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Paragon Institute Scrutinizes Medicaid Financing: Provider Taxes, FMAP, and Emerging Policy Challenges

INTRODUCTION

On April 10, 2025, Applied Policy attended Paragon Health Institute's session on the Hill about its recently published policy paper, "Addressing Medicaid Money Laundering: The Lack of Integrity with Medicaid Financing and the Need for Reform".[1] The session, presented by Brian Blase (President) and Niklas Kleinworth (Policy Analyst), focused on the significant growth of Medicaid expenditures over the last two decades, the shifting of Medicaid funding responsibility from states to the federal government through provider taxes and other "financing gimmicks", and Paragon's policy recommendations for Congress. Though the presentation was mainly derived from the paper referenced above, it also included material from their other recent publications, including "Medicaid's True Improper Payments Double Those Reported by CMS," and "Medi-Cal-amity: California's Reckless Expansion of Medicaid Long-Term Care to the Affluent".

BACKGROUND – WHAT IS A PROVIDER TAX?

States and the federal government share responsibility for funding the Medicaid program under a complex set of rules and regulations. For this presentation, Paragon focused primarily on the role of provider taxes, a legitimate financing mechanism introduced in the 1980s, that has evolved significantly since their introduction.

Congress established the Medicaid program in 1965, with states that elected to participate (all states since 1982) receiving federal matching funds based on their average income level relative to the national average. At minimum, states receive funds equal to 50 percent of the total cost of Medicaid, with some states and territories receiving reimbursement up to 83 percent in FY2026.[2] These payments, and the formula used to determine the reimbursement rate, are known as the Federal Matching Assistance Percentage (FMAP).

Though the majority of Medicaid funding for almost all states is derived from the federal government, states are still responsible for providing the balance of funding. To meet this obligation, all states except Alaska have increasingly relied on provider taxes. From Medicaid's inception through the early 1980s, states paid for their share of Medicaid costs through state general funds. However, as Medicaid costs grew and economic pressures mounted, many states realized they could tax Medicaid providers, or create similar donation programs, to inflate their level of state contributions.[3] These inflated

[1] Please note that Paragon Health Institute frequently uses colorful rhetoric including "money laundering" to describe provider taxes. Provider taxes are a legal method for funding Medicaid but have been the subject of debate since their inception.

[2] https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

[3] https://fiscalpolicy.org/wp-content/uploads/2024/03/MCO-Tax-Final-1.pdf

contributions triggered higher federal matching funds, which were then redirected back to providers through increased Medicaid expenditures. In some cases, states even guaranteed providers that paid the tax would receive at least the amount they had paid in Medicaid expenditures. This is known as a hold harmless provision.[4] Paragon refers to this legal, yet controversial strategy as "Money Laundering" (See Figure 1).

Figure 1.

