, Nat'l Assn. of Medicaid Dirs. (Jun. 30, 2025), https://medicaiddirectors.org/resource/why-did-they-do-it-that-way-program-integrity/.
[20] 42 C.F.R. § 455.2.
[21] These are all real examples of fraud that state MFCUs prosecuted in fiscal year 2023. *See* HHS & U.S. Dep't of Justice, Office Inspector Gen. ("OIG"), *Health Care Fraud and Abuse Control Program FY 2023* 14-15, 17-18 (2024), https://oig.hhs.gov/documents/hcfac/10087/HHS%20OIG%20FY%202023%20HCFAC.pdf.
[22] 42 C.F.R. § 455.2.
[23] CMS, *Medicare Fraud & Abuse: Prevent, Detect, Report* 6 (2026), https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/fraud-abuse-mln4649244.pdf.
[24] 42 U.S.C. § 1396b(u)(1)(D); *see also, e.g.*, CMS, *2025 Medicaid & CHIP Supplemental Improper Payment Data* 49 (2026), https://www.cms.gov/files/document/2025-medicaid-chip-supplemental-improper-payment-data.pdf [hereinafter "2025 PERM Report"].
[25] CMS, *supra* note 3.
[26] The Medicaid Act has been called, at different turns, "almost unintelligible to the uninitiated," "Byzantine" and "among the most intricate ever drafted by Congress," "a morass of bureaucratic complexity," "an aggravated assault on the English language, resistant to

attempts to understand it," and a "Serbonian bog." *See May v. Azar*, 302 So. 3d 222, 228-29 (Ala. Civ. App. 2019) (internal citations omitted) (collecting cases).

[27] *See, e.g.*, Margot Sanger-Katz & Sarah Kliff, *Why a G.O.P. Medicaid Requirement Could Set States Up for Failure*, N.Y. TIMES (Jun. 28, 2025), https://www.nytimes.com/2025/06/28/upshot/republicans-medicaid-work-requirement.html (commenting that outdated Medicaid computer systems combined with OBBBA's reductions in federal funding could cause "major failures" in state eligibility systems).

[28] HHS, *supra* note 3, at 156.

[29] 2025 PERM Report, *supra* note 24, at 49.

[30] *Id.* at 40. In fiscal year 2025, CMS identified 1,049 total payment errors. 608 of those errors were related to a lack of documentation, and another 172 errors were related to some other minor administrative mistake that prevented reviewers from confirming that a payment was correctly made on behalf of an eligible individual. In total, about 58 percent of payment errors were improper payments related to a lack of documentation, and about 16 percent were related to a minor administrative mistake. In contrast, only 81 errors (about 8 percent) were connected to payments made on behalf of confirmed ineligible people. *Id.* This figure encompasses eligibility-related improper payments for both MAGI and non-MAGI Medicaid programs. In general, improper payment rates are higher for non-MAGI Medicaid, likely due to the increased administrative requirements, such as paper documentation, for non-MAGI eligibility determinations. *See, e.g.*, Alice Burns et al., *Medicaid Eligibility and Enrollment Policies for Seniors and People with Disabilities (Non-MAGI) During the Unwinding*, KFF (Jun. 20, 2024), https://www.kff.org/medicaid/medicaid-eligibility-and-enrollment-policies-for-seniors-and-people-with-disabilities-non-magi-during-the-unwinding/.

[31] *See, e.g.*, MACPAC PERM Overview, *supra* note 7.

[32] *Id.* (noting that "PERM findings can be used to identify potential problem areas that can inform corrective actions").

[33] Selena Simmons-Duffin, *Medicaid keeps getting more popular as Republicans aim to cut it by $800 billion*, NAT'L PUB. RADIO: ALL THINGS CONSIDERED (Jun. 17, 2025), https://www.npr.org/sections/shots-health-news/2025/06/17/nx-s1-5435312/medicaid-cuts-big-beautiful-bill-trump-kff-poll; Louis Jacobson, *What Are 'Improper' Medicaid Payments, and Are They as High as a Trump Official Said?*, KFF Health News (Jun. 11, 2025), https://kffhealthnews.org/medicaid/fact-check-medicaid-improper-payment-trump-omb-director-russell-vought-claim/ (commenting that 2024 PERM data showed it was "rare for ordinary beneficiaries to be scamming the government"); David Machledt, *Medicaid is Even Leaner as Accountability Improves*, Nat'l Health Law Prog. (Feb. 25, 2025),

https://healthlaw.org/medicaid-is-even-leaner-as-accountability-improves/; Andy Schneider, *The Truth about Fraud Against Medicaid*, Georgetown Univ. Ctr. for Children & Families (Jan. 10, 2025), https://ccf.georgetown.edu/2025/01/10/the-truth-about-fraud-against-medicaid/.

[34] *See* Blase, *supra* note 2; U.S. Senate Comm. on Homeland Security & Governmental Aff., *The Centers for Medicare & Medicaid Services Has Been a Poor Steward of Federal Medicaid Dollars* 11-12 (2018), https://www.hsgac.senate.gov/wp-content/uploads/imo/media/doc/2018-06-20 Medicaid Fraud and Overpayments Majority Staff Report.pdf.

[35] *See, e.g.*, Dublois & Ingram, *supra* note 2.

[36] *Id*.

[37] It appears that the report conflated the CHIP improper payment statistics with the Medicaid improper payment statistics. 83.8 percent of CHIP improper payments were eligibility-related. Nothing in the 2020 PERM report suggests that more than 80 percent of Medicaid improper payments were eligibility-related. *See* CMS, *2020 Medicaid & CHIP Supplemental Improper Payment Data* 7 (2020), https://www.cms.gov/files/document/2020-medicaid-chip-supplemental-improper-payment-data.pdf/ [hereinafter "2020 PERM Report"].

[38] *Id*. at 14.

[39] *Id*.

[40] Because the PERM eligibility component was suspended between 2015 and 2018 to give states time to acclimate to the new requirements of the Affordable Care Act (ACA), the FY 2020 data includes eligibility data from 2012 (the most recent Cycle 3 measurement prior to 2015), which was measured using different methodology. *See* Jessica Mathers et al., *A Look at the Medicaid Payment Error Rate Measurement (PERM) Program and Upcoming Changes and Impacts*, KFF (Feb. 13, 2026), https://www.kff.org/medicaid/a-look-at-the-medicaid-payment-error-rate-measurement-perm-program-and-upcoming-changes-and-impacts/; 2020 PERM Report, *supra* note 37, at 3.

[41] 42 U.S.C. § 1396a(a)(61) (requiring establishment of MFCU).

[42] HHS, Office Inspector Gen., *Medicaid Fraud Control Units Annual Report: Fiscal Year 2025* 8 (2026), https://oig.hhs.gov/documents/evaluation/11553/OEI-09-26-00140.pdf.

[43] Nat'l Assn. of Medicaid Dirs., *supra* note 19.

[44] *See, e.g.*, Ala. Admin. Code § 560-X-4-.01(1)-(2) (purpose and responsibilities of Alabama Medicaid Agency's Program Integrity Division); Wash. Admin. Code § 182-502A-301 (authority of Washington State Health Care Authority to conduct program integrity activities).

