How Medicaid Provider Taxes Work

NAMD National Association of Medicaid Directors

This explainer provides a high-level overview of Medicaid provider taxes, how they work, why states use them, and recent changes made under H.R. 1 - the One Big Beautiful Bill Act (OBBBA).

What are provider taxes?

- **Purpose**: Provider taxes help states finance their share of Medicaid program costs. Medicaid is jointly funded by states and the federal government, and provider tax revenue can be matched with federal dollars to help cover the program costs in addition to resources from the state general fund. In FY 2024, states reported that about 68% of Medicaid spending came from state general funds, while the remaining 32% came from other sources, including local government funds and provider taxes.
- **Definition**: State-imposed taxes or fees on certain health care providers (like hospitals, nursing facilities, or managed care organizations) where at least 85% of the tax burden falls on health care items, services, or entities.
- **Who Uses Them?** All states except Alaska have at least one provider tax. Many have three or more.

Common Types of Provider Taxes

- Nursing facilities (46 states)
- Hospitals (45 states)
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IDD) (32 states)
- Managed care organizations (20 states)

How do provider taxes work?

States collect taxes from certain providers and use that revenue as the state share of Medicaid spending. The federal government then matches those funds based on the state's FMAP (Federal Medical Assistance Percentage).

To qualify for FMAP, provider taxes must meet federal requirements:

1. **Broad-based** – The tax applies to all providers in a class (e.g., all hospitals).
2. **Uniform** – The rate is the same for all providers in that class.
3. **No Hold Harmless** – States cannot guarantee providers will receive all or most of their tax payment back. In other words, taxpayers (e.g., providers) are not "held harmless" for the taxes that they pay. However, federal law currently provides an exception if the provider tax is set at 6% or less of a provider's net patient revenue. This is otherwise known as the "safe harbor threshold". States generally keep their tax rate below 6% to comply with this federal requirement.

FYI

CMS allows waivers for the first two rules if the tax is shown to be "generally redistributive" (drawing more revenue from non-Medicaid services and not directly tied to Medicaid payments).

How are the dollars generated used by Medicaid programs?

States use provider taxes to finance key parts of their Medicaid programs. For example, provider taxes are commonly used to maintain or increase provider payment rates; fund supplemental payments for certain provider categories such as uncompensated care pools for hospitals or rural hospitals; finance coverage expansions and new eligibility groups; and support long-term services and supports (LTSS), including home and community-based services (HCBS). During economic downturns, provider taxes also provide states with a tool to balance budgets without cutting benefits or reducing eligibility.

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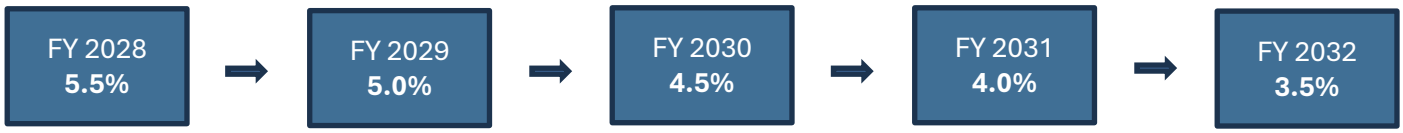
What did OBBBA change?

The One Big Beautiful Bill Act (OBBBA) sets new parameters for how states can use provider taxes to support their Medicaid programs. The law distinguishes between taxes that were already in place by July 4, 2025, and those adopted after that date, creating separate rules for each.

- **No new provider taxes**: OBBBA sets a 0% threshold for any provider tax that did not exist **before July 4, 2025.** This means that while current taxes can continue under new limits, any new taxes created after that date will not be allowed to generate federal matching funds. The 0% threshold takes effect on October 1, 2026, effectively ending the use of **new** provider taxes as a Medicaid financing tool.
- **Step down of existing taxes in expansion states:** States that already had provider taxes in place before July 4, 2025 can continue using them, but under new limits beginning October 1, 2026. In non-expansion states, each tax will be capped at the rate it was set at on July 4, 2025, locking in the existing tax level but preventing increases. In expansion states, caps will gradually step down, **beginning at 5.5% of net patient revenue in FY 2028 and declining to 3.5% by FY 2032.** If the tax in an expansion state was already lower than these new caps, that existing lower rate would apply instead of the adjusted cap. Nursing facility and ICF/IDD taxes are excluded from these reductions.



Key Dates

- **July 4, 2025** is the key point of distinction, which determines whether a tax is treated as "existing" (and therefore grandfathered) or "new."
- **October 1, 2026** is when the new caps and the 0% hold harmless threshold officially take effect for existing taxes.
- **October 1, 2028** is when expansion states begin the gradual reduction of the maximum tax rates, stepping down from 5.5% of net patient revenue in FY 2028 to 3.5% by FY 2032.

In summary, provider taxes are a common Medicaid financing tool that almost all Medicaid programs use to fund certain components of the program. OBBBA introduces new rules that impact states differently based on whether a tax was already in place before July 4, 2025 and if it is an expansion state or not. Beginning October 1, 2026, states will no longer be permitted to create new provider taxes, and existing taxes will face caps that differ for expansion and non-expansion states. These changes set new parameters that states will need to incorporate into future Medicaid budget forecasting and financing decisions.

Additional Reading

- KFF: 5 Key Facts About Medicaid and Provider Taxes
- Congress.gov: Medicaid Provider Taxes
- MACPAC: Health Care-Related Taxes in Medicaid