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Medicaid Provider Taxes

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SUMMARY

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Medicaid Provider Taxes

States are able to use revenues from health care provider taxes to help finance the state share of Medicaid expenditures. Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers. For states to be able to draw down federal Medicaid matching funds, the provider tax must be both broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers). Also, states are not allowed to hold the providers harmless for the cost of the provider tax (i.e., states cannot guarantee that providers receive their money back).

A vast majority of states use at least one provider tax to help finance Medicaid. Many of these states use the provider tax revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This financing strategy allows states to fund increases to Medicaid payment rates without the use of state general funds because the increased Medicaid payment rates are funded with provider tax revenue and federal Medicaid matching funds. States also use provider tax revenues to fund other Medicaid or non-Medicaid purposes.

States first began using health care provider taxes to help finance the state share of Medicaid expenditures in the mid-1980s. Some states were particularly aggressive in their use of provider taxes. As a result, in the early 1990s, the federal government imposed statutory and regulatory limitations on states' use of health care provider tax revenue to finance Medicaid.

While federal requirements allow states to impose provider taxes on 19 classes of health care providers, the classes of providers that are most often taxed include nursing facilities, hospitals, and intermediate care facilities for individuals with intellectual disabilities (ICF/ID). States' use of Medicaid provider taxes has increased over the years.

Limiting or eliminating states' use of provider taxes in financing Medicaid has been identified as a way to reduce federal Medicaid spending. The Congressional Budget Office assumes this approach would reduce states' Medicaid expenditures. Since the federal government pays a share of every dollar spent on states' Medicaid programs, federal Medicaid expenditures would decrease if states reduced their Medicaid expenditures. This policy option has been included in some recent policy proposals, and a version of this policy could be part of a legislative package aimed at reducing federal Medicaid expenditures during the 119th Congress.

This report provides background regarding states' use of provider taxes in the 1980s and describes the relevant federal statutes and regulations, which were mostly established in the early 1990s. The report explains how states use provider taxes to help finance Medicaid and provides information regarding the extent to which states currently use such taxes. The report ends with a discussion of past and present proposals that would impact Medicaid provider taxes.

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Introduction

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports.[1] Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and five territories choose to participate. Each state designs and administers its own version of Medicaid under broad federal rules, and Medicaid is jointly financed by the federal government and the states.

States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations), and the federal government reimburses states for a share of these costs.[2] The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP).[3] The FMAP varies by state according to each state's per capita income. For FY2025, FMAPs range from 50.0% to 76.9%.[4]

The state share of Medicaid expenditures is funded through a variety of sources. At least 40% of each state's share of Medicaid expenditures must be financed by the state, and up to 60% of the state's share may come from local governments.[5] In state fiscal year (SFY) 2024, states reported that about 68% of the state share of Medicaid costs was financed by state general funds (most of which are raised from personal income, sales, and corporate income taxes). The remaining 32% was financed by other funds (including local government funds, provider taxes, fees, donations, assessments, and tobacco settlement funds).[6]

Currently, almost all states use provider taxes to finance a portion of their state share of Medicaid expenditures. Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers.[7] In order for states to be able to draw down federal Medicaid matching funds, the provider tax must be both broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers). States are not allowed to hold the providers harmless for the cost of the provider tax (i.e., they cannot guarantee that providers receive their money back).[8]

In SFY2025, 49 states and the District of Columbia are using at least one provider tax to finance Medicaid.[9] Many of these states use the provider tax revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This

[1] For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*.

[2] For a broader overview of financing issues, see CRS Report R42640, *Medicaid Financing and Expenditures*.

[3] For more information about the FMAP, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

[4] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2024, Through September 30, 2025," 88 *Federal Register* 81090, November 21, 2023.

[5] Section 1902(a)(2) of the Social Security Act.

[6] National Association of State Budget Officers, *2024 State Expenditure Report: Fiscal Years 2022-2024 State Spending*, 2024.

[7] Section 1903(w)(3)(A) of the Social Security Act. 42 C.F.R. 433.55.

[8] Section 1903(w)(3) of the Social Security Act. 42 C.F.R. 433.68. These requirements are explained in more detail in the "Federal Statutes and Regulations" section, below.

[9] Elizabeth Hinton et al., *As Pandemic-Era Policies End, Medicaid Programs Focus on Enrollee Access and Reducing Health Disparities amid Future Uncertainties: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025*, Kaiser Family Foundation and the National Association of Medicaid Directors, October 2024 (hereinafter, Hinton et al., *As Pandemic-Era Policies End*).

financing strategy allows states to fund increases to Medicaid payment rates without the use of state general funds because the increased Medicaid payment rates are funded with provider tax revenue and federal Medicaid matching funds. States also use provider tax revenue to fund other Medicaid or non-Medicaid purposes.

This report begins by providing background regarding states' use of provider taxes in the 1980s and describing the relevant federal statutes and regulations, which were mostly established in the early 1990s. The report next explains how states use provider taxes to help finance Medicaid and provides information regarding the extent to which states currently use such taxes. The report ends with a discussion of the policy proposals that would impact Medicaid provider taxes.