[45] *See* 42 C.F.R. §§ 455.13(b)(2) (Medicaid agencies must have methods for investigating suspected fraud cases that afford due process), 455.15 (requiring a full investigation of

potential fraud or abuse), 455.16 (investigation must continue until legal action is initiated, the case is closed or dropped due to insufficient evidence, or the matter is otherwise resolved between the agency and the accused provider or enrollee); *see also* 42 C.F.R. § 1007.5 (requiring that the MFCU be a "single, identifiable entity of the state government"); CMS, *Frequently Asked Question (FAQs): Medicare & Medicaid Fraud, Waste, and Abuse Prevention Mini-Course & Podcast Series* 1 (Nov. 2022), https://web.archive.org/web/20250602111359/https:/cmsnationaltrainingprogram.cms.gov/sites/default/files/shared/C-10_FAQ_Medicare_%26_Medicaid_Fraud_Waste_Abuse_Prevention_12-8-2022.pdf (although this guidance has been archived, it reflects the requirements of the relevant federal regulations).

[46] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106608, IMPROPER PAYMENTS AND FRAUD: HOW THEY ARE RELATED BUT DIFFERENT 3 (2023), https://www.gao.gov/assets/d24106608.pdf; *see also* U.S. GOV'T ACCOUNTABILITY OFF. , GAO-24-107482, IMPROPER PAYMENTS: KEY CONCEPTS AND INFORMATION ON PROGRAMS WITH HIGH RATES OR LACKING ESTIMATES 5 (2024), https://www.gao.gov/assets/gao-24-107482.pdf (referencing guidance from the Office of Management and Budget (OMB) stating that "agencies may **only** report their improper payments as intentional after the amount is determined to be fraudulent through the adjudication process") (emphasis added).

[47] Sarah Grusin, *A Promise Unfulfilled: Automated Medicaid Eligibility Decisions*, Nat'l Health Law Prog. (Jun. 30, 2021), https://healthlaw.org/a-promise-unfulfilled-automated-medicaid-eligibility-decisions/.

[48] *Compare* Rachel M. Werner et al., *Projected Mortality Impacts of the Budget Reconciliation Bill*, U. Penn. Leonard Davis Inst. of Health Econ. (Jun. 3, 2025), https://ldi.upenn.edu/our-work/research-updates/research-memo-projected-mortality-impacts-of-the-budget-reconciliation-bill/ (estimating roughly 30,000 annual deaths from Medicaid and ACA coverage losses attributable to OBBBA, including coverage losses resulting in loss of access to prescription drug subsidies for low-income Medicare enrollees who are also enrolled in Medicaid), *and* Sophie Novack, *As Texas Throws 1.8 Million Off Medicaid, Children Pay the Price*, TEX. MONTHLY (Jan. 25, 2024), https://www.texasmonthly.com/news-politics/medicaid-disenrollment-texas-children/ (describing treatment setbacks for a child with a disability following her erroneous termination from Medicaid), *and* Wafa W. Tarazi et al., *Impact of Medicaid Disenrollment in Tennessee on Breast Cancer Stage at Diagnosis and Treatment*, 123 CANCER 3312, 3317 (2017), https://acsjournals.onlinelibrary.wiley.com/doi/pdf/10.1002/cncr.30771 (finding that people disenrolled from Medicaid in Tennessee were more likely to be diagnosed with breast cancer at

a later stage), *with* Angela Wyse & Bruce D. Meyer, *Saved by Medicaid: New Evidence on Health Insurance and Mortality from the Universe of Low-Income Adults* (Nat'l Bureau of Econ. Research, Working Paper No. 33719, 2025), https://www.nber.org/system/files/working_papers/w33719/w33719.pdf (finding that expanding Medicaid eligibility to new populations reduced mortality hazard by 21 percent among new enrollees).

[49] Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Effects of Churn on Potentially Preventable Hospital Use* 3-5 (2022), https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf [hereinafter "Effects of Churn on Potentially Preventable Hospital Use"].

[50] Cathy Zhang, *Churning Point: Lessons from Medicaid Pandemic Policies*, Bill of Health (Oct. 19, 2021), https://petrieflom.law.harvard.edu/2021/10/19/medicaid-churn-pandemic/ (citing Patricia Boozang & Adam Striar, *The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage*, State Health & Value Strategies (Sept. 17, 2021), https://shvs.org/the-end-of-the-covid-public-health-emergency-potential-health-equity-implications-of-ending-medicaid-continuous-coverage/).

[51] Sarah Sugar et al., *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* 4, U.S. Dep't of Health & Hum. Servs. Assistant Sec'y for Planning & Evaluation (2021), https://aspe.hhs.gov/sites/default/files/documents/5f6e4d78d867b6691df12d1512787470/medicaid-churning-ib.pdf.

[52] One widely-cited analysis found that a single person's churning (including disenrolling and re-enrolling) resulted in administrative costs of between $400 and $600 in 2015. Katherine Swartz et al., *Evaluating State Options for Reducing Medicaid Churning*, 34 HEALTH AFF. 1180, 1181 (Jul. 2015), https://pmc.ncbi.nlm.nih.gov/articles/PMC4664196/pdf/nihms708512.pdf.

[53] *See* Effects of Churn on Potentially Preventable Hospital Use, *supra* note 49; Zhang, *supra* note 50; Sugar et al., *supra* note 51; Swartz et al., *supra* note 52; *see also, e.g.*, Tricia Brooks, *Rescinding the Eligibility and Enrollment Rule Would Thwart Efforts to Improve Efficiency in Medicaid and Efforts to Reduce Improper Payments*, Georgetown Univ. Ctr. for Children & Families (May 6, 2025), https://ccf.georgetown.edu/2025/05/06/rescinding-the-eligibility-and-enrollment-rule-would-thwart-efforts-to-improve-efficiency-in-medicaid-and-efforts-to-reduce-improper-payments/ (describing how the 2024 Eligibility and Enrollment Final Rule, which was designed to simplify and streamline Medicaid enrollment and renewal processes, would have saved money, reduced administrative burden, and improved program integrity); *see also* Charly Gilfoil & Alicia Emanuel, *New Medicaid & CHIP Eligibility and Enrollment Rule: What*

Advocates Need to Know, Nat'l Health Law Prog. (2024), https://healthlaw.org/resource/new-medicaid-chip-eligibility-and-enrollment-rule-what-advocates-need-to-know/.

[54] Jennifer Wagner & Judith Solomon, *Continuous Eligibility Keeps People Insured and Reduces Costs*, Ctr. on Budget & Policy Priorities (May 4, 2021), https://www.cbpp.org/research/health/continuous-eligibility-keeps-people-insured-and-reduces-costs#many-people-remain-uninsured-cbpp-anchor.

[55] Lunna Lopes et al., *KFF Survey of Medicaid Unwinding*, KFF (Apr. 12, 2024), https://www.kff.org/medicaid/poll-finding/kff-survey-of-medicaid-unwinding/ (finding that 23 percent of those disenrolled remain uninsured).

[56] Shameek Rakshit et al., *The Burden of Medical Debt in the United States*, Peterson-KFF Health Sys. Tracker (Feb. 12, 2024), https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/; Laura Hawks et al., *Trends in Unmet Need for Physician and Preventive Services in the United States, 1998-2017*, 180 JAMA INTERNAL MED. 439 (2020), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2759743 (increased hospitalizations for uninsured patients with cardiovascular disease and hypertension); Steffie Woolhandler & David Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 ANNALS OF INTERNAL MED. 424 (2017), https://www.acpjournals.org/doi/10.7326/M17-1403?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed (discussing excess mortality among the uninsured population).

