Policy Summary: Limiting Medicaid Provider Taxes

Proposals Under Review

This policy would lower the health care provider tax safe harbor threshold from current level of 6% to 4% from 2026-2027 and 3% in 2028 and after.

Estimated Ten-Year Savings (2025-2034) - House Estimated Savings: $175B; CBO Score: $48B (5%), $241B (2.5%)[1]

Background

Many states use financing mechanisms[2] – such as provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs) – as permissible sources of state share to draw down federal matching funds. These mechanisms allow states to leverage funds from healthcare providers or public entities instead of relying solely on general state revenues.

Some policymakers argue that heavy reliance on provider taxes may undermine the principle of the state-federal partnership, as it shifts more of the financial responsibility away from the state's general budget. To mitigate these concerns, there are a range of federal requirements and restrictions. For example, Congress prohibits "hold harmless" arrangements[3], meaning states cannot guarantee that providers who pay these taxes will receive an equal or greater amount back in Medicaid payments or supplemental disbursements, supporting the integrity of matching requirements by promoting a sustainable partnership between state and federal funding. There is an exception to this rule for taxes that fall below 6% of a provider's net patient revenue, which has been established by Congress as the "safe harbor threshold"[4].

Historical Traction

Provider taxes have long been a tool for states to generate Medicaid funding but concerns over federal cost shifting have led to repeated attempts to limit their use. The 1991 Medicaid Voluntary Contribution and Provider-Specific Tax Amendments served as a vehicle for banning hold-harmless arrangements and establishing the safe harbor threshold.[5]

There have been several efforts in recent years to reduce the 6% safe harbor threshold. A temporary reduction to 5.5% was enacted from January 2008 through September 2011– during the Great Recession – before returning to its current level of 6%. This was enacted in the Tax Relief and Health Care Act of 2006 (P.L. 109-432), specifically § 1903 (w)(4)(c)(ii) of the Act. Both the Bush and Obama administrations proposed further reductions to curb federal Medicaid spending broadly, leading to increased scrutiny of state financing mechanisms, including provider taxes. The Bowles-Simpson Commission, a bipartisan commission created in 2010 to address fiscal sustainability, endorsed phasing them out [7].

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[1] "GOP budget menu outlines sweeping spending cuts." Politico; January 13, 2025
[2] "Non-federal financing" MACPAC; 2020
[3] "Prohibition on Hold Harmless Provisions in Provider Taxes" CMS
[4] Social Security Act § 1903(w)(4)(C)(ii)
[5] "Medicaid Provider Taxes: Background and Policy Issues." Congressional Research Service (CRS); April 2023.

States – especially those that rely heavily on provider taxes – have resisted changes due to potential funding shortfalls [8]. Recent proposals, including the Better Care Reconciliation Act of 2017, sought to lower the cap to 5%, but opposition from states and providers has kept the 6% limit intact [9]. In 2019, the Trump Administration proposed the Medicaid Fiscal Accountability Rule (MFAR) that introduced new limits on SDPs, supplemental payments to physicians, capping them at 50% of base payments (or 75% in rural and designated health professional shortage areas) with projected savings of $222M. MFAR was withdrawn in 2020 by CMS due to political pushback from a range of stakeholders.

Key Considerations

- **Limits to growth of SDPs funded by Provider Assessments**
  Restricting or reducing the amount of revenue able to be generated by provider assessments could undermine state financial resources and negatively impact Medicaid service delivery by reducing SDPs funded by provider assessments.

- **Pressure on alternative sources of state share**
  Limiting provider taxes would constrain providers and states in supporting state share, putting additional pressure to use alternative approaches like CPEs and IGTs. Provider taxes and IGTs work in tandem to maximize Medicaid funding, and any restrictions on provider taxes could hinder states' ability to generate necessary revenue to support IGTs. This could result in decreased federal matching funds and jeopardize the financial stability of Medicaid programs.

Scenarios Under Review

Policymakers are considering various approaches to modifying provider tax thresholds. Key scenarios that have emerged include:

- **Reducing the Provider Tax Safe Harbor Threshold to 5%**

Past Congressional Budget Office (CBO) analyses explored lowering the provider tax safe harbor from its current 6% threshold to 5%.

- **Reducing the Provider Tax Safe Harbor Threshold to 4% in 2026-2027 and 3% in 2028**

Recent information on proposal under review by Budget Committee suggests a potential phased approach.