

Oregon's New Medicaid Financing Scheme

Combining Provider Taxes and IGTs to Maximize Federal Funds

By Chris Medrano and Brian C. Blase, PhD

States use provider taxes as part of a legalized money laundering apparatus to deliver large Medicaid payments, using almost entirely federal funds, to politically powerful hospital systems. The One Big Beautiful Bill (OB BB) put meaningful restrictions on this money laundering apparatus, but some states—along with hospitals and highly compensated consultant groups—are exploring workarounds. One such workaround is a new scheme in Oregon.

Oregon's scheme exempts a powerful hospital system from taxes yet includes its patient revenue in the state's tax base. This allows higher tax rates on other hospitals—above the 6 percent safe harbor threshold—serving as a new money laundering tactic that channels federal funds without state contribution. The Centers for Medicare and Medicaid Services (CMS) should investigate whether Oregon's scheme breaches existing provider tax laws and recent One Big Beautiful Bill Act (OB BB) restrictions. At minimum, Oregon's structure pushes beyond the intent of federal law and may violate the requirements governing provider taxes.

Furthermore, Oregon has an intergovernmental transfer (IGT) arrangement with the state's large hospital system, which is public. Its IGT scheme allows that system to transfer funds to the state, which the state uses as the nonfederal share of a state-directed payment (SDP) that flows back to the system. This circular financing structure enables the state to draw down federal matching funds tied

KEY TAKEAWAYS

Oregon's provider tax and IGT arrangements exploit rules to generate federal Medicaid funds without meaningful state contributions, pushing beyond the intent of federal law—and potentially outside its limits.

By including the state's largest hospital in the tax base while exempting it from the tax, the state artificially lowers the apparent tax rate while maintaining a higher effective rate on other providers.

State-directed payments return provider tax revenues—and additional federal matching funds—to hospitals, completing a circular financing loop.

These financing mechanisms inflate Medicaid spending and increase federal costs without net state contribution.

Oregon's approach reflects broader vulnerabilities in Medicaid financing that warrant federal scrutiny and reform, and federal policymakers should shut it down before other states try to mimic it.

to those payments, effectively amplifying the transfer. The result is a net increase in federal

funding to that system without a commensurate increase in state financial contribution.

Together, Oregon's provider tax and IGT arrangements illustrate how states are considering structuring Medicaid financing mechanisms to maximize federal matching funds while minimizing their own fiscal exposure. These schemes raise significant legal and policy questions, and CMS should investigate them.

Background on Medicaid Money Laundering with Provider Taxes

States have long used money-laundering-like tactics to obtain federal Medicaid funding with little actual state contribution. A typical Medicaid provider tax money laundering scheme looks like this:

- (1) A state first imposes a \$1 million tax on hospitals.
- (2) The state then spends that same \$1 million back on those hospitals in the form of higher Medicaid payments as its non-federal share (typically 30 percent of the total payments). The state knows that its \$1 million payment will generate \$2.33 million in federal funding.
- (3) The federal government then pays its federal share, which would amount to \$2.33 million in this hypothetical scenario.¹ Thus, the hospitals net \$2.33 million.

This "tax" thus produces a windfall for hospitals at no net cost to the state. The original \$1 million tax simply serves as a circular financing mechanism used to generate higher Medicaid payments. States use hospital tax revenues to cover the nonfederal share of Medicaid payments that benefit hospitals. Because these provider funds

substitute for state funds, the state redirects its own money elsewhere, while hospitals still net significant federal funds.

Federal Limits on Provider Tax Schemes

In 1991, Congress sought to curb such Medicaid money laundering tactics by passing the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (Pub. L. No. 102-234). The law limits the use of state provider taxes as a source of nonfederal match for state Medicaid expenditures.

The Social Security Act and CMS regulations distinguish between provider taxes that serve as permissible state financing mechanisms and those structured to generate excessive federal Medicaid matching funds.² CMS reduces federal Medicaid matching funds when provider tax revenues do not meet certain requirements. To avoid these reductions, states must structure their taxes to be broad-based, uniform, and free of hold-harmless arrangements. A hold-harmless agreement means either (a) the state pays providers back for taxes or (b) some providers reimburse other providers for the tax burden.

