Preserve and Improve Medicaid

State Action to Protect the Most Vulnerable and Taxpayers

Niklas Kleinworth Brian Blase

PARAGON HEALTH INSTITUTE

DECEMBER 2025

The authors are grateful to Chris Medrano, Kip Piper, Hayden Dublois, Katherine Hall, Mark Howell, Chris Jones, Drew Snyder, and the Paragon team for their exceptional comments and work in review of the paper.

Copyright © 2025 Paragon Health Institute

All parts of this publication are protected by copyright and/or related rights. You are free to reproduce, store in a retrieval system, or transmit in any form or by any means — electronic, mechanical, photocopy, recording, or any other — as well as modify the work as long as proper attribution is given to the authors and Paragon Health Institute as the original publication source, and a link to the Paragon Health Institute website (www.paragoninstitute.org) is provided.

ABOUT THE AUTHORS

Niklas Kleinworth is a policy analyst at the Paragon Health Institute focusing on Medicaid, state policy initiatives, and data analysis. Niklas previously served as the policy director for a state-level policy think tank in his home state of Idaho. Niklas received his BS in political science and minor in pre-health professions from the University of Idaho and an AA in general studies from North Idaho College. His work has been featured by *Forbes*, *The Epoch Times*, *Reason*, *Bitcoin Magazine*, *American Thinker*, and Fox News Radio. Niklas lives with his wife and two daughters in northern Virginia.

Brian C. Blase, PhD, is the president of Paragon Health Institute. He is also a visiting fellow at the Foundation of Government Accountability. From 2017 through 2019, he was a special assistant to the president for economic policy at the White House's National Economic Council. Brian guided the House Committee on Oversight and Government Reform's health care and entitlement program oversight and investigation efforts from 2011 to 2014 and then served as the Senate Republican Policy Committee's health policy analyst from 2014 to 2015. He has held research positions at the Mercatus Center at George Mason University and at the Heritage Foundation. He has a PhD in economics from George Mason University and publishes regularly in outlets such as *The Wall Street Journal*, the *New York Post*, *The Hill*, *Health Affairs*, and *Forbes*. He lives in northern Florida with his wife and five children.

EXECUTIVE SUMMARY

What This Paper Covers

The One Big Beautiful Bill (OBBB) makes the most significant Medicaid reforms in decades, strengthening program integrity, curbing financing abuses, and improving access to care — particularly in rural communities. The OBBB contains the most consequential reforms in the program's history and seeks to better focus Medicaid on its original purpose of serving the truly needy while promoting fiscal responsibility.

This paper describes the perverse incentives built into Medicaid's financing structure, outlines how the OBBB addresses these long-standing challenges, and provides best practices for states to implement and build upon these key reforms. It is intended as a resource for state policymakers to prepare for the impending policy debates in state capitals and for state agencies charged with implementation.

What We Found

Medicaid is plagued by perverse incentives that are fundamental to its very structure through an open-ended federal reimbursement of state spending. This policy encourages states to spend more to receive more federal money, leading to the proliferation of financing schemes that function as de facto money laundering mechanisms to obtain federal funds without commensurate state expenditures. The Affordable Care Act's 90 percent federal reimbursement rate for able-bodied, working-age adults — providing roughly seven times more federal funding per state dollar than for traditional Medicaid enrollees — has diverted resources from the truly needy.

Improper payments remain a structural threat to Medicaid's long-term viability. True improper payments in Medicaid exceed $1 trillion over the past decade when eligibility errors are fully accounted for. Weak verification rules, permissive self-attestation policies, and poor cross-checking with other programs left millions enrolled improperly, including at least 2.8 million individuals with duplicate coverage. Meanwhile, programs such as hospital presumptive eligibility encourage payouts for services rendered to patients who are ineligible.

The vastly higher reimbursement rate for expansion enrollees distorted state incentives and contributed to worsening outcomes for traditional enrollees. Labor force detachment among able-bodied adults — and men in particular — has worsened for decades, reducing the ratio of workers financing Medicaid from more than five per enrollee in 1988 to fewer than two today. Without reform, the financing structure will contribute to a fiscal crisis.

Medicaid managed care has become the dominant delivery system in most states, covering three-quarters of enrollees, yet oversight, accountability, and financial transparency remain weak. Nearly half of managed care medical loss ratio filings are incomplete, and many states do not require or verify audited financial statements. Additionally, state-directed payments undermine transparency in rate-setting and have ballooned corporate welfare in the program. The absence of reliable financial and utilization data makes it impossible for states to ensure that taxpayers and enrollees receive value.

Past efforts to address health challenges in rural communities have too often turned into vast corporate welfare programs for large, urban health systems instead. Arbitrary regulations — such as certificate of need laws, scope-of-practice limits, and suppressed insurance options — reinforced monopolies, erected barriers to entry, and raised costs for patients.

Why It Matters

Medicaid's current structure incentivizes a focus on revenue — not ensuring accurate eligibility, prudent spending, or improved access for vulnerable populations. The OBBB offers a generational opportunity to reorient Medicaid toward work, program integrity, and upward mobility and to restore the program to serve those it was intended to help. As a joint federal-state program, the durability and impact of these reforms will depend entirely on state implementation — and states now have opportunities for additional reforms that were previously impossible.

What We Recommend

States should pursue the following policy options to strengthen program integrity, prioritize the truly vulnerable, bolster accountability and transparency, and expand options for patients:

1. Strengthen Program Integrity

- Require documentation for proof of eligibility and reject self-attestation
- Conduct regular data cross-checks with federal databases
- Verify eligibility referrals from HealthCare.gov
- Use modest premiums to reinforce proper enrollment and program value

- Close hospital presumptive eligibility loopholes through a "three strikes" policy
- Commission recurring eligibility audits to identify vulnerabilities in eligibility verification

2. Ensure Successful Community Engagement Requirements

- Prohibit self-attestation for compliance and exemptions
- Reject optional exemptions
- Establish clear, enforceable exemptions (especially for medical frailty), where they are required
- Enacting a soft rollout ahead of the federal deadline to minimize errors
- Require vendors to integrate systems across welfare programs and be paid for performance

3. Hold Managed Care Organizations Accountable

- Implement better reporting standards on medical loss ratio, spending, and enrollment data including enrollees with zero claims
- Curtail the impact of shell games to ensure appropriate rate setting
- Strictly enforce reporting requirements with sanctions for noncompliance

4. Maximize the Rural Health Transformation Program

- Expand access to short-term, limited-duration health insurance plans
- Ban taxpayer subsidization of junk food
- Roll back certificate of need laws
- Allow non-physicians to practice at the top of their training

INTRODUCTION

The 2025 Reconciliation Act — dubbed the One Big Beautiful Bill (OBBB) — introduced the most substantial reforms to the joint federal-state Medicaid program in its 60-year history.[1] Perverse incentives and a lack of accountability have long plagued Medicaid, resulting in shrinking value for enrollees.[2] Meanwhile, the ability for state and federal taxpayers to fund the program is becoming untenable as the program swallows up more resources each year, crowding out funding for other government services and raising federal deficits.[3]

The OBBB starts to realign incentives within the program to bolster program integrity and refocus on the truly vulnerable populations it was originally designed to serve — low-income children, pregnant women, people with disabilities, and the elderly. To ensure that the OBBB reforms succeed, states will need to play a central role in their positive implementation. We identified four core priorities that states should capitalize upon:

- Strengthening program integrity
- Prioritizing the truly vulnerable
- Bolstering accountability and transparency, particularly in managed care
- Maximizing benefits from the rural health transformation fund

Both enrollees and taxpayers deserve a better Medicaid program. This paper outlines Medicaid's structural challenges, the policy reforms enacted in the OBBB, and how states could capitalize on these changes to improve the program.

MEDICAID'S PERVERSE INCENTIVES

States and the federal government share in Medicaid's cost. The share of the costs the federal government is required to reimburse states for traditional enrollees — children, pregnant women, seniors, and individuals with disabilities — is calculated by the federal medical assistance percentage (FMAP). The FMAP is largely a function of state per capita income and is between 50 percent and 77 percent of Medicaid spending for traditional enrollees, depending on the state.

1 P.L. 119-21.

2 Brian Blase and Drew Gonshorowski, "Medicaid Financing Reform: Stopping Discrimination Against the Most Vulnerable and Reducing Bias Favoring Wealthy States," Paragon Health Institute, July 2024, https://paragoninstitute.org/medicaid/medicaid-financing-reform-stopping-discrimination-against-the-most-vulnerable-and-reducing-bias-favoring-wealthy-states/.

3 Brian Blase and Drew Gonshorowski, "Resisting the Wave of Medicaid Expansion: Why Florida Is Right," Paragon Health Institute, December 2023, https://paragoninstitute.org/medicaid/resisting-the-wave-of-medicaid-expansion-why-florida-is-right/.

This financing structure creates limited accountability because state policymakers decide how much to spend, while federal taxpayers automatically cover at least half the cost. This mismatch between who spends and who pays is the foundation of Medicaid's cost, integrity, and enrollment challenges. Minnesota's recent fraud scheme, in which fake diagnoses and nonexistent services led to hundreds of millions of dollars of fraud, illustrates how weak oversight and guaranteed federal matching funds invite exploitation.[4]

Although the FMAP design was intended to provide more federal help to poorer states, the opposite occurs in practice.[5] Wealthier states extract far more federal Medicaid dollars per low-income resident because open-ended matching rewards higher spending rather than genuine need. The core structural problem with Medicaid is the federal government's open-ended reimbursement of state spending. As a result, higher state Medicaid spending automatically generates more federal funding.