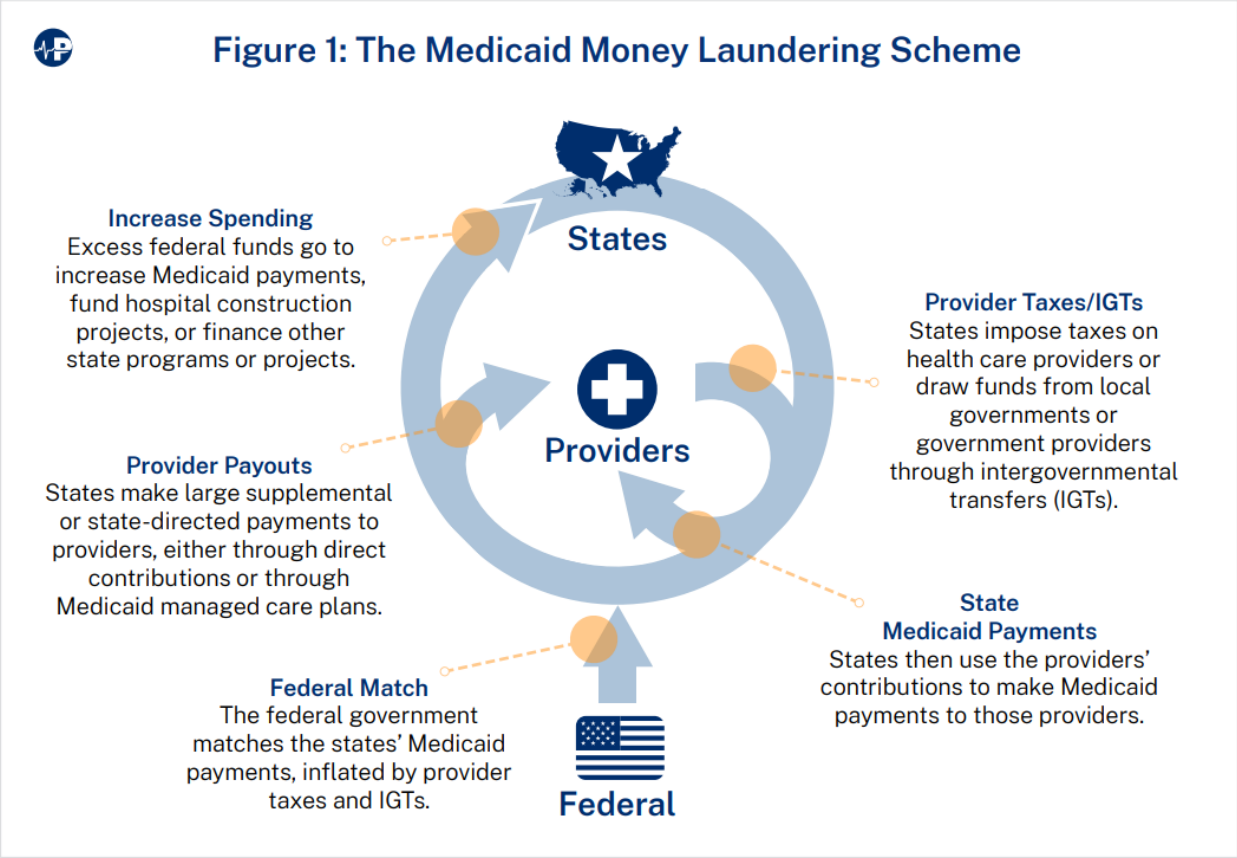

Figure 1 adapted from Figure 1 in Paragon Health Institute, "Medicaid Money Laundering: Understanding State Financing Gimmicks," April 2025. Available at: https://paragoninstitute.org/report/medicaid-money-laundering

As more states quickly adopted new provider taxes and donation programs, Congress intervened in 1991 by establishing a set of detailed regulations to limit the scope of provider taxes.[5] These rules imposed three main requirements for provider taxes, with important caveats:

- **Broad-Based**: The tax must apply to an entire class of providers

[4] https://fiscalpolicy.org/wp-content/uploads/2024/03/MCO-Tax-Final-1.pdf
[5] For a detailed discussion of these rules, see the Congressional Research Service's Report: "Medicaid Provider Taxes". https://www.congress.gov/crs-product/RS22843

- **Uniform**: The tax burden must fall equally on the entire class of providers
- **No "hold harmless" provision:** States may not directly or indirectly guarantee that taxpayers will be reimbursed for the same amount as they paid.

However, Congress included two critical exceptions:

1. **Taxes below 6 percent of provider revenues were exempt from these rules, and,**
2. **The broad-based and uniformity requirements could be waived if the tax was deemed to be "redistributive"- that is, if it shifted money to Medicaid providers.**

Functionally, these guardrails forced states to stay under the 6 percent limit (Until recently – see further discussion in *New Developments in the Realm of MCO Taxes – California Leads the Way)* to avoid compliance hurdles and stakeholder opposition based on their shares of Medicaid beneficiaries and expected changes in revenues.[6] While the 1991 rules formalized provider taxes as a Medicaid financing tool, they also entrenched a system that directly increased federal matching payments through a circuitous funding mechanism.

RECENT DEVELOPMENTS IN PROVIDER TAXES – 2010 TO TODAY

Blase and Kleinworth opened with an overview of the sharp growth in Medicaid spending in the last two decades. They attributed this growth to a series of policy changes, primarily the Medicaid expansion, the rise of Managed Care Organization (MCO) taxes, and the suspension of eligibility checks during the COVID-19 pandemic. Additionally, Blase and Kleinworth cited broader trends of state reliance on provider taxes and other funding mechanisms and insufficient oversight.

Although Congress formally authorized provider taxes as a Medicaid financing mechanism in 1991, many states underutilized the strategy until policy changes around 2010 caused dramatic increases in both the scope and level of federal matching funds being dispersed to states. (See Figure 2.)

[6] https://fiscalpolicy.org/wp-content/uploads/2024/03/MCO-Tax-Final-1.pdf

Figure 2.

