American Hospital Association™

Advancing Health in America

Fact Sheet: Medicaid Provider Taxes

The Issue

The Medicaid program is jointly financed by the federal and state governments. States finance the non-federal share of Medicaid spending through various sources, including general fund revenue and taxes on health care providers and other entities specifically designed to help finance the program, among other sources. States' approaches to financing their share of the program are subject to federal rules and oversight, including limits on the amount of revenue that states can generate through provider taxes. Congress is contemplating further restrictions on states' ability to finance their share of Medicaid spending through such taxes.

AHA Take

The AHA calls on Congress to reject changes to states' use of provider taxes, which help fund their Medicaid programs. Even small adjustments in the use of this financing source would result in negative consequences for Medicaid beneficiaries as well as the broader health care system.

Why?

- **Further restricting states' ability to impose taxes on health care providers will create financing gaps for states.** Most states would be unable to close the financing gap created by further limiting states' ability to tax providers. States would need to make significant cuts to Medicaid to balance their budgets, including reducing eligibility, eliminating or limiting benefits, and reducing already low payment rates for providers.
- **Some states might raise taxes on their residents to close financing gaps.** States can use various sources to finance the non-federal share and would look to other sources if Congress limited their ability to use provider taxes. This means that some states would have to consider increasing other forms of taxes, including income and sales tax, levied on all state residents.
- **Some elderly and disabled and other "optional" but highly vulnerable populations would lose Medicaid coverage.** While states would likely try to address most of the financial losses by reducing enrollment and coverage for adults, such as the expansion population, it is unlikely they would save sufficient funding as those Medicaid beneficiaries tend to be the lowest-cost population for the program. Therefore, states will likely need to look to reduce enrollment and services for other non-mandatory populations, such as certain disabled individuals and those living in nursing facilities. In many cases, these individuals will not have alternative sources of coverage, increasing the financial burden on families and other caretakers, as well as the providers who will in many cases need to continue caring for them.

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Why? (continued)

- **State Medicaid agencies could limit or eliminate "optional" benefits.** States could also address financial losses by limiting or eliminating non-mandatory benefits for all Medicaid beneficiaries, such as prescription drug coverage, clinic services, and physical and occupational therapy. Without coverage, individuals and families may forgo necessary care entirely if they cannot afford to pay out-of-pocket.
- **Loss of health care services would be widespread across communities.** State Medicaid agencies could also choose to address financial losses by reducing already low payment rates. Loss of federal Medicaid funds would not only impact providers' ability to care for the low-income and uninsured, but it would also pull resources away from essential services, including emergency, trauma, maternal and behavioral health care services. As a result, hospitals, health systems and other providers would likely be unable to continue offering the full range of services, which would impact care for everyone in a community.

Background

Medicaid is a joint federal-state program that provides comprehensive health care coverage for over 70 million people in the United States. The federal and state governments share the responsibility of financing the Medicaid program. States pay health care providers and managed care organizations and report this spending to the Centers for Medicare & Medicaid Services (CMS) quarterly to receive federal reimbursement.

The federal-state financing structure incentivizes both federal and state authorities to manage spending and cost growth to meet their respective budget goals. There are also significant federal requirements and oversight in place governing state contributions to Medicaid spending to ensure the integrity of financing arrangements.

Federal Share

The federal share of Medicaid spending is based on each state's Federal Medical Assistance Percentage (FMAP). FMAP is a measure of each state's wealth relative to the national average, and CMS calculates FMAPs annually by comparing the state's per capita income to the national average. The statutory minimum is 50%, and the maximum is 83%. In other words, the federal government contributes at least 50% but no more than 83% of the financing of state's Medicaid programs for most spending. However, there are some instances in which federal law requires that the federal government pay more or less than that percentage. For example, most state administrative spending is eligible for a 50% federal match rather than the state's usual FMAP. Some services, such as certain home and community-based services, may be eligible for a higher FMAP. Additionally, a higher FMAP may be available for certain populations, including the ACA Medicaid expansion population.

Non-federal Share

States are responsible for financing the remainder of their programs and have broad authority to pursue their own Medicaid financing approaches through various sources. However, federal law requires that at least 40% of non-federal share must be financed by the state and up to 60% may come from local governments. According to a 2020 Government Accountability Office report, in the state fiscal year 2018, 68% of state funds came from state general revenues, 12% from local governments (including intergovernmental transfers and certified public expenditures), 17% from health care-related taxes and 4% from other sources.[1]

Some of the sources include:

- General revenue, which could result from sales, income, property and other statewide taxes.
- Intergovernmental transfers (IGTs), which are a transfer of funds from a government entity (such as a county or public hospital) to the state Medicaid agency.
- Certified public expenditures (CPEs), which occur when a government entity certifies that it has incurred an expense that is eligible for federal match.

Provider Taxes, Fees and Other Assessments

States also can finance the non-federal share by applying health care-related taxes, often referred to as provider taxes, fees or other assessments. States can implement these taxes through various approaches, including determining which providers to tax (e.g., hospitals and health systems, nursing facilities, managed care organizations) and on what basis to apply the tax (e.g., per admission or bed, share of net revenue, flat taxes). Forty-nine states and the District of Columbia imposed at least one health care-related tax in fiscal year 2024.[2]

Many federal requirements limit states' use of provider taxes. Provider taxes must be broad-based and uniform, meaning they must apply consistently to all providers in a certain category and cannot be limited to providers who participate in the Medicaid program. For example, a state could not impose a higher tax on Medicaid inpatient days than inpatient days covered by other sources. Providers cannot be guaranteed to receive Medicaid payments equal to the amount of taxes they pay; however, there is an exception to this rule for taxes that fall below 6% of net patient revenue. This threshold is known as the "safe harbor threshold." Finally, provider taxes typically require legislative approval in most states.

1 gao.gov/products/gao-21-98

2 kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-provider-rates-and-taxes/