States' Initial Use of Provider Taxes in the 1980s

In the mid-1980s, states began using provider taxes along with provider donations[10] to help finance Medicaid. Essentially, Medicaid providers would donate funds or agree to be taxed, and the revenue from these taxes and donations would be used to finance a portion of the state's share of Medicaid expenditures. In some cases, Medicaid providers initiated these provider tax and donation arrangements because states would often use the provider tax and donation revenue to raise Medicaid payment rates. Plus, these arrangements were often designed in such a way as to hold the Medicaid providers harmless for the cost of their taxes or donations.[11]

Here is an example of how the provider tax arrangements operated in the 1980s. In a state, hospitals with high Medicaid utilization could agree to pay $10 million in provider taxes, and the state would increase Medicaid payments to hospitals with high Medicaid utilization by $20 million. Assuming the state had a 60% FMAP, the state would then receive $12 million in federal Medicaid matching funds (60% of $20 million). In the end, hospitals with high Medicaid utilization would have gained $10 million ($20 million in increased Medicaid payments minus $10 million in tax payments), the state would have gained $2 million ($22 million from the hospitals and the federal government minus the $20 million paid to the hospitals), and the federal government would have paid $12 million.[12]

Essentially, states were borrowing funds from Medicaid providers in order to draw down federal funds and increase Medicaid payment rates to the providers that had paid taxes or donated funds. The providers were often fully reimbursed for the cost of their tax payment or donation. For this reason, provider tax mechanisms were politically viable for states.

These financing arrangements became a point of contention between the federal government and the states. While not all states were using these Medicaid financing strategies, some states were particularly aggressive in their use of provider taxes and donations in financing Medicaid. This aggressive use of these Medicaid financing strategies motivated congressional action to curb states' use of the provider tax and donation arrangements.

[10] Provider donations are any donation or other voluntary payment made to a state or unit of local government by a health care provider. Section 1903(w)(2) of the Social Security Act.

[11] Andy Schneider et al., *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002.

[12] In this example, the provider tax arrangement allowed for hospitals with high Medicaid utilization to receive increased Medicaid payments. Without the provider tax arrangement, the Medicaid payments to hospitals with high Medicaid utilization would have been less.

Federal Statutes and Regulations

In 1991, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) to restrict the use of provider donations in financing Medicaid to extremely limited situations[13] and to limit states' ability to draw down federal Medicaid matching funds with provider tax revenue.[14]

The 1991 law defines a provider tax as any licensing fee, assessment, or other mandatory payment in which 85% or more of the burden falls upon health care providers. In order for states to claim federal matching payments for provider tax revenues, the 1991 law

- requires provider taxes to be broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers)—in other words, states cannot limit the provider taxes to only Medicaid providers; and
- prohibits states from a direct or indirect guarantee that providers receive their money back (or be "held harmless").

The Secretary of Health and Human Services (HHS) is authorized to waive the broad-based and uniform requirements of provider taxes. In order to receive a waiver of either the broad-based or uniform requirement, a state needs to prove that the net impact of the tax is "generally redistributive" and the amount of the tax is not directly correlated to Medicaid payments.[15]

"Generally redistributive" is defined as the tendency of a state's provider tax to derive revenues from non-Medicaid services in a class and to use these revenues as the state's share of Medicaid expenditures. According to the quantitative tests set forth in regulation, a provider tax is perfectly redistributive if the tax burden for Medicaid providers is the same under a tax without the waiver as under the tax with the waiver. The redistributive nature of a provider tax increases as the tax burden falls more heavily on providers with relatively fewer Medicaid patients.[16]

Classes of Providers

The specified 19 classes of providers used to ensure tax programs are "broad-based" are those that provide the following:[17]

- inpatient hospital services,
- outpatient hospital services,

[13] Provider donations are permissible if they do not exceed $5,000 per year in the case of an individual provider or $50,000 per year in the case of a "health care organization entity" (42 C.F.R. 433.66(a)(1)). Also, provider donations are allowed if the donations are made by a hospital, clinic, or similar entity (such as federally qualified health centers) for the direct costs of state or local agency personnel who are stationed at the facility to determine the eligibility of individuals for Medicaid or to provide outreach services to eligible (or potentially eligible) Medicaid individuals (i.e., outstationed eligibility workers) (42 C.F.R. 433.66(a)(2)). Provider donations for outstationed eligibility workers may not exceed 10% of a state's administrative costs for the Medicaid program (42 C.F.R. 433.67).

[14] The statute regarding provider taxes can be found in Section 1903(w) of the Social Security Act, and the accompanying regulations can be found at 42 C.F.R. Part 433.

[15] Rural and sole community providers are expressly cited as allowable exemptions to both the broad-based and uniform requirements with Secretary approval.

[16] Health Care Financing Administration, "Medicaid Program; Limitations on Provider-Related Donations and Health-Care Related Taxes; Limitations on Payments to Disproportionate Share Hospitals," 57 *Federal Register* 55118, November 24, 1992.

[17] 42 C.F.R. 433.56.