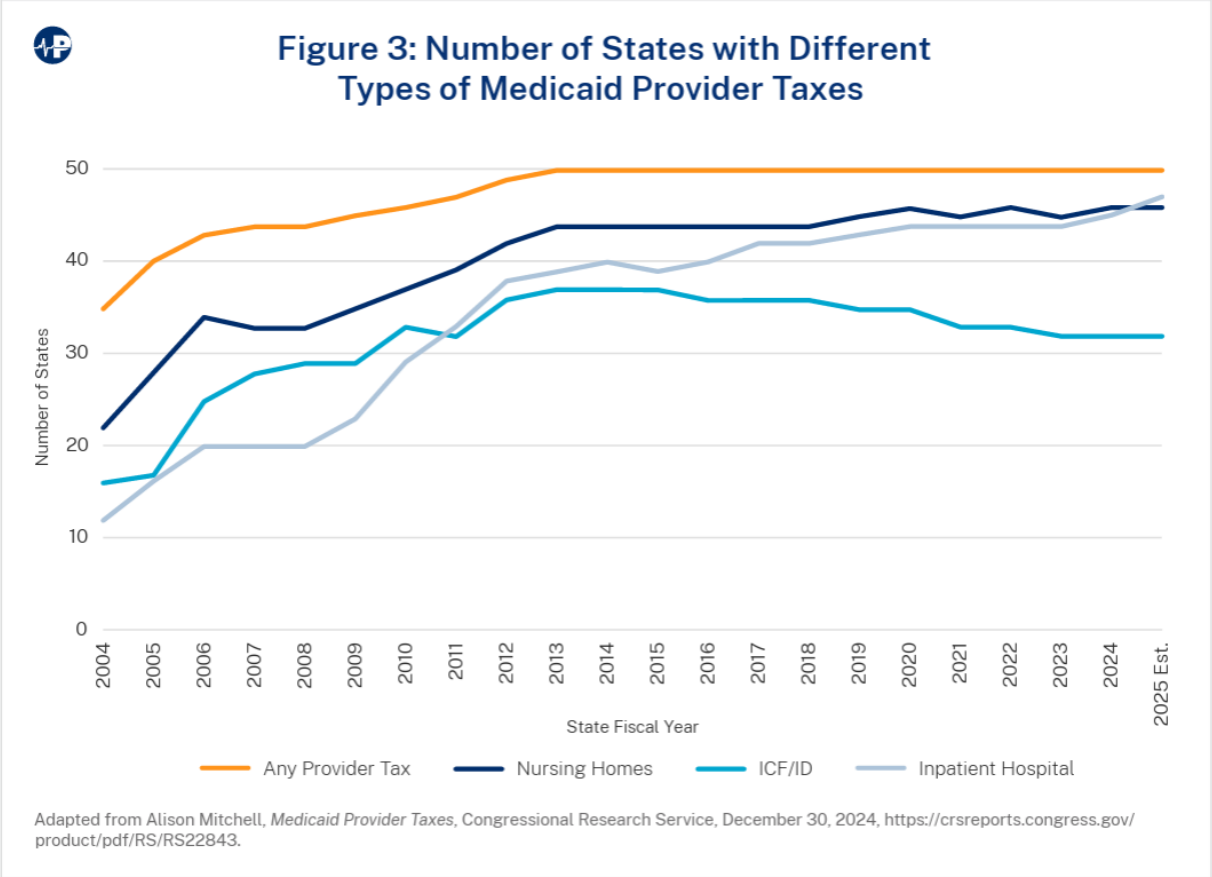

Figure 2 adapted from Figure 3 in Paragon Health Institute, "Medicaid Money Laundering: Understanding State Financing Gimmicks," April 2025. Available at: https://paragoninstitute.org/report/medicaid-money-laundering

The Affordable Care Act and Medicaid Expansion

In 2010, President Obama signed the Affordable Care Act (ACA), which among many other provisions, established the Medicaid expansion. This new policy created enhanced FMAPs beginning in 2014 for states who opted[7] to expand Medicaid to cover all adults under the age of 65 with incomes up to 138 percent of the Federal Poverty Level (FPL).[8] Prior to the expansion (and for states currently without it),

[7] The Affordable Care Act originally required all states to expand Medicaid. However, following a 2012 Supreme Court decision, the expansion was made optional. For further discussion, see Kaiser Family Foundation's Report: "A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion". https://www.kff.org/wp-content/uploads/2013/01/8347.pdf

[8] This rate applies to "parents and adults without dependent children who were previously not eligible for Medicaid." https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/#:~:text=The%20ACA%20expanded%20Medicaid%20coverage,expansion%20an%20option%20for%20states.

Medicaid eligibility by FPL varied significantly by state and eligibility pathway.[9] As of 2025, 41 states and the District of Columbia have chosen to expand Medicaid through the ACA provisions.[10]

From 2014 to 2016, the federal government covered 100 percent of the cost of newly eligible enrollees under expansion. That share gradually decreased to a permanent level of 90 percent by 2020, where it remains. This elevated FMAP for expansion beneficiaries provided states a new opportunity to expand their Medicaid populations with limited state expenditures. Since states are allowed to use provider taxes to fund their state-level contribution for the expansion, states can draw even more federal dollars with a smaller share of state general fund monies.[11] Figure 3 illustrates this through a comparison of the share of state general funds, provider tax revenues, and federal funds used for Medicaid. Figure 4 further recalculates the federal share to remove provider tax revenues (what Paragon refers to as the "purported" vs. "actual" federal share).

Figure 3.

