G.O.P. Targets a Medicaid Loophole Used by 49 States to Grab Federal Money

States have long used taxes on hospitals and nursing homes to increase federal matching funds. If Republicans end the tactic, red states could feel the most pain.

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May 6, 2025 Updated 1:56 p.m. ET

In 1989, New Hampshire's Republican governor, Judd Gregg, had a gaping budget hole he didn't know how to fill. His health secretary came up with a solution: a tax maneuver he'd learned through the grapevine that would force Washington to send the state millions in extra Medicaid funds.

It was called a Medicaid provider tax, and New Hampshire was among the first states to try it. New Hampshire taxed its hospitals and returned dollars to them as higher payments for Medicaid patients' care. On paper, the tax inflated the state's Medicaid spending, allowing it to collect more matching funds from the federal government.

"It was a way of the state basically gaming the federal government, for lack of a better term," Mr. Gregg said recently.

What started as creative budgeting in New England has, over four decades, snowballed into a mainstay of financing Medicaid, the insurance program for the poor that covers 72 million Americans. Every state but Alaska has at least one such tax. In some states, provider taxes and related payments bring in more than a third of overall federal funding for the program.

Long after these taxes have become entrenched, congressional Republicans are now considering curtailing or ending them as one way to achieve the steep federal spending reductions proposed in the House budget. If they did, it would save the federal government about $600 billion over the next decade, a large chunk of the $880 billion in cuts that the House committee that oversees Medicaid has been charged with finding.

The change could hit some Republican-led states the hardest, a recent analysis shows, because their Medicaid budgets tend to be more reliant on the medical provider tax strategy.

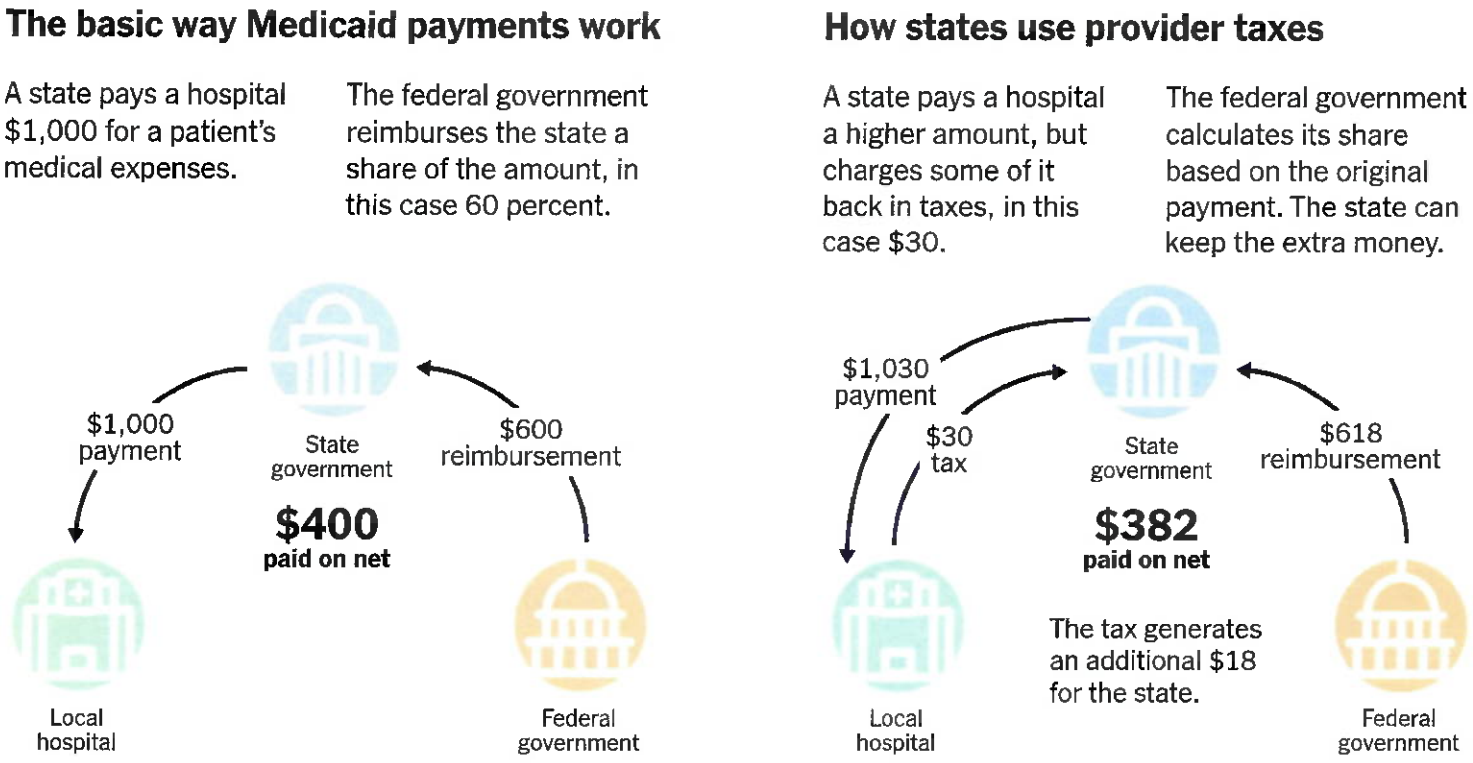
Even so, the idea has gained traction among conservative think tanks and congressional Republicans, who have recently described the payments as gimmicks, scams and even "money laundering."