This open-ended matching encourages states to search for ways to maximize federal revenue without increasing their own general-fund contributions and leads to very creative financing gimmicks. Such schemes are primarily accomplished with provider taxes levied against hospitals or insurers, using those taxes to increase Medicaid payments to those same providers or insurers — typically through supplemental payments and state-directed payments.[6] States use the tax revenue to draw down new federal matching funds and return those funds to those same providers in higher Medicaid payments — effectively converting the process into a government-sanctioned money laundering scheme. The additional federal money may not even go to health care, as states can deposit the funding in their general funds and use it for unrelated spending. Another scheme relates to intergovernmental transfers, which result in states overpaying government-owned or government-operated facilities to claim additional federal reimbursement.[7] Figure 1 illustrates how these various schemes shift the fiscal responsibility of Medicaid from states to the federal government, with the aggregate federal share of Medicaid spending now approximating 75 percent.

The cumulative effect is a system that finances poor policymaking by incentivizing maximization of federal revenues over program integrity or fiscal prudence. For example, California and Oregon used these schemes to obtain federal funds to provide health care for

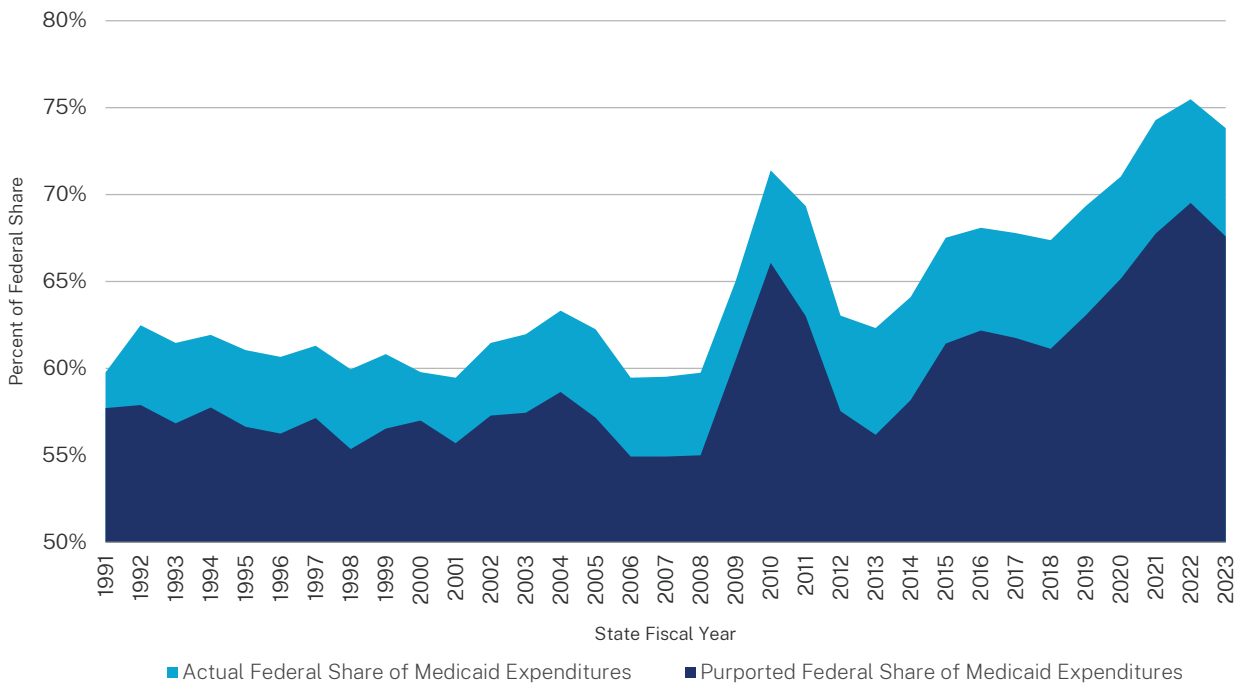
4 Ryan Thorpe and Christopher Rufo, "'The Largest Funder of Al-Shabaab Is the Minnesota Taxpayer,'" *City Journal*, November 19, 2025, https://www.city-journal.org/article/minnesota-welfare-fraud-somalia-al-shabaab.

5 Blase and Gonshorowski, "Medicaid Financing Reform."

6 Brian Blase and Niklas Kleinworth, "Addressing Medicaid Money Laundering," March 2025, Paragon Health Institute, https://paragoninstitute.org/wp-content/uploads/2025/03/AddressingMedicaidMoneyLaundering_FOR_RELEASE_V4.pdf.

7 Chris Medrano et al., "The Local Loop: How States Turn Medicaid into a Government Provider Payday Scheme," Paragon Health Institute, December 15 2025, https://paragoninstitute.org/medicaid/the-local-loop-how-states-turn-medicaid-into-a-government-provider-payday-scheme/.

Figure 1: Significant Increase in Both the Purported and Actual Federal Share of Medicaid Over Time



SOURCE: NASBO State Expenditure Report, 1991-2024.

NOTE: The purported federal share of Medicaid expenditures is the percentage of federal funds relative to total Medicaid spending. The actual federal share is the percentage of federal funding relative to total Medicaid spending, less provider taxes and intergovernmental transfers (which represent money-laundered funds). Based on a report from the GAO, we assume 87.5 percent of "other funds" reported by NASBO are from provider taxes and IGTs. We use the following formulas to calculate the purported and actual federal shares: Purported Federal Share = (Total Federal Medicaid Spending) / (Total Medicaid Spending) * 100% Actual Federal Share = (Total Federal Medicaid Spending) / [Total Medicaid Spending - (Other State Spending * 0.875)] *100%.

undocumented immigrants.[8] New York used them to help fill a $4 billion budget shortfall in 2025.[9] North Carolina used these funds to implement Medicaid expansion to able-bodied, working-age adults without contributing any real state funds for the 10 percent state share of the cost of expansion enrollees.[10]

These money laundering schemes have fiscally dangerous compounding effects as well. Being financed by federal money, these schemes pit states against one another as they jockey to prevent *their* taxpayers from being the ones subsidizing the largesse of others without getting anything in return — driving additional spending and more financing schemes.

8 Paul Winfree and Brian Blase, "California's Insurance-Tax Shuffle: How Federal Money Ends Up Paying for Medicaid for Illegal Immigrants," Paragon Health Institute and Economic Policy Innovation Center, March 12, 2025, https://paragoninstitute.org/medicaid/californias-insurance-tax-shuffle-how-federal-money-ends-up-paying-for-medicaid-for-illegal-immigrants/; Emily Kopp, "Oregon Now Spends More on Program Offering Free Health Care for Illegal Immigrants Than State Police," *Daily Caller*, October 13, 2025, https://dailycaller.com/2025/10/13/oregon-now-spends-more-on-program-offering-free-health-care-for-illegal-immigrants-than-state-police/.

9 Blase and Kleinworth, "Addressing Medicaid Money Laundering."

10 Jaymie Baxley, "'Big Beautiful Bill' Could Unravel NC's Medicaid Expansion," *NC Health News*, June 27, 2025, https://www.northcarolinahealthnews.org/2025/06/27/bill-could-unravel-expansion/.

The Affordable Care Act (ACA) worsened these perverse incentives by offering a 90 percent federal match for able-bodied adults — far higher than for children, pregnant women, seniors, or people with disabilities. For every dollar states spend on expansion enrollees, Washington pays nine — nearly seven times the federal support states receive for a dollar spent on traditional Medicaid populations.[11] Put differently, for every dollar cut from Medicaid expansion, states save only 10 cents. But for every dollar cut for traditional enrollees' Medicaid, states can save an average of 43 cents — creating a perverse incentive.[12]

This lopsided incentive structure has distorted program priorities and diverted resources away from vulnerable enrollees. For example, growth in spending on children in expansion states was slower than that for non-expansion states between 2013 and 2019.[13] Additionally, traditional Medicaid enrollees experienced more difficulty accessing services and have suffered from longer wait times and worsening mental health in states that adopted Medicaid expansion.[14] Lastly, hundreds of thousands of individuals with claims of mental or physical disabilities have continued to wait on Medicaid waiting lists since Medicaid expansion was adopted, including tens of thousands who have died waiting for care while able-bodied adults have been prioritized.[15]

The 90 percent FMAP also gives states poor incentives to ensure that enrollees are eligible and enrolled in the correct eligibility category. Because the federal government bears all (or nearly all) of the cost of expansion enrollees, states lack the financial stake to conduct rigorous eligibility reviews.[16] They have large incentives to improperly enroll people eligible under traditional categories as expansion enrollees in order to claim the enhanced match. As a result, millions of people are improperly enrolled in Medicaid expansion, including both those who are ineligible for the program at all and those who should be enrolled in other categories at lower FMAP rates.[17]

---

11 Brian Blase, "Medicaid's Broken Math: $9 for the Able-Bodied, $1.33 for the Truly Needy," Paragon Health Institute, https://paragoninstitute.org/paragon-pic/medicaids-broken-math-9-for-the-able-bodied-1-33-for-the-truly-needy/.