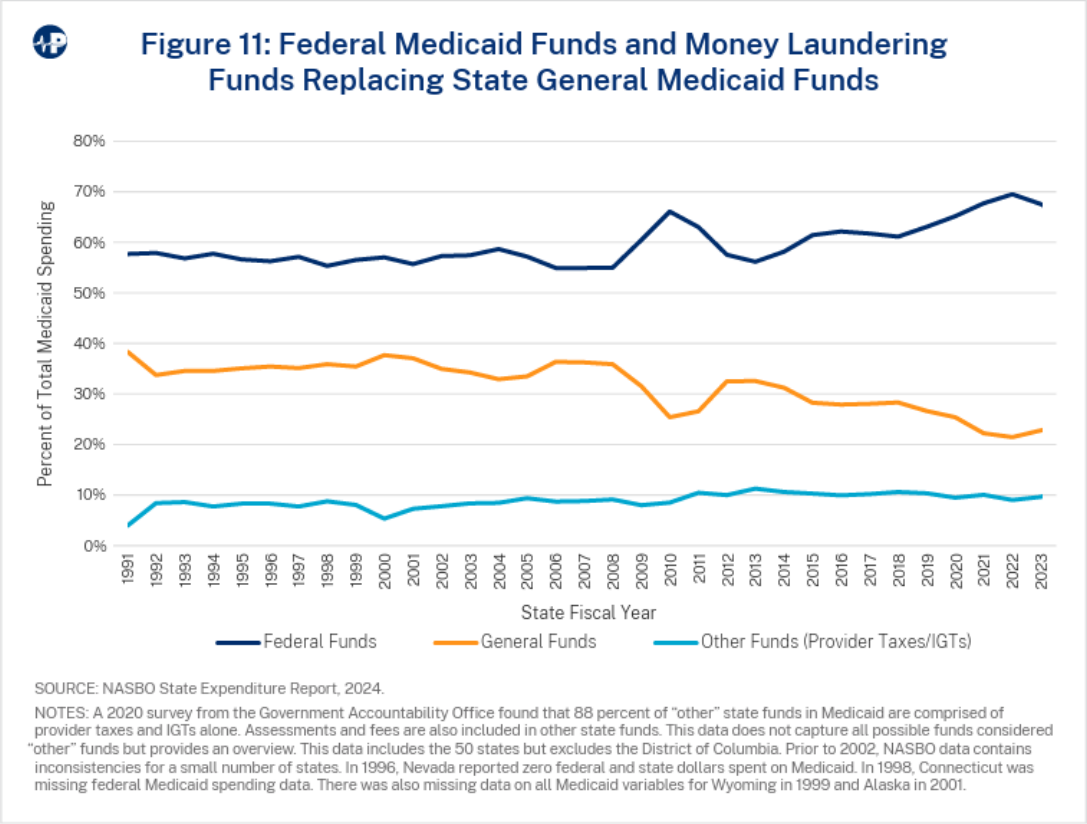

Figure 3 adapted from Figure 11 in Paragon Health Institute, "Medicaid Money Laundering: Understanding State Financing Gimmicks," April 2025. Available at: https://paragoninstitute.org/report/medicaid-money-laundering

[9] https://www.macpac.gov/medicaid-101/eligibility/
[10] https://www.kff.org/status-of-state-medicaid-expansion-decisions/
[11] https://fiscalpolicy.org/wp-content/uploads/2024/03/MCO-Tax-Final-1.pdf

Figure 4.