[57] Lopes et al., *supra* note 55 (finding that Medicaid enrollees who obtained other types of coverage after being disenrolled from Medicaid were significantly more likely to report being worried about the cost of health care services, unexpected medical bills, and affording prescription drugs than those who retained their Medicaid coverage).

[58] Grusin, *supra* note 47.

[59] OBBBA § 77106(a)(2)(B)(ii).

[60] *Id.* at § 77106(a)(4).

[61] *See, e.g.*, Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Medicaid as a Share of States' Total Budgets and State-Funded Budgets* (Feb. 2026), https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-5.-Medicaid-as-a-Share-of-States-Total-Budgets-and-State-Funded-Budgets-SFY-2023.pdf; Nat'l Ass'n of State Budget Officers, *2025 State Expenditure Report* 12, 41 (2025), https://www.nasbo.org/reports-data/state-expenditure-report; Rebecca Thiess et al., *How Federal Funding Flows to State Governments, by Policy Area*, Pew Charitable Trusts (Mar. 5, 2025), https://www.pew.org/en/research-and-analysis/articles/2025/03/05/how-federal-funding-flows-to-state-governments-by-policy-area.

[62] KFF, *The Role of Medicaid in State Economies: A Look at the Research* 3 (2009), https://www.kff.org/wp-content/uploads/2013/01/7075_02.pdf [hereinafter "The Role of Medicaid in State Economies"].
[63] *See, e.g.*, *By the Numbers: The Republican 'Big Ugly Bill' Would Have Devastating Impacts on New York Health Care Providers, Patients, Employee and Communities*, N.Y. Off. of the Governor (Jul. 1, 2025), https://www.governor.ny.gov/news/numbers-republican-big-ugly-bill-would-have-devastating-impacts-new-york-health-care-providers (estimating that New York will lose 65,000 jobs and $14.4 billion in economic activity due to OBBBA Medicaid cuts); *Federal Medicaid Cuts & Arizona's Economy* 7, Ariz. Chamber Found. 6-8 (2025), https://azchamberfoundation.org/wp-content/uploads/2025/03/033025-Final-Report-Economic-Impact-of-Medicaid-Funding-Cuts15.pdf (estimating that, for **each** $1 billion reduction in Medicaid spending, Arizona will lose more than 36,000 jobs and see a $3.7 billion contraction in overall economic activity) (emphasis added).
[64] *See, e.g.*, *Senate AHCA Includes Medicaid Repeal and Replace Provisions for States*, Fitch Ratings (Jun. 22, 2017), https://www.fitchratings.com/research/us-public-finance/senate-ahca-includes-medicaid-repeal-replace-provisions-for-states-22-06-2017.
[65] Emily Katz Sayag, *How SNAP and Medicaid Changes Will Impact State Education Budgets*, Nat'l Conf. of State Legislatures (Oct. 3, 2025), https://www.ncsl.org/state-legislatures-news/details/how-snap-and-medicaid-changes-will-impact-state-education-budgets.
[66] Riley Judd & Justin Theal, *New Federal Medicaid Policies Compound State Budget Pressures*, Pew Charitable Trusts (Jan. 13, 2026), https://www.pew.org/en/research-and-analysis/articles/2026/01/13/new-federal-medicaid-policies-compound-state-budget-pressures.
[67] Carrie Welton et al., *Cuts to Health & Nutrition Programs Will Harm Millions of Americans and, Once Again, Imperil State High Education Affordability for a Generation of Students*, The Inst. for College Access & Success (Apr. 25, 2025), https://ticas.org/anti-poverty/snap-medicaid-cost-shift-to-states/; Tristan Stein & Arianna Fano, *State Funding and College Costs: Reviewing the Evidence*, Bipartisan Policy Ctr. (Dec. 16, 2024), https://bipartisanpolicy.org/explainer/state-funding-and-college-costs-reviewing-the-evidence/.
[68] 42 C.F.R. § 431.1010(b)(2); *see also* Mathers et al., *supra* note 40.
[69] OBBBA § 71106(a)(2)(B)(ii).
[70] Mathers et al., *supra* note 40.
[71] CMS, *2023 Medicaid & CHIP Supplemental Improper Payment Data* 52 (2023), https://www.cms.gov/files/document/2023-medicaid-chip-supplemental-improper-payment-data.pdf [hereinafter "2023 PERM Report"] (showing that South Carolina had an eligibility-related improper rate of 8.7 percent in 2023); *see also* CMS, *2024 Medicaid & CHIP*

Supplemental Improper Payment Data 52 (2024), https://www.cms.gov/files/document/2024-medicaid-and-chip-supplemental-improper-payment-data.pdf [hereinafter "2024 PERM Report"] (showing that Alaska had an eligibility-related improper payment rate of 9.5 percent in 2024).

[72] 2024 PERM Report, *supra* note 71, at 52.

[73] 2023 PERM Report, *supra* note 71, at 52.

[74] *Id.*

[75] 2025 PERM Report, *supra* note 24, at 52.

[76] 2023 PERM Report, *supra* note 71, at 52.

[77] *Id.*

[78] *Id.*

[79] 2024 PERM Report, *supra* note 71, at 52.

[80] 2023 PERM Report, *supra* note 71, at 52.

[81] *Id.*

[82] 2025 PERM Report, *supra* note 24, at 52.

[83] 2024 PERM Report, *supra* note 71, at 52.

[84] *Cf.* Gina Plata-Nino, *A Backgrounder on SNAP Quality Control, Payment Error Rates and Tolerance Threshold, and Cost-Sharing*, Food Research & Action Ctr. (Apr. 1, 2026), https://frac.org/blog/a-backgrounder-on-snap-quality-control-payment-error-rates-and-cost-sharing (OBBBA changes to SNAP financing tying state cost-sharing requirements to error rates "rest on a flawed premise: that SNAP payment error rates provide a simple, controllable, and reliable measure of state performance. **In practice, error rates reflect an extraordinarily complex administrative process**. . .") (emphasis added).

[85] As the adage goes: "If you know 1 state's Medicaid program, you know 1 state's Medicaid program." *See, e.g.*, Michael Goldberg, *Georgia has the Nation's Only Medicaid Work Requirement. Mississippi Could be Next*, AP NEWS (Feb. 21, 2024), https://apnews.com/article/medicaid-expansion-mississippi-georgia-south-dakota-cbec740c9657b1f5c2a1ac313286d796.

[86] *See, e.g.*, Robin Rudowitz et al., *Medicaid 101*, *in* HEALTH POL'Y 101 1, 1 (Drew Altman ed., 2025), https://files.kff.org/attachment/health-policy-101-medicaid.pdf.

[87] Generally resulting in lower improper payment rates for managed care. *See* The Improper Use of Improper Payments, *supra* note 8.

[88] *See* Perry et al., *supra* note 9.

[89] *See* The Improper Use of Improper Payments, *supra* note 8; Matthew M. Young et al., *Complexity, Errors, and Administrative Burdens*, 26 PUB. MGMT. REV. 2847, 2848 (2024),

https://digitalgovernmenthub.org/wp-content/uploads/2024/10/Complexity-errors-and-administrative-burdens.pdf; *cf.* Plata-Nino, *supra* note 84.

[90] *See* Plata-Nino, *supra* note 84.

[91] *See* CMS, *2021 Medicaid & CHIP Supplemental Improper Payment Data* 53 (2021), https://www.cms.gov/files/document/2021-medicaid-chip-supplemental-improper-payment-data.pdf-1 [hereinafter "2021 PERM Report"].