These requirements prevent states from "money laundering" by imposing taxes only on providers that would benefit most from the resulting higher Medicaid payments. If states wish to use provider taxes to finance the nonfederal share of Medicaid, the tax cannot simply target the providers that receive the largest payments through the program. Instead, states must apply taxes more broadly, which can make these schemes more politically challenging because some providers may be taxed without receiving offsetting increases in Medicaid payments.

CMS, in implementing the statute's requirements, created what is known as the 6 percent safe

harbor for provider taxes. Under the safe harbor, if a tax's revenue is less than or equal to 6 percent of total net patient revenues, CMS will presume that there is no hold-harmless agreement and will not subject the tax to closer scrutiny.³ To stay within this safe harbor, states almost always keep provider tax rates at or below 6 percent. The OBBA prohibited federal reimbursement for any new or increased provider taxes effective on July 4, 2025, and enacted a phasedown of the hold-harmless threshold from 6 percent to 3.5 percent from 2028 to 2032, after which it remains at 3.5 percent.

REQUIREMENTS THAT PROVIDER TAXES MUST FOLLOW FOR FEDERAL REIMBURSEMENT

Broad-based.

- A provider tax is broad-based if "the tax is imposed with respect to all non-federal, non-public providers in the class."⁴
- It must also be "imposed uniformly."⁵

No hold-harmless agreement.

- *Safe harbor:* CMS will not scrutinize the tax if the state's revenue from the tax would amount to no more than 6 percent of a provider class's net patient revenue.⁶

Oregon's Provider Tax Scheme

Oregon's provider tax scheme circumvents the 6 percent safe harbor threshold through three steps.

Step 1: Use Public Hospitals to Appear Safe-Harbor Compliant

Oregon applies the tax scheme on "typically large urban hospitals that receive standard Medicare Diagnostic Related Group (DRG)-based reimbursement."⁷ Historically, the state has taxed its DRG hospitals at the 6 percent maximum safe harbor rate. In 1995, Oregon Health Sciences University (OHSU), the state's largest hospital system,⁸ was designated as a unique governmental entity by state law.^{9 10} Historically, it has been counted as a DRG hospital.¹¹ However, in 2017, the state exempted OHSU from the tax, treating revenues generated from OHSU as an intergovernmental transfer (IGT) instead of a provider tax.¹²

Step 2: Stay Above the 6 Percent Threshold

Although OHSU does not pay the provider tax, the state still counts OHSU's revenue in the denominator when calculating whether the tax remains within the hold-harmless safe harbor.¹³ With an inflated denominator, the state can tax other DRG hospitals at a higher rate while staying below the 6 percent rate only by including OHSU's revenue.

Oregon increased the tax rate¹⁴ to 10.54 percent on outpatient services and 7.73 percent on inpatient services from July 1, 2025, to September 30, 2025.¹⁵ Beginning on October 1, 2025, Oregon set rates at 9.80 percent for outpatient services and 8.64 percent for inpatient services.¹⁶

By way of analogy, imagine a homeowner who counts his neighbor's house as part of his property for the purpose of qualifying for a tax exemption but then pays taxes only on his own house. The neighbor's property is included when it is beneficial but ignored when it is time to pay taxes. Similarly, Oregon is counting OHSU's net patient

revenues as part of its provider tax base but then exempting OHSU from the provider tax.

Step 3: Pay DRG Hospitals through Higher Rates

Just like other states, Oregon uses state-directed payments (SDPs) to pay hospitals through managed care organizations.¹⁷ A state uses an SDP to direct insurers to pay providers certain amounts.¹⁸ CMS approved Oregon's SDP on September 9, 2025.¹⁹ In total, this SDP increased hospital spending by \$1 billion in 2025.²⁰ These payments effectively return the provider tax revenues—and additional federal matching funds—to hospitals, completing the circular financing loop. CMS also said that, based on its preliminary determination, “this SDP proposal likely qualifies for the temporary grandfathering period” under the OBBB. Oregon submitted the SDP under its Section 1115 waiver, which CMS approved in 2022.²¹

Oregon's Provider Tax Scheme Could Be Illegal

Oregon's provider tax scheme may run afoul of long-standing statutory restrictions and the OBBB.

