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The Local Loop

How States Turn Medicaid into a Government Provider Payday Scheme

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During the debate over the One Big Beautiful Bill (OBBB), the 2025 budget reconciliation act, much attention focused on the health care provider tax gimmick and how states use it to draw down an excess share of federal funds. However, another heavily abused Medicaid financing mechanism, intergovernmental transfers (IGTs), has received less scrutiny.

The federal government reimburses states for a substantial share of their Medicaid expenditures. This open-ended reimbursement structure creates a powerful incentive for states to develop financing strategies that maximize federal funds without corresponding contributions from the state's general fund.

Since Medicaid's inception in 1965, states have used IGTs to help finance their share of Medicaid spending. When used legitimately, IGTs involve local governments helping cover a portion of the state's overall Medicaid costs or specific program expenses. However, states and localities also use IGTs to finance massive Medicaid rate increases for specific government-owned or -operated health care providers, shifting costs entirely to federal taxpayers. In the 1990s and 2000s, as Congress and successive administrations restricted provider taxes and excessive supplemental payments, states adapted by developing increasingly clever IGT arrangements to draw down federal funds without any genuine state or local government contributions. With new restrictions on provider taxes and state-directed payments (SDPs)—payments that states require insurers to make to providers that have significantly raised Medicaid spending in recent years—enacted in the OBBB, many states may turn to more IGT games to draw down more federal funds.

This brief explains how Medicaid financing works, describes the legitimate and abusive uses of IGTs,

KEY TAKEAWAYS

States exploit intergovernmental transfers (IGTs) to inflate Medicaid payments to government-owned or -operated providers, generating large federal matching funds without any real state or local spending. IGTs create windfalls for politically favored providers.

California pays government ambulance providers three times (and soon potentially five times) what private providers receive for the same Medicaid transports, funded entirely by an IGT scheme.

IGT schemes undermine fairness, efficiency, and access by shifting costs to federal taxpayers while disadvantaging private providers that deliver identical services.

Congress and CMS should limit IGT abuse, enforce parity between private and government payers for providing identical services, and rigorously scrutinize state IGT proposals.

traces the history of IGT reform, illustrates IGT abuse using California's overpayments to public ambulance providers, examines the statutory authority to prevent wasteful spending, and offers policy recommendations to restore integrity, fairness, and fiscal sustainability in Medicaid financing.

How Medicaid Financing Works

The federal government and the states share the responsibility for funding each state's Medicaid program. The federal government contributes a percentage of each state's Medicaid costs, while the state pays the remaining amount. The federal government's share is called the Federal Medical Assistance Percentage (FMAP). The state's share is called the "nonfederal share," because it can include both state and local funds.

The specific federal share varies depending on what the expenditure is for:

- Most Medicaid-covered services for regular eligibility groups receive an FMAP between 50 percent and about 77 percent[2] based on the state's per capita income relative to the national average.
- Medicaid costs of childless, non-disabled adults that a state elects to cover under the Affordable Care Act expansion receive a much higher FMAP of 90 percent.
- Most administrative costs incurred by state Medicaid agencies qualify for a 50 percent FMAP, although certain state administrative expenses are at a 75 percent or 90 percent rate.[3] Nationally, state Medicaid program administrative costs (federal and nonfederal shares combined) averaged 4.44 percent in fiscal year 2024.
    - However, the true administrative costs of operating state Medicaid programs are considerably higher once managed care contracting is taken into account. Administrative costs of Medicaid insurers average 15.4 percent.[4]
    - Further, the Centers for Medicare and Medicaid Services (CMS) requires states to claim the applicable FMAP rate (based on each enrollee's eligibility group and therefore up to 90 percent) for risk contractors' administrative costs.[5]

Nationwide, in 2023, the federal government financed nearly 75 percent of actual Medicaid program expenditures, well above the historical 60 percent share.[6]

States can fund their nonfederal shares from several sources: general fund tax revenues, federally permissible provider taxes and donations, and transfers from local governments. These local-to-state transfers are called intergovernmental transfers. Federal law requires that states pay at least 40 percent of the nonfederal share from their own funds and also protects states' ability to obtain IGTs from other government entities in the state.