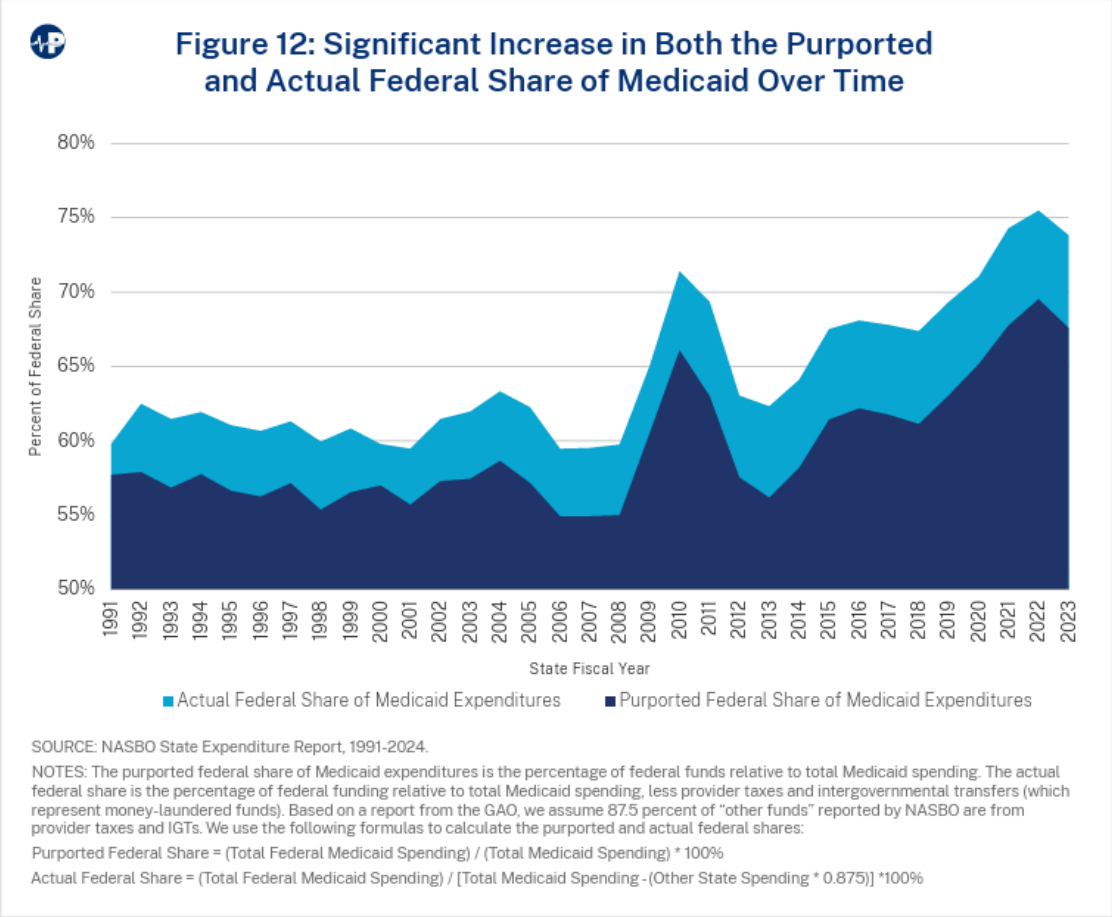

Figure 4 adapted from Figure 12 in Paragon Health Institute, "Medicaid Money Laundering: Understanding State Financing Gimmicks," April 2025. Available at: https://paragoninstitute.org/report/medicaid-money-laundering

PARAGON'S PAIN POINTS: MCO TAXES, ELIGIBILITY CHECKS, AND REIMBURSEMENT RULES

While the ACA significantly increased the federal share of Medicaid spending by encouraging states to adopt expansion, Blase and Kleinworth highlighted additional drivers of federal spending growth. These include the rise of MCO taxes, relaxed eligibility verification during the COVID-19 pandemic, and changes to reimbursement rules that permit higher payment rates.

New Developments in the Realm of MCO Taxes – California Leads The Way

Although states have been authorized to impose provider taxes on MCOs to help pay for their share of Medicaid expenditures since 1991, new tax structures in California and proposed in New York have

raised concerns about unintended results.[12] According Kaiser Family Foundation analysis, as of 2022 MCOs are the "predominant Medicaid delivery system for most states," with 35 of the 41 states that utilize MCOs reporting that at least 75 percent of their Medicaid beneficiaries are served through MCOs.[13]

As the prevalence of MCOs continued to rise, the Deficit Reduction Act (DRA) of 2005 imposed additional restrictions, effective in 2009, prohibiting states from applying provider taxes solely to Medicaid-Participating MCOs. These restrictions subjected MCO taxes to the original criteria applied to other taxes (i.e., broad-based, uniform, and no hold harmless provisions).[14] This by-in-large limited the MCO provider taxes to the 6 percent level due to opposing interests from MCOs based on their Medicaid beneficiary mix. Only a few states pursued CMS waivers that allowed their MCO taxes to bypass the uniformity and broad-based tests, provided they were deemed "redistributive."

This equilibrium disappeared in 2023, when California received a CMS waiver to implement a novel tax that raised a record amount of funds solely through provider taxes and federal matching – approximately $5 billion/year.[15] This came following a series of earlier efforts where California had continually tested the limits of what could be deemed "redistributive". In 2014 CMS removed an earlier MCO tax, then approved a revised tax in 2016 that generated approximately $1.4 billion annually.[16] In 2023 after submitting their newest proposal, CMS approved their waiver, determining the tax to be "redistributive" under their statistical test criteria. However, in CMS's opinion, the tax violated the spirit (but not the letter) of the law. In an attachment to CMS's letter, they stated their concern that "this tax fails to be generally redistributive in nature," and signaled a plan to "develop and propose new regulatory requirements … to address this issue."[17]

Following California's lead, New York received a CMS waiver for a similar tax that they expect to generate approximately $4 billion annually beginning in 2025, once again without state outlays beyond provider tax revenue.[18] Other states may adopt similar approaches unless regulatory changes are enacted. Paragon has criticized these developments, labeling California's strategy the "MCO Tax Scam" (See Figure 5). This tax also coincided with California's extension of Medicaid benefits to all California residents regardless of immigration status in January 2024, an expansion expected to cost $2.9 billion in fiscal year 2024-25 (referred to as coverage for "Illegal Immigrants" in Figure 5).[19]

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[12] https://ccf.georgetown.edu/2023/10/11/how-did-we-get-here-a-recent-legislative-history-of-medicaid-managed-care/
[13] https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[14] https://www.govinfo.gov/content/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf
[15] https://lao.ca.gov/Publications/Report/4992
[16] https://fiscalpolicy.org/wp-content/uploads/2024/03/MCO-Tax-Final-1.pdf
[17] https://www.dhcs.ca.gov/Documents/CA-MCO-Tax-Waiver.pdf
[18] As of time of writing, New York received a waiver to institute the tax in December 2024 (https://www.health.ny.gov/health_care/medicaid/rates/dfrs/docs/2024-12-20_cms_letter.pdf), but has not passed its state budget. For further discussion of Governor Hochul's proposed budget, see: https://www.mwe.com/insights/new-york-executive-budget-proposes-amendments-to-mco-provider-tax/
[19] https://www.ppic.org/blog/in-first-in-nation-state-law-all-low-income-residents-qualify-for-medi-cal/

Figure 5.