[92] *See* 2024 PERM Report, *supra* note 71, at 52.

[93] *See* CMS, *2022 Medicaid & CHIP Supplemental Improper Payment Data* 53 (2022), https://www.cms.gov/files/document/2022-medicaid-chip-supplemental-improper-payment-data.pdf-0 [hereinafter "2022 PERM Report"]. Importantly, CMS did not publish state-specific PERM data prior to 2021, so those states' improper payment rates for 2019 (which would have been their first cycle with the reintegrated eligibility component) are not readily available.

[94] *See* 2021 PERM Report, *supra* note 91, at 53; *see also* Samantha Artiga & Robin Rudowitz, *Medicaid Program Integrity and Current Issues*, KFF (Dec. 10, 2019), https://www.kff.org/medicaid/medicaid-program-integrity-and-current-issues/ (discussing the timing of the 2021 PERM reports and the reintegration of the PERM eligibility component).

[95] 2024 PERM report, *supra* note 71, at 52.

[96] Based on Hawaii's FY 2021 federal match percentage of 53.02 percent. *See* ALISON MITCHELL, CONG. RESEARCH SERV., R43487, MEDICAID'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) 16 (2025), https://www.congress.gov/crs-product/R43847.

[97] *See* CMS, *Expenditure Reports from MBES/CBES*, https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes (last visited Jun. 15, 2026) [hereinafter "CMS Expenditure Reports"].

[98] *See, e.g.*, Claire Stremple, *Months-Long Backlog for Alaska's Aid Program Triggers Second Lawsuit*, ALASKA BEACON (Apr. 20, 2023), https://alaskabeacon.com/briefs/months-long-backlog-for-alaskas-aid-programs-triggers-second-lawsuit/; Lisa Phu, *Lawsuit Says Alaska Department of Health Exposed Thousands to Hunger Risk by Not Giving Food Aid*, ALASKA BEACON (Jan. 20, 2023), https://alaskabeacon.com/2023/01/20/lawsuit-says-alaska-department-of-health-exposed-thousands-to-hunger-risk-by-not-giving-food-aid/; Sean Maguire, *Alaska's Medicaid Backlog Violates Federal and State Law, Attorneys Say*, ANCHORAGE DAILY NEWS (Jan. 6, 2023), https://www.adn.com/alaska-news/2023/01/06/alaskas-medicaid-backlog-violates-federal-and-state-law-attorneys-say/.

[99] OBBBA § 71106(a)(4).

[100] *See* 2025 PERM Report, *supra* note 24, at 49-50.

[101] 42 U.S.C. § 1396b(u)(1)(D); *see also, e.g.*, 2025 PERM Report, *supra* note 24, at 49. Improper payments are not a concept limited to Medicaid, and different federal programs address them differently. However, the scope of this paper is confined to Medicaid improper payments.

[102] Figures based on author's calculations. Between FY 2021 and FY 2025, CMS identified a total of 10,199 payment errors through PERM reviews. 7,351 of those errors fell into the listed categories. *See* 2025 PERM Report, *supra* note 24, at 40; 2024 PERM Report, *supra* note 71, at 41; 2023 PERM Report, *supra* note 71, at 42; 2022 PERM Report, *supra* note 93, at 43; 2021 PERM Report, *supra* note 91, at 42.

[103] Figures based on author's calculations. Out of the 10,199 total errors, 409 were related to payments made on behalf of confirmed ineligible people, and 286 were related to payments made on behalf of people who were eligible but incorrectly enrolled. *See* 2025 PERM Report, *supra* note 24, at 40; 2024 PERM Report, *supra* note 71, at 52; 2023 PERM Report, *supra* note 71, at 42; 2022 PERM Report, *supra* note 93 at 43; 2021 PERM Report, *supra* note 91, at 42. An enrollee's eligibility category is significant in the PERM context for 2 reasons. First, Medicaid enrollees found eligible for other categories of Medicaid are prohibited from being enrolled in expansion. *See* 42 U.S.C. §§ 1396a(a)(10)(i)(VIII), (e)(14); *see generally* 77 Fed. Reg. 17144, 17167 (discussing the categories of individuals who cannot enroll in expansion and how individuals who could be eligible for either an optional category or expansion may enroll in either, but cannot enroll in expansion once determined eligible on a MAGI-excepted basis); 42 C.F.R. § 433.112. Second, federal match for expansion is significantly higher than "regular" federal match – the expansion matching rate is 90 percent, whereas regular federal match ranged from a low of 50 percent (the statutory floor) to a high of 76.90 percent for FY 2026. *See* Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Medicaid Expansion to the New Adult Group* (Mar. 20, 2023), https://www.macpac.gov/subtopic/medicaid-expansion/; KFF, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=1&sortModel=%7B%22colId%22:%22FMAP%20Percentage%22,%22sort%22:%22desc%22%7D (last visited Jun. 20, 2026);

[104] *See, e.g.*, CMS, *Fiscal Year 2025 Improper Payments Fact Sheet* (Jan. 15, 2026), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet (noting that 77.17 percent of Medicaid improper payments in FY 2025 "were the result of insufficient documentation, **which is generally not indicative of fraud or abuse**") (emphasis added).

[105] OBBBA § 71106(b).

[106] *See* Perry et al., *supra* note 9.
[107] OBBBA § 71106(a)(4).
[108] *See, e.g.*, GARRETT HATCH, CONG. RESEARCH SERV., R48296, IMPROPER PAYMENTS: ONGOING CHALLENGES AND RECENT LEGISLATIVE PROPOSALS 11-12 (2026), https://www.congress.gov/crs-product/R48296 (discussing lasting progress made in certain programs and uneven progress in others); *see also* 82 Fed. Reg. at 31158 (discussing evolution of improper payments legislation); PIIA, *supra* note 5.
[109] *See* Edward Sheen, *Eliminating Improper Payments: A Review Framework for Action, and Seven Fundamental Questions* 55 J. GOV'T FIN. MGMT. 44, 46 (2006).
[110] *See id.*; *see also* Robert A. Greer & Justin Bullock, *Decreasing Improper Payments in a Complex Federal Program*, 78 PUB. ADMIN. REV. 14, 17 (2017), *available at* https://justinbullock.org/wp-content/uploads/2022/09/Greer-and-Bullock-2018-Decreasing-Improper-Payments-in-a-Complex-Federal-Program-PAR.pdf.
[111] *See* Sheen, *supra* note 109, at 46.
[112] Hatch, *supra* note 108, at 11.
[113] *See, e.g.*, Farah Erzouki, *States Need More Time to Prepare for Medicaid Work Requirement*, Ctr. on Budget & Policy Priorities (Apr. 27, 2026), https://www.cbpp.org/research/health/states-need-more-time-to-prepare-for-medicaid-work-requirement; Andy Schneider, *Implementing Costly Medicaid Work Reporting Requirements: Who Will Foot the Bill?*, Georgetown Univ. Ctr. for Children & Families (Feb. 11, 2026), https://ccf.georgetown.edu/2026/02/11/implementing-costly-medicaid-work-reporting-requirements-who-will-foot-the-bill/.
[114] *See, e.g.,* Schneider, *supra* note 113.
[115] In general, increased administrative burden has a negative impact on error rates. *See, e.g.*, Young, *supra* note 89, at 2848 (concluding that, in the unemployment insurance context, "administrative errors are more frequent where program rule complexity is greater, namely, where state eligibility requirements and benefit determination processes are more complex.").
[116] *See* Rolonda Donelson & Madeline Morcelle, *Protect Medicaid Funding Issue #14: Medicaid Work Requirements Hurt State Economies*, Nat'l Health Law Prog. (2024), https://healthlaw.org/wp-content/uploads/2024/09/014-PMF-State-Budgets.pdf. A 2019 GAO report estimated that the cost of implementing work requirements ranged from $6.1 million in New Hampshire to $271.6 million in Kentucky, and administrative spending on Georgia's Pathways to Coverage program has far outpaced spending on medical assistance. U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-149, MEDICAID DEMONSTRATIONS: ACTIONS NEEDED TO ADDRESS WEAKNESSES IN OVERSIGHT OF COSTS TO ADMINISTER WORK REQUIREMENTS 20 (2019),