What Are Intergovernmental Transfers?

IGTs are funds transferred from local governmental entities to the state government. In the Medicaid context, counties, municipalities, special districts,[7] and government-owned or operated health care providers (such as county hospitals, county nursing homes, or state university health systems) may transfer funds to the state to help finance Medicaid expenditures.[8]

Section 1902(a)(2) of the Social Security Act has governed Medicaid financing since the program's inception in 1965. It establishes the basic framework for the federal and nonfederal share and allows a part of the nonfederal share to come from units of government within the state—provided the state contributes at least 40 percent of the nonfederal share from its own funds, such as revenue from state income, sales, and corporate taxes. Section 1903(w)(6)(A), enacted in 1991, clarifies how states can use IGTs and prohibits the federal government from limiting IGTs provided by government entities—but only so long as the state complies with Section 1902(a)(2). Congress added this carve-out to preserve existing authority for IGTs and certified public expenditure arrangements while restricting the private-provider donation schemes that had proliferated in the late 1980s.

These provisions establish that IGTs are a long-standing, permissible financing tool. Some states, such as New York, rely on transfers from counties to help finance Medicaid. Used in this way, IGTs simply reflect one way that states bear their share of the financing obligations. The problem arises when states structure IGT arrangements not to share costs, but to inflate federal payments without any genuine state or local spending for the purpose of benefitting publicly owned or operated providers.

How States Abuse Intergovernmental Transfers

The core abuse involves coupling IGTs with supplemental Medicaid payments to specific government-owned or operated providers so that the federal funds flow to the very entities that made the transfers. These schemes can be accurately described as "money laundering" arrangements in which government-owned or operated providers contribute funds to the state (via transfers), which the state then reallocates back to those same providers as Medicaid payments, generating federal matching funds in the process.[9]

The Basic Scheme: IGTs + Supplemental Payments

The abuse of the IGT mechanism works as follows:

1. First, the state submits a State Plan Amendment (SPA) to CMS for approval. The SPA significantly increases the payment rates that Medicaid pays to certain government-owned providers—such as county hospitals, municipal ambulance services, or publicly operated nursing homes. The higher rates are supplemental payments made on top of the standard base Medicaid rates to public and privately owned or operated providers of the same type. Supplemental payments can be multiples of the base rate.
    - The sum of base and supplemental rates is limited, in theory, by the CMS-established upper payment limits (UPLs) for certain provider types (more on UPLs below). Hence, these supplemental payments are often referred to as UPL payments.[10]
    - *Example*: The base rate Medicaid pays for a particular service is $100 per service, but the state creates a SPA that adds a $500 supplemental payment for a public provider. For 1,000 services at that provider, this creates $500,000 in supplemental payments on top of $100,000 in base payments.
2. Second, public providers send the states IGTs to fund the nonfederal component of the supplemental payments. Private providers

cannot participate, which is why they are paid significantly lower rates.

- *Example*: To fund the nonfederal 40 percent share of the $500,000 in supplemental payments, the county hospital transfers $200,000 to the state via an IGT.

3. Third, the state pays the nonfederal share of base payment costs from its general fund, which can include tax revenues from providers. For the supplemental payments, however, the state uses IGT funds to secure the 50–90 percent FMAP.
    - *Example*: The state uses the $200,000 IGT as the nonfederal share of the supplemental rate. The state then draws down $300,000 in federal matching funds (applying the 60 percent FMAP to the $500,000 expenditure). The state incurs no general-fund cost for the supplemental payments.
4. Each participating public provider or public sector owner receives in supplemental payments at least $2 and as much as $10 for each $1 it transfers to the state in IGTs.
    - The participating providers thereby net a significant profit margin from the IGT-funded supplemental payment arrangement.
    - The state bears its normal non-federal share of base Medicaid payments. For supplemental payments, however, the public provider's IGT funds serve as the non-federal match, drawing down federal matching funds and eliminating any net general-fund cost to the state for those payments.
    - The only losers are federal taxpayers and the private providers the arrangement discriminates against.
    - *Example:* The state Medicaid program pays the public hospital $600,000 (a $100,000 base payment and a $500,000 supplemental payment). With a 60% federal and 40% non-federal match, the federal share is $360,000 (60% of $600,000). The remaining $240,000 non-federal share is $40,000 financed by the state (40% of the $100,000 base payment) and $200,000 in IGT funds (40% of the $500,000 supplemental payment). The public hospital receives its $100,000 base payment plus a net gain of $300,000 from the supplemental payment ($500,000 less the $200,000 IGT funds used as the non-federal match). In total, the hospital's $400,000 net gain is funded by $360,000 in federal dollars and only $40,000 in state general funds. The $600,000 in payments cost the state budget only $40,000.