12 Tarren Bragdon, "The Damage Done by ObamaCare's Medicaid Expansion," testimony before the Senate Permanent Subcommittee on Investigations, November 6, 2025, https://www.hsgac.senate.gov/wp-content/uploads/Bragdon-Testimony.pdf.

13 Charles Blahous and Liam Sigaud, "The Affordable Care Act's Medicaid Expansion Is Shifting Resources Away from Low-Income Children," Mercatus Center, December 13, 2022, https://www.mercatus.org/research/research-papers/affordable-care-acts-medicaid-expansion-shifting-resources-away-low-income.

14 Liam Sigaud, "Losing Focus: How the ACA's Medicaid Expansion Left Traditional Enrollees Behind," Paragon Health Institute, February 10, 2025, https://paragoninstitute.org/paragon-prognosis/losing-focus-how-the-acas-medicaid-expansion-left-traditional-enrollees-behind/.

15 Nicholas Horton, "Waiting for Help: The Medicaid Waiting List Crisis," Foundation for Government Accountability, March 6, 2018, https://thefga.org/research/medicaid-waiting-list/.

16 On paper, states are obligated to fund the 10 percent share of the cost of Medicaid expansion enrollees. But, as discussed, some states leverage financing gimmicks — essentially legalized money laundering schemes — to circumvent this obligation. Some states fund the 10 percent state share with a tax on providers, relieving the state of any *real* cost to the general fund for the expansion population. The state assesses providers (typically hospitals), leverages the nine-to-one rate of return, and then returns the "tax" to the provider plus a portion of the federal funds received. This relieves the state of any financial incentives to control costs and incentivizes providers to raise prices to maximize revenue from the gimmicks. The only real cost is borne by the federal government in these cases. North Carolina is one example of a state in which its Medicaid expansion is funded entirely with financing schemes.

17 Liam Sigaud, "Ineligible Enrollment in the ACA's Medicaid Expansion: Evidence, Costs, and Remedies," Paragon Health Institute, May 12, 2025, https://paragoninstitute.org/medicaid/ineligible-enrollment-in-the-acas-medicaid-expansion-evidence-costs-and-remedies/.

The Generational Opportunity for Reform Presented by the OBBB

Fortunately, the OBBB takes some of the first steps in the program's history to correct structural problems with the Medicaid program. The OBBB contains three main categories of Medicaid reforms. First, the law tamps down on legalized Medicaid money laundering schemes — particularly provider taxes and state-directed payments — reducing corporate welfare that benefits insurers and powerful hospital systems. Second, the law provides incentives to lower improper payments, particularly aimed at better ensuring that only eligible people are enrolled. Third, the OBBB contains a work and community engagement requirement for able-bodied, working-age adults without dependents under the age of 14. State policymakers should capitalize on the opportunities these reforms present through effective implementation of the act's provisions (such as community engagement requirements) and go even further with free-market reforms that would improve the health care sector for all residents in their states.

How OBBB Curbed Medicaid Money Laundering and Corporate Welfare

Building on the perverse incentives created by open-ended federal reimbursement, states developed money laundering mechanisms to finance their share of Medicaid spending with illusory dollars. The most common practice involves provider taxes, which the providers — typically hospital systems — lobby for the state to assess on them. The state taxes the provider, uses the revenue to increase Medicaid payments to that same provider, claims the federal match, and then recycles the proceeds back to the provider. Provider taxes have drawn bipartisan condemnation in the past. President Obama proposed limits on them during the 2011 deficit reduction talks. Then-Vice President Joe Biden referred to them as "scams" that should be eliminated.[18]

The OBBB froze existing provider taxes in place and phases down the provider tax "safe harbor" in Medicaid expansion states — starting in 2028, until it reaches 3.5 percent in 2032.[19] The 3.5 percent safe harbor was the budget proposal from then-President Obama.[20] By targeting the phasedown in expansion states, the OBBB wisely targeted the abuse to where the money laundering mechanism has the greatest rate of return — the nine-to-one match for expansion enrollees.

The main growth in corporate welfare in Medicaid over the past few years has occurred through an increase in state-directed payments (SDPs). SDPs are add-on payments that

18 Blase and Kleinworth, "Addressing Medicaid Money Laundering."

19 Provider tax safe harbors are regulatory exemptions that allow states to impose taxes on health care providers and still receive federal Medicaid matching funds so long as the taxes meet technical criteria, even when the economic burden of the tax is effectively returned to the providers through higher Medicaid payments.

20 Blase and Kleinworth, "Addressing Medicaid Money Laundering."

states require managed care plans to make — often to hospitals — on top of regular Medicaid rates. A 2024 Biden administration rule clarified that states can pay providers, mainly hospitals, up to average commercial rates (ACR) — transforming Medicaid into a significant profit source for large hospital systems as ACR exceed 2.5 times Medicare rates for hospital services.[21] By linking Medicaid to ACR, perverse Medicaid policy put upward pressure on prices paid by employers and employees for health care services. The OBBB required that new SDPs cannot exceed Medicare rates (and 110 percent of Medicare rates in non-Medicaid expansion states) and put in place a mechanism to gradually bring existing SDPs into compliance with those limits.

STRENGTHENING PROGRAM INTEGRITY

A central threat to Medicaid's long-term viability is the rapid growth of improper payments and ineligible enrollment. These problems are driven by weak verification rules, lax federal oversight, absent federal enforcement, and incentives that reward states for maximizing enrollment rather than ensuring accurate eligibility determinations and payment amounts. Safeguarding Medicaid's long-term viability requires that funds go only to those who are eligible for the program. Yet the Centers for Medicare and Medicaid Services (CMS) reports $543 billion in Medicaid improper payments over the past decade.[22] Paragon estimates that the true amount of improper payments is nearly double the official estimates ($1.1 trillion between 2015 and 2025) when accounting for the full extent of improper enrollment.[23]

Federal law limits Medicaid payment errors to 3 percent under the Payment Error Rate Measurement (PERM) threshold — a safeguard that is meant to protect taxpayers but is rarely enforced through actual disallowances of federal matching funds. For example, 11 of the 17 states surveyed by CMS had improper payment rates greater than *five* times the 3 percent PERM limit in 2019.[24] Likewise, in 2021, eight of the 17 states surveyed had error rates exceeding five times the PERM limit. That year only one state, South Dakota, met the 3 percent federal statutory limit.[25] Table 1 shows the Medicaid improper payment rates for the

21 Blase and Kleinworth, "Addressing Medicaid Money Laundering."

22 Brian Blase and Rachel Greszler, "Medicaid's True Improper Payments Double Those Reported by CMS," Paragon Health Institute and Economic Policy Innovation Center, March 3, 2025, https://paragoninstitute.org/medicaid/medicaids-true-improper-payments-likely-double-those-reported-by-cms/.

23 Blase and Greszler, "Medicaid's True Improper Payments."

24 PERM estimates the number of improper payments from one-third of states each year, taking a sample of the claims paid, then averaging the national improper payments rate based on all states over the three-year survey cycle. Increasingly, those states with services paid by managed care organizations do not include all improper payments, so the rate is artificially low in most cases. CMS does not typically release state-by-state PERM rates. These numbers were gathered from a public records request from Americans for Prosperity, "AFP Foundation Gets CMS to Release State-Level Medicaid Improper Payment Data After Years of Stonewalling," press release, January 20, 2022, https://americansforprosperity.org/press-release/afp-foundation-gets-cms-to-release-state-level-medicaid-improper-payment-data-after-years-of-stonewalling/.

25 Americans for Prosperity, "AFP Foundation Gets CMS."

Table 1: Recent State-level PERM Audits Show Few Below the Federal 3% Limit

State	Projected 2019 Improper Payment Rate	Projected 2019 Improper Payment Loss (Millions)	State	Projected 2021 Improper Payment Rate	Projected 2021 Improper Payment Loss (Millions)
Arkansas	34.0%	$1,573	Alaska	34.8%	$553
Connecticut	43.8%	$2,086	Arizona	17.0%	$1,842
Delaware	31.3%	$862	Washington, D.C.	36.2%	$813
Idaho	39.8%	$561	Florida	11.7%	$1,677
Illinois	37.3%	$4,445	Hawaii	38.3%	$582
Kansas	27.8%	$519	Indiana	28.8%	$3,180
Michigan	14.0%	$1,575	Iowa	4.7%	$192
Minnesota	18.6%	$1,330	Louisiana	19.6%	$1,718
Missouri	31.7%	$2,063	Maine	21.6%	$467
New Mexico	10.6%	$413	Mississippi	8.0%	$350
North Dakota	28.3%	$230	Montana	12.0%	$166
Ohio	44.3%	$6,836	Nevada	25.8%	$744
Oklahoma	14.7%	$384	New York	11.8%	$5,039
Pennsylvania	14.2%	$2,282	Oregon	11.3%	$849
Virginia	11.8%	$530	South Dakota	1.0%	$6
Wisconsin	21.7%	$1,566	Texas	8.9%	$1,967
Wyoming	10.2%	$31	Washington	4.6%	$639

SOURCE: Americans for Prosperity, "AFP Foundation Gets CMS to Release State-Level Medicaid Improper Payment Data After Years of Stonewalling," January 20, 2022, https://americansforprosperity.org/press-release/afp-foundation-gets-cms-to-release-state-level-medicaid-improper-payment-data-after-years-of-stonewalling/.

