REPORT *Published February 17, 2026 · 9 minute read*

Medicaid Provider Taxes: A Framework for Reform

David Kendall

The Republican budget bill disguises a fiscal hatchet job as reform. Their cuts to Medicaid provider taxes were supposed to end abusive state practices but, instead, were a way to exploit a specific problem and justify sweeping cuts. The irony? The alleged problem could be solved with straightforward reforms: setting federal limits on hospital rates and demanding more transparency from states. Provider taxes should be used to strengthen access to care in Medicaid, not pad the profits of providers.

To help Congress prepare for reversing the damage caused by the GOP budget bill, this memo explains the purpose of provider taxes, Republican overreach with their cuts, and a new approach to regulating provider taxes.

What Are Medicaid Provider Taxes and Why Are They Controversial?

The federal government and each state share the cost of Medicaid, which provides working-class Americans with health care and long-term care. The federal government matches state funding dollar-for-dollar in wealthier states and gives more in poorer states and for certain groups like working adults. States use provider taxes as part of their share of the costs.

Provider taxes have been part of Medicaid since the 1980s. [1] They started when President Reagan's Administration allowed hospitals to donate money to a state to receive federal matching funds in 1986. [2] West Virginia, which was facing a bleak economy, then collected donations from hospitals and paid them back while drawing down federal funding for its Medicaid program. Florida used the same approach with a tax on hospitals. New Hampshire was another early adopter of provider taxes during an economic downturn. [3]

States tax groups of providers like hospitals and nursing homes at rates in the range of less than 3.5% to 6% of the provider's revenue. [4] The taxes account for 17% of the states' Medicaid budgets. [5] The rest of the budget comes from the states' general revenues, county-level taxes, and other contributions.

These tax schemes allowed a state to avoid spending its own money to obtain federal matching funds for Medicaid. In the late 1980s and early 1990s, provider taxes (and provider "donations" to state budgets) made up nearly a quarter of those states' Medicaid budgets. [6] These schemes violated the original idea of Medicaid financing, which encouraged states to enact a Medicaid program while keeping them on the hook financially to prevent cost overruns.

The 1991 Legislation to Curb Abuse

To prevent such abuses, a Democratic Congress set limits on provider taxes in a bill negotiated with governors and signed by President George H.W. Bush in 1991. [7] That law prevents states from taxing hospitals and doctors without the state being on the hook for a significant portion of the taxes and spending. For example, it required that the provider tax apply equally to all of a provider's revenue (including from non-Medicaid patients), rather than taxing only Medicaid revenue. That made provider taxes less open to abuse because most hospitals wouldn't benefit from provider taxes, only those with many Medicaid patients. [8]

Another part of the 1991 law prohibited states from guaranteeing providers payments that are equal to or more than the provider tax they pay. In other words, states cannot hold providers harmless from the cost of provider taxes. States can avoid proving they are following this prohibition if the provider tax doesn't exceed 6% of a provider's revenue. They must, however, still follow the other rules that require taxes be spread across large groups of patients.

Current Situation

Over the 24 years that provider taxes have been authorized and regulated under federal law, states have increasingly taken advantage of the funding opportunities. Every state, except Alaska, and Washington, DC, has a provider tax on at least one group of providers, mostly hospitals or nursing homes. [9]

Current regulations make provider taxes more like a state's general revenue source. That's because they apply to a hospital's revenue from all patients. In turn, providers pass the taxes along to consumers in the form of higher insurance premiums through their health plans. Nonetheless, a few states have pushed the boundaries of what is legal, leading to federal corrective action. [10] More enforcement over states' practices would be possible if the federal government had a complete accounting of states' provider taxes. [11] Administrations from both parties have proposed new rules and enforced existing rules to keep provider taxes under control, but none of that has settled the political debate on the future of these taxes. [12]

Other problems with Medicaid relate to provider taxes as well. Although provider taxes have the potential to end the historic underfunding of care for Medicaid patients, Medicaid payments remain very uneven. For example, hospitals receiving extra funding to care for Medicaid and uninsured patients still lose money on Medicaid patients in 21 states, even in states with significant sources of non-general revenue including hospital taxes like Florida, Iowa, and Ohio. [13] (See chart in appendix.) Provider taxes can also help expand coverage. Some states have used provider taxes to expand coverage to working adults. [14] An additional 1.5 million people would have Medicaid coverage if their state had done that. [15]

What Have Republicans Recently Done to Provider Taxes?