The Federal Matching Multiplier Effect

Because of the federal matching multiplier, a relatively modest IGT can generate large federal monies flowing to the state, resulting in net gains for providers far beyond what any genuine state contribution would justify. In typical IGT-funded supplemental payment arrangements, the transferred funds need only account for 10–50 percent of the total payment. Because the public provider receives the full supplemental payment, the federal share—amounting to 50–90 percent of the total—becomes the provider's net gain.[11] A 2004 *Health Affairs* article found that 19 states using supplemental payment programs with IGTs had nearly maximized the permissible nonfederal share through these arrangements, with IGTs

accounting for nearly 60 percent of the states' share.[12]

The result is that states and public providers effectively recycle funds to stake a claim for more federal dollars, without any actual state contribution, and public providers receive a windfall. This mechanism allows states and public providers to inflate Medicaid outlays to benefit politically powerful providers while undermining program integrity and distorting resource allocation.

Upper Payment Limits as Enablers

While the federal government limits how much states can pay certain providers, states manipulate these rules to get away with paying many multiples of the base rate. UPLs cap the aggregate amount a state can pay providers for certain services.[13] UPLs are generally set at what Medicare pays for the service or what Medicare would have paid if Medicare covered the service.[14] Critically, the UPL is an aggregate limit applied to all providers within an ownership group—state-owned, non-state but government-owned, or privately owned.[15] This means states can pay far more than Medicare rates to some providers so long as their aggregate payments to all the providers with the ownership group stay below the limit. States exploit this by paying government-owned providers well above average rates while keeping private provider rates low, ensuring that the aggregate stays within the UPL while creating enormous rate disparities.

Moreover, UPLs exist only for certain provider types—most notably inpatient hospitals, outpatient hospitals, and skilled nursing facilities. For many other provider categories, including ambulance services and most physicians, no federal UPL exists. This gap allows states to pay government-owned providers in these categories multiples of what private providers receive.

A Brief History of IGT Abuse and Reform

By 2000, IGT abuse had become serious enough to spur legislative action. Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act, which required the Department of Health and Human Services (HHS) to apply an aggregate UPL to non-state-government facilities and phase down excess payments by 15 percent per year over six years.[16] The Government Accountability Office (GAO) reported that this transition period reflected states' reliance on the excessive federal funds and was calibrated based on how long each state had maintained such arrangements.[17]

After President George W. Bush took office, HHS issued a rule that eliminated the elevated UPL for non-state public hospitals.[18] Previously, states could pay those facilities up to 150 percent of Medicare rates (plus disproportionate share hospital payments that are permitted on top of UPL ceilings). The Bush administration lowered its UPL for non-state hospitals to 100 percent of Medicare rates—the same ceiling that applied to other hospitals. To justify this change, the administration cited an HHS Office of Inspector General report that found that these providers were not retaining the extra payments—instead, the funds were being transferred directly back to the states via IGTs and used for other purposes.[19] As the rule stated, because the public hospitals were not retaining the funds available under the higher UPL, the elevated limit was neither furthering their special mission nor ensuring continued access for Medicaid beneficiaries.[20]

Despite these restrictions, states continued to exploit IGTs. A 2004 GAO report found that, even under the new regulations, states could still aggregate payments to all local government nursing homes into a single UPL to generate excessive federal matching payments beyond their standard Medicaid claims.[21]