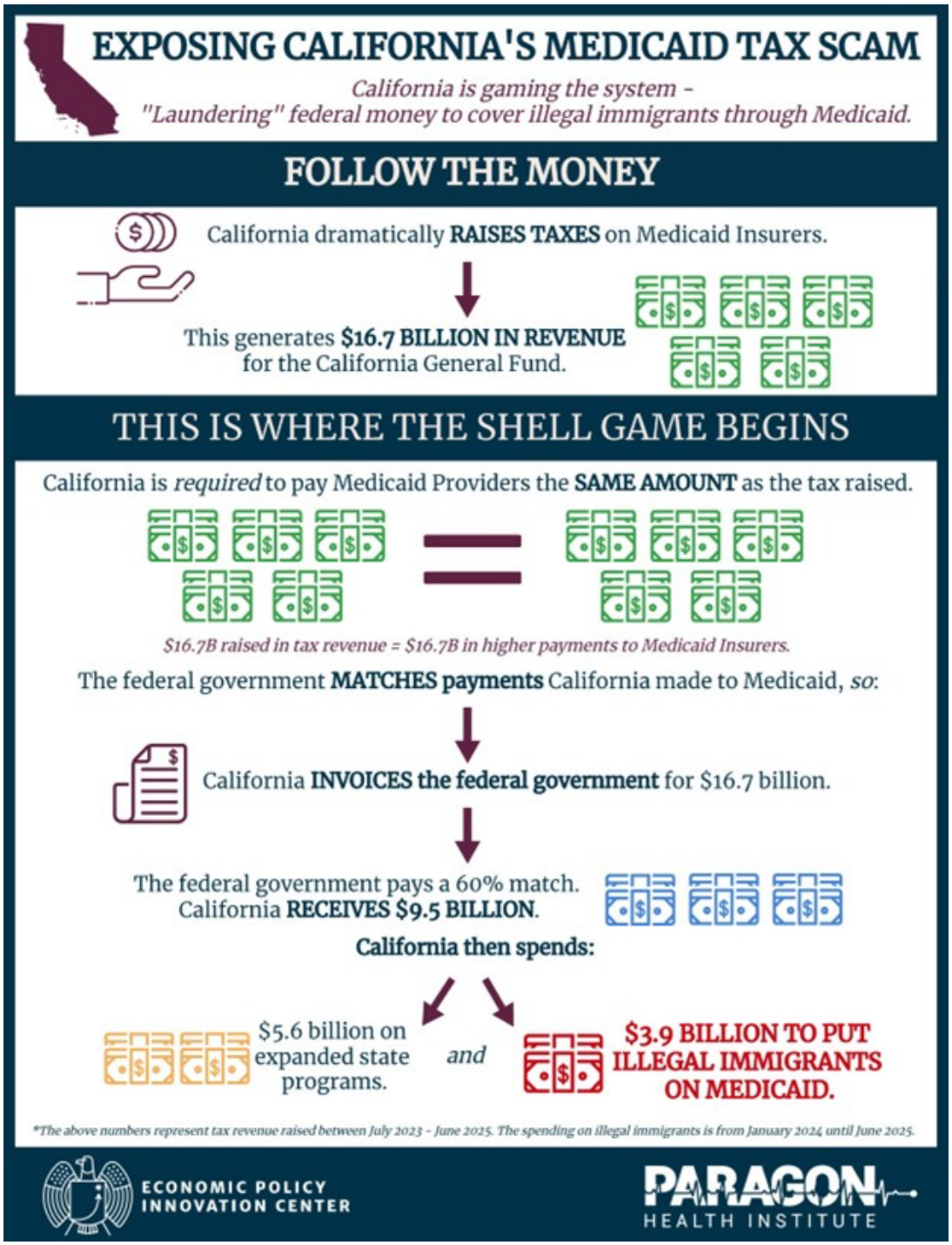

Figure 5 adapted from Paragon Health Institute, "Medicaid Money Laundering: Understanding State Financing Gimmicks," April 2025. Available at: https://paragoninstitute.org/report/medicaid-money-laundering

Eligibility Checks and the COVID-19 Pandemic

Blase and Kleinworth also asserted that the suspension of eligibility checks across much of the past decade led to significant Medicaid overpayments. As part of its annual oversight process, CMS conducts Payment Error Rate Measurement (PERM) audits in approximately one third of states (17 per cycle).[20] CMS highlights on their website the PERM rate or the "the improper payment rate is not a "fraud rate" but rather reflects the percentage of payments that fail to meet statutory, regulatory, or administrative requirements."[21] The final rate is determined as a weighted average over three years.