https://www.gao.gov/assets/gao-20-149.pdf; U.S. GOV'T ACCOUNTABILITY OFF., GAO-25-108160, MEDICAID DEMONSTRATIONS: INFORMATION ON ADMINISTRATIVE SPENDING FOR GEORGIA WORK REQUIREMENTS 7 (2025), https://www.gao.gov/assets/gao-25-108160.pdf.

[117] *See, e.g.*, Emily Zylla & Elizabeth Lukanen, *H.R. 1 Medicaid Implementation: An Administrative Cost Monitoring Guide for States*, State Health & Value Strategies (Jul. 6, 2026), https://shvs.org/resources/h-r-1-medicaid-implementation-an-administrative-cost-monitoring-guide-for-states/.

[118] *See, e.g.*, Young, *supra* note 89, at 2848; Jennifer M. Haley et al., *More Frequent Medicaid Redeterminations Would Reduce Health Insurance Coverage and Increase Administrative Costs*, Urban Inst. (May 21, 2025), https://www.urban.org/urban-wire/more-frequent-medicaid-redeterminations-would-reduce-health-insurance-coverage-and.

[119] Errors related to retroactive eligibility would be monetary loss errors, as an enrollee incorrectly granted retroactive coverage would not have been program-eligible during the time period in which they accrued paid claims and therefore "the payment[s on their behalf] should not have occurred." *See, e.g.*, 2025 PERM Report, *supra* note 24, at 49.

[120] 42 U.S.C. § 1396a(a)(34) (2025). Although retroactive eligibility is required by statute, a significant minority of states had already used Section 1115 waivers to shorten retroactive coverage periods or altogether eliminate retroactive eligibility for some populations and have demonstrated the harm from decreased retroactive coverage. *See, e.g.*, Jane Perkins & Catherine McKee, *Medicaid Retroactive Coverage: Stop These Waivers!*, Nat'l Health Law Prog. (2021), https://healthlaw.org/wp-content/uploads/2021/08/Medicaid-Retroactive-Coverage-Issue-Brief-8.27.21.pdf.

[121] OBBBA § 71112.

[122] Elizabeth Edwards & Shandra Hartly, *How Increased Data Matching Burdens States and Enrollees for Little Benefit in Finding Fraud*, Nat'l Health Law Prog. (May 15, 2025), https://healthlaw.org/how-increased-data-matching-burdens-states-and-enrollees-for-little-benefit-in-finding-fraud/.

[123] *Id.*; *see also* HHS, Office Inspector Gen. ("OIG"), *Public Assistance Information Reporting System: State Participation in the Medicaid Interstate Match is Limited* 14 (2014), https://acf.gov/sites/default/files/documents/paris/hhs_oig_fundamentals_2_508.pdf.

[124] *See, e.g.*, Sarah Grusin & Elizabeth Edwards, *Recent Filing in Lawsuit Describes Medicaid Unwinding Harms in Tennessee*, Nat'l Health Law Prog. (Aug. 3, 2023), https://healthlaw.org/resource/recent-filing-in-lawsuit-describes-medicaid-unwinding-harms-in-tennessee/; *see also* Bradley Corallo et al., *Unwinding of Medicaid Continuous Enrollment: Key Themes from the Field*, KFF (Jan. 10, 2024), https://www.kff.org/medicaid/unwinding-of-

medicaid-continuous-enrollment-key-themes-from-the-field/ (describing enrollee difficulty with obtaining assistance with renewals through call centers).

[125] *See, e.g.*, David A. Lieb, *Federal officials Raise Concerns about Long Call Center Wait Times as Millions are Dropped from Medicaid*, PBS NEWSHOUR (Aug. 17, 2023), https://www.pbs.org/newshour/politics/federal-officials-raise-concerns-about-long-call-center-wait-times-as-millions-are-dropped-from-medicaid (describing reports of people "giving up" on renewing their Medicaid coverage due to call center issues).

[126] Michelle Yiu & Elizabeth Edwards, *Unwinding Call Center Data Shows Ongoing Problems*, Nat'l Health Law Prog. (2023), https://healthlaw.org/resource/unwinding-call-center-data-shows-ongoing-problems/.

[127] *See, e.g.*, Amanda Avery et al., *Case Explainer: Chianne D. v. Harris*, Nat'l Health Law Prog. (2026), https://healthlaw.org/resource/case-explainer-chianne-d-v-harris/; Cassandra LaRose, *Unwinding Issues Show Medicaid Eligibility Systems Need Better Oversight to Ensure Coverage*, Nat'l Health Law Prog. (Oct. 28, 2024), https://healthlaw.org/unwinding-issues-show-medicaid-eligibility-systems-need-better-oversight-to-ensure-coverage/; Phil Galewitz et al., *'Worse Than People Can Imagine': Medicaid 'Unwinding' Breeds Chaos in States*, KFF HEALTH NEWS (Nov. 2, 2023), https://kffhealthnews.org/medicaid/medicaid-unwinding-disenrollment-redetermination-state-delays/.

[128] *See, e.g.*, Tricia Brooks et al., *A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of the Continuous Enrollment and Beyond*, KFF (Jun. 20, 2024), https://www.kff.org/medicaid/a-look-at-medicaid-and-chip-eligibility-enrollment-and-renewal-policies-during-the-unwinding-of-continuous-enrollment-and-beyond/ (describing state efforts to improve eligibility systems). *But see* Hatch, *supra* note 108, at 18 ("When agencies have to establish new programs or quickly scale up existing ones, they often do not develop and implement adequate internal controls to prevent and detect improper payments"); HHS, *Fiscal Year 2015 Agency Financial Report* 194 (2015), https://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf [hereinafter "HHS FY15 Financial Report"] (". . . it is not unusual to see increases in improper payment rates following the implementation of new requirements because it takes time for states to make systems changes required for compliance").

[129] *See, e.g.,* Mathers et al., *supra* note 40; HHS FY15 Financial Report, *supra* note 128, at 193. More specifically, the ACA implemented new requirements that all "referring or ordering" providers be enrolled as Medicaid providers, that states screen providers using a "risk-based screening process" prior to enrollment, and that providers include their National Provider Identifier (NPI) on all claims. 42 U.S.C. §§ 1396a(a)(77), (kk)(1)(A), (kk)(7); *see also* HHS

FY15 Financial Report, *supra* note 128, at 194 (noting the connection between the increase in improper payments and the new ACA requirements).

[130] HHS FY15 Financial Report, *supra* note 128, at 194.

[131] *See, e.g.*, KFF, *Health Reform Implementation Timeline*, (Jul. 18, 2013), https://www.kff.org/interactive/implementation-timeline/.