NOTE: The 2020 PERM audit was not complete that year because of the pandemic.

17 states reviewed in 2019 and the 17 states, including the District of Columbia, reviewed in 2021.

Eligibility errors make up the most significant share of payment errors in Medicaid, accounting for approximately two-thirds of all spending on errors.[26] Since the ACA expansion, eligibility checks have become more important, because able-bodied, working-age adults have more frequent income changes than do people in other eligibility categories, and states receive a much higher federal reimbursement rate for these enrollees. Yet many states allow enrollees to self-attest critical eligibility information such as income, residency, legal status, and family

26 The federal government conducted full eligibility audits to test the accuracy and completeness of state eligibility reviews in 2018 and 2019 only, pausing such reviews in the Obama and Biden administrations. See Blase and Greszler, "Medicaid's True Improper Payments"; CMS, "2020 Medicaid and CHIP Supplemental Improper Payment Data," November 2020, https://www.cms.gov/files/document/2020-medicaid-chip-supplemental-improper-payment-data.pdf.

size.[27] This practice severely undermines proper eligibility determinations and invites abuse. Similar changes at the federal level — such as a 2012 rule prohibiting states from conducting eligibility redeterminations for able-bodied, working-age enrollees more frequently than once per year — have compounded the problem.[28]

Federal rules have historically limited states' ability to verify citizenship before enrolling them in Medicaid. Under the 90-day reasonable opportunity period (ROP), states must enroll applicants even when citizenship or lawful presence cannot be verified — creating a clear vulnerability to improper enrollment.[29] CMS's preliminary audit found that several states were still improperly providing Medicaid coverage to undocumented immigrants.[30] In just six states, the cost of this abuse exceeds $1 billion in federal funds, the majority of which accrued during 2024 and 2025.[31] Similarly, between 2019 and 2023, the number of individuals covered by ROPs who were ultimately unable to prove satisfactory citizenship status or lawful residency increased by 400 percent.[32] Some of these individuals remained on ROPs for as long as 14 years.[33]

These weak verification practices compound one another and create additional vulnerabilities across states and programs. Beyond a lack of documentation, states fail to effectively cross-check enrollees across other states and programs. CMS found that 2.8 million enrollees are either enrolled in Medicaid in multiple states or enrolled in both Medicaid and subsidized ACA plans.[34] This enables the fraudulent use of services by ineligible enrollees. Paragon estimates that 6.6 million people were improperly enrolled in Medicaid expansion in 2024 — growing from 4.9 million (one in three expansion enrollees) in 2019.[35]

Most states administer their Medicaid programs through managed care organizations (MCOs). In these states, the states pay insurers directly and the insurers contract with, and then pay,

27 Hayden Dublois et al., "How Federal Lawmakers Can Combat Waste, Fraud, and Abuse in Medicaid," Foundation for Government Accountability, May 15, 2025, https://thefga.org/research/federal-lawmakers-can-combat-waste-fraud-and-abuse-in-medicaid/.

28 CMS, "*Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010*," final rule, 77 Fed. Reg. 17144–17217 (March 23, 2012), https://www.govinfo.gov/content/pkg/FR-2012-03-23/pdf/2012-6560.pdf.

29 42 U.S.C. § 1320b–7(d)(4); 42 C.F.R. 435.956.

30 DrOzCMS (@DrOzCMS), "Buckle up for this one. Based on our initial set of audits, more than $1B of federal taxpayer dollars were being spent on funding Medicaid for illegal immigrants. And my team is getting it back," X, October 31, 2025, https://x.com/DrOzCMS/status/1984249538731745687.

31 States include California ($1,310.0 million), Illinois ($29.8 million), Oregon ($5.4 million), Washington ($2.4 million), the District of Columbia ($2.1 million), and Colorado ($1.5 million). For timelines, see Alec Shemmel, "Key Trump Agency Vows to Claw Back over $1B Benefiting Illegals in Blue States: 'Won't Tolerate It,'" *Fox News*, October 30, 2025, https://www.foxnews.com/politics/key-trump-agency-vows-claw-back-over-1b-benefitting-illegals-blue-states.

32 Hayden Dublois, "How Congress Can Stop States from Diverting Medicaid Resources to Illegal Aliens," Foundation for Government Accountability, March 30, 2025, https://thefga.org/research/stop-states-from-diverting-medicaid-resources-to-illegal-aliens/.

33 Hayden Dublois, "Diverting Medicaid Resources to Illegal Aliens."

34 CMS, "CMS Finds 2.8 Million Americans Potentially Enrolled in Two or More Medicaid/ACA Exchange Plans," press release, July 17, 2025, https://www.cms.gov/newsroom/press-releases/cms-finds-28-million-americans-potentially-enrolled-two-or-more-medicaid/aca-exchange-plans.

35 Sigaud, "Ineligible Enrollment in the ACA's Medicaid Expansion."

health care providers. As a result of managed care and the massive amount of improper eligibility determinations, the government spends billions in monthly payments for ineligible individuals, even if those enrollees do not access services.[36] All told, these duplicate enrollees cost taxpayers an estimated $14 billion annually.[37]

Hospital presumptive eligibility is another pathway that is commonly abused. Presumptive eligibility allows approved hospitals to render services for uninsured patients and then bill Medicaid for those services based on the presumption that patients are eligible for the program. Providers must collect self-attested information from the patients to determine whether they would be eligible for Medicaid, but no additional verification is required at that point.

This structure incentivizes hospitals to enroll patients before eligibility is verified, ensuring payment even when the patient later proves ineligible. Medicaid must pay for services rendered to these patients, even if the patient is found to be ineligible after a proper review. If the patient is later found to be ineligible, the hospital retains the payment and the patient receives the services at no cost to him or her.

Unsurprisingly, hospital presumptive eligibility has been a recipe for fraud. A 2019 PERM audit found that 43 percent of spending on a sample of presumptively eligible enrollees was improper.[38] Data collected from a sample of state Medicaid agencies by the Foundation for Government Accountability suggest that up to 70 percent of individuals determined to be presumptively eligible by hospitals are ultimately found to be ineligible.[39]

OBBB Provisions to Better Ensure Eligibility Integrity

Because Medicaid is a welfare program in which eligibility is largely a function of household income, proper eligibility determinations are vital to preserve the program for those who most need it and to protect taxpayers who finance the program. Incorrect eligibility determinations generally lead to wasteful payments to health insurers, as the vast majority of Medicaid enrollees are in managed care plans. Importantly, a feature of Medicaid — retrospective eligibility — protects people who are improperly disenrolled and who are eligible but not enrolled. Under retrospective eligibility, people eligible for Medicaid but not currently enrolled

36 MCOs are private insurance companies contracted by state Medicaid agencies to administer the program. Rather than being paid for services as they are used (as in a fee-for-service system), an MCO is paid a flat monthly rate, called a "capitated payment," to manage services for enrollees on behalf of the state.

37 CMS, "CMS Finds 2.8 Million Americans."

38 CMS, "2019 Medicaid and CHIP Supplemental Improper Payment Data," November 2019, https://www.cms.gov/files/document/2019-medicaid-chip-supplemental-improper-payment-data.pdf.

39 Jonathan Bain, "Eligible for Welfare Until Proven Otherwise," Foundation for Government Accountability, September 21, 2020, https://thefga.org/research/hospital-presumptive-eligibility/.

can sign up at the time of care to have any services they received in the preceding three months covered by the program.[40]

To strengthen program integrity, the OBBB requires states to remove deceased enrollees, check for duplicate enrollment, and conduct more frequent eligibility checks. The law also requires better PERM enforcement by restricting the ability of the Department of Health and Human Services (HHS) to waive enforcement of the federal error limit for states.

Removing Deceased Enrollees

To more expeditiously remove deceased enrollees, the OBBB requires states to check their enrollment and provider databases against the federal Death Master File at least quarterly to detect and remove deceased enrollees and providers. This provision takes effect January 1, 2027.

Checking for Duplicate Enrollment

The OBBB also requires states to verify the residence of enrollees and check against a new centralized HHS database of enrollees to identify those who are enrolled in multiple states at the same time.[41] States will not be required to check the new database for duplicate enrollees until after October 1, 2029.

Semi-Annual Redeterminations for Able-Bodied, Working-Age Enrollees

The OBBB requires states to redetermine eligibility at least every six months for able-bodied, working-age adults in the program (and they may choose to verify more frequently) starting on January 1, 2027. This is a welcome departure from the ACA's approach, which prohibited states from verifying eligibility more frequently than once per year. These arbitrary restrictions previously allowed ineligible enrollees to remain on the rolls, and they allowed people whose circumstances changed to remain enrolled even though they were no longer eligible.[42]

States should review expansion enrollees, in particular, more frequently, as their eligibility depends heavily on household income and employment — two factors that are highly variable for many enrollees. As a welfare program, able-bodied, working-age adults should be on Medicaid for only a short period of time. The goal should really be to promote their upward mobility with higher paying jobs and access to better, private health coverage.

