FINANCIAL MECHANICS OF MEDICAID PROVIDER TAXES

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Medicaid provider taxes have been in the news lately.[1] This little-known aspect of Medicaid funding does not typically get much attention. It is estimated that provider taxes may be the foundation upon which $110.2 billion of Medicaid directed payments in 2024[2] were built. State direct payments are payments made by managed care plans to health care providers in accordance with direction from the states. The managed care plans receive funding for these directed payments from the state and the majority of this funding is provided by the federal government. This paper describes how provider taxes contribute to helping states pay for Medicaid.

Medicaid is a government-funded health insurance program that provides free or low-cost coverage to eligible low-income individuals and families. It is jointly funded by the federal and state governments and is administered by individual states, meaning eligibility rules and benefits can and do vary by state. Medicaid covers a wide range of healthcare services, including hospital visits, doctor appointments, prescription drugs, nursing home care, and preventive services. Some eligibility groups that commonly qualify for Medicaid include low-income adults, children, pregnant women, elderly individuals, and people with disabilities. The Affordable Care Act (ACA) gave states the option to expand Medicaid coverage to low-income adults.

The Federal Medical Assistance Percentage (FMAP) is the percentage of Medicaid costs that the federal government pays to each state. It determines how much financial support states receive to fund their Medicaid programs. The FMAP varies by state and is based on a formula that considers a state's average per capita income relative to the national average. The base state FMAP ranges from 50% to 76.9%[3] meaning the federal government covers at least half of a state's Medicaid costs. However, because of various enhancements to the FMAP the average federal share in Medicaid cost in FFY 2023 was 69%[4].

The following table shows the impact of an incremental increase in state spending.

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[1] https://www.politico.com/news/2025/02/27/republicans-medicaid-plan-00206540

[2] https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf

[3] Ten states have a 50% FMAP (e.g., California and New York) while Mississippi is the state with the highest FMAP at 76.9%. The US Virgin Islands, Guam, American Samoa, and Northern Mariana Islands have an 83% FMAP. There is a higher FMAP for certain groups. The Children's Health Insurance Program (CHIP) has an FMAP ranging from 65% to 85%. Medicaid expansion under the Affordable Care Act (ACA) has a 90% FMAP.

[4] https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/

Table 1 – Incremental Increase in State Spending

	State Share	Federal Share	Total
FFY 2023 Medicaid Spending	$274B	$606B	$880B
Share	31%	69%	100%
Increment of $31 Added State Spending[5]	$31	$69	$100

Since the federal share depends on what the state spends on Medicaid, if the state could find $31 dollars to fund the state share, it could increase its Medicaid expenditures $100[6]. The challenge for the state is coming up with the additional state funding. Raising broad-based taxes such as income or sales taxes is unpopular, making this approach more difficult. In the past few years, states have resorted to using taxes focused on Medicaid providers and managed Medicaid insurers. For example, if the state increased the managed Medicaid taxes by 5% this would increase the Managed Care Organization (MCO) expense 5% which would be built into the capitation rates, keeping the MCOs whole. The state's share of the 5% would be 1.55% and the federal share 3.45%, in effect giving the state 1.90% (3.45% - 1.55%) to spend on program enhancements or offsets to the state's costs for Medicaid.

The return of funding by an MCO tax to the MCO is straight forward. The MCO tax must be included in the development of the MCO capitation payment, so the MCO is reimbursed for the tax it pays. The other source of funding is provider taxes, however, the return of funding to the providers is a little more complicated. States impose taxes on healthcare providers (hospitals, nursing facilities, etc.) and use the collected revenue to increase Medicaid payments, which in turn receive federal matching funds. The Federal Regulations require provider taxes to be broad-based, meaning they apply to all providers within a certain category and cannot be limited to Medicaid participants. The tax must be uniformly imposed, meaning it applies consistently to all providers in the same category. There is a "safe harbor" threshold, currently at 6% of net patient revenue, where states are allowed to collect revenues under "hold-harmless" arrangements, meaning providers are not guaranteed to receive Medicaid payments equal to the amount of taxes paid. This has led to many thoughtfully designed programs to attract federal dollars while satisfying regulatory requirements.

The additional federal funding is used to offset the state's cost, enhance benefits and increase provider fee schedules especially for facilities that serve a disproportionate share of Medicaid members.

A recent[7] report by Kaiser Family Foundation on the 2023 financial condition of hospitals found that rural hospitals and those with high Medicaid shares have the lowest operating margins.

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[5] The formula to calculate any amount: Total $ = State $/(1-FMAP)

[6] The lowest return is where the FMAP is 50%. In that case the state funding is matched with Federal funding.

[7] https://www.kff.org/health-costs/issue-brief/hospital-margins-rebounded-in-2023-but-rural-hospitals-and-those-with-high-medicaid-shares-were-struggling-more-than-others/

Table 2 – 2023 Hospital Operating Margins

	Aggregate 2023 Operating Margin	Number of Hospitals
All Hospitals	5.2%	4,200
Hospitals >= 26% Medicaid Discharges	2.3%	543
Rural	1.7%	146
Urban	2.3%	397

The 5.2% operating margin amounts to about $79 billion[8]. So, the reductions in directed payments will erode operating margins and put financial stress on those hospitals with higher Medicaid market share.

There are several proposals to reduce Medicaid enrollment and funding, including limiting provider taxes. It is difficult to understand the impact without having more details of what will likely emerge. In addition, Medicaid programs and use of provider taxes vary by state, so the impact will vary by state. Nevertheless, it seems clear that funding cuts will impact hospitals, with financially distressed and rural hospitals being most affected.

Please contact Ed Mailander at ed.mailander@wakely.com with any questions or to follow up on any of the concepts presented here.

[8] https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20spending%20on%20health%20consumption%20expenditures,%20$U.S.%20billions,%20by%20payer,%202023

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