[132] *See id.*

[133] *See, e.g.*, HHS FY15 Financial Report, *supra* note 128, at 193 (noting that states would be conducting eligibility review pilots in lieu of actual eligibility reviews for fiscal years 2015 through 2018).

[134] CMS, Dear State Health Official (Dec. 22, 2020) (SHO # 20-004), https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf; *see also* CMS, *ARCHIVED: Unwinding and Returning to Regular Operations after COVID-19*, https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/archived-unwinding-and-returning-regular-operations-after-covid-19 (last visited Aug. 8, 2026) (collecting unwinding-related materials and resources CMS released between 2021 and 2024).

[135] *See* Gilfoil & Emanuel, *supra* note 53.

[136] *See, e.g.*, *OBBBA Medicaid Policy Timeline*, Nat'l Assn. of Medicaid Dirs. (Aug. 12, 2025), https://medicaiddirectors.org/resource/obbba-medicaid-policy-timeline/.

[137] 91 Fed. Reg. 33348 (Jun. 1, 2026). Certain provisions of the rule have been challenged. *See, e.g., Commonwealth of Mass. et al. v. Oz et al.*, O'Neill Inst. Health Care Litigation Tracker (last updated Aug. 7, 2026), https://litigationtracker.law.georgetown.edu/litigation/commonwealth-of-massachusetts-et-al-v-oz-et-al/.

[138] OBBBA § 71110(a)(xx)(1). States have the option to request a "good faith" exemption to delay implementation of work requirements for up to 2 years. OBBBA § 71110(a)(xx)(11). However, federal officials have indicated that they intend to grant very few of these requests. *See* Margot Sanger-Katz & Sarah Kliff, *How Medicaid's New Work Requirement Will Work*, N.Y. TIMES (Nov. 3, 2025), https://www.nytimes.com/2025/11/03/upshot/medicaid-work-requirements-faq.html. Additionally, some states have chosen to implement work requirements early: Nebraska began work requirements on May 1, 2026, and Montana and Arkansas began them on July 1, although Arkansas was a "soft launch" with no penalties for noncompliance until January 2027. *See* Hannah Grabenstein, *As States Face Stricter Medicaid Work Requirements, Nebraska is an Early Test*, PBS NEWS (Jun. 5, 2026), https://www.pbs.org/newshour/nation/as-states-face-stricter-medicaid-work-requirements-nebraska-is-an-early-test; Emma Soukup, *Arkansas and Montana Implement Medicaid Work*

Requirements Before Deadline, BALLOTPEDIA NEWS (Jul. 10, 2026), https://news.ballotpedia.org/2026/07/10/arkansas-and-montana-implement-medicaid-work-requirements-before-deadline/.

[139] *A Summary of Federal Medicaid Work Requirements*, Ctr. for Health Care Strategies (Jun. 2026), https://www.chcs.org/resource/a-summary-of-national-medicaid-work-requirements/.

[140] *Id.*

[141] *See* HHS, *Department of Health and Human Services Agency Financial Report Fiscal Year 2021* 225 (2021), https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf; HHS, *Department of Health and Human Services Agency Financial Report Fiscal Year 2020* 226 (2020), https://www.hhs.gov/sites/default/files/fy-2020-hhs-agency-financial-report.pdf; HHS, *FY 2019 Agency Financial Report* 216-17 (2019), https://www.hhs.gov/sites/default/files/fy-2019-hhs-agency-financial-report.pdf; HHS, *Department of Health and Human Services FY 2018 Agency Financial Report* 212 (2018), https://www.hhs.gov/sites/default/files/fy-2018-hhs-agency-financial-report.pdf.

[142] *See, e.g.*, 2022 PERM Report, *supra* note 93, at 53; 2021 PERM Report, *supra* note 91, at 53; *see also* discussion *supra* pp. 9-10.

[143] *Summary of Changes to SNAP in Reconciliation (H.R. 1)*, No Kid Hungry (Oct. 7, 2025), https://bestpractices.nokidhungry.org/resource/summary-changes-snap-reconciliation-hr1.

[144] *See* Lauren Kallins & Ashton Thompson, *How States Are Responding to New SNAP Requirements*, Nat'l Conference of State Legislatures (Mar. 10, 2026), https://www.ncsl.org/state-legislatures-news/details/how-states-are-responding-to-new-snap-requirements (summarizing proposed changes).

[145] Jie Jenny Zou, *Advocates Say 'Chaos' Is Mounting as Counties Implement New SNAP Rules*, N.Y. FOCUS (Apr. 27, 2026), https://nysfocus.com/2026/04/27/snap-work-rules-trump-new-york; *see also, e.g.*, Linda Qiu, *The Trump Administration Has Changed Almost Every Aspect of Food Stamps*, N.Y. TIMES (Apr. 26, 2026), https://www.nytimes.com/2026/04/26/us/trump-administration-food-stamps.html.

[146] *See, e.g.*, Jillian Humphries, *Data Coordination at SNAP and Medicaid Agencies: A National Landscape Analysis* 4-5, Benefits Data Trust & Ctr. Health Care Strategies (2023), https://digitalgovernmenthub.org/wp-content/uploads/2023/02/bdt_chcs_datasharing.pdf (finding that most states have fully integrated SNAP and Medicaid eligibility systems).

[147] *See, e.g.*, Guangli Zhang et al., *The Relationship Between Agency Understaffing and Administrative Burdens in Medicaid and SNAP*, Wash. Univ. Ctr. for Soc. Dev. Research 2 (2025), https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1987&context=csd_research;

Dawn Cutler-Tran, *Medicaid Agency Workforce Challenges and Unwinding*, Nat'l Assn. of Medicaid Dirs. (Mar. 10, 2023), https://medicaiddirectors.org/resource/medicaid-agency-workforce-challenges-and-unwinding/.

[148] Sam Whitehead, *States Face Another Challenge with Medicaid Work Rules: Staffing Shortages*, KFF HEALTH NEWS (Apr. 9, 2026), https://kffhealthnews.org/news/article/medicaid-cuts-work-requirements-state-staff-shortages/.

[149] 2024 PERM Report, *supra* note 71, at 52.

[150] *Id.* (showing that Alaska had a projected monetary loss eligibility improper payment rate of 0 percent); *see also id.* at 49 (explaining the difference between insufficient documentation errors and monetary loss errors).

[151] For context, Alaska's entire Medicaid spending for fiscal year 2024 was $2,729,409,570. Alaska's federal match for fiscal year 2024 was 50 percent, meaning Alaska's share of the cost of operating its Medicaid program that year was about $1.36 billion. KFF, *Total Medicaid Spending*, https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/ (last visited Aug. 24, 2026); *see also* Mitchell, *supra* note 96, at 16; CMS Expenditure Reports, *supra* note 97.

[152] *See* 2023 PERM Report, *supra* note 71, at 52.

[153] *See* Mitchell, *supra* note 96, at 16.

[154] 2023 PERM Report, *supra* note 71, at 52.

[155] Preethi Rao et al., *State-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act* 4, 7-8 RAND (2026), https://www.rand.org/pubs/research_reports/RRA4098-1-v2.html.

[156] Kallins & Thompson, *supra* note 144.

[157] Qiu, *supra* note 145.