40 Section 71112 of the OBBB changed the time frames for retroactive eligibility from three months for all eligibility categories to one month for expansion enrollees and two months for traditional enrollees.

41 HHS is required to create the centralized enrollment database by 2029.

42 77 Fed. Reg. 17144.

Reducing Payment Errors

The OBBB aims to reduce chronic Medicaid improper payments rates by restricting "good faith" waivers for states with PERM rates above 3 percent. This means states could start facing the disallowance of federal matching funds for excess erroneous payments as soon as of October 1, 2029.[43] Though this was how accountability through PERM was originally designed to work, the OBBB makes positive reforms to prevent good faith waivers from merely exempting states' chronic noncompliance.

Promoting Value Through Cost-Sharing

The OBBB requires states to implement cost-sharing policies for expansion enrollees above the federal poverty line (FPL). These fees can be up to $35 per visit, and the aggregate annual cost cannot exceed 5 percent of the enrollee's income. There are no cost sharing requirements for primary care, prenatal care, pediatric services, substance use disorder services, and certain providers.[44] Modest cost sharing gives enrollees a stake in their use of services that reduces the overuse of services and ensures greater value from the expenditure. These requirements also mirror those for lower-income people with ACA exchange plans in states without Medicaid expansion, who have copayments associated with the plans.[45]

How States Can Best Ensure That Only Those Eligible Are Enrolled

Because most Medicaid improper payments are due to erroneous or negligent eligibility reviews, states should focus on improved eligibility checks before initial enrollment and with more frequent and higher-quality redeterminations. It also means addressing features prone to abuse, such as presumptive eligibility. We recommend that states take five actions to preserve Medicaid resources for the most vulnerable, improve program integrity, and best meet PERM requirements to avoid disallowances.

1) Require Documentation for Proof of Eligibility

States should verify eligibility before applicants are enrolled and begin receiving benefits to the greatest extent permitted by federal law. States should generally prohibit applicants' ability to self-attest critical eligibility criteria by requiring documentation for income, residency, and household size prior to enrollment. States should verify information submitted by applicants using state and federal databases that collect tax documentation, earnings information, new hire data, Supplemental Security Income information, beneficiary records,

43 The term *disallowance* refers to when the federal government withholds federal matching funds to a state due to a violation of some requirements.

44 *Certain providers* includes federally qualified health centers, rural health clinics, certified community behavioral health clinics, and emergency services.

45 Chris Medrano et al., "What Made It into Law: Health Provisions of the One Big Beautiful Bill," Paragon Health Institute, July 10, 2025, https://paragoninstitute.org/medicaid/what-made-it-into-law-health-provisions-of-the-one-big-beautiful-bill/.

and pension information. States should frequently monitor this information to flag any changes that would affect eligibility.[46]

States should also require their Medicaid agencies to check legal status against federal immigration databases and remove ineligible applicants from the rolls. To address eligibility issues common to immigrant households, states should also require:

- inclusion of income of all ineligible household members when calculating financial eligibility,
- a question of immigration status on all hospital presumptive eligibility applications and deny any presumptive eligibility application where a recipient does not certify that he or she is legally present.

2) Verify Eligibility Information from HealthCare.gov

Given recent developments showing massive fraud and inaccurate eligibility determinations within the federal health insurance exchange, HealthCare.gov, it is essential for states to verify any eligibility information collected by the platform.[47] A recent undercover investigation by the Government Accountability Office (GAO) revealed that 96 percent of fictitious applications created by GAO were successfully enrolled in coverage to collect a federal subsidy.[48] Paragon's research illustrates that 6.4 million people were improperly enrolled in fully subsidized ACA coverage, with much greater abuse in states that use HealthCare.gov to run their exchanges.[49]

Recent data from CMS shows that 839,000 applications submitted to HealthCare.gov were determined eligible for Medicaid.[50] Given the scale of fraud in the federal exchange, states should verify all eligibility information submitted through HealthCare.gov before allowing an individual to enroll in the program by requiring documentation from the enrollee and checking against federal databases mentioned in the previous section. This includes household size, income, residency, and citizenship. This simple measure would work to stem the vulnerabilities in the federal exchange that would otherwise be imported into state Medicaid rolls.

46 Much of this data is accessible through sources such as the state revenue department, the Social Security Administration, HHS, the U.S. Department of Housing and Urban Development, and the Internal Revenue Service.

47 Brian Blase et al., "The Greater Obamacare Enrollment Fraud," Paragon Health Institute, June 2025, https://paragoninstitute.org/wp-content/uploads/2025/06/The-Greater-Obamacare-Enrollment-Fraud_RELEASE_V4.pdf.

48 GAO, *Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance premium Tax Credit Persist*, December, 3, 2025, https://www.gao.gov/assets/gao-26-108742.pdf.

49 Blase et al., "The Greater Obamacare Enrollment Fraud."

50 CMS, "2025 Marketplace Open Enrollment Period Public Use Files," 2025, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files.

3) Ensure Proper Enrollment and Promote Value Through Nominal Premiums

States should build on the cost sharing requirements of the OBBB by implementing minimum premium payments for expansion enrollees through an 1115 waiver request to CMS. This would ensure that Medicaid enrollees place some value on enrollment and would reduce waste and fraud, including "phantom" enrollment.

When coverage is zero cost to the enrollee, it leads to fraud and waste. For example, tremendous fraud followed the enhanced COVID-era ACA subsidy boosts that created fully subsidized plans for enrollees claiming income between 100 percent and 150 percent of FPL. This policy outcome led to many people being enrolled in insurance without their knowledge — evidenced by more than twice as many enrollees in this category making no claims in 2024 compared to other markets.[51] About 40 percent of enrollees in fully subsidized plans with income between 100 percent and 150 percent of FPL made no claims last year.[52] A minimum premium payment for enrollees aligns Medicaid with the original design of the ACA exchanges and better ensures that people obtain some value for the coverage, are not enrolled in other plans, and have not been enrolled fraudulently.

These challenges extend into Medicaid coverage as well, particularly for coverage administered by MCOs, where the state pays the insurer the entire premium amount. Medicaid has long offered low value for many enrollees, and millions are improperly enrolled in MCO Medicaid plans.[53] Therefore, it is critical for enrollees to have some modest stake in the cost for their coverage and to help rectify issues such as duplicate, deceased, or unaware enrollees.

4) Close the Hospital Presumptive Eligibility Loophole

Hospital presumptive eligibility incentivizes improper enrollment. States can correct these perverse incentives through a "three strikes" system such as the one adopted by Indiana in 2025 and previously adopted in other states, such as Maine.[54] Indiana permits certain hospitals to enroll individuals through presumptive eligibility so long as they meet certain standards, and it imposes a disciplinary process for those who fail to meet the standard:

51 Brian Blase, "The Rise of Phantom Obamacare Enrollees: Biden COVID Credits Drive Massive Increase in Individual Market Enrollees with No Medical Claims," Paragon Health Institute, August 13, 2025, https://paragoninstitute.org/paragon-prognosis/the-rise-of-phantom-obamacare-enrollees-biden-covid-credits-drive-massive-increase-in-individual-market-enrollees-with-no-medical-claims/.

52 Blase, "The Rise of Phantom Obamacare Enrollees."

53 Amy Finkelstein et al., abstract of "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment," *Journal of Political Economy* 127, no. 6 (December 2019), https://www.journals.uchicago.edu/doi/10.1086/702238; Sigaud, "Ineligible Enrollment in the ACA's Medicaid Expansion."

54 Jonathan Ingram, "Manage Effectively: Make Medicaid More Accountable," in *Don't Wait for Washington: How States Can Reform Health Care Today*, ed. Brian Blase (Paragon Health Institute, 2021), https://paragoninstitute.org/wp-content/uploads/2023/12/dont-wait-for-washington.pdf; see also Section 12-15-4-1.5 of the Indiana Code.

1. The first violation results in a written warning from the state.
2. The second violation results in a written notice from the state and mandatory staff training for the facility on proper eligibility determinations.
3. The third violation results in the hospital losing its ability to issue presumptive eligibility determinations.

The three-strikes approach provides clear expectations for providers, ensuring that those who receive care through presumptive eligibility are genuinely eligible for the program. This reform would permit hospitals to enroll eligible people for Medicaid but would protect against the clear opportunities for abuse that currently exist.[55]

5) Commission Meaningful Eligibility Audits

States should have audits conducted of their eligibility systems to determine the effectiveness of limiting ineligible people from the program. For example, states should commission independent, secret-shopper audits of their Medicaid programs — much like the one designed by the GAO for its evaluation of HealthCare.gov.[56] This would allow state policymakers to see the vulnerabilities with the status quo and encourage them to take corrective actions to protect tax dollars and ensure that only those who are eligible are enrolled.