In their budget bill that passed in July, 2025, Republicans cut a trillion dollars from health care, which included $191 billion from new limits on provider taxes. [16] Based on the mistaken claim that provider taxes are inherently abusive, they banned new provider taxes and cut the 6% limit to 3.5% for any state that has expanded Medicaid under the Affordable Care Act (ACA). [17] That means states will lose nearly half of the revenue that they had been counting on from provider taxes with no chance of correcting any abuses.

The budget bill's impact on provider taxes will hurt working-class families in three ways:

1. Takes health care coverage from 1.1 million people. The key benefit for Republicans from cutting provider taxes was the savings from cutting coverage, which they used to partially offset the budgetary costs of extending tax cuts. The Congressional Budget Office estimates that the cut to provider taxes would reduce coverage because some states will choose to end coverage for groups of people, like working adults. [18] Had the Republicans simply wanted to cut provider taxes without cutting coverage, they could have redirected the budgetary savings into coverage instead of tax cuts for the wealthy.

2. Attacks coverage for working adults. By cutting provider taxes only in states that have expanded coverage for working adults under the ACA, their budget bill discourages further Medicaid expansion and may cause some states to repeal expansion. [19] Let's be clear about the cruel impact of this action, which comes on top of so-called work requirements that will make it harder for working adults to work. [20] Medicaid expansion of coverage to working adults ends one of the greatest inequities in health care: the lack of coverage for people whose income was previously too high to qualify for Medicaid and too low to afford coverage through an employer. **It costs the federal government almost as much to provide Medicaid coverage for this working-class group as it loses in tax breaks for people with an income of $150,000 who have coverage through their employer.** [21]

3. Puts Medicaid financing for the working class in limbo. Instead of fixing specific problems with provider taxes, it freezes the problem in place. States will still have a strong claim for using provider taxes and will likely argue that the provider tax cuts will curb abuses to the detriment of states that have acted responsibly. The debate will continue—creating uncertainty over Medicaid financing—because Republicans have acted on a false premise that provider taxes are inherently abusive.

What Is a Balanced Fix for Provider Taxes?

As Democrats look to reverse the damage caused by Republican cuts to Medicaid in the future, they can adopt three requirements to ensure that provider taxes are put to good use and not for questionable financing schemes.

1. Cap the prices Medicaid pays to providers. The potential abuse from a state increasing provider taxes to pay for ever-higher provider payments would end with a cap on Medicaid prices. This cap would apply in any state using provider taxes and would require a consistent standard across existing policies for upper payment limits and state-directed payments. [22] The price cap would be limited to a percentage of Medicare rates, which are under constant federal scrutiny for adequacy. It would also apply to payments to publicly owned health providers that receive inflated payments from deals between state and local governments known as inter-government transfers. [23] It would exclude any payments for uncompensated care to prevent losses for hospitals that take care of people without coverage. The cap would also allow states that pay below Medicaid rates to increase payments to an adequate level using tightly regulated provider taxes.

2. Require states to improve enrollment in Medicaid. To stop states using provider taxes to shift costs to the federal government and use those states' funds for something other than Medicaid, states should be required to ensure that they are spending money to improve enrollment in Medicaid if they use provider taxes for health care coverage. As of 2022, 6.4 million people were eligible for, but not enrolled in, Medicaid and the Children's Health Insurance Program, including two million children. [24] Enrollment should be as automatic as it is for people getting coverage at work as Senator Chris Van Hollen (D-MD) and Representative Ami Bera (D-CA) have proposed. [25]

3. Require states to report full details on provider taxes and supplemental payments. The federal government can't monitor Medicaid for abuse without full reports from states on the exact amounts raised from provider taxes and spent through various supplemental Medicaid payments (e.g., disproportionate share for hospitals with many Medicaid or uninsured patients). While the Centers for Medicare and Medicaid Services have begun this work, it needs to do more to ensure a complete picture of Medicaid financing. [26]

Conclusion

New requirements for provider taxes should be part of a broader reform that cleans up other areas of Medicaid. [27] Given the problems with provider taxes over the years, some reformers might be tempted to ban them altogether. The effect on individual states,

however, would be impossible to predict because federal policymakers lack information about how exactly states are using them and supplemental payments. That's why Congress should pursue an incremental approach that avoids the drastic reductions in coverage enacted by Republicans and reduces the potential for abuse by states.

Appendix

1. Coughlin, Teresa A. and David Liska. "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues." *The Urban Institute*, Oct. 1997, www.urban.org/sites/default/files/publication/71236/307025-The-Medicaid-Disproportionate-Share-Hospital-Payment-Program.PDF. Accessed 3 Feb. 2026; United States, Congress, Congressional Research Service. "Medicaid Provider Taxes," 30 Dec. 2024, www.congress.gov/crs-product/RS22843#fn35. Accessed 3 Feb. 2026.