The Problem Today: California's Ground Ambulance Example

While CMS has phased down some supplemental payments over time, states continue to use IGT-funded arrangements to draw down excessive federal funds. In May 2025, the Medicaid and CHIP Payment and Access Commission reported that in fiscal year 2022, UPL-related supplemental payments for inpatient and outpatient hospital services still totaled approximately $15.8 billion.[22] In 2020, GAO reported that out of $224 billion in nonfederal share Medicaid spending, $22 billion derived from IGTs.[23] In 2022, GAO estimated that states used either provider taxes or IGTs to fund $8.4 billion of the nonfederal share for SDPs under managed care—and noted that this figure was likely an underestimate because states do not fully disclose the sources of their nonfederal shares.[24]

States and government providers that are not subject to UPLs have significantly abused IGTs in recent years. One particularly egregious example of IGT abuse is California's Ground Emergency Medical Transportation (GEMT) program, which pays public ambulance providers vastly more than it does private providers for identical services. The California Medicaid (Medi-Cal) scheme works similarly to the four steps provided above, except that it flips the order of steps one and two.

1. **Extra payments to public providers.** Medi-Cal pays public providers of GEMT services large supplemental payments in addition to their base Medicaid rates.
2. **The IGT proposal is explicitly designed to prevent any state general fund spending.** California requires that these supplemental payments be funded entirely by IGTs from local public providers. The legislature's own documentation states that the law's purpose is to provide the supplemental reimbursement "without any expenditure from the General Fund."[25] Furthermore, the state appears to be using these federal funds to help finance local firefighter pensions.[26]
3. **The State submits its SPA to CMS.** Starting in 2024, California began paying public providers $1,065 per transport—more than three times the $339 it pays for private GEMT providers.[27] In 2025, CMS approved the SPA, which allows federal matching funds for the supplemental payments to GEMT providers.
4. **Suppressed rates for private providers.** California law explicitly limits the amount private emergency transport providers may collect, ensuring that they receive far less than their government counterparts.

The result is clear evidence of abuse of both federal taxpayers and private providers. California has submitted a SPA for 2025 that would allow the state to pay public GEMT providers $1,597 per transport.[28] The state has since submitted a new SPA for 2026 seeking an even higher rate of $1,636.81.[29]

The 2025 SPA claims that the resulting payment amount "will not exceed 100 percent of the actual cost of providing a transport." Given that private GEMT providers currently receive about one-fifth

of that amount for the same service, such an assertion is implausible. Notably, the state dropped this language from its subsequent 2026 SPA submission.

Recent Developments: The OBBB and the Remaining IGT Loophole

The OBBB introduced tighter restrictions on provider taxes and on SDPs, which have become the main tool states use to funnel extra Medicaid funds to politically powerful providers.[30] The legislation caps new SDPs, ties them to Medicare rates, freezes new provider taxes, and phases down existing provider taxes in expansion states.

However, the OBBB did not address two critical gaps. First, it did not restrict states' use of IGTs to receive funds from public providers, whether local or state-owned. Second, it did not prohibit states from using IGT-funded supplemental payments to pay public providers vastly more than they do private providers for identical services.

Facing new constraints on provider taxes, states may increasingly turn to IGTs to obtain more federal Medicaid dollars without commensurate state spending. The higher 90 percent FMAP for the Affordable Care Act expansion population magnifies the returns from these maneuvers, making them especially attractive in expansion states.

CMS's Authority to Deny Inefficient SPA Requests

Federal law gives CMS meaningful authority to deny SPAs to curb payment abuses—regardless of how the nonfederal share is derived. Of course, to deny a SPA, CMS must articulate legitimate reasons. Otherwise, the denial could be challenged in court as arbitrary and capricious and vacated under the Administrative Procedure Act.

CMS has a history of denying SPA requests where the proposed payment methodology is not "consistent with efficiency, economy and quality of care" as required by Section 1902(a)(30)(A) of the Social Security Act. Although these denials are rare and often challenged, federal courts have upheld such determinations and have even applied the statute's efficiency requirement to overturn SPAs approved by CMS. Below are two examples of cases that show how courts may evaluate SPA compliance with Section 1902.