Between 2015 and 2024, CMS only conducted complete PERM audits, including eligibility checks, in two cycles (2019 and 2020). From 2020 through 2024, eligibility checks were explicitly prohibited due to provisions in the Families First Coronavirus Response Act and the requirements of the COVID-19 public health emergency (PHE). These regulations mandated states to maintain continuous Medicaid enrollment and prohibited disenrollment of ineligible beneficiaries until the end of the PHE. In a prior publication, Blase estimated that up to 20 million beneficiaries may have remained enrolled despite no longer meeting eligibility criteria.[22]

For the 2019 and 2020 PERM audits cycles, CMS reported PERM rates of 26.2 percent and 27.5 percent respectively, more than double the rolling averages of approximately 10 percent from 2015-2018 (See Figure 6.). In 2019 alone, this represented a jump in expected improper payments from approximately $38 to $60 billion. Paragon estimates the cumulative total amount of improper payments between 2015 and 2024 as $1.1 trillion; more than double CMS' PERM estimate from the same period of $543 billion.

[20] https://www.cms.gov/files/document/perm-manual-december-2021.pdf
[21] https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm
[22] Blase and Albanese, "America's Largest Health Care Programs Are Full of Improper Payments."

Figure 6.

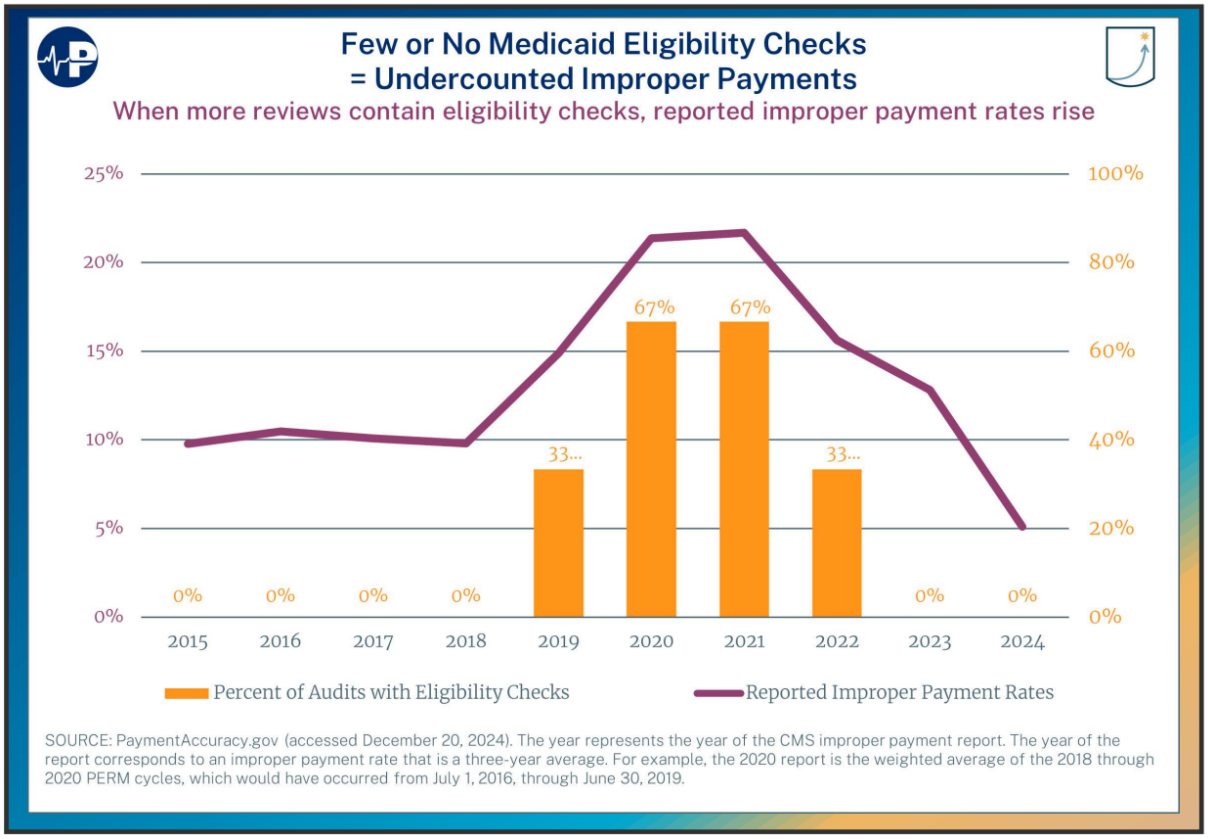

Figure 6 adapted from Paragon Health, "Medicaid's True Improper Payments Double Those Reported by CMS," March 2025. Available at: https://paragoninstitute.org/medicaid/medicaids-true-improper-payments-likely-double-those-reported-by-cms/