2. Coughlin, Teresa A. and David Liska. "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues." *The Urban Institute*, Oct. 1997, www.urban.org/sites/default/files/publication/71236/307025-The-Medicaid-Disproportionate-Share-Hospital-Payment-Program.PDF. Accessed 3 Feb. 2026.

3. Sanger-Katz, Margot and Sarah Kliff. "G.O.P. Targets a Medicaid Loophole Used by 49 States to Grab Federal Money." *The New York Times*, 10 May 2025, www.nytimes.com/2025/05/06/upshot/medicaid-hospitals-republicans-cuts.html. Accessed 3 Feb. 2026.

4. Hinton, Elizabeth et al. "A View of Medicaid Today and a Look Ahead: Balancing Access, Budgets and Upcoming Changes: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2025 and 2026." *KFF*, 13 Nov. 2025, www.kff.org/medicaid/50-state-medicaid-budget-survey-fy-2025-2026/#13defeb9-d9f5-4be4-9c36-451a5b4bcb70. Accessed 3 Feb. 2026.

5. United States, Congress, Government Accountability Office. "Medicaid: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight," 7 Dec. 2020, www.gao.gov/products/gao-21-98. Accessed 3 Feb. 2026; "Fact Sheet: Medicaid Provider Taxes." *American Hospital Association*, Feb. 2025, www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid-provider-taxes. Accessed 3 Feb. 2026.

6. United States, Congress, General Accounting Office, letter to Congressman John Dingell, 23 Jan. 1996, www.gao.gov/assets/hehs-96-76r.pdf. Accessed 3 Feb. 2026.

7. United States, Congress, House. Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. *Congress.gov*, www.congress.gov/bill/102nd-congress/house-bill/3595. 102nd Congress, 1st Session, House Resolution 3595, enacted 12 Dec. 1991. United States, Congress, Senate. HCFA Regulation Restricting Use of Medicaid Provider Donations and Taxes. Committee on Finance, 19 Nov. 1991, https://upload.wikimedia.org/wikipedia/commons/5/59/FEDLINK_-_United_States_Federal_Collection_%28IA_hcfaregulationre00unit%29.pdf., Hearing on S. 1886 transcript. Accessed 3 Feb. 2026. Government Printing Office, 102nd Congress, 1st Session.

8. "Medicaid Provider Taxes Inflate Federal Matching Funds." *Committee for a Responsible Federal Budget*, 28 Sep, 2023, www.crfb.org/papers/medicaid-provider-taxes-inflate-federal-matching-funds. Accessed 3 Feb. 2026.

9. Hinton, Elizabeth et al. "A View of Medicaid Today and a Look Ahead: Balancing Access, Budgets and Upcoming Changes: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2025 and 2026." *KFF*, 13 Nov. 2025, www.kff.org/medicaid/50-state-medicaid-budget-survey-fy-2025-2026/#13defeb9-d9f5-4be4-9c36-451a5b4bcb70. Accessed 3 Feb. 2026.

10. United States, Department of Health and Human Services, Office of Inspector General. "Pennsylvania's Gross Receipts Tax On Medicaid Managed Care Organizations Appears to be an Impermissible Health-Care-Related Tax," May 2014, oig.hhs.gov/oas/reports/region3/31300201.pdf. Accessed 3 Feb. 2026; United States, Department of Health and Human Services, Centers for Medicare and Medicaid Services. "CMS Moves to Shut Down Medicaid Loophole—Protects Vulnerable Americans, Saves Billions." Press release, 12 May 2025, www.cms.gov/newsroom/press-releases/cms-moves-shut-down-medicaid-loophole-protects-vulnerable-americans-saves-billions. Accessed 3 Feb. 2026.

11. Medicaid Provider Taxes Inflate Federal Matching Funds." *Committee for a Responsible Federal Budget*, 28 Sep, 2023, www.crfb.org/papers/medicaid-provider-taxes-inflate-federal-matching-funds. Accessed 3 Feb. 2026; United States, Congress, Government Accountability Office. "Medicaid: CMS Needs More Information on States′ Financing and Payment Arrangements to Improve Oversight," 7 Dec. 2020, www.gao.gov/products/gao-21-98. Accessed 3 Feb. 2026.

12. United States, Office of Management and Budget. "Fiscal Year 2013 Budget of the U.S. Government." 13 Feb. 2012, www.govinfo.gov/content/pkg/BUDGET-2013-BUD/pdf/BUDGET-2013-BUD.pdf. Accessed 3 Feb. 2026; Medicaid Provider Taxes Inflate Federal Matching Funds." *Committee for a Responsible Federal Budget*, 28 Sep, 2023, www.crfb.org/papers/medicaid-provider-taxes-inflate-federal-matching-funds. Accessed 3 Feb. 2026.