EFFECTIVELY IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS

After the implementation of the ACA, the much higher federal reimbursement rate for expansion enrollees created perverse incentives that shifted Medicaid resources from the most vulnerable — children, pregnant women, seniors, and people with disabilities — to able-bodied, working-age adults. In expansion states, traditional Medicaid enrollees have a harder time obtaining health care services by many metrics, including increased wait times for care, slower emergency response, and worse mental health.[57]

As government welfare programs, including Medicaid, have expanded significantly over the past few decades, fewer able-bodied, working-age people are working — an essential attribute for people to gain personal independence and achieve upward mobility. This problem is particularly apparent for men. Table 2 shows the labor force participation rate for

55 Ingram, "Manage Effectively: Make Medicaid Moore Accountable."

56 GAO, *Preliminary Results from Ongoing Review*.

57 Sigaud, "Losing Focus."

Table 2: Working-age Men (Ages 25-54) are Increasingly Not in the Labor Force

	Men	Women
1988		
Not In Labor Force	3.2 M	14.2 M
Labor Force Participation	93.6%	72.7%
2004		
Not In Labor Force	5.8 M	15.5 M
Labor Force Participation	90.40%	75.30%
2024		
Not In Labor Force	6.8 M	14.3 M
Labor Force Participation	89.3%	77.9%

SOURCE: Bureau of Labor Statistics, n.d., Infra-Annual Labor Statistics: Working-Age Population: From 25 to 54 Years for United States; Bureau of Labor Statistics, n.d., Infra Annual Labor Statistics: Labor Force Participation Rate: From 25 to 54 Years.

men and women in 1988, 2004, and 2024. From 1988 to 2024, the percentage of men ages 25–54 in the labor force dropped from 93.6 percent to 89.3 percent.[58] By contrast, the labor force participation rate among women increased over this period from 72.7 percent to 77.9 percent.

As a result of enrollment growth and declining labor force participation, fewer than two workers financed each Medicaid enrollee in 2024, compared to more than five workers per enrollee in 1988.[59]

Expansive welfare benefits discourage work for many enrollees. Public records obtained by the Foundation for Government Accountability from state Medicaid agencies suggest that 62 percent of able-bodied, working-age adults on Medicaid did not have reported income.[60] Extended detachment from work isolates enrollees from their communities, erodes job skills, worsens physical and mental health, and severely limits upward mobility.

58 *Labor force* is defined as "all persons who are either employed or unemployed, representing the total supply of labour available for the production of goods and services in the economy. Employed persons are those of working age who, during a short reference period, engaged in any activity to produce goods or provide services for pay or profit. This includes those 'at work' (i.e. worked at least one hour), as well as those 'not at work' due to temporary absence from a job or working-time arrangements (e.g. shift work, flexitime, or compensatory leave). Unemployed persons are those of working age who, in the reference period, did not have a job, were available for work, and had actively sought employment." See OECD, "Labour Force," https://www.oecd.org/en/data/indicators/labour-force.html. Data from Bureau of Labor Statistics, "Infra-Annual Labor Statistics: Labor Force Participation Rate: From 25 to 54 Years," https://fred.stlouisfed.org/series/LRAC25TTUSM156S.

59 Author's calculations from Medicaid and CHIP Payment Access Commission (MACPAC), Medicaid enrollment statistics, and the annual average of BLS Current Employment Statistics. See MACPAC, "Exhibit 8. Medicaid Enrollment and Spending," December 2024, https://www.macpac.gov/macstats/; Bureau of Labor Statistics, "Current Employment Statistics — CES (National)," https://www.bls.gov/ces/data/.

60 Jonathan Ingram and Michael Greibrok, "Medicaid Work Requirements Would Help Move Millions of Able-Bodied Adults from Welfare to Work," Foundation for Government Accountability, April 14, 2025, https://thefga.org/research/medicaid-work-requirements-from-welfare-to-work/.

Embracing Upward Mobility

To encourage enrollees to become more financially secure and engage with their communities, the OBBB imposes modest community engagement requirements on Medicaid eligibility for able-bodied, working-age adults with dependents older than 14 years old. This policy includes those adults who are eligible through the ACA Medicaid expansion and those who are eligible due to their children's enrollment. States must fully implement the community engagement requirements by January 1, 2027.

Enrollees must complete at least 80 hours per month of work, job training, education, or community service to meet the requirement.[61] Crucially, as it pertains to employment, this 80-hours-per-month requirement is tied to the federal minimum wage, so as individuals' earnings increase, they need to work less to maintain compliance with the community engagement requirements. For example, an individual earning $14.50 (twice the federal minimum wage) would need to work only 40 hours per month.

To be eligible, people must meet the requirement for at least one month before enrolling and for each month thereafter.[62] The law explicitly exempts from the requirement pregnant women, children, seniors, medically frail individuals, parents with children younger than 14, caregivers, certain seasonal workers, Native Americans, and those already meeting work requirements under other federal programs. Of these exemptions, the medical frailty one will be the most subject to potential abuse.

Ensuring the Success of Community Engagement Requirements

States' successful implementation of the work and community engagement requirements would maximize the benefit to enrollees and their communities. There is a risk that exemptions can be abused to limit the impact of the policy reforms. Therefore, states should ensure that only people who meet the exemptions are granted them and take the following steps to ensure a smooth rollout.

Prohibit Self-Attestation for Compliance

States should require documentation from enrollees to demonstrate compliance with the requirements and not accept self-attestation of compliance. This includes both new applicants who must prove compliance and existing enrollees who must prove continued eligibility. States should pursue compliance checks at least quarterly for the requirements. To

61 Alternatively, enrollees may qualify by earning at least minimum wage multiplied by 80 hours per month, averaged over the previous six months if they are seasonal workers. See Section 71119(a)(xx)(2)(F) of the OBBB.

62 States may choose to extend this lookback period for up to three months pre-enrollment.

do this, states can use existing wage data sources without having to make new, large investments in data infrastructure.

Promote Integrity in Exemptions

States should ensure that exemptions to the requirements are clearly defined and enforceable, particularly for people claiming medical frailty. States should never rely on self-attestation for this exemption and should instead require documentation from health care providers to affirm physical or mental impairments that prevent employment.

Furthermore, states should not accept exemption designations on behalf of enrollees from MCOs. Because MCOs receive payments for enrollees they cover, they have incentives to maximize enrollment and thus grant inappropriate exemptions.

Avoiding Optional Exemptions

States should not adopt any additional optional exemptions beyond the large number provided in the OBBB. These include short-term hardship exemptions and geographic waivers, as similar waivers are abused in other welfare programs.[63] Such policies would only undermine the purpose of the requirements by keeping enrollees on welfare and out of the workforce, disengaged from their communities.

Enact a Soft Rollout of Requirements to Minimize Errors

States should implement a "soft rollout" of the work requirements ahead of the January 1, 2027, federal deadline. A soft rollout of the requirements would give states the opportunity to pressure test new tracking systems, reporting procedures, and disenrollment protocols before they would be subject to federal requirements. This would help to ensure a successful rollout while avoiding erroneous disenrollments. During a provisional period, enrollees would be required to report to the agency on their adherence to the new requirements but would not be disenrolled for noncompliance.

Seek Competent Vendors

In some cases, it may be efficient for states to contract with vendors to administer the community engagement requirements. At a minimum, states should ensure that vendors could integrate with other welfare programs with existing work requirements for programs such as Temporary Assistance for Needy Families and the Supplemental Nutrition Assistance

63 Matthew Dickerson, "Work Requirements Not Workarounds: Ending Food Stamp Waiver Abuse," Economic Policy Innovation Center, April 28, 2025, https://epicforamerica.org/wp-content/uploads/2025/04/EPIC-Paper-Eliminate-Food-Stamp-Geographic-Work-Requirement-Waivers-4.28.2025.pdf.

Program (SNAP). States should also consider tying vendor payments to the accuracy of their determinations.

HOLDING MANAGED CARE ORGANIZATIONS ACCOUNTABLE TO TAXPAYERS

Medicaid managed care has become the dominant delivery system in most states, yet oversight, accountability, and financial transparency are severely lacking. As of 2022, three-quarters of all Medicaid enrollees were enrolled in MCOs.[64] More than half of all states cover at least 80 percent of their Medicaid enrollees with MCOs.[65] Figure 2 shows the penetration of Medicaid MCOs by state.

States rely heavily on MCOs to control costs and improve outcomes in Medicaid. However, available evidence shows no fiscal savings, high administrative costs, weak financial reporting, unreliable medical loss ratio (MLR) data, limited auditing, and excessive rates — without evidence of improved access or quality.[66] These weaknesses allow insurers to profit from generous state and federal payments while offering little measurable improvement in care quality or program integrity.[67]

A central problem is the failure of many states to enforce MLR requirements and financial reporting standards.[68] The MLR is intended to ensure that at least 85 percent of capitation payments are devoted to medical services and quality improvement rather than administration, profits, or overhead. Yet nearly half of Medicaid MCO MLR filings were found to be incomplete, frequently omitting critical data on non-claims (administrative) spending.[69] Even among the states that review filings, many do not verify essential datapoints, allowing states to submit incomplete or unverifiable information without meaningful consequence.

These oversight failures have significant fiscal implications. In many states, capitation payments — especially for ACA expansion adults — exceed what insurers spend on actual

64 MACPAC, "Exhibit 29. Percentage of Medicaid Enrollees in Managed Care by State," Medicaid and CHIP Payment Access Commission (MACPAC), July 1, 2022,December 2024, https://www.macpac.gov/publication/percentage-of-medicaid-enrollees-in-managed-care-by-state/.