- nursing facility services,
- services of intermediate care facilities for individuals with intellectual disabilities,
- physicians' services,
- home health care services,
- outpatient prescription drugs,
- services of Medicaid managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation),[18]
- ambulatory surgical centers,
- dental services,
- podiatric services,
- chiropractic services,
- optometric/optician services,
- psychological services,
- therapist services,[19]
- nursing services,[20]
- laboratory and X-ray services,[21]
- emergency ambulance services, and
- other health care items or services for which the state has enacted a licensing or certification fee.[22]

Requiring that all providers within a class be taxed, as opposed to only Medicaid providers, dampened the appeal of provider taxes. Prior to the 1991 law, provider taxes were often imposed only on Medicaid providers. These provider tax arrangements were agreed to (and sometimes initiated) by the Medicaid providers because the Medicaid providers could be held harmless from the cost of the tax through increased Medicaid payment rates. However, since providers with relatively fewer Medicaid patients cannot be as easily held harmless from the cost of the tax, the broad-based requirement restricted the use of provider taxes because the providers with relatively fewer Medicaid patients are more likely to oppose the imposition of provider taxes.

[18] The Deficit Reduction Act of 2005 (P.L. 109-171) modified this class of providers by changing "Medicaid managed care organizations" to all "managed care organizations." This change further broadened the group upon which a tax could be imposed, thereby reducing the potential for abusive tax programs.

[19] Therapist services include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological therapy, and rehabilitative specialist services.

[20] Nursing services include nurse midwives, nurse practitioners, and private duty nurses.

[21] Laboratory and X-ray services are defined as services provided in a licensed, free-standing laboratory or X-ray facility. The definition does not include laboratory or X-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department.

[22] The licensing or certification fee must be broad-based and uniform. In addition, the payer of the fee cannot be held harmless for the cost of the fee. Also, the aggregate amount of the fee cannot exceed the state's estimated cost of operating the licensing or certification program.

Hold Harmless

Regulations describe three tests that are applied to provider taxes in order to determine whether taxpayers (i.e., the providers paying the provider tax) are held harmless. Taxes that fail any of these tests are determined to have a hold harmless provision in violation of the law. The three tests are as follows:

- A *positive correlation test* is used to determine whether a state or other unit of government imposing the tax provides directly or indirectly for a non-Medicaid payment to the taxpayers in an amount that is positively correlated to either the tax amount or the difference between their Medicaid payment and the tax amount.[23]
- The *Medicaid payment test* is violated if all or any portion of the Medicaid payment to the taxpayer varies based *only* on the amount of the total tax payments.
- The *guarantee test* is violated if the state or other unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

Under the guarantee test, the existence of an indirect guarantee is determined through a two-prong test. The first prong of the guarantee test relates to the rate at which taxpayers are taxed. That is, if the provider tax is applied at a rate less than 6%[24] of the net patient service revenues received by the taxpayer, the tax is permissible under the guarantee test.[25]

The second prong of the guarantee test is the "75/75 rule," which is applied to provider taxes imposed at a rate greater than the threshold amount specified in the first prong of the guarantee test (currently 6%). When the provider tax produces revenue in excess of the threshold amount, the tax is considered to hold the taxpayers harmless (i.e., violate the hold harmless test) if more than 75% of the taxpayers in the provider class receive 75% or more of the cost of the tax back through enhanced Medicaid payments or other state payments.[26]

In other words, a state can impose a provider tax above the threshold amount (currently 6%) and draw down federal matching funds on the tax revenue, as long as the state can prove that the "75/75 rule" has not been violated (i.e., more than 75% of the taxpaying providers do *not* receive more than 75% of the cost of the tax back through enhanced Medicaid rates).

If a state imposes a provider tax above the threshold amount and violates the "75/75 rule" (i.e., more than 75% of the taxpaying providers receive more than 75% of the cost of the tax back through enhanced Medicaid rates), then the full amount of the tax revenue would be offset from the state's Medicaid expenditures. This means the provider tax revenue could still be used to fund Medicaid, but the state would not be able to draw down federal Medicaid matching funds on the provider tax revenue. Specifically, the revenue from provider taxes that do not meet federal

[23] An example of a violation of the positive correlation would be if a state gave a portion of the tax revenue to private pay patients in the form of grants in order to compensate the patients for the tax added to their bill from the provider.

[24] For the period of January 1, 2008, through September 30, 2011, the Tax Relief and Health Care Act of 2006 (P.L. 109-432) changed the threshold to 5.5% of net patient service revenues. On October 1, 2011, the threshold reverted to 6% of net patient service revenues.

[25] 42 C.F.R. 433.68(f)(3)(i)(A). Some interpret this provision as a waiver of the hold harmless tests when the tax is applied at a rate below the 6% threshold. For this reason, the threshold has been referred to as a "safe harbor."