Medicaid Reimbursement Rule Changes in 2024

The discussion addressed a 2024 Biden-era rule change that permits states to boost directed Medicaid payments for certain types of providers to the average commercial rate. Historically, Medicare and Medicaid typically reimburse at lower rates than commercial payers, with Medicaid having the lowest rates - 72 cents on the dollar compared to Medicare according to a 2019 KFF analysis.[23] The disparity between Medicare and commercial payers is even larger, with Paragon estimating the average commercial payment at 200 to 300 percent the Medicare rate. This is consistent with findings from the Congressional Budget Office, which in a 2022 report estimated commercial payments at around 200 percent of Medicare rates between 2013 to 2018.[24]

[23] https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[24] https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf

While Paragon expressed support for raising Medicaid payments to at least Medicare levels, they argued allowing payments to reach commercial rates was more than a step too far. They raised concerns about the fiscal sustainability of this approach and its potential to further inflate federal Medicaid spending.

PARAGON'S RECOMMENDATIONS

Paragon's recommendations focus primarily on curbing federal Medicaid expenditures and increasing the share of Medicaid funding provided by states (excluding revenue from provider taxes).

Provider Taxes → Block Grants

Paragon's preferred long-term solution to the provider tax arrangement would be to replace current Medicaid funding mechanisms with capped federal block grants. Under this approach, the federal government would provide states a fixed amount of funding, and states would be required to cover any additional Medicaid costs. Paragon argues that a shift from federal to state responsibility would likely drive more prudent use of Medicaid funds and increased oversight at the state level. However, by their own admission, Paragon sees this change as politically infeasible and highly unlikely. Paragon estimates that eliminating provider taxes entirely could save approximately $700 billion over the next decade, adjusting a $612 billion estimate over the same period from a 2024 CBO report.[25] Total savings, however, would depend on the level of block grant funding compared with existing federal Medicaid spending.

Reforming Provider Taxes

As a far more politically viable alternative, Paragon also proposes several modifications to the current provider tax system; primarily reducing the safe harbor rate and modifying MCO tax regulations to prohibit states from following in the footsteps of California's 2023 MCO Tax. Specifically, Paragon recommends lowering the provider tax safe harbor threshold to reduce the overall magnitude of provider tax funds being used to generate additional federal matching funds. Its proposed policy options ranged from a 1 percent cut to eliminating it entirely, though they seemed to settle on a 3.5 percent level, aligning with a similar proposal in President Obama's FY2013 Budget.[26] Paragon estimates reducing the safe harbor threshold to 3.5 percent could save $200 billion over ten years based on adjusted CBO data.[27]

Paragon also recommends tightening provider tax regulations to prevent other states from replicating California's innovative provider tax models, which Paragon views as exploiting regulatory loopholes. While no savings estimate was provided for this recommendation, the implication is that curbing practices could mitigate future federal liabilities.

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[25] https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf
[26] Refer to pg. 36 of the FY 2013 Budget
[27] https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf

Adjusting the FMAP Formula

Blase and Kleinworth also briefly proposed reforms to the FMAP rate. Specifically, they propose narrowing eligibility for the enhanced FMAP under the ACA expansion by limiting it to individuals earning up to 100 percent of FPL for "able-bodied working adults." Affected beneficiaries between 100 and 138 percent FPL would be directed to ACA Marketplace coverage. Paragon did not provide additional information on this proposal in their presentation.

Paragon President, Brian Blase, presents Paragon's proposal to adjust the FMAP formula.

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Remove the Biden-Era Rate Adjustment

Paragon recommended rescinding the 2024 Biden-era rule that permits certain state directed payments to supplement Medicaid payments up to average commercial payer rates. While they expressed support for aligning Medicaid payments to match Medicare rates, they argued that using commercial benchmarks risks driving excessive federal spending. No budget impact estimate was provided for this recommendation.

Increased Oversight

Paragon also called for enhanced oversight of Medicaid spending, particularly at the state level. In Paragon's view, states currently have limited incentives to ensure program integrity given their relatively small financial contribution, especially when provider taxes are excluded from the equation. This misalignment, they argued, reduces the pressure to prevent waste, fraud, and abuse.

To illustrate their concern, during the presentation, Paragon cited a recent article in Bloomberg titled "Medicaid's Gatekeepers Fail to Catch Fraud, and Often Don't Try," which describes alleged failures by a prominent state-funded Medicaid oversight contractor to identify billions in waste and fraud. Paragon also pointed to the ongoing lack of eligibility audits at the federal and state levels as a key contributor to improper enrollment and related overpayments. Paragon did not provide projected cost savings for these proposals.

Other Changes

Finally, Paragon briefly discussed potential changes to Certified Public Expenditure (CPE) policies and State-Directed Payments.