"It's a way that the state is basically just creating federal money out of thin air," said Brian Blase, the president of the Paragon Institute and the author of a recent paper that analyzes some of the most elaborate ways states exploit the loophole. In Arizona, legislators established a hospital tax in 2020 that allowed it to increase hospital payments by more than $1 billion, without spending any additional state funds. Mr. Blase is encouraging lawmakers to reform the system as part of their budget bill.

In its simplest form, the tax maneuver works like this: When a Medicaid patient goes to the hospital, the federal government and state usually share the costs. The ratio varies from one state to another, depending on how poor the state is, but the federal government often pays around 60 percent of the bill.

States that use provider taxes to get more money usually start by paying the hospitals more. If the federal government is paying 60 percent and the state 40 percent, when a state bumps a payment to $1,030 from $1,000, the federal government chips in $618 instead of $600.

With the tax, the state can actually earn itself money while also raising the hospital payment. Even if the state fully reimbursed the hospital for the amount of the tax, it would have some extra left over, because the new federal money more than covers the difference.



Note: States pay different shares of Medicaid costs. This example illustrates when a state pays 40 percent, a common scenario. • The New York Times

Medicaid spends $870 billion annually, so states can generate tens or hundreds of millions of dollars this way.

Over time, as the rules have become more complicated and as consultants have developed new strategies, the financing mechanisms have become more complex, and the money has become harder to track. But measurements show the total federal contribution has grown even as the official match rates haven't changed.

The government does not know exactly how much money states have raised with these taxes and related strategies. The Centers for Medicare and Medicaid Services, which pays the federal share of the program, does not track all revenue

associated with provider taxes. Neither does the Medicaid and CHIP Payment and Access Commission, the organization created by Congress to analyze Medicaid spending.

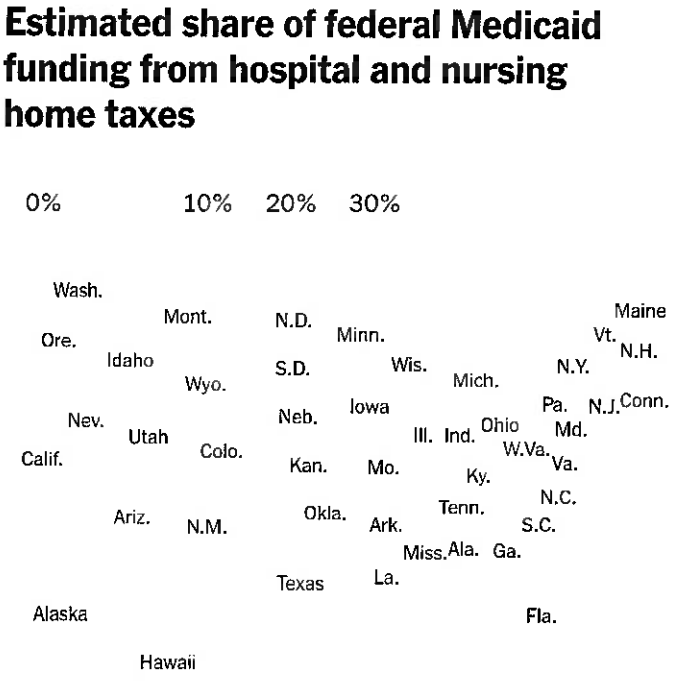
For years, the use of provider taxes in New Hampshire was openly described as "Mediscam" by state officials. In other states, there are less colorful euphemisms, like "tax and match" in Maine. "Medicaid maximization" was a widespread term in the early 2000s, when the taxes were getting off the ground.