65 MACPAC, "Exhibit 29."

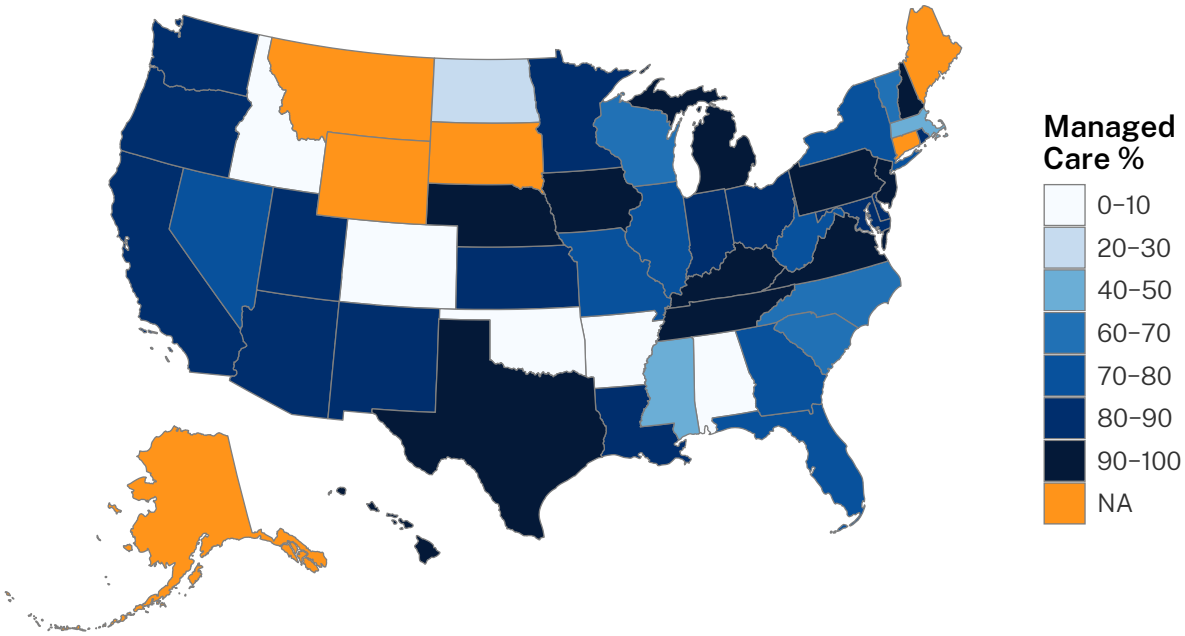
66 Brian Blase, "Managed Care in Medicaid: Need for Oversight, Accountability, and Reform," Paragon Health Institute, October 10, 2022, https://paragoninstitute.org/medicaid/managed-care-in-medicaid-need-for-oversight-accountability-and-reform/; Medrano et al., "The Local Loop"; Daniel Arnold and Brent Fulton, "United Healthcare Pays Optum Providers More Than Non-Optum Providers," November 3, 2025, https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00155.

67 Blase, "Managed Care in Medicaid."

68 The MLR is the ratio of claims paid and quality improvement expenses relative to premium revenues. In essence, it is the percentage of premiums that goes for medical care rather than administrative expenses and profits. Relatedly, actuaries also consider the administrative loss ratio to measure the ratio of administrative costs relative to premium revenues.

69 HHS, Office of Inspector General, "CMS Has Opportunities to Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios," September 2022, https://oig.hhs.gov/oei/reports/OEI-03-20-00231.asp.

Figure 2: More than Half of States Cover at Least 80% of Medicaid Enrollees Using MCOs (2022)



SOURCE: MACStats: Medicaid and CHIP Data Book, December 2024, Exhibit 29.
NOTE: No state fell within the 30 to 40 percent category.

medical claims, hiding true administrative spending.[70] Because detailed financial disclosures are not routinely required or audited, excessive payments often go undetected or unrecovered. Rebate and remittance provisions tied to the MLR floor are seldom enforced, allowing federal and state dollars intended for medical care to flow into insurer profits. At the same time, plans receive monthly payments for large numbers of enrollees with no claims, including individuals who may be ineligible or improperly enrolled.

Visibility into how plans use taxpayer funds is limited. Many states do not require or verify audited financial statements, high-quality encounter data, or independent actuarial validations of rate-setting assumptions.[71] Without accurate data, states cannot determine whether capitation rates reflect actual utilization patterns or insurer costs. As a result, managed care often operates without the risk-based discipline it is intended to embody.

These structural problems are compounded by the explosive growth of SDPs in managed care. Nationally, SDPs comprise more than $100 billion each year and are often funded through

70 Chad Terhune and Anna Gorman, "Insurers Make Billions off Medicaid in California During Obamacare Expansion," *Los Angeles Times*, November 5, 2017, https://www.latimes.com/business/la-fi-medicaid-insurance-profits-20171101-story.html

71 Blase, "Managed Care in Medicaid."

provider taxes that recycle federal dollars back to politically favored providers.[72] The Biden administration's 2024 rule expanded SDP authority by permitting payments up to average commercial rates, an inflationary policy that encouraged providers to raise charges to secure even higher Medicaid payments.[73] Although the OBBB rightly capped SDP reimbursement at Medicare rates (or 110 percent of Medicare for non-expansion states), SDPs remain hidden within MCO capitation structures, making them difficult for legislatures, auditors, and even actuaries to evaluate.

Improving Transparency in Medicaid Managed Care

These challenges within Medicaid managed care programs point to a need for additional transparency in data, additional verification measures, proper rate setting, and real MLR reporting along with sanctions for failing to meet these requirements. These reforms should be enacted through better reporting standards, appropriate rate-setting and avoiding shell games, and strict enforcement.

1) Better Reporting Standards

States should require MCOs to provide detailed information about their business operations and any instances where conflicts of interest could arise. These requirements should include:

- Complete, audited MLR and administrative loss ratio (ALR) filings, including non-claims spending and quality-improvement expenditures.
- Independently audited financial statements for MCOs, their subcontractors, and other related entities. At a minimum, the following data elements should be available for public scrutiny:
  - Total services and total spending by billing code and provider
  - Total spending on medical, non-claims, and non-benefit services
  - Total number of enrollees without any claims during their enrollment
  - Total number and share of enrollees receiving services in emergency rooms, as well as total services and total spending by billing code for emergency room care
  - SDPs by type and provider
  - Sources of SDP revenue (e.g., provider taxes, intergovernmental transfers)
  - SDP quality strategies and metrics evaluations

72 Blase and Kleinworth, "Addressing Medicaid Money Laundering."

73 Jackson Hammond, "Biden's Medicaid Changes: Hight Cost, Misguided Policy," Paragon Health Institute, November 6, 2024, https://paragoninstitute.org/medicaid/bidens-medicaid-changes-high-costs-misguided-policy/.

- Spending and utilization counts for mandatory and optional Medicaid benefits
- Spending on services delivered through third-party contractors, by service type
- Total prescription drug spending by national drug code identifier

States should reject late or incomplete filings and impose sanctions on noncompliant entities.

2) Appropriate Rate Setting and Avoiding Shell Games

States should ensure that capitation rates are set through independent or qualified in-house actuarial reviews. They should avoid conflicts of interest with actuarial firms that simultaneously advise both MCOs and the state. States should also scrutinize zero-claim enrollees, enrollment anomalies, and unusual patterns of non-utilization to prevent plans from receiving capitation payments for individuals who are not legitimately enrolled.

Additional reporting requirements may incentivize MCOs to obscure transactions, particularly through related parties. States should explicitly prohibit preferential treatment of providers and subcontractors related to MCOs, their own subcontractors, or their parent companies — practices that inflate health care costs and distort actuarial assessments.

3) Strict Enforcement

For information-gathering efforts to be effective, states should follow up to ensure that accountability goals are met. This includes validating that expenditures align with reported MLR and ALR data and with underlying rate-setting assumptions for MCOs, their subcontractors, and any related parties. States should also enforce remittance provisions by collecting payments from MCOs that fail to meet required MLR standards.

These reforms would significantly strengthen Medicaid managed care oversight, restore financial integrity, and ensure that state and federal dollars are used for medical care rather than excessive administrative costs, hidden SDP arrangements, or insurer profits.

MAXIMIZING THE BENEFIT OF THE RURAL HEALTH TRANSFORMATION PROGRAM

For too long, policy efforts to address health care access in rural communities have failed to make care more accessible or affordable. Programs intended to provide support for small rural health facilities, such as 340B and disproportionate share hospital programs, were

ultimately captured by large, urban hospital systems rather than improving access in rural communities.[74]

Exacerbating this misdirection of funding, rural communities are grappling with arbitrary regulatory hurdles. Such regulations are sold as ways to help rural health care, but they actually thwart efforts to best meet the health needs of those communities.

Certificate of need (CON) laws are one such example of these crushing regulations. CON laws are state-level policies that were originally coerced into existence by federal policy and were sold as a way to curb health care costs. Instead, these regulations work to entrench monopolies and discourage innovation. These laws require providers to justify to regulators the need for investments in new technology, services, or facilities. Though federal requirements for these laws have since been repealed, 38 states and Washington, D.C., continue to enforce CON or CON-like laws.[75]

Evidence suggests that CON laws raise the per capita health care costs by roughly 10 percent by artificially capping the supply of services and encouraging market consolidation.[76] These regulations most often restrict the growth of nursing homes, psychiatric services, and hospitals.[77] As demand continues to increase, so do prices for services offered at these facilities.