Minnesota v. CMS: *UPL Compliance Is Not Enough*

In *Minnesota v. Centers for Medicare & Medicaid Services*, Minnesota challenged CMS's disapproval of a SPA that would provide $1.5 million in annual supplemental payments to county-owned nursing homes, with the state funding its share through IGTs.[31] CMS denied the SPA on the grounds that Minnesota failed to demonstrate that the proposal was consistent with efficiency, economy, and quality of care as required by Section 1902(a)(30)(A). CMS also found that the proposal failed to show compliance with Section 1902(a)(19), which requires that plans be "in the best interests of the recipients" and "consistent with simplicity of administration." The state argued that its SPA complied because it satisfied CMS's UPL requirements.[32]

The Eighth Circuit rejected Minnesota's argument, explaining that UPL compliance is not the exclusive measure of economy and efficiency and does not prevent the Secretary from finding that a SPA violates the statute.[33] The court further held that CMS's denial was not arbitrary and capricious

because the Secretary had recently promulgated regulations governing UPLs and demonstrating a commitment to detecting abusive funding requests.[34] Further, the court held, substantial evidence showed that Minnesota had not demonstrated that its SPA was economical and efficient or in the best interests of recipients.[35]

Christ the King Manor: *CMS Must Enforce Statutory Standards*

Another relevant case, *Christ the King Manor, Inc. v. Secretary, U.S. Department of Health and Human Services*,[36] illustrates how courts will enforce compliance with efficiency and economy standards even after CMS has approved a SPA. Pennsylvania submitted two SPAs that would have changed rate-calculation methodologies for private and public nursing homes.[37] Private nursing facilities sued, arguing that CMS failed to consider whether Pennsylvania's methodology complied with Section 1902(a)(30)(A), including its quality-of-care and access considerations.[38]

The Third Circuit agreed and set aside CMS's approval, holding that it was arbitrary and capricious.[39] The court emphasized that there was no indication in the record as to how Pennsylvania settled on its particular rate-calculation methodology, that there were no studies or analyses of any kind, and that the only data the state provided was a spreadsheet comparing rates under the proposed SPA with those paid the previous year.[40]

The court rejected the state's argument that reliance on its prior methodology sufficed, explaining that the same methodology applied in a different context may have a different effect: "The fifth blow to a boxer's chin may be no more forceful than the previous four, but still be forceful enough to shatter a weakened jaw."[41] The court also noted that the state's spreadsheet showing that payments to nonpublic facilities would increase did not, by itself, tell CMS anything about the SPA's effect on quality of care or access.[42] As in the Minnesota case, the court held that an unsupported assertion that a plan meets the statutory requirements, without any accompanying explanation or evidence, is not a sufficient basis for CMS approval.[43]

These cases establish that CMS has an affirmative obligation to ensure that SPA requests comply with the law and must closely scrutinize IGT-funded supplemental payment proposals—such as California's GEMT program that would pay public ambulance providers five times the rate paid to private providers for the same Medicaid-covered service.

Recommendations

Ultimately, the most effective way to reduce this gamesmanship is to realign incentives through block-grant or capped-allotment Medicaid models that reward efficiency and honest budgeting rather than creative financing schemes.[44] Short of significant structural reform to the program, Congress and CMS should take the following steps:

- **Prohibit self-financing IGT arrangements.** Bar states from using IGTs from the same entities (or their governmental owners) that receive enhanced payments.
- **Require payment parity for identical services.** Prohibit providers and other vendors that are related parties of states, local governments, or Medicaid-contracted insurers from receiving higher rates or other preferential financial and nonfinancial treatment.

- **Impose aggregate payment caps for all provider types.** Extend UPLs or equivalent ceilings to all provider categories in fee-for-service and managed care delivery systems.
- **Scrutinize SPAs rigorously and deny non-compliant requests.** CMS should closely examine SPAs and deny any that are inconsistent with statutory requirements, particularly Section 1902(a)(30)(A)'s efficiency, economy, and quality of care standards.