[158] *See* Alex Baumhardt, *Oregon Economy Slows, Will Take $888 Million Revenue Hit in Next Two Years from Trump Budget*, OR. CAP. CHRON. (Aug. 27, 2025), https://oregoncapitalchronicle.com/2025/08/27/oregon-economy-slows-will-take-888-million-revenue-hit-in-next-two-years-from-trump-budget/; Kristin Collins, *H.R. 1 and its Impact on Virginia Tax Conformity*, Va. Senate Fin. & Appropriations Comm. (2025), https://sfac.virginia.gov/pdf/committee_meeting_presentations/2025/Interim/09162025_No2_Tax%20Presentation.pdf; *Effects of the One Big Beautiful Bill Act on the State of Nebraska's Tax Revenue*, Neb. Dept. of Revenue (2025), https://revenue.nebraska.gov/sites/default/files/doc/research/Big%20Beautiful%20Bill%20-%2060%20Days%20Report%20-%20Final.pdf.

[159] *See Executive Order D 2025 022* (Nov. 30, 2025), https://spl.cde.state.co.us/artemis/goserials/go4312internet/go43122025022internet.pdf;

Executive Order D 2025 014 (Aug. 28, 2025), https://content.leg.colorado.gov/sites/default/files/letter-08-28-25.pdf.

[160] The real impacts of these policies are stark. Idaho recently cut $22 million in services for enrollees with disabilities. Colorado's proposed 2027 budget includes, among other cuts, a 2 percent cut in reimbursement rates across the board and capping the number of hours that family members can work as paid caregivers. Oklahoma is considering 2 ballot measures that would gut its expansion by removing it from the state constitution (instead codifying it in statute, which would allow legislators to alter it) and adding a trigger provision that would end expansion if federal match falls below 90 percent. South Dakota is considering adding a similar trigger provision to its constitutional amendment for expansion. *See* Kyle Pfannenstiel, *Idaho governor approves $22M in Medicaid disability budget cuts*, IDAHO CAP. SUN (Mar. 27, 2026), https://idahocapitalsun.com/2026/03/27/idaho-governor-approves-22m-in-medicaid-disability-budget-cuts/; Jesse Paul & Rae Solomon, *Lawmakers Finish Drafting Colorado's Budget with Final Round of Major Cuts to Address Roughly $1.5 Billion Shortfall*, COLO. SUN (Apr. 1, 2026), https://coloradosun.com/2026/04/01/colorado-budget-draft-billion-shortfall-2026/; Shalina Chatlani, *Republican Lawmakers in 3 States Want Voters to Alter or Scrap Medicaid Expansion*, STATELINE (Apr. 22, 2026), https://stateline.org/2026/04/22/republican-lawmakers-in-3-states-want-voters-to-alter-or-scrap-medicaid-expansion/; *see also* Maya Goldman, *States Begin Living with Medicaid Austerity*, AXIOS (Apr. 1, 2026), https://www.axios.com/2026/04/01/state-budgets-medicaid-austerity.

[161] For instance, Idaho cut adult dental services, Oklahoma removed 22,000 children from its Medicaid rolls, South Carolina proposed a temporary 2.5 percent cut in **all** state spending, Texas considered imposing a $10 annual fee on Medicaid enrollees, and Massachusetts considered increasing copays and restricting certain prescription medications. Mary Guiden, *Deficit-Plagued States Dole Out Medicaid Cuts*, STATELINE (May 15, 2002), https://stateline.org/2002/05/15/deficit-plagued-states-dole-out-medicaid-cuts/; Leighton Ku et al., *Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for One Million People*, Ctr. on Budget & Policy Priorities (2003), https://www.cbpp.org/sites/default/files/archive/12-23-02health.pdf; *see also* The Role of Medicaid in State Economies, *supra* note 62, at 2.

[162] *See, e.g.*, January Angeles & Judith Solomon, *Recession Threatens State Health Care Programs*, Ctr. on Budget & Policy Priorities (2010), https://www.cbpp.org/research/recession-threatens-state-health-care-programs.

[163] *See* Mitchell, *supra* note 96, at 6-13.

[164] *See* Micah Johnson & Andrea Ducas, *$1 Trillion in Medicaid Cuts -- $1 Trillion in Tax Giveaways for the Richest 1 Percent: The One Big 'Beautiful' Bill's Budget Math*, Ctr. for American Progress (Jul. 3, 2025), https://www.americanprogress.org/article/1-trillion-in-medicaid-cuts-1-trillion-in-tax-giveaways-for-the-richest-1-percent-the-one-big-beautiful-bills-budget-math/; Geraldine Doetzer, *Medicaid Financing After OBBBA: Changes to State Directed Payments and Provider Taxes*, Nat'l Health Law Prog. (2025), https://healthlaw.org/resource/medicaid-financing-after-obbba-state-directed-payments-and-provider-taxes/.

[165] The Improper Use of Improper Payments, *supra* note 8.

[166] Young, *supra* note 89, at 2848.

[167] Donald P. Moynihan et al., *Policymaking by Other Means: Do States Use Administrative Barriers to Limit Access to Medicaid?* 48 ADMIN. & SOC'Y 497 (2013). The levels of administrative burden are often in line with political actors' attitudes about a program or its participants. *See, e.g.*, Martin Baekgaard et al., *Why Do Policymakers Support Administrative Burdens? The Roles of Deservingness, Political Ideology, and Personal Experience* 31 J. PUB. ADMIN. RES. & THEORY 184, 197 (2021), https://academic.oup.com/jpart/article/31/1/184/5908124 ("We also find that the framing of the deservingness of an individual social assistance recipient predicts policymakers' willingness to impose requirements on their constituents").

[168] W. Clay Fannin, *Can reducing administrative burdens increase benefit amounts? Evidence from SNAP simplified reporting*, 47 APPLIED ECON. PERSPS. & POL'Y 893, 965 (2025), https://onlinelibrary.wiley.com/doi/epdf/10.1002/aepp.13508.

[169] Annie Lowrey, *The Time Tax*, THE ATLANTIC (Jul. 27, 2021), https://www.theatlantic.com/politics/archive/2021/07/how-government-learned-waste-your-time-tax/619568/.

[170] Fannin, *supra* note 168, at 972. Simplified reporting is a policy option that reduces the information enrollees must provide to their SNAP agency between recertifications, requiring only that SNAP households report changes occurring between recertifications that would render them ineligible for the program based on gross income. *Id.* at 968.

[171] *See* Donald Moynihan et al., *Administrative Burden: Learning, Psychological, and Compliance Costs in Citizen-State Interactions*, 25 J. PUB. ADMIN. RES. 43, 65 (2014), https://digitalgovernmenthub.org/wp-content/uploads/2022/07/muu009.pdf; Donald Moynihan & Pamela Herd, *How Administrative Burdens Undermine Public Programs*, Niskanen Ctr. (May 17, 2023), https://www.niskanencenter.org/how-administrative-burdens-undermine-public-programs/.

