How Provider Taxes Fund Medicaid and Why Cuts Hurt People with Disabilities

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The Medicaid program is jointly financed by the federal and state governments. States finance the non-federal share of Medicaid spending through various sources, including general fund revenue and taxes on health care providers and other entities specifically designed to help finance the program, among other sources. States' approaches to financing their share of the program are subject to federal rules and oversight, including limits on the amount of revenue that states can generate through provider taxes. Provider taxes are often misunderstood.

Here's how it works: States collect this tax from providers and then use that revenue to help pay their portion of Medicaid costs. This state spending, in turn, unlocks a larger stream of federal matching funds. Because the federal government pays a significant portion of each state's Medicaid expenses—anywhere from 50% to 75% or more—the money generated from provider taxes effectively draws down more federal dollars to support the state's Medicaid program. This allows states to maintain or even expand their Medicaid services without having to dip heavily into their general funds, which are also needed for education, transportation, and other public services. Think of it like a matching gift program. A state puts in a certain amount of money from the provider tax, and the federal government matches it, boosting the total funds available for Medicaid.

Changes in the House bill: Through a budget reconciliation bill, Congress is contemplating further restrictions on states' ability to finance their share of Medicaid spending through such taxes. The House bill (H.R. 1), passed on May 22, prohibits states from establishing any new provider taxes or from increasing the rates of existing taxes. H.R. 1 also revises the conditions under which states may receive a waiver of the requirement that taxes be broad-based and uniform such that some currently permissible taxes, such as those on managed care plans (state-directed), will not be permissible in future years. This provision overlaps with a proposed rule released May 12, 2025. This provision would be effective upon enactment, but states may have at most 3 fiscal years to transition existing arrangements that are no longer permissible.

The Senate bill cuts deeper than the House: The Senate bill includes new language not in the House-passed bill that would lower the provider cap or safe harbor threshold of 6 percent starting on October 1, 2026 but only in Medicaid expansion states. The threshold would be reduced to 5.5 percent in fiscal year 2027, 5 percent in 2028, 4.5 percent in 2029, 4 percent in 2030 and then to 3.5 percent in fiscal year 2031 and thereafter. The lower thresholds would apply to existing taxes and assessments on all provider types including hospitals, except for nursing homes and intermediate care facilities for individuals with intellectual disabilities (so long as the taxes on such nursing homes and intermediate care facilities were already in effect as of May 1, 2025 and are otherwise in compliance with the current 6 percent threshold). Puerto Rico and the other territories would be exempt from the reduced safe harbor threshold. See more from a Georgetown University analysis.

The Ripple Effect of Cuts: Direct and Indirect Hits on People with Disabilities

Proposals to cut or limit these provider taxes could have a devastating impact on the services that people with disabilities rely on to live independently and participate fully in their communities. Here's why:

- **Cutting optional, but essential, services:** While Medicaid has certain mandatory benefits, many of the services that are most critical for people with disabilities are considered "optional" under federal law. This includes things like home and community-based services (HCBS), which provide support for daily living activities, personal care, and respite for caregivers. Without these services, many individuals with disabilities would be forced into more restrictive and costly institutional settings like nursing homes. The vast majority of Medicaid spending on optional services (86%) are services that support people with disabilities and older adults. Other optional services at risk include durable medical equipment, physical and occupational therapy, and dental care. Between 2010 and 2012, in response to a reduction in federal Medicaid funding, every state and DC cut spending to one or more HCBS programs (see each state's cuts here). Service reductions and the reduced number of people enrolled greatly increased the waiting lists for the HCBS programs. (See Health Affairs).
- **Reducing provider payments:** Since Medicaid is already a large part of states' budgets, states will likely be forced to cut services. States could try to save money by paying doctors, hospitals, and other providers less for the services they deliver to Medicaid recipients. This can lead to a shortage of providers willing to accept Medicaid, making it much harder for people with disabilities to find the specialized care they need.

- **Reducing reimbursement rates for HCBS providers:** States could also lower the payment rates for community providers which would exacerbate the existing crisis with finding and retaining direct support professionals. Low reimbursement rates already means HCBS providers in many states cannot attract enough direct care workers (DCW) and related support staff to meet the need.
- **Serving few people in the community:** Since HCBS services are optional services states could decide to serve few people which would increasing waiting lists for services or cause more people to be served in nursing homes and other institutions.
- **Tightening eligibility:** Another option for states is to make it harder for people to qualify for Medicaid in the first place. This could mean lowering the income threshold for eligibility or adding more restrictive asset limits, leaving many low-income individuals with disabilities without any health insurance coverage at all.

For people with disabilities, these cuts are not just about numbers on a budget spreadsheet. They represent a potential loss of independence, a decline in health and well-being, and a significant step backward in their ability to lead full and integrated lives. Without Medicaid, people with disabilities and older adults who need care to remain in their homes and communities have nowhere else to turn. Without access to critical benefits like HCBS, individuals are more likely to end up in costly institutional settings, experience preventable hospitalizations, and face a decline in overall health and well-being. The very services that enable them to work, go to school, and be active members of their communities are often the first on the chopping block when Medicaid funding is threatened.

Provider taxes are a critical financial tool that helps states fund their share of the Medicaid program, which in turn secures vital federal funding. Any reduction or elimination of these taxes would create immense pressure on state budgets, with people with disabilities bearing a heavy and disproportionate burden through the loss of essential services that are fundamental to their health and independence.

For more details, see Five Key Facts About Medicaid and Provider Taxes