It Potentially Violates the Requirement That Provider Taxes Cannot Have Hold-Harmless Agreements

The Social Security Act bars federal reimbursement when a provider tax includes a hold-harmless arrangement.²²

In this case, there are indications that Oregon intended to hold the hospitals harmless. In 2017, the Oregon Health Authority (OHA) explicitly stated that the hospital tax program was first created not simply to fund the program but “to

generate revenue to expand coverage and increase hospital reimbursement levels.”²³ In September 2024, before the state increased the tax, OHA also submitted the increased SDP to CMS for \$1.01 billion covering 2025, which CMS ultimately approved in September 2025.²⁴ OHA subsequently noted its intent to fund these payments with the hospital's tax revenues. In 2025, the OHA noted that of those tax revenues, “\$1.1 billion is slated to support” the state's Medicaid program—approximately the same amount as the new SDP. OHA went on to note that the rest of the tax revenue would “provide enhanced reimbursements to DRG hospitals and qualified directed payments.”²⁵ Taken together, these facts strongly suggest a hold-harmless arrangement that warrants CMS investigation.

It May Fall Outside of the Safe Harbor for the Hold-Harmless Agreement Prohibition

As discussed above, CMS regulations provide a safe harbor from application of the hold-harmless prohibition when the taxes assessed on providers are equal to or less than 6 percent of those providers' net patient revenue.²⁶

While Oregon asserted that “CMS considers exempted entities' revenue in determining what the 6% maximum rate for provider assessments,”²⁷ this assertion is at odds with the statute's purpose and the regulations.

First, the statute's hold-harmless test is meant to ensure that the state is not simply promising to repay providers for their tax revenues. Although the statute does not spell out every detail of the calculation, it makes little sense to include revenues from an entity that does not pay the tax in this calculation when determining whether taxed providers are being held harmless.

Second, the regulations expressly state that the provider tax revenues must be less than or equal to 6 percent “of the revenues received by the taxpayer.”²⁸ OHSU does not pay the provider tax, so it is not a “taxpayer.” Therefore, its revenues should not be included in the hold-harmless calculation. By including non-taxpayer (OHSU) revenues in the denominator of the hold-harmless calculation, Oregon is understating the actual rate of return to taxpaying providers.

Oregon's IGT Scheme

Oregon also has another Medicaid money laundering scheme with OHSU that depends on an intergovernmental transfer (IGT). This arrangement mirrors the same circular financing structure as the provider tax: The state uses government-owned providers to generate federal matching funds without new state spending. While the OBBB contained the most significant reforms to date to limit states' ability to abuse provider taxes, it did not address IGTs.

Background on IGT Schemes

IGTs were not originally nefarious. They were designed to allow states and local governments to share legitimate Medicaid costs. Unfortunately, IGTs are often nefarious in practice. Many states twist IGTs into money laundering schemes that artificially inflate federal payments to specific government-owned providers without any net increase in state or local spending.

In a typical IGT scheme, government-owned providers transfer money to the state. The state uses those same funds as the nonfederal Medicaid share to make higher Medicaid payments to those same facilities, claiming federal dollars in the process. Thus, the state channels the original funds and a share of the

federal dollars back to the same entities that supplied the funds.

The schemes can lead to massive funding disparities for identical services. In California, public ambulance services receive payments three times higher than their private counterparts do for identical Medicaid transport.²⁹ Such schemes may also negatively affect health outcomes, as they prioritize maximizing federal dollars over delivering real care.³⁰ One 2025 study found that Indiana's nursing home IGT scheme diverted money from nursing homes to hospitals and coincided with a shift of patients into the lowest-quality nursing homes and was associated with worse outcomes, including an estimated 50 additional resident deaths per year.