CON encourages market consolidation by denying applications for new services where they already exist through other providers. Incumbent providers often have their own employees sit on CON boards and deny applications of would-be competitors.[78] This further raises prices by entrenching market power of just a few providers.[79]

State scope-of-practice limits for non-physician medical professionals is yet another example of an inflationary regulatory burden on rural communities. For physicians, private credentialing boards and professional organizations govern their practice of medicine.[80] By

74 Bill Finerfrock, "Rural Health Transformation Fund Offers States a Way to Improve Rural Health Care Access," Paragon Health Institute, October 2025, https://paragoninstitute.org/medicaid/rural-health-transformation-fund-offers-states-a-way-to-improve-rural-health-care-access-heres-what-states-should-do.

75 Some sources report that only 34 states and D.C. have active CON laws. However, the Cicero Institute's numbers include four states that do not have official CON laws but have CON-like restrictions on providers: Arizona, Louisiana, Minnesota, and Wisconsin. Cana Cossin et al., "Comprehensive Certificate of Need (CON) Laws Dataset," Cicero Institute, July 17, 2025, https://ciceroinstitute.org/blog/comprehensive-certificate-of-need-con-laws-dataset/.

76 Chris Jones and Tanner Jones, "Ranking Certificate of Need Laws in All 50 States," Cicero Institute, December 2024, https://ciceroinstitute.org/wp-content/uploads/2024/12/50-State-CON-Rankings-Report-12-5-2024.pdf.

77 Matthew Mitchell, "Welcome Competition: Scale Back Certificate of Need Laws," in Blase, *Don't Wait for Washington*.

78 Mitchell, "Welcome Competition."

79 Mitchell, "Welcome Competition."

80 Graboyes and Bryan, "Unshackle Providers."

contrast, non-physicians face many similar credentialing requirements but are often subject to stricter, government-imposed limits despite being trained to offer a higher standard of care.

Scope-of-practice laws raise costs by creating shortages, duplicating services, and reinforcing provider monopolies.[81] Unnecessarily requiring patients to visit physicians for services that non-physicians such as nurse practitioners, physician assistants, and pharmacists are trained to provide forces them into higher-cost care settings. Scope-of-practice laws also lead to duplicative payments when an initial evaluation by a non-physician must be followed by a second visit with a physician to start treatment. Further, these arbitrary regulations are anti-competitive, driving up overall health care prices by sheltering physician practices from would-be competitors.

Several states have already rolled back portions of their scope-of-practice limitations in order to better meet the needs of their residents, particularly in rural areas.[82] For example, Colorado, Idaho, Indiana, Iowa, and Montana have all expanded prescriptive authority for pharmacists.

Short-term, limited-duration insurance (STLDI) has historically provided a critical access point to affordable coverage in rural areas where employer-sponsored insurance options are limited. In 2018, the Trump administration expanded access to STLDI plans, setting the initial contract period to 364 days and allowing enrollees to renew their plans for up to three years. Evidence shows that this helped both STLDI enrollees and the greater insurance market.[83] Yet the Biden administration restricted these plans in a 2023 rule, cutting the initial contract period to just three months and the total duration of the plan to four months.

Good nutrition is increasingly recognized as a crucial component of overall health. A healthy diet and physical activity can reduce one's risk for chronic disease — but federal welfare programs such as SNAP reinforce unhealthy behaviors. SNAP recipients are more likely to purchase unhealthy food than are their peers in the same income groups.[84] SNAP enrollees are also at a higher risk of developing chronic disease.[85] Thus, funding the purchase of junk food through SNAP means taxpayers are subsidizing the cost of chronic disease twice over — first in its manifestation and progression and then for its ongoing treatment and mitigation. To

81 Graboyes and Bryan, "Unshackle Providers."

82 Tim Frost and McKenzie Richards, "2025 Policy Strategies for Full Practice Authority," Cicero Institute, August 2025, https://ciceroinstitute.org/research/2025-policy-strategies-for-full-practice-authority/.

83 Brian Blase, "Short-Term Health Plans, Long-Term Benefits: States that Allow Short-Term Coverage Have Stronger Health Insurance Markets," Paragon Health Institute, September 2023, https://paragoninstitute.org/private-health/short-term-health-plans-long-term-benefits/.

84 Paige Terryberry, "Make America Healthy Again: Stop Taxpayer-Funded Junk Food," Foundation for Government Accountability, January 16, 2025, https://thefga.org/research/make-america-healthy-again-stop-taxpayer-funded-junk-food/.

85 Jerolda Mande and Graceb Flaherty, "Supplemental Nutrition Assistance Program as a Health Intervention," *Current Opinion in Pediatrics 35*, no. 1 (February 2023): 33–38, , https://journals.lww.com/co-pediatrics/fulltext/2023/02000/supplemental_nutrition_assistance_program_as_a.8.aspx.

address this problem, several states recently received federal approval for waivers that ban spending on junk food purchases using SNAP benefits — particularly for soda and candy.[86]

States Should Maximize Use of the Rural Health Transformation Program

The OBBB created the Rural Health Transformation Program (RHTP). This fund aims to make a $50 billion investment in rural communities over the next five years for the purpose of benefitting *those* communities rather than urban and suburban medical centers and hospitals. As the Trump administration recognized, this is not only a significant funding opportunity but also an opportunity to catalyze reforms to policies that have long damaged health care in these rural areas.[87] States have the opportunity to get additional funding through the program if they commit to making certain policy changes — such as those outlined above — and follow through on those commitments by the end of 2027.

States that commit to making these policy changes are given half credit and funding for those promises at the time of application and will receive full credit after enacting those reforms into law. This provides not only an incentive for states to make these changes but an additional financial impetus to build on those reforms once passed. States should take advantage of this opportunity.

Policies to Capitalize on OBBB Rural Health Investments

In light of additional RHTP funds now available, states should consider implementing the following policies:

1. To bolster insurance options, states should expand access to STLDI plans to the fullest extent allowed under federal law. As the 2023 Biden limitations are not being enforced, states should push to restore the Trump-era flexibilities of an initial contract period of 364 days and up to 36 months of renewability at a minimum.[88]
2. To prevent taxpayers from subsidizing products that contribute to overweight and poor overall health, states should ban the taxpayer subsidization of junk food in SNAP.

86 These states include Arkansas, Colorado, Florida, Hawaii, Idaho, Indiana, Iowa, Louisiana, Missouri, Nebraska, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, and West Virginia. See April Rubin, "SNAP Junk Food Ban Expands to 6 More States," *Axios*, https://www.axios.com/2025/12/10/snap-junk-food-ban-trump-states.

87 CMS, "CMS Launches Landmark $50 Billion Rural Health Transformation Program," press release, September 15, 2025, https://www.cms.gov/newsroom/press-releases/cms-launches-landmark-50-billion-rural-health-transformation-program.

88 Department of Labor, "Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury Regarding Short-Term, Limited-Duration Insurance," August 7, 2025, https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/short-term-limited-duration-insurance/stldi-statement-08-07-2025.

3. To enable rural communities to meet the demand for services, states should work to roll back CON laws.
4. Finally, states should allow health care professionals to practice at the top of their training and expand services, including those for pharmacists, nurse practitioners, physician assistants, and emergency medical technicians. Ohio is one example of a state that seeks to expand pharmacist prescriptive authority as part of its RHTP application submission.[89]

Implementing these policies would eliminate key regulatory hurdles impinging access and raising costs in rural communities, thereby maximizing the subsequent financial investments from the RHTP.

CONCLUSION

The OBBB marks a decisive shift away from a Medicaid program driven by enrollment volume and financing gimmicks toward one grounded in integrity, accountability, and upward mobility. For those reforms to be best implemented, states should take a variety of important actions:

- Reducing payment errors by requiring documentation, promoting accountability in hospital presumptive eligibility, and requiring premium payments on expansion enrollees.
- Ensuring the smooth rollout of the community engagement requirements by requiring documented activity compliance, limiting exemptions (particularly for medical frailty), and considering a soft rollout before the federal deadline.
- Holding Medicaid MCOs accountable by imposing more transparency of spending and services, instituting regular independent audits, ensuring true actuarial soundness, increasing scrutiny of MLR filings, and posting this information for public review.
- Seizing opportunities to remove arbitrary, anti-competitive, and inflationary regulatory barriers negatively affecting rural communities. These include repealing CON laws, expanding scope-of-practice authority for non-physicians, and restoring access to STLDI.

89 Ohio Department of Health, "Ohio Rural Health Transformation Program Project Narrative," November 2025, https://odh.ohio.gov/know-our-programs/rural-health-transformation-program/media/rht-program-narrative.

Taken together, these reforms would allow states to build on the OBBB to improve program integrity, expand patient choice, and bolster access to care. Many of these policies are long-awaited free market reforms. Most have impacts that reach beyond Medicaid. Policymakers should seize this opportunity to improve Medicaid while expanding choice and accountability.