Medicaid Provider Taxes: Statutory and Regulatory Changes

Recent federal action signals a significant restructuring of how states may use healthcare-related taxes to fund their share of Medicaid costs. This federal action includes provider tax restrictions enacted in the One Big Beautiful Bill Act (OBBBA) and a Centers for Medicare and Medicaid Services (CMS) final rule closing what the agency characterizes as a statistical "loophole" in Medicaid financing.

One Big Beautiful Bill Act Changes

The OBBBA introduced significant new restrictions on how states may use Medicaid provider taxes, with rules varying depending on whether a tax existed before July 4, 2025, and whether the state expanded Medicaid under the Affordable Care Act.

The law significantly restricts Medicaid provider taxes by freezing existing rates and lowering the "safe harbor" threshold

The key changes under the law are:

- No new provider taxes: Any tax created after July 4, 2025, faces a 0% safe harbor threshold, meaning it cannot generate federal matching funds. This effectively prohibits new provider taxes starting October 1, 2026.
- Caps on existing taxes in non-expansion states: Existing taxes are locked in at the rate in effect on July 4, 2025, and states may not increase them.
- Step-down caps in expansion states: Existing taxes may continue but must decline gradually, from a cap of 5.5% in FY 2028 down to 3.5% by FY 2032. Nursing facility and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) taxes are excluded from these reductions.

CMS Final Rule on Medicaid Provider Tax Loopholes

CMS has increased its oversight of financing and payment mechanisms that appear to work together to inflate the federal match without equivalent state investment. Previously, states were allowed to draw down a federal match if their provider taxes did not exceed 6% of a provider's net patient revenue, which is known as the "safe harbor" threshold.

CMS issued a final rule closing what it considers loopholes in how states can tax healthcare providers to fund Medicaid programs. States no longer can impose higher tax rates on providers who serve Medicaid patients compared to those who do not.

Many states have been using special taxes on healthcare providers, particularly hospitals and managed care organizations, to help pay for their share of Medicaid costs. Some states structured these taxes so that providers serving more Medicaid patients paid disproportionately higher rates. This rule closes that loophole.

Under federal law, state healthcare taxes must be "generally redistributive," meaning the tax burden should be spread fairly across all providers, not concentrated on those serving Medicaid populations. CMS found that some states were exploiting a mathematical loophole that allowed them to:

- Charge higher effective tax rates to Medicaid providers
- Use complex language to hide the true impact
- Shift more of the state's Medicaid costs to the federal government

A tax automatically fails under the new regulatory standard if Medicaid providers face higher effective tax rates than non-Medicaid providers, even if it passes the statistical test. CMS will no longer approve new or renewed tax arrangements that meet the old statistical test but fail the new fairness standard.

A tax will fail the "generally redistribute standard" under three newly prohibited taxes structures:

First Prohibited Tax Structure: A tax that explicitly charges a higher rate on Medicaid taxable units (e.g., Medicaid member months, bed days, or revenue) than on non-Medicaid taxable units within the same provider class, regardless of any stated policy justification.

- *Example: An MCO tax of $200 per Medicaid member per month versus $20 per non-Medicaid member per month.*

Second Prohibited Tax Structure: A tax that explicitly defines taxpayer groups by their volume or percentage of Medicaid business and charges higher-Medicaid-volume providers a higher rate than lower-Medicaid-volume providers, regardless of any stated policy justification.

- *Example: Nursing facilities with more than 40 Medicaid-paid bed days taxed at $200 per bed day, while those with 40 or fewer Medicaid-paid bed days are taxed at only $20 per bed day.*

Third Prohibited Tax Structure: A tax that achieves the same disproportionate effect on Medicaid providers as the first or second structures but uses indirect or vague language to avoid explicitly referencing Medicaid.

- *Example: A hospital discharge tax charging $10 per discharge for beneficiaries of a "joint Federal and State healthcare program" and $5 for all others—a prohibited structure because that phrase effectively describes Medicaid*.

Conclusion

Medicaid provider taxes have long been a critical state financing tool, but the combined impact of the One Big Beautiful Bill Act and the CMS final rule marks a significant tightening of federal oversight. For AMGA members, these shifts will likely translate into changes in Medicaid payment rates and supplemental payment structures as states are forced to reassess their financing strategies. Staying engaged in the regulatory process and monitoring state-level responses will be essential as the full impact of these changes unfolds.