13. United States, Congress, Medicaid and CHIP Payment and Access Commission. "Chapter 3: Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States," Mar. 2024, www.macpac.gov/wp-content/uploads/2024/03/Chapter-3-Annual-Analysis-of-Medicaid-Disproportionate-Share-Hospital-Allotments-to-States.pdf. Accessed 3 Feb. 2026; National Association of State Budget Officers. "2025 State Expenditure Report." 2025, www.nasbo.org/reports-data/state-expenditure-report. Accessed 3 Feb. 2026.

14. State of Indiana, Family and Social Services Administration, Healthy Indiana Plan. "HIP 2.0 Financing Overview," www.in.gov/fssa/hip/files/HIP_2.0_Financing_Overview.pdf. Accessed 3 Feb. 2026.

15. Author's calculations based on Drake, Patrick et al. "A Closer Look at the Remaining Uninsured Population Eligible for Medicaid and CHIP." *KFF*, 15 Mar. 2024, www.kff.org/uninsured/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/. Accessed 3 Feb. 2026.

16. United States, Congress, Congressional Budget Office. "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline," 21 July 2025, www.cbo.gov/publication/61570. Accessed 3 Feb. 2026.

17. The provider tax changes do not apply to nursing homes. See National Association of State Medicaid Directors. "How Medicaid Provider Taxes Work: An Explainer," 2025, medicaiddirectors.org/resource/how-medicaid-provider-taxes-work-an-explainer/. Accessed 3 Feb. 2026.

18. United States, Congress, Congressional Budget Office. "Distributional Effects of Public Law 119-21," 11 Aug. 2025, https://www.cbo.gov/publication/61367. Accessed 3 Feb. 2026.

19. The Hilltop Institute, University of Maryland, Baltimore County. "What's the Impact of Phasing Provider Taxes Down to 3.5% for Medicaid Expansion States?" 1 July 2025, hilltopinstitute.org/publication/whats-the-impact-of-phasing-provider-taxes-down-to-3-5-for-medicaid-expansion-states/. Accessed 3 Feb. 2026.

20. Kendall, David. "Why Work Requirements in Medicaid Won't Work." Third Way, 25 Mar. 2025, www.thirdway.org/memo/why-work-requirements-in-medicaid-wont-work. Accessed 3 Feb. 2026.

21. Author's calculations based on Drake, Patrick et al. "A Closer Look at the Remaining Uninsured Population Eligible for Medicaid and CHIP." *KFF*, 15 Mar. 2024, www.kff.org/uninsured/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/. Accessed 3 Feb. 2026.

22. Elliott, Blair & David Kendall. "How to Improve Medicaid's Supplemental Payments to Hospitals." *Third Way*, 3 Feb. 2026, www.thirdway.org/memo/how-to-improve-medicaids-supplemental-payments-to-hospitals. Accessed 3 Feb. 2026.

23. United States, Congress, Government Accountability Office. "Medicaid: Primer on Financing Arrangements." 14 July 2020, www.gao.gov/products/gao-20-571r. Accessed 3 Feb. 2026.

24. Author's calculations based on Drake, Patrick et al. "A Closer Look at the Remaining Uninsured Population Eligible for Medicaid and CHIP." *KFF*, 15 Mar. 2024, www.kff.org/uninsured/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/. Accessed 3 Feb. 2026; "Medicaid and CHIP Monthly Enrollment." *KFF*, Oct. 2025, www.kff.org/medicaid/state-indicator/medicaid-and-chip-monthly-enrollment/. Accessed 3 Feb. 2026.

25. United States, Congress, Senate. “Easy Enrollment in Health Care Act.” Congress.gov, www.congress.gov/bill/119th-congress/senate-bill/2057. 119th Congress, 1st Session, Senate Resolution 2057. Accessed 3 Feb. 2026.

26. United States, Congress, Government Accountability Office. “Medicaid: CMS Needs More Information on States′ Financing and Payment Arrangements to Improve Oversight,” 7 Dec. 2020, www.gao.gov/products/gao-21-98. Accessed 3 Feb. 2026.

27. Elliott, Blair, David Kendall, and Darbin Wofford. “Rescuing Medicaid: A Modern Medicaid Agenda for Working-Class Families.” Third Way, 27 Aug. 2025, www.thirdway.org/report/rescuing-medicaid-a-modern-medicaid-agenda-for-working-class-families. Accessed 3 Feb. 2026.