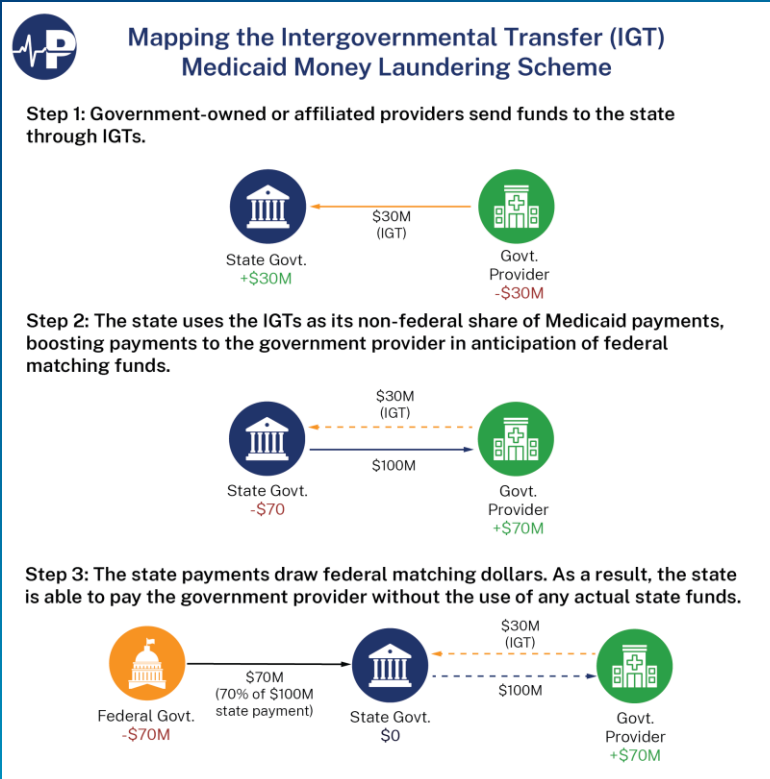
The Mechanics of Oregon's IGT Scheme

In addition to its provider tax, Oregon has an IGT arrangement with OHSU that recently increased by \$291 million.³¹ This brings the total IGT to \$1.2 billion over the current 2025–2027 biennium.³²

Under this scheme, OHSU gets “paid back” for transferring its IGT through a special SDP reserved for “Public Academic Health Centers,” of which there is only one in Oregon: OHSU.³³ CMS approved this SDP on November 14, 2025.³⁴ These payments were worth an estimated \$976 million in 2025.³⁵ The payment and the IGT appear connected because the nonfederal share used to finance the SDPs (\$294 million)³⁶ is roughly equal to the IGT (\$291 million).

IGT Schemes Raise Significant Concerns

IGTs enable states to circumvent the Social Security Act's vision of shared federal-state financing for Medicaid to extract additional federal funds without commensurate state spending. With the OBBB's new restrictions on provider taxes, some states may look to rely more



heavily on IGTs to fund Medicaid. This could result in states skewing their resources toward politically well-connected providers, such as OHSU.

This structure causes genuine harm. In the United States, laws prohibit financial incentives for referrals (such as kickbacks or certain self-referrals) because they can lead providers to put financial interests ahead of patients' needs and potentially compromise quality of care. These Medicaid schemes, while permissible, mirror such illegal self-referrals. They let state and local governments skew funds toward public providers and large hospital systems in ways that can be detrimental to outcomes for Medicaid enrollees.

Conclusion

Oregon's provider tax and IGT arrangements raise serious questions about compliance with federal Medicaid financing rules as well as the program's payment design. By exempting a dominant public hospital system from taxation while still using its revenues to inflate the tax base, the state appears to have engineered a mechanism that undermines the spirit, if not the letter, of long-standing statutory safeguards. If permitted to stand, this approach risks becoming a blueprint for other states to bypass the 6 percent safe harbor and hold-harmless restrictions, eroding federal oversight and significantly increasing federal Medicaid expenditures without corresponding state investment. To prevent states from circumventing the hold-harmless threshold, which

was meant to limit provider tax schemes, CMS should eliminate the safe harbor altogether or clarify that such tax configurations would not qualify for it.

