



Provider Taxes: Their Role in Medicaid Financing

Center Forward Basics

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Center Forward brings together members of Congress, not-for profits, academic experts, trade associations, corporations and unions to find common ground. Our mission: to give centrist allies the information they need to craft common sense solutions.

Key Definitions:

- **Provider taxes:** Health care-related fees, assessments, or other mandatory payments that states place on health care providers to help finance the state's share of Medicaid expenditures.
- **Medicaid Base Rates:** The fixed payment amount determined by insurance payers or government health care programs for specific health care services.
- **Supplemental Payments:** Medicaid payments to providers that are separate from and in addition to the base payments for services rendered to Medicaid enrollees. These payments help to mitigate low Medicaid base rates. Examples include quality initiatives, graduate medical education (GME), state directed payments, and certain types of facilities (e.g., rural or safety-net providers), among other reasons.
- **Medicaid Expansion:** Part of the Affordable Care Act (ACA), provides states with the option to expand Medicaid eligibility guidelines to include adults under

Overview

Provider taxes are health care-related fees, assessments, or other mandatory payments that U.S. states place on health care providers to help finance the state's share of Medicaid expenditures. Nearly every state uses at least one provider tax to help finance Medicaid. Provider Taxes are defined in federal statute and regulations as taxes for which at least 85% of the tax burden falls on health care items, services, or entities that provide or pay for health care items or services, such as hospitals or managed care organizations. Provider taxes may be imposed as a percentage of provider revenues or using an alternative formula, such as a flat tax on facility beds or inpatient days.

Generally, states use provider tax revenues to fund Medicaid, including **Medicaid base rates** and **supplemental payments**, and to finance eligibility expansions (i.e., **Medicaid expansion**). Supplemental payments enable states to mitigate low base rates and strengthen financial support for Medicaid providers. States also use supplemental payments funded by provider taxes to support a range of investments into their Medicaid programs, such as improving access to behavioral health services and providing home- and community-based services for children, among other initiatives.

Legislative and Regulatory Framework

States first used health care provider taxes to help finance the non-federal share of Medicaid expenditures in the mid-1980s. In the early 1990s, the federal government imposed limits on states' use of health care provider tax revenue to finance Medicaid, as set out in the [Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991](#). These amendments stipulate that provider taxes must be **broad-based** (imposed on all providers within a specified class), **uniform** (applying the tax equally to all providers within the specified class), and generally may not **hold taxpayers harmless** (guaranteeing that providers will receive the tax revenues back) unless they were under the **safe harbor** threshold of 6 percent of a provider's revenue.

CMS has defined 19 provider classes on which states may impose provider taxes. These most often include hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities (ICF/ID).

When signed into law on July 4th, 2025, [H.R. 1](#) placed new restrictions on states' abilities to utilize the provider tax funding structure. These changes included a prohibition on new provider taxes and a freeze on increases to existing taxes. H.R. 1 also established reduced safe harbor limits on provider taxes in states that adopted Medicaid expansion. The 41 states, including D.C., that have adopted Medicaid expansion will see the current safe harbor threshold reduced from 6 percent to 5.5 percent in fiscal year 2028, 5 percent in 2029, 4.5 percent in 2030,

4 percent in 2031, and then to 3.5 percent in fiscal year 2032 and thereafter. States that have not expanded Medicaid will remain at their tax rate as of July 4th, 2025.

Lastly, H.R. 1 redefined the conditions under which states can receive CMS approval for waivers for the broad-based and uniform requirements. States must obtain CMS approval for waivers to deviate from these rules, or, if the tax is non-compliant, provide justification, such as a "redistributive" impact. H.R. 1 prohibits any tax from being permissible under this waiver if it effectively charges lower rates to providers and managed care organizations with less Medicaid revenue or fewer Medicaid patients and higher rates to providers with more Medicaid revenue or more Medicaid patients. On January 29th, 2026, CMS finalized a rule which codified these H.R. 1 provisions, while providing a timeline for compliance for MCOs prior to State Fiscal Year (SFY) 2028 and other healthcare providers prior to SFY 2029.

Over time, states have increased their usage of and reliance on provider taxes. As of 2025, provider taxes accounted for approximately 18% of non-federal Medicaid funding nationwide. Reductions in state financing will, in turn, reduce federal matching funds.

Look Ahead

According to the CBO, the changes to provider taxes are expected to reduce Medicaid funding by \$226 billion over the next 10 years. Providers have expressed concern that the decrease in provider tax funding will significantly complicate states' ability to finance their share of the Medicaid program, likely reducing providers' ability to care for Medicaid patients. As a result of these changes, states will need to mitigate reduced tax revenues and may be required to pursue legislative adjustments such as increasing taxes in other sectors such as property or sales tax or reducing funding for publicly supported programs.

These modifications to provider taxes underscore the broader fiscal challenges facing the Medicaid program as federal and state governments reassess funding mechanisms. The extent to which states can absorb reductions in federal support will likely vary based on existing financing strategies, economic conditions, and political considerations. Policymakers will be tasked with balancing budgetary pressures against the goal of maintaining adequate access to care for Medicaid populations. As implementation unfolds, continued analysis will be necessary to evaluate the long-term effects of these revisions on state budgets, provider participation, and patient access and outcomes within the Medicaid program.

age 65 with household income up to 138% of the federal poverty level (regardless of assets).

- **Broad-Based Requirement:** The requirement that provider taxes must be imposed on all providers within a specified class of providers.
- **Uniformity Requirement:** The requirement that provider taxes must apply equally to all providers within a specified class.
- **Hold Taxpayers Harmless:** When tax-paying providers are guaranteed that they will receive their money back through increased Medicaid payments.
- **Safe Harbor:** An indirect hold harmless guarantee where a health care-related tax produces revenue that exceeds 6 percent of net patient revenue.

Key Statistics:

- All states (except Alaska) finance part of the state share of Medicaid funding through at least one provider tax, and 41 states have three or more provider taxes in place.
- Policies laid out in H.R. 1 are expected to cut federal Medicaid spending by \$226 billion over the next 10 years.
- 41 states, including D.C., have expanded Medicaid.
- As of July 1, 2025, 31 Medicaid expansion states reported having a non-exempt provider tax exceeding 3.5%, meaning they will be required to reduce provider taxes.
- As of 2025, provider taxes accounted for around 18% of the non-federal share Medicaid funding nationwide.

Link to Additional Resources

- Children’s Hospital Association: [Provider Tax Fact Sheet](#)
- Congressional Budget Office: [Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act](#)
- Federation of American Hospitals: [Provider Tax Fact Sheet](#)
- Modern Medicaid Alliance: [Cutting Medicaid Funding Through Restrictive State Financing Rules](#)
- Georgetown University McCourt School of Public Policy: [CMS Issues New Guidance on H.R. 1’s Restrictions on State Use of Provider Taxes to Finance Medicaid](#)
- KFF: [5 Key Facts About Medicaid and Provider Taxes](#)
- KFF: [Federal and State Share of Medicaid Spending](#)
- KFF: [Medicaid Enrollment & Spending Growth: FY 2025 & 2026](#)
- KFF: [Medicaid Financing: The Basics](#)
- Library of Congress: [Provider Taxes](#)
- MACPAC: [Health Care Related Taxes in Medicaid](#)