[172] Young, *supra* note 89, at 2862.
[173] *See* Joshua McCabe & Leah Sargeant, *Disentangling In-Work and Child Tax Credits to Address Improper Payments: An Incremental Approach to Comprehensive Reform* 1, Niskanen Ctr. (Mar. 2025), https://www.niskanencenter.org/wp-content/uploads/2025/03/Disentangling-In-Work-and-Child-Tax-Credits-to-Address-Improper-Payments.pdf; Sydney Warda, *EITC Correspondence Audits: An Equal Protection Issue*, 70 DEPAUL L. REV. 777, 781-82 (2021), https://via.library.depaul.edu/cgi/viewcontent.cgi?article=4173&context=law-review.
[174] For instance, several states that eliminated their TANF asset tests in the late 1990s and early 2000s saw either no change or a decline in their TANF enrollment following the elimination of the asset test. *See* Rebecca Vallas & Joe Valenti, *Asset Limits Are a Barrier to Economic Security and Mobility*, Ctr. for American Progress (Sept. 10, 2014), www.americanprogress.org/article/asset-limits-are-a-barrier-to-economic-security-and-mobility/; *see also* Rebecca Mary Myerson et al., *Navigating Medicaid: Experimental Evidence on Administrative Burden and Coverage Loss* 4-5 (Nat'l Bureau of Econ. Research, Working Paper No. 34191, 2026), https://www.nber.org/system/files/working_papers/w34191/w34191.pdf (commenting that simplifying the Medicaid renewal process by implementing "information interventions," such as reaching out to enrollees due for renewal via a pre-recorded phone call and ensuring the agency has correct contact information, is "unlikely to increase Medicaid renewal for people who are ineligible").
[175] *See, e.g.*, Ariel Jurow Kleiman et al., *Can We Automate the Safety Net?*, CAN WE STILL GOVERN? (Jun. 15, 2026), https://donmoynihan.substack.com/p/can-we-automate-the-safety-net (discussing how administrative burden results in millions of people not enrolling in programs or taking up benefits for which they are eligible, such as Medicaid coverage, ACA coverage, SNAP, and EITC); Ashley Fox et al., *Administrative Easing: Rule Reduction and Medicaid Enrollment* 10, Pub. Admin. & Policy Faculty Scholarship (2020), https://scholarsarchive.library.albany.edu/cgi/viewcontent.cgi?article=1010&context=rockefeller_pad_scholar (". . . adding additional administrative burdens to prevent fraud can also function to exclude those who would otherwise be eligible for benefits . . .").
[176] *See* Vernon K. Smith et al., *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences* 10, 13, KFF (2001), https://www.kff.org/wp-content/uploads/2001/04/2239-eliminating-the-medicaid-asset-test.pdf; Donna Cohen & Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families* 13, KFF (2004), https://www.kff.org/wp-content/uploads/2013/01/beneath-the-surface-barriers-threaten-to-slow-progress-on-expanding-health-coverage-of-children-and-families-pdf.pdf.

[177] *See* Smith et al., *supra* note 176, at 10, 13.
[178] *See generally id.*; *see also* Cohen & Cox, *supra* note 176, at 13; CMS, *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage* 3 (Aug. 2001) [hereinafter "Continuing the Progress"].
[179] Victoria Wachino & Alice M. Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling, and Retaining Eligible Children* 18, Nat'l Acad. for State Health Policy (2009), https://ccf.georgetown.edu/wp-content/uploads/2012/03/maximizing-kids-enrollment.pdf.
[180] Administrative rules "have a significant effect on the capacity of eligible claimants to access services[.]" *See* Moynihan et al., *supra* note 167, at 518; *see also* Keith Marzilli Ericson et al., *Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment* (Nat'l Bureau of Econ. Research, Working Paper No. 30885, 2023), https://www.nber.org/system/files/working_papers/w30885/w30885.pdf.
[181] *See* Benjamin Sommers et al., *Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability of Care*, 39 HEALTH AFF. 1522 (2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00538.
[182] *See, e.g.*, Pamela Herd & Rebecca A. Johnson, *Rationing Rights: Administrative Burden in Medicaid Long-Term Care Programs*, 50 J. HEALTH POLITICS, POL'Y & L. 223, 225 (2025).
[183] *See, e.g.*, Haley et al., *supra* note 118.
[184] OFFICE OF MGMT. & BUDGET, STUDY TO IDENTIFY METHODS TO ADDRESS EQUITY: REPORT TO THE PRESIDENT 21 (2021), https://digitalgovernmenthub.org/wp-content/uploads/2022/06/OMB-Report-on-E013985-Implementation_508-Compliant-Secure-v1_1.pdf.
[185] *See, e.g.*, Pamela Herd, *Improving Older Adults' Health by Reducing Administrative Burden*, 101 MILBANK Q. 507 (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10126975/; Mariana Chudnovsky & Rik Peeters, *The unequal distribution of administrative burden: A framework and an illustrative case study for understanding variation in people's experience of burdens*, 55 SOC. POL'Y ADMIN. 527 (2021), https://onlinelibrary.wiley.com/doi/10.1111/spol.12639.
[186] *See* Shandra Hartly, *The Red Tape Divide: How Medicaid Paperwork Burdens Hit Rural Communities Harder* 5, Nat'l Health Law Prog. (2026), https://healthlaw.org/resource/the-red-tape-divide-how-medicaid-paperwork-burdens-hit-rural-communities-harder/.
[187] Benefits Tech Advocacy Hub, *A Technical Guide for States to Reduce Procedural Terminations from Medicaid's Work Reporting Requirements* (2026), https://www.btah.org/static/files/work-requirements-guide.pdf.
[188] 42 C.F.R. § 435.945(a); *see also* CMS, *What are the Eligibility Factors for Which States Can/Cannot Accept Self-Attestation?* 4, Medicaid/CHIP Affordable Care Act Implementation

Answers to Frequently Asked Questions (May 21, 2012), https://www.medicaid.gov/sites/default/files/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf.

[189] Self-declaration of Medicaid eligibility factors has not been linked to fraud in any meaningful way. *See, e.g.*, James Marton et al., *Enhanced Citizenship Verification and Children's Medicaid Coverage*, 54 ECON. INQUIRY 1465, 1672 (2016), https://onlinelibrary.wiley.com/doi/epdf/10.1111/ecin.12316 (prior to the Deficit Reduction Act of 2005's new requirements for citizenship verification, self-declaration of citizenship did not lead to noncitizens gaining Medicaid coverage); Jacob Press, *Poor Law: The Deficit Reduction Act's Citizenship Documentation Requirement for Medicaid Eligibility*, 8 U. PENN. J. CONST. L. 1033, 1042-44 (2006) (concluding that, even with self-declaration of citizenship status prior to the Deficit Reduction Act of 2005's new requirements, there was a "negligible level of citizenship fraud by undocumented immigrants seeking full Medicaid coverage"); *see also, e.g.*, Continuing the Progress, *supra* note 178, at 3 (discussing how states preserved program integrity while permitting self-declaration to improve access to Medicaid and CHIP in the early 2000s).

[190] *See* Leighton Ku et al., *Improving Medicaid's Continuity of Coverage and Quality of Care* 14, George Washington Univ. Dep't of Health Policy (2009), https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1247&context=sphhs_policy_facpubs (citing Danielle Holahan & Elise Hubert, *Lessons from States with Self-Declaration of Income Policies* 8-10, United Hosp. Fund (2004) https://web.archive.org/web/20060112173443/https://uhfnyc.org/usr_doc/lessons.pdf/).

[191] Benefits Tech Advocacy Hub, *supra* note 187.

[192] *See, e.g.*, Elizabeth Edwards & David Machledt, *Principles for Fairer, More Responsive Automated Decision-Making Systems*, Nat'l Health Law Prog. (2023), https://healthlaw.org/resource/principles-for-fairer-more-responsive-automated-decision-making-systems/.

[193] *See, e.g.*, N. Tatiana Masters, *Jezebel at the Welfare Office: How Racialized Stereotypes of Poor Women's Reproductive Decisions and Relationships Shape Policy Implementation*, 18 J. POVERTY 109 (2014), https://pmc.ncbi.nlm.nih.gov/articles/PMC4002050/.