About the Authors

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¹ If the \$1 million state share is 30 percent, the federal share is \$2.33 million.

² See 42 U.S.C. § 1396b(w)(3)(B)-(D) (establishing broad-based, uniformity, and hold-harmless requirements); 42 C.F.R. § 433.68(c)-(f) (implementing these standards).

³ 42 C.F.R. § 433.68(f)(3)(i)(A). "An indirect guarantee will be determined to exist under a two prong "guarantee" test. If the health care-related tax or taxes on each health care class are applied at a rate that produces revenues less than or equal to 6 percent of the revenues received by the taxpayer, the tax or taxes are permissible under this test."

⁴ 42 U.S.C. § 1396b(w)(3)(B)(i).

⁵ 42 U.S.C. § 1396b(w)(3)(B)(ii).

⁶ Title 42, Section 433.56, of the *Code of Federal Regulations* lists 19 provider or service classes. These include inpatient hospital services, outpatient hospital services, nursing facility and ICF/IID services, physician and other practitioner services, home health and personal care services, prescription drugs, managed care organization services, ambulatory surgical center services, dental and other ancillary services (e.g., therapy, lab, and x-ray), emergency ambulance services, and other state-defined health care services.

⁷ Oregon Health Authority (OHA), "Oregon Hospital Types," <https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/OHA%20Hospital%20Type%20Document.pdf>.

⁸ Definitive Healthcare, "Largest IDNs in Oregon," July 19, 2024, <https://www.definitivehc.com/resources/healthcare-insights/largest-idns-oregon>.

⁹ Oregon Secretary of State. Education-related entities. Oregon Blue Book. <https://sos.oregon.gov/blue-book/Pages/education-related-entities.aspx>.

¹⁰ Or. Rev. Stat. § 353.020 (establishing OHSU as an independent public corporation and governmental entity), https://oregon.public.law/statutes/ors_353.020.

¹¹ P.3 <https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalDocuments/Hospital%20and%20health%20system%20finance%20snapshot%20OHSU.pdf>.

¹² "Under this IGT program, OHSU no longer pays the provider tax paid by other hospitals in Oregon. Instead, because OHSU is an Oregon public corporation, it transfers funds directly to the state to be used for Oregon's Medicaid program" (KPMG, "Independent Auditors' Report," October 25, 2024, p. 45,

<https://www.ohsu.edu/sites/default/files/2024-12/ohsu-financial-stmt-audited-fy24.pdf>.

¹³ "CMS considers exempted entities' revenue in determining what the 6% maximum rate for provider assessments" (Dave Baden and Rochelle Layton, "Oregon Health Plan Financing and Medicaid Provider Assessment," OHA, February 18, 2025, p. 8, <https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/291328>).

¹⁴ Assessed on net patient revenue.

¹⁵ See the relevant section of the Oregon tax code at https://secure.sos.state.or.us/oard/displayDivisionRules.action%3BSESSIONID_OARD%3DsZS-RaV4KKhzd38G2OApe5Ku_vTuUmSL2ib03AlybpuHIQdgQjW%2199228750?selectedDivision=1702&.

¹⁶ *Ibid.*

¹⁷ Oregon uses different terms for these same concepts — for example, qualified directed payments (QDPs) and coordinated care organizations instead of SDPs and managed care organizations, respectively.

¹⁸ Oregon DRG hospitals receive a specially designated QDP. See an explanation at https://oregon.public.law/rules/oar_410-125-0230.

¹⁹ CMS, letter to Emma Sandoe, Medicaid Director, OHA, September 9, 2025, https://www.medicaid.gov/medicaid/managed-care/downloads/OR_Fee_%20IPH.OPH2_Renewal_20250101-20251231.pdf.