[26] 42 C.F.R. 433.68(f)(3)(i)(B).

requirements would be deducted from the state's Medicaid expenditures prior to the calculation of the federal financial participation.[27]

To date, no state has imposed a provider tax at a rate above the threshold amount specified in the first prong of the guarantee test (i.e., 6%). Thirty-eight states had reported at least one Medicaid provider tax above 5.5% of net patient revenue as of July 1, 2024.[28]

States' Current Use of Provider Taxes

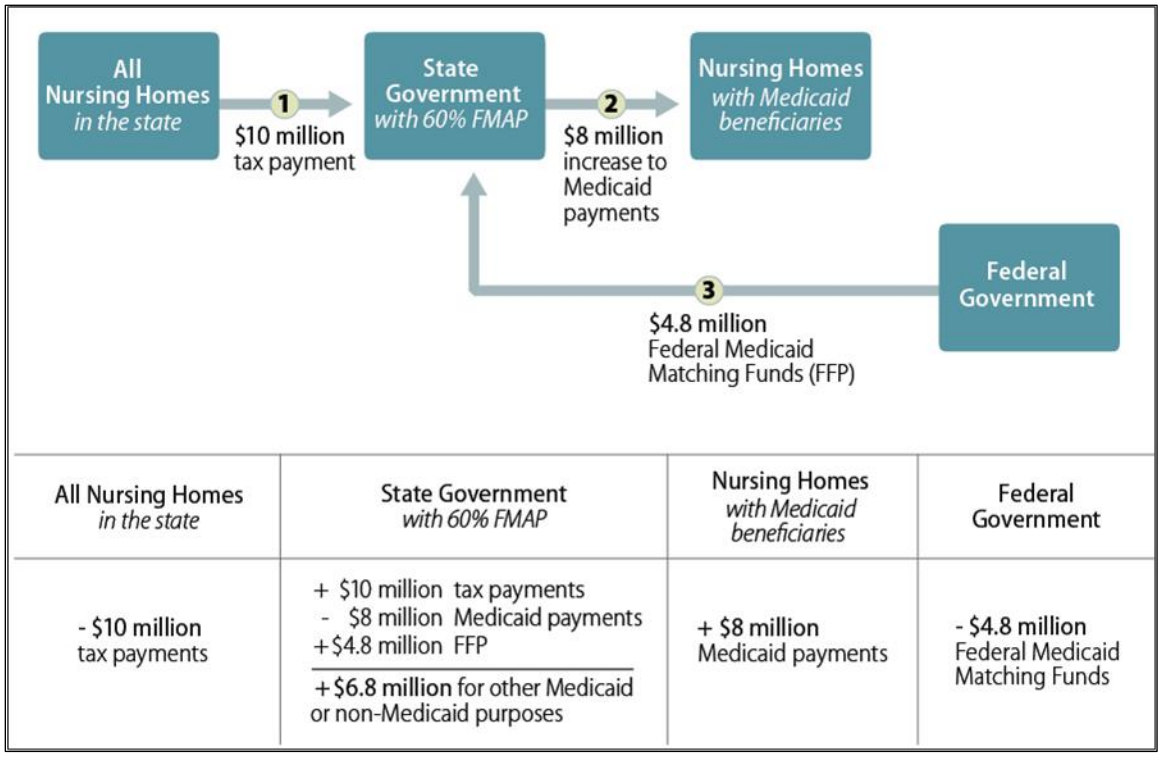
States' use of provider tax revenue varies from state to state, but states often use provider tax revenue to draw down federal Medicaid matching funds in order to increase Medicaid payments for the same providers that are responsible for paying the tax. A simple example of this is illustrated in **Figure 1**. In this example, a state with a 60% FMAP imposes a provider tax on all nursing homes in the state, and the state collects $10 million in tax revenue through this provider tax. The state then increases Medicaid payments to nursing homes, which means nursing homes with Medicaid enrollees receive an additional $8 million. With these Medicaid expenditures, the state draws down $4.8 million (60% of $8 million) in federal Medicaid matching funds. In this example, the state was able to increase Medicaid payments to nursing homes without the use of any state general funds, and the state is left with $6.8 million to use for other Medicaid or non-Medicaid purposes.[29]

[27] 42 C.F.R. 433.70.

[28] Hinton et al., *As Pandemic-Era Policies End*.

[29] In this example, the provider tax arrangement allowed for nursing homes to receive increased Medicaid payment rates. Without the provider tax arrangement, the Medicaid payment rates to nursing homes would have been less, unless the state had provided sufficient general fund revenue (or another source of revenue) to fund the payment increase.

Figure 1. Provider Tax Example for a State with 60% FMAP Using Nursing Home Provider Tax Revenue to Increase Medicaid Payments to Nursing Homes



All Nursing Homes *in the state*	State Government *with 60% FMAP*	Nursing Homes *with Medicaid beneficiaries*	Federal Government
- $10 million tax payments	+ $10 million tax payments - $8 million Medicaid payments +$4.8 million FFP +$6.8 million for other Medicaid or non-Medicaid purposes	+ $8 million Medicaid payments	- $4.8 million Federal Medicaid Matching Funds

Source: CRS.

In SFY2025, 49 states and the District of Columbia are using at least one provider tax to help finance Medicaid.[30] While federal requirements allow states to impose taxes on 19 classes of providers, the classes of providers that are most often taxed include nursing facilities, hospitals, and intermediate care facilities for individuals with intellectual disabilities (ICF/ID). Detail regarding the types of provider taxes used by each state is provided in **Table A-1** of the **Appendix**.

Provider Tax Revenue

The full amount of provider tax revenues used by states to help finance the state share of Medicaid expenditures is unknown; however, several entities make an effort to collect data on provider tax revenue. The Centers for Medicare & Medicaid Services (CMS) collects some information from states regarding the amount of provider tax revenue through data included on the CMS-64 form,[31] but this information is underreported. The National Association of State Budget Officers (NASBO) augments the information collected by CMS, but the NASBO information is also incomplete.