Conclusion

California's GEMT payment program illustrates just how distorted Medicaid financing has become. Two providers delivering the exact same service receive payments that differ by a factor of three or more—solely because one is publicly owned and can thus participate in an IGT arrangement. Nothing about patient needs, service costs, or the quality of care justifies such a disparity. This is clearly a state political strategy to obtain more federal funds—likely for unionized public fire departments with underfunded pension funds—at the expense of ambulance services in outlying areas and of those lacking political influence.[45] If California's pending SPA is approved, the disparity will exceed five-to-one.

These financing schemes undermine Medicaid's federal-state partnership. When states recycle funds through IGTs to inflate the federal match, they shift costs to federal taxpayers, favor government-owned providers over private competitors delivering identical services, allocate resources through cronyism rather than market competition, and drain resources intended for the most vulnerable. Federal oversight becomes a game of whack-a-mole, chasing new permutations of the same basic laundering tactics to obtain inflated payments for the same service. Without proactive reform, states will continue to launder federal Medicaid funds through public-provider IGTs, repeating the cycle that followed the 2001 crackdown.

Closing the IGT loophole is vital to restore financial integrity to Medicaid, ensure fair treatment of providers, and uphold the federal-state partnership that forms the core of the nation's safety net. The same service should receive the same payment, regardless of who provides it.