²⁰ "CMS has completed our review of the following Medicaid managed care SDP(s): Uniform increase established by the state for inpatient and outpatient hospital services provided by Diagnosis-Related Group (DRG) hospitals for the rating period covering January 1, 2025 through December 31, 2025, incorporated in the capitation rates through a separate payment term of up to \$1,011,000,000" (CMS, letter to Sandoe, September 9, 2025).

²¹ See *ibid.* at Section II, Question 8(b), citing CMS's previous approval of its Section 1115 waiver, which allowed the state to contract with managed care plans only in certain geographical areas. The waiver can be found at <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-Demonstration-Amendment.pdf>.

²² Section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act; 42 C.F.R. § 433.68(f)(3).

²³ See OHA, "Oregon Health Plan Financing and Medicaid Provider Taxes," February 24, 2017, p. 9.

<https://olis.oregonlegislature.gov/liz/2017R1/Downloads/CommitteeMeetingDocument/100071>.

²⁴ CMS, letter to Sandoe, September 9, 2025.

²⁵ “Assuming the renewal of these taxes that are set to expire at the end of September 2025, current service level revenues from the hospital provider tax are anticipated to be \$1.7 billion in the 2025-27 biennium. Of that total, \$1.1 billion is slated to support the Oregon Health Plan. The remaining funding is used to provide enhanced reimbursements to DRG hospitals and qualified directed payments to Type A and Type B rural hospitals to maintain quality and access” (Oregon Legislative Fiscal Office, “2025-27 Budget Review: Oregon Health Authority,” p. 20, <https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/290024>).

²⁶ 42 C.F.R. § 433.68(f)(3)(i)(A).

²⁷ “CMS considers exempted entities’ revenue in determining what the 6% maximum rate for provider assessments” (Baden and Layton, “Oregon Health Plan Financing and Medicaid Provider Assessment”).

²⁸ 42 C.F.R. § 433.68 (f)(3)(i)(A). The regulatory history confirms that the hold-harmless threshold is calculated by comparing the tax revenue raised by the state to the revenues received by the tax-paying providers for the particular items and services subject to the assessment. See, for example, 73 Fed. Reg. 9685, 9695 (Feb. 22, 2008) (“The phrase ‘revenues received by the taxpayer,’ has been interpreted by CMS to be, the net patient service revenue, received by the health care provider. This would include all revenues

received from all payers for providing the particular service that is assessed by the State and would not include revenues unrelated to the service being assessed.”)

²⁹ Mark Howell and Ryan Long, “State Funding Gimmicks Drive Unequal Ambulance Payments in Medi-Cal,” Paragon Health Institute, July 9, 2025, <https://paragoninstitute.org/paragon-pic/state-funding-gimmicks-drive-unequal-ambulance-payments-in-medi-cal/>.

³⁰ Martin B. Hackmann et al., “Creative Financing and Public Moral Hazard: Evidence from Medicaid and the Nursing Home Industry,” National Bureau of Economic Research, August 2025, <https://www.nber.org/papers/w34118>.

³¹ Oregon Legislative Fiscal Office, “2025-27 Budget Review,” p. 29.

³² Oregon Legislative Fiscal Office, “2025-27 Budget Review,” p. 8.

³³ See an explanation at https://oregon.public.law/rules/oar_410-125-0230. OHSU’s website itself states that it is Oregon’s “only academic health center.” OHSU, “About OHSU Health Care,” <https://www.ohsu.edu/health/about-ohsu-health-care>.

³⁴ CMS, letter to Emma Sandoe, Medicaid Director, OHA, November 14, 2025, https://www.medicaid.gov/medicaid/managed-care/downloads/OR_Fee_%20IPH.OPH3_Renewal_20250101-20251231.pdf.

³⁵ CMS, letter to Sandoe, November 14, 2025. Rounded up from \$975,888,000. The estimated federal share is \$681,700,530. The estimated nonfederal share is \$294,187,470.

³⁶ CMS, letter to Sandoe, November 14, 2025.