A portion of the CMS-64 form collects information regarding the provider donations, taxes, fees, and assessments collected by states. While states are required to provide this information to CMS

[30] Hinton et al., *As Pandemic-Era Policies End*.

[31] States submit the CMS-64 form to CMS on a quarterly basis, and the CMS-64 form is a statement of expenditures for which states are entitled to federal Medicaid matching funds. States are required to provide supporting documentation for total Medicaid expenditures. The provider tax information is reported in section CMS-64.11 of the form, and the provider tax information is provided to CMS for informational rather than reimbursement purposes.

for informational purposes, states report this information inconsistently, and the provider tax information is likely underreported.[32]

NASBO publishes an annual State Expenditure Report,[33] which provides information regarding the state and federal shares of Medicaid expenditures. The report specifies the sources of the states' share of Medicaid expenditures as either state general funds or "other state funds," which are revenues collected by the state that are restricted by law for particular governmental functions or activities. The "other state funds" category for Medicaid includes provider taxes, fees, donations, assessments, and local funds.

The primary source for NASBO's "other state funds" information is the CMS-64 expenditure data, but NASBO augments this data. Specifically, NASBO collects detailed information from some states regarding the amount of provider taxes, fees, donations, assessments, and local funds used to finance the state share of Medicaid expenditures. However, NASBO acknowledges that its State Expenditure Report does not capture 100% of the provider taxes, fees, assessments, and local funds used to finance the state share of Medicaid expenditures.

The available data (shown in **Figure 2**), while limited, indicate a trend showing that states' use of "other state funds" has increased significantly as a percentage of the state share of Medicaid expenditures since SFY1990. For SFY2022 and SFY2023 (estimate), "other state funds" have comprised about 29% of the state share of Medicaid expenditures. "Other state funds" were greater than general funds in five states: Alabama, Illinois, Louisiana, Oklahoma, and Utah.[34]

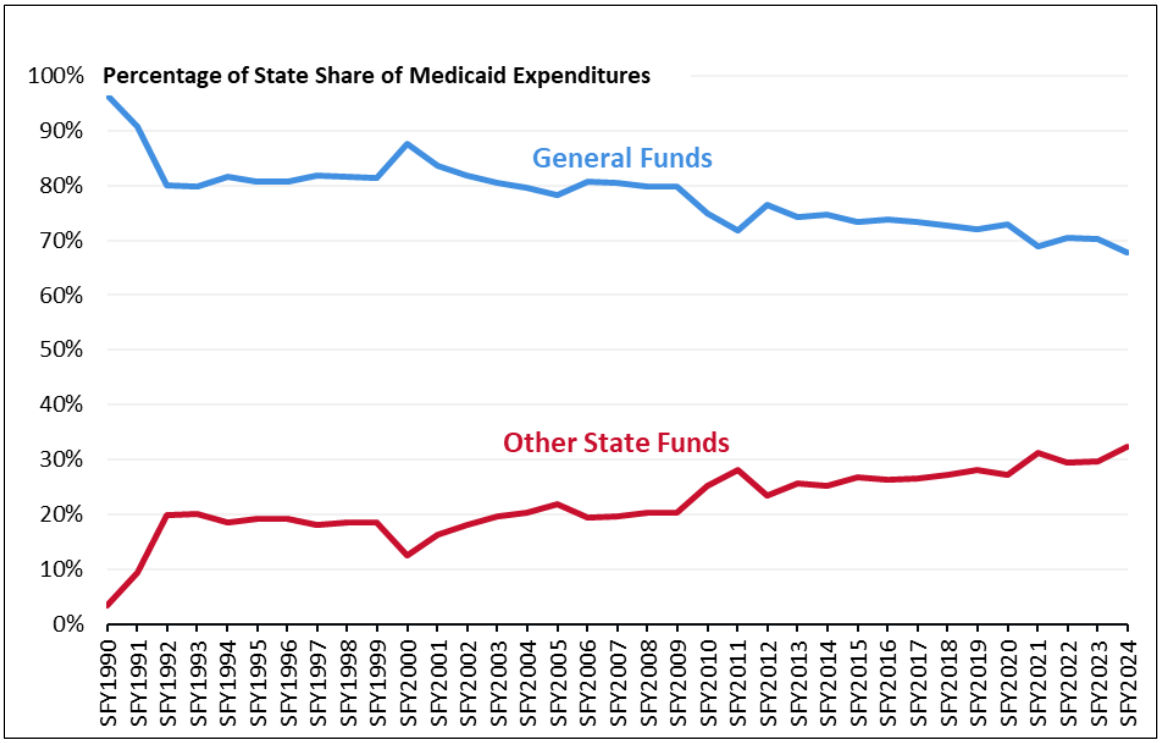
[32] U.S. Government Accountability Office (GAO), *Medicaid: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight*, GAO-21-98, December 2020 (hereinafter, GAO-21-98); GAO, *Medicaid Financing: States' Increased Reliance on Fund from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, GAO-14-627, July 2014 (hereinafter, GAO-14-627).

[33] National Association of State Budget Officers, *2024 State Expenditure Report: Fiscal Years 2022-2024 State Spending*, 2024.

[34] Ibid.