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[1] Not admitted to practice law; under the supervision of Demetrios L. Kouzoukas.
[2] Allison Mitchell, "Medicaid's Federal Medical Assistance Percentage (FMAP)," Congressional Research Service, April 2, 2025, https://www.congress.gov/crs-product/R43847.
[3] 42 C.F.R. 433.15.
[4] The 15.42 percent estimate is the sum of (a) the composite five-year average of non-benefit expenses—including administration, provider taxes, other taxes and fees, contribution to reserves, risk margin, cost of capital, and other operational costs—that states must reimburse in capitation rates (per 42 C.F.R. 438.5(e)) and (b) a conservative 2 percent estimate for certain other administrative costs (quality improvement activities, external quality review, and health information technology) states must reimburse in capitation rates as if benefit claims expenses (per 42 C.F.R. 438.8(e)(3)). Derived from analysis of Milliman annual reports on Medicaid managed care financial results for 2021, 2022, 2023, and 2024, available at https://www.milliman.com/en/Insight/Worldwide-insight.
[5] 42 C.F.R. 438.812(a).
[6] See Brian Blase and Niklas Kleinworth, "Addressing Medicaid Money Laundering: The Lack of Integrity with Medicaid Financing and the Need for Reform," Paragon Health Institute, March 2025, Figure 12, https://paragoninstitute.org/medicaid/addressing-medicaid-money-laundering-the-lack-of-integrity-with-medicaid-financing-and-the-need-for-reform/.
[7] Special districts include hospital, health care, and public health districts are special-purpose, quasi-independent local government entities allowed under state law to own or operate health care services. Many states allow health-related special districts, including California, Florida, Minnesota, New York, Texas, Virginia, and Washington.
[8] Federally owned or operated providers, such as Veterans Health Administration or War Department facilities, do not qualify.
[9] For a visual representation, see Paragon Health Institute, "The Provider Tax Money Laundering Scheme, Explained," May 19, 2025, https://paragoninstitute.org/medicaid/the-provider-tax-money-laundering-scheme-explained/.
[10] UPLs are established in CMS regulations or sub-regulatory guidance.
[11] For a fuller explanation of the law's requirements on provider taxes, see Blase and Kleinworth, "Addressing Medicaid Money Laundering," p. 11.
[12] Teresa A. Coughlin et al., "States' Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs* 23, no. 2 (March 2004), https://www.healthaffairs.org/doi/10.1377/hlthaff.23.2.245.
[13] Regulatory UPLs exist for inpatient hospitals, outpatient hospitals, and skilled nursing facilities. Disproportionate share hospital payments may exceed UPLs but are subject to separate limits. Academic-affiliated physicians and non-physician practitioners have a CMS-invented sub-regulatory UPL based on average commercial rates. Most other Medicaid provider types lack formal UPLs.
[14] Intermediate Care Facilities for Individuals with Intellectual Disabilities are an exception, as Medicare does not cover the service. Still, a comparable UPL based on Medicare cost reimbursement principles applies to these facilities.
[15] Ownership groups include (1) state-owned or -operated, (2) non-state-government-owned or -operated, and (3) privately owned (for-profit or nonprofit).
[16] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554. See also 66 Fed. Reg. 3149-3150 (2001).
[17] GAO, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*, February 2004, https://www.gao.gov/products/gao-04-228.
[18] "Medicaid Program; Modification of the Medicaid Upper Payment Limit for Non-State Government-Owned or Operated Hospitals," 67 Fed. Reg. 2602 (January 18, 2002), https://www.federalregister.gov/documents/2002/01/18/02-1482/.
[19] 67 Fed. Reg. at 2603 ("The OIG has issued several reports demonstrating that a portion of the enhanced payments made as part of the UPL process are being transferred directly back to the State via intergovernmental transfers and used for other purposes...).
[20] Ibid.
[21] GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, March 2004, p. 7, https://www.gao.gov/assets/gao-04-574t.pdf.
[22] Medicaid and CHIP Payment and Access Commission, *Medicaid Base and Supplemental Payments to Hospitals*, May 2025, p. 7, https://www.macpac.gov/wp-content/uploads/2025/05/Medicaid-Base-and-Supplemental-Payments-to-Hospitals-UPDATE-2.pdf.
[23] GAO, *Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures*, December 2020, p. 17, https://www.gao.gov/assets/gao-21-98.pdf.
[24] GAO, *Medicaid: CMS Should Take Steps to Improve Oversight of Disproportionate Share Hospital Payments*, May 2024, p. 15, https://www.gao.gov/assets/gao-24-106202.pdf.
[25] California Assembly Bill 1705 (2019), https://legiscan.com/CA/text/AB1705/id/2056327. This explicit legislative language reveals that states are not even attempting to hide their intention to increase federal revenues without commensurate state spending.
[26] Bob Goldberg, "California Fire Departments Fleece American Taxpayers," *RealClearHealth*, May 9, 2025, https://www.realclearhealth.com/articles/2025/05/09/california_fire_departments_fleece_american_taxpayers_1109253.html.
[27] California paid the providers those rates even though the SPA was not approved until 2025. The SPA is available at https://www.dhcs.ca.gov/SPA/Documents/SPA-24-0002-Approval.pdf.
[28] California Department of Health Care Services, State Plan Amendment 25-0002 (Pending), https://www.dhcs.ca.gov/SPA/Documents/SPA-25-0002-Pending.pdf.
[29] California Department of Health Care Services, State Plan Amendment 25-0030 (Pending), https://www.dhcs.ca.gov/SPA/Documents/SPA-25-0030-Pending.pdf.
[30] The OBBB caps new SDPs, tying them to Medicare rates (or 110 percent of Medicare in non-expansion states). Because states use SDPs to compensate providers for their provider tax contributions, reducing SDPs reduces the incentive to use provider taxes. The legislation also freezes new provider taxes and phases down existing provider taxes in expansion states. Furthermore, it closes certain loopholes that allowed states to tax Medicaid plans or providers at elevated rates and return those funds via inflated payments.
[31] Minnesota v. Centers for Medicare & Medicaid Services, 495 F.3d 991 (8th Cir. 2007).

[32] Minnesota also argued that CMS's scrutiny of the SPA request was effectively imposing new substantive requirements on states and that this was improper because CMS did not first go through notice-and-comment rulemaking. The court rejected this argument, holding that "the increased scrutiny of Minnesota's 2003 plan amendment … was consistent with the Secretary's authority in an individual adjudication." 495 F.3d at 998.
[33] Ibid. at 997-98.
[34] Ibid. at 998.
[35] Ibid. at 998-99.
[36] Christ the King Manor, Inc. v. Secretary, U.S. Department of Health and Human Services, 730 F.3d 291 (3d Cir. 2013).
[37] Ibid. at 300 n. 8.
[38] Ibid. at 302.
[39] Ibid. at 305.
[40] Ibid. at 309.
[41] Ibid. at 311.
[42] Ibid. at 314.
[43] Ibid. at 312, 314.
[44] See Blase and Kleinworth, "Addressing Medicaid Money Laundering," p. 45.
[45] Goldberg, "California Fire Departments Fleece American Taxpayers."