The federal government allows states to have provider taxes as long as they don't go above a certain percentage, meant to be applied across all providers in a category — not just as a windfall to a hospital that treats a high number of Medicaid patients. With the government's blessing, there are now 19 different types of health care providers that can be taxed, not just hospitals but also dentists and even chiropractors, and numerous approved ways to pay them back.

"It's absolutely legal, and that's the problem," said Rodney Whitlock, a vice president at McDermott+ Consulting and a longtime Republican Senate staffer who worked on reining in provider taxes in the 2000s, with limited success.

The proposals circulating on Capitol Hill to ban the taxes do not include provisions to replace any lost dollars with new funding sources, which would leave some states with big holes in their Medicaid budgets. In some places, more than a third of federal Medicaid spending would vanish. To adjust to less money coming in, some would probably cut Medicaid coverage for working-age adults. Others would reduce payments to hospitals and nursing homes, or look at other parts of the state budget for cuts, like public education. A few might raise taxes.

"If you take away this money, that's a policy decision," said Robin Rudowitz, director of the Medicaid program at KFF, a health research group. "It's not an issue of cracking down on fraud."



Source: The Hilltop Institute • This map underestimates the effect of provider taxes in the Dakotas, which tax other health care providers, and North Carolina, which recently made major policy changes. • The New York Times

The federal government typically spends a larger share in poorer states, which tend to be in the South, and many of the states that stand to lose the most from the policy are governed by Republicans.

Because there are no precise federal estimates of the tax's effects, a team of researchers at The Hilltop Institute at the University of Maryland-Baltimore County pieced together data from various sources to provide rough calculations about how much money the taxes are currently generating for states.

Using conservative assumptions, the analysis found that the change could mean a budget hole of at least $2.7 billion for South Carolina next year — about a third of what the Medicaid program spent there last year. In Mississippi, where the Medicaid program also relies heavily on provider taxes, the state could lose about $2.1 billion in federal funds, roughly 37 percent of what the state typically gets from the federal government.

Other cuts lawmakers are considering — like reducing spending for Obamacare's Medicaid expansion — would cut more disproportionately from richer states led by Democrats. But those policies may not have the same rhetorical appeal as cracking down on provider taxes.

The federal government has repeatedly attempted and failed to roll back provider taxes, both under Democrats and Republicans. In 2006, federal officials tried to do it through regulation, and Congress largely blocked the effort in the face of lobbying from governors and hospitals. In the 2010s, President Obama issued two budgets that proposed limits on their use, but Congress declined to pursue the idea.

Hospitals continue to discourage Congress from making the cuts. "For those out there who are specifically suggesting these are illegitimate, nothing could be further from the truth," said Stacey Hughes, an executive vice president of the American Hospital Association. "These supplemental payments are scrubbed and go through significant regulatory scrutiny."

Government watchdog agencies have also produced detailed reports and recommendations for reform. A 2020 report from the Government Accountability Office estimated that states, on average, were using the taxes to get the federal government to pay an extra 5 percent of their Medicaid bills. An Office of Inspector General investigation in 2018 recommended that the government "re-evaluate" its current rules. The Biden administration created a regulation prohibiting pooling arrangements that shift funds around to ensure all hospitals get back their provider tax money. It doesn't kick in until 2028. The Trump administration is working on a regulation that may rein in some Medicaid taxes, but the full language has not yet been made public.

"That's the whole problem with the conversation here is we should have been having it in the early '90s," said Andy Schneider, a longtime Democratic congressional staffer who is now a research professor of public policy at Georgetown.

After his stint as New Hampshire's governor, Mr. Gregg was elected to the Senate and went on to chair the budget committee there. When he first encountered Medicaid provider taxes as governor, his state was in a deep fiscal hole. When he got to Congress, he started viewing them differently. But they had become so entrenched that they were difficult to reform.

"At the time, I was happy to game the federal government because we were in crisis," he said. "I always assumed it would go away. It didn't. It continued, and became a fait accompli that has continued on and on and on."

Additional work by Guilbert Gates and Alicia Parlapiano.

***A correction was made on May 6, 2025**: An earlier version of this article misstated the name of the organization created by Congress to analyze Medicaid spending. It's the Medicaid and CHIP Payment and Access Commission, not the Medicaid Advisory Commission.*

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