Figure 2. General Fund and Other State Funds as a Percentage of the State Share of Medicaid Expenditures

(SFY1990 to SFY2024 estimate)



Sources: National Association of State Budget Officers, *State Expenditure Report,* various years.

Notes: SFY = state fiscal year. The figure includes expenditures from the 50 states in all years and the District of Columbia for SFY2021 through SFY2024. "Other state funds" includes provider taxes, fees, donations, assessments, and local funds.

While NASBO data does not provide detail about the "other state funds," a Government Accountability Office (GAO) analysis of data reported by states in response to a GAO questionnaire focusing on the nonfederal share of Medicaid payments found that provider taxes comprised 51% of "other state funds" in SFY2018.[35]

States' use of "other state funds" has increased during or directly after recessions that occurred during the time period shown in **Figure 2** (SFY1990 through SFY2023). The United States was in recession from (1) July 1990 through March 1991, (2) March 2001 through November 2001, (3) December 2007 through June 2009, and (4) February 2020 through April 2020.[36] During or after these recessions, states' use of Medicaid provider taxes increased because during recessions, states usually experience a reduction in state revenue that impacts states' ability to finance the Medicaid program with general fund revenue. Medicaid provider tax revenue can provide a way for states to continue funding the Medicaid program during times of state budget constraints.

[35] Local funds comprised 36% of the "other state funds" in FY2018, and 13% of the "other state funds" came from other sources of funds, including tobacco settlement funds and state trust funds. (Calculated by CRS using GAO-21-98, Figure 2 and Figure 3.)

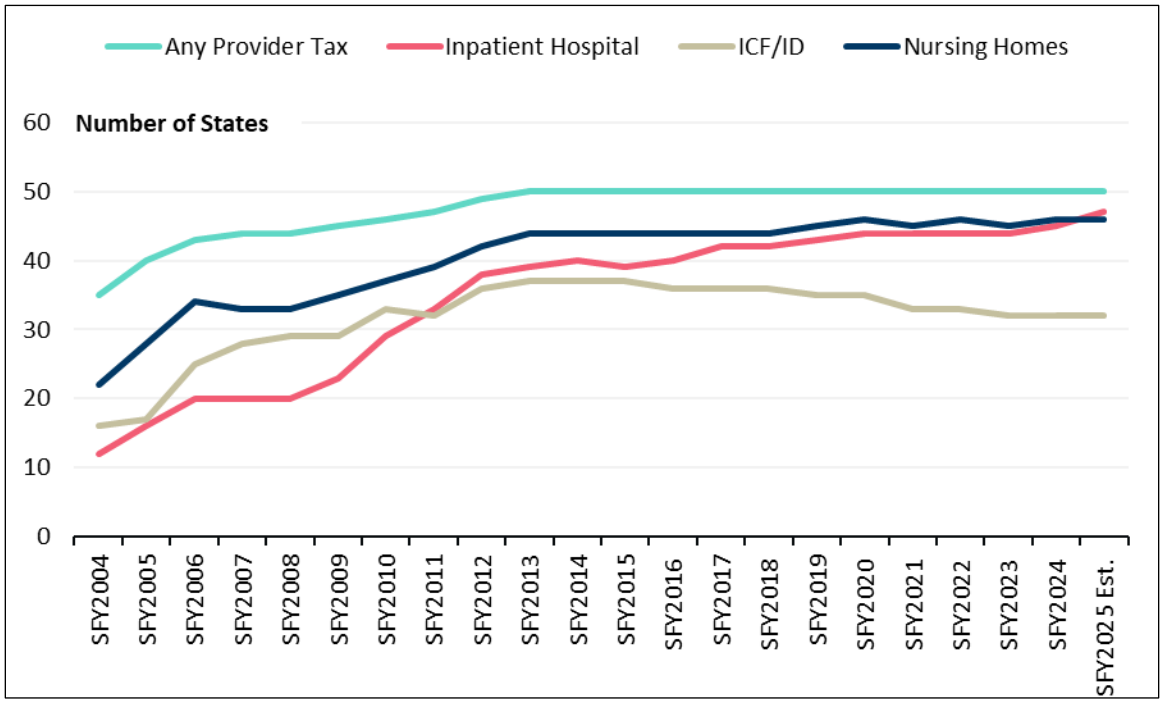
[36] National Bureau of Economic Research, "US Business Cycle Expansions and Contractions," at https://www.nber.org/cycles.html.

Number of Provider Taxes

States' use of Medicaid provider taxes has increased over time. **Figure 3** shows that the number of states with different types of Medicaid provider taxes has increased. The number of states with any Medicaid provider tax increased from 35 states in SFY2004 to 50 states (including the District of Columbia) in SFY2025.[37] There have been 50 states (including the District of Columbia) with at least one Medicaid provider tax in every year since SFY2013; Alaska is the only state without a Medicaid provider tax during that time. Thirty-nine states had three or more provider taxes in place in SFY2024, and 42 states are expected to have three or more provider taxes in SFY2025.[38]

Figure 3. Number of States with Different Types of Medicaid Provider Taxes

(SFY2008 to SFY2025 proposed)



Sources: Various years of the Kaiser Family Foundation's annual Medicaid budget survey. (Elizabeth Hinton et al., *As Pandemic-Era Policies End, Medicaid Programs Focus on Enrollee Access and Reducing Health Disparities amid Future Uncertainties: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025*, Kaiser Family Foundation and the National Association of Medicaid Directors, October 2024.)

Notes: ICF/ID = Intermediate care facilities for individuals with intellectual disabilities. SFY = state fiscal year.

States use the revenue from Medicaid provider taxes to fund Medicaid and non-Medicaid aspects of the state budget. In response to a GAO questionnaire, some states mentioned the purpose for implementing Medicaid provider taxes had been to maintain or increase Medicaid provider payments during times of state budget constraints in order to limit the use of state general fund

[37] Various years of the Kaiser Family Foundation's annual Medicaid budget survey. (Hinton et al., *As Pandemic-Era Policies End*.)

[38] Ibid.

revenues.[39]States commonly use Medicaid provider tax revenue to fund Medicaid base rates,[40] Medicaid DSH payments,[41] and non-DSH supplemental payments;[42] to avoid Medicaid benefit cuts; and to expand Medicaid benefits. In addition, some states have used revenue from provider taxes to finance the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion in their state.[43]

Medicaid provider tax revenue has been used to finance a larger share of Medicaid DSH payments and non-DSH supplemental payments than Medicaid base rates. In FY2018, provider tax revenue financed 22% of Medicaid DSH payments and non-DSH supplemental payments, while provider tax revenue financed 15% of Medicaid base rates.[44]

Oversight of Provider Taxes

CMS is responsible for determining whether states abide by the statutory and regulatory requirements pertaining to provider taxes. States are not required to receive CMS approval for provider taxes that adhere to the federal requirements. However, states seeking waivers from the broad-based and uniform requirements do need CMS approval.

Current Issues

Limiting or eliminating states' use of provider taxes in financing Medicaid has periodically been identified as a way to reduce federal Medicaid spending. In the early 2010s, there were some proposals to limit or eliminate states' use of provider taxes, but provider tax proposals were not a focus in the past couple years. However, the Congressional Budget Office (CBO) included limiting states' use of Medicaid provider taxes in its most recent list of options for reducing the deficit, as it has done in previous iterations of that list.[45]

[39] GAO-21-98; GAO-14-627.

[40] Medicaid base rates are the Medicaid provider payment rates for services rendered to Medicaid enrollees. For more information about Medicaid provider payments, see CRS Report R43357, *Medicaid: An Overview*.

[41] Medicaid DSH payments are one type of supplemental payment, and federal statute requires that states make Medicaid DSH payments to hospitals treating large numbers of low-income patients. For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

[42] Supplemental payments are Medicaid payments to providers that are separate from and in addition to the payments for services rendered to Medicaid enrollees. For more information about Medicaid supplemental payments, see CRS Report R45432, *Medicaid Supplemental Payments*.

[43] For more information about the Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*. Bryce Ward, *The Impact of Medicaid Expansion on States' Budgets*, The Commonwealth Fund, Issue Brief, May 5, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets; Dee Mahan and Eliot Fishman, *Options to Generate the State Share of Medicaid Expansion Costs*, Families USA, January 2019, https://familiesusa.org/wp-content/uploads/2019/09/MCD_States-Share-10-Percent_Fact-Sheet.pdf.

[44] GAO-21-98.

[45] Congressional Budget Office (CBO), *Options for Reducing the Deficit: 2025 to 2034*, December 12, 2024, https://www.cbo.gov/budget-options/60897; CBO, *Options for Reducing the Deficit, 2023 to 2032-Volume I: Larger Reductions*, December 7, 2022, https://www.cbo.gov/budget-options/58623; CBO, *Budget Options Volume I: Health Care*, December 2008, https://www.cbo.gov/system/files/110th-congress-2007-2008/reports/12-18-healthoptions.pdf.

CBO provided three policy options for limiting states' use of Medicaid provider taxes:

1. Lowering the safe harbor from 6.0% to 5.0% (savings of $48 billion from FY2025 to FY2034);
2. Lowering the safe harbor from 6.0% to 2.5% (savings of $241 billion from FY2025 to FY2034); and
3. Eliminating states' ability to use Medicaid provider tax revenue to finance Medicaid (savings of $612 billion from FY2025 to FY2034).

The savings from these policy options increase as the safe harbor percentage decreases, which reduces states' ability to utilize Medicaid provider tax revenue for financing the state share of Medicaid. It is uncertain how states would respond to the reduction or elimination of their ability to use Medicaid provider taxes. States could backfill the provider tax revenue with state general fund revenue, or, instead of backfilling for the provider tax revenue, states could make cuts to the optional aspects of the Medicaid program to account for the loss of provider tax revenue. CBO expects these policy options would reduce federal Medicaid expenditures because CBO assumes states would reduce some of their Medicaid expenditures in response to these policy options. Since the federal government pays a share of every dollar spent on states' Medicaid programs, a reduction in state Medicaid expenditures would result in decreased federal Medicaid expenditures.

In addition, limiting or eliminating states' use of Medicaid provider tax revenue to finance the state share of Medicaid expenditures has been included in some recent policy proposals.[46] Congress could face consideration of this policy as part of a package of policies aimed at reducing federal Medicaid expenditures in the 119th Congress.[47]

[46] Republican Study Committee, *Fiscal Sanity to Save America*, FY2025 Budget Proposal, https://hern.house.gov/uploadedfiles/final_budget_including_letter_word_doc-final_as_of_march_25.pdf; Project 2025, *Mandate for Leadership: The Conservative Promise*, Project 2025 Presidential Transition Project, https://static.project2025.org/2025_MandateForLeadership_FULL.pdf; Brian Blasé and Joe Albanese, *Turning the Tide on Red Ink: Commonsense Policies to Make Federal Health Programs More Sustainable*, Paragon Health Institute, March 2023, https://paragoninstitute.org/wp-content/uploads/2024/07/Turning-the-Tide-on-Red-Ink_FOR-RELEASE_V2.pdf.

[47] Sigi Ris and Donna Haseley, "Paragon: DOGE Could Cut $2.1 Trillion with Medicaid, Medicare Reforms," November 26, 2024, https://insidehealthpolicy.com/daily-news/paragon-doge-could-cut-21-trillion-medicaid-medicare-reforms?utm_medium=ihpbn; Jacob Bogage, Jeff Stein, and Dan Diamond, "Trump Allies Eye Overhauling Medicaid, Food Stamps in Tax Legislation," November 18, 2024, https://www.washingtonpost.com/business/2024/11/18/gop-targets-medicaid-food-stamps/.

Appendix. Types of Provider Taxes Used by States

A vast majority of states use provider taxes to finance Medicaid. As shown in **Table A-1**, 50 states (including the District of Columbia) used at least one provider tax in SFY2025. Alaska is the only state without a Medicaid provider tax in SFY2025.

Hospital and nursing home taxes were the most popular type of provider tax, with 47 and 46 states using hospital and nursing home taxes, respectively. Intermediate care facilities for individuals with intellectual disabilities (ICF/ID) provider taxes were used by 32 states. States also had managed care organization (MCO) taxes (22 states), ambulance taxes (20 states), and other types of provider taxes (10 states).

Table A-1. State-by-State Provider Taxes, by Type, SFY2025

State	Type of Provider Tax					
	Hospital	ICF/ID	Nursing Home	MCO	Ambulance	Other
Alabama	X	—	X	—	X	X
Alaska	—	—	—	—	—	—
Arizona	X	—	X	—	—	—
Arkansas	X	X	X	X	X	—
California	X	X	X	X	X	—
Colorado	X	X	X	—	—	—
Connecticut	X	X	X	—	—	—
Delaware	—	—	X	—	—	—
District of Columbia	X	X	X	X	—	—
Florida	X	X	X	—	—	—
Georgia	X	—	X	—	X	—
Hawaii	X	—	X	—	—	—
Idaho	X	X	X	—	—	—
Illinois	X	X	X	X	—	—
Indiana	X	X	X	—	—	—
Iowa	X	X	X	X	—	—
Kansas	X	—	X	X	—	—
Kentucky	X	X	X	—	X	X[a]
Louisiana	X	X	X	X	X	X
Maine	X	X	X	—	—	—
Maryland	X	—	X	X	—	—
Massachusetts	X	—	X	X	X	—
Michigan	X	—	X	X	X	—
Minnesota	X	X	X	X	X	X
Mississippi	X	X	X	—	X	—
Missouri	X	X	X	—	X	X
Montana	X	—	X	—	—	—
Nebraska	X	X	X	—	—	—
Nevada	X	—	X	—	—	—
New Hampshire	X	—	X	X	—	—

State	Type of Provider Tax					
	Hospital	ICF/ID	Nursing Home	MCO	Ambulance	Other
New Jersey	X	X	X	X	—	X
New Mexico	X	X	X	—	—	—
New York	X	X	X	X	—	X[a]
North Carolina	X	X	X	—	—	—
North Dakota	—	X	—	—	—	—
Ohio	X	X	X	X	—	—
Oklahoma	X	X	X	X	X	—
Oregon	X	—	X	X	X	—
Pennsylvania	X	X	X	X	—	—
Rhode Island	X	—	X	X	—	—
South Carolina	X	X	—	—	X	—
South Dakota	—	X	—	—	—	—
Tennessee	X	X	X	—	X	—
Texas	X	—	X	X	—	X[a]
Utah	X	X	X	—	X	—
Vermont	X	—	X	—	X	—
Virginia	X	X	—	—	—	—
Washington	X	—	X	X	X	—
West Virginia	X	X	X	X	X	X[a]
Wisconsin	X	X	X	—	—	—
Wyoming	X	—	X	—	X	X[a]
Number of States	**47**	**32**	**46**	**22**	**20**	**10**

Source: Elizabeth Hinton et al., *As Pandemic-Era Policies End, Medicaid Programs Focus on Enrollee Access and Reducing Health Disparities amid Future Uncertainties: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025*, Kaiser Family Foundation and the National Association of Medicaid Directors, October 2024.

Notes: SFY = state fiscal year; ICF/ID = Intermediate care facilities for individuals with intellectual disabilities; MCO = managed care organization. The budget survey started collecting information about MCO provider taxes in SFY2021 and ambulance provider taxes in SFY2023.

a. This state has multiple "other" provider taxes.

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