Provider Tax Restrictions and State Implementation Capacity

How the Medicaid financing freeze constrains work requirement infrastructure.

The Spreadsheet That Did Not Balance

Rachel Morrison, Deputy Director for Finance at her state's Medicaid agency, opened the budget model for work requirement implementation in October 2025. Fourteen months until December 2026. Her state served 387,000 expansion adults facing new requirements. Actuaries estimated 60,000 to 75,000 would need navigation support. Professional navigators would cost $45 million to $60 million annually.

She started with traditional financing. Medicaid administrative costs receive 50 percent federal match. A $50 million navigation program would cost the state $25 million. General fund revenues were flat. The governor had made clear that new general fund commitments for Medicaid were not happening in an election year.

Her state, like virtually every state, funded Medicaid partly through provider taxes. The hospital tax brought in $280 million annually at 5.8 percent. The nursing home tax added $85 million. Together these provider taxes funded nearly 40 percent of the state's Medicaid match.

Rachel assumed she could propose a modest increase to 6.0 percent on hospitals, generating $10 million that would draw down $10 million in federal match. That $20 million would cover most navigation costs.

Then she remembered the provider tax freeze. OB3 /H.R.1 took effect July 4, 2025. No increases allowed. Her state's taxes were locked at current rates. She pulled up the legislation. Section 71115 was explicit: states could not increase rates beyond July 4, 2025 levels. The freeze would last ten years.

She adjusted the model. Navigation infrastructure: $50 million cost, $25 million state share. Provider tax revenue: locked. General fund availability: zero. The math did not work. She could not fund navigation without either cutting provider rates or finding general fund money that did not exist.

Cutting provider rates was politically impossible. Hospitals and nursing homes would revolt if Medicaid payments decreased to finance administration. General fund increases required legislative action the governor would not support.

She ran scenarios. Professional navigators were expensive but necessary for complex cases. Community health workers cost less but served fewer people. Volunteers cost almost nothing but had no track record at scale. Mixing approaches might cut costs to $30 million, leaving $15 million state share. Still unworkable.

What if the state delayed navigation infrastructure? That would guarantee coverage losses among eligible people failing to navigate administrative complexity. What if the state requested an extension? Extensions did not solve financing. Whether requirements started December 2026 or June 2027, the provider tax freeze remained in effect.

Rachel scheduled a meeting with her director. The policy team was developing implementation plans assuming adequate financing. The budget reality was that adequate financing would not

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materialize. Someone needed to tell the implementation team that planned infrastructure could not be funded. Someone needed to explain that the state's traditional financing mechanism no longer existed.

The provider tax freeze was not a work requirement provision. It was deficit reduction targeting Medicaid financing Congress viewed as budget gimmickry. But its timing created collision with work requirement preparation. States needed to build infrastructure now. Their financing tool had been eliminated. The spreadsheet did not balance.

The Provider Tax Mechanism

Provider taxes represent a financing strategy that forty-nine states used as of 2025 to fund their share of Medicaid costs. ***The mechanism is straightforward: a state imposes a tax on healthcare providers, typically hospitals, nursing homes, or managed care organizations. The tax generates revenue that the state uses to fund its portion of Medicaid spending.*** The federal government then matches that state spending according to the Federal Medical Assistance Percentage, which ranges from 50 percent to 76 percent depending on state per capita income.

The mathematics create federal leverage. A state imposes a $100 million hospital tax. The state uses that $100 million as its Medicaid match. The federal government contributes an additional $100 million at a 50 percent match rate. The state now has $200 million total to spend on Medicaid. It can increase provider payment rates using this $200 million. Hospitals pay $100 million in tax but receive $200 million in increased payments, netting $100 million benefit. The federal government pays $100 million it would not have paid absent the state's tax scheme.

This dynamic explains both why states adopted provider taxes aggressively and why Congress moved to restrict them. ***From a state budget perspective, provider taxes are nearly free money.*** The state imposes the tax, providers pay it, the state uses it to draw down federal match, providers get the money back through higher Medicaid rates. The state's budget position barely changes, but federal spending increases substantially.

From a federal budget perspective, provider taxes inflate federal Medicaid spending without corresponding increases in state commitment. States engineer financing arrangements that maximize federal participation while minimizing actual state general fund contributions. The Congressional Budget Office estimated that provider taxes and similar mechanisms shifted approximately five percentage points of Medicaid financing responsibility from states to the federal government compared to what the statutory match rates would suggest.

OB3 /H.R.1's provider tax provisions aimed to curtail this dynamic. Section 71115 froze provider tax rates at July 4, 2025 levels. States cannot create new provider taxes. States cannot increase rates on existing provider taxes above what was in effect on that date. The freeze applies to all states but hits expansion states particularly hard through additional restrictions. For expansion states, the legislation also established declining safe harbor thresholds, reducing from 6 percent of provider revenue in 2026 to 3.5 percent by 2032. States that had taxed providers at or near the 6 percent threshold must reduce rates over time, further constraining their financing flexibility.

The CBO projected these restrictions would save the federal government approximately $89 billion over ten years through reduced Medicaid spending. The savings come from states being unable to use provider taxes to generate additional federal match, effectively forcing states to either reduce Medicaid spending or find alternative revenue sources.

The Financing Constraint

The provider tax freeze creates immediate financing challenges for states preparing work requirement implementation. Navigation infrastructure, exemption verification systems, community partnerships, and provider support all require funding. These functions qualify as Medicaid administrative activities eligible for 50 percent federal match, but only if states contribute their 50 percent share first.

Before the freeze, states would have financed new administrative costs through the same mechanism they used for other Medicaid expansions: increase provider taxes modestly to generate state revenue, use that revenue to draw down federal match, and fund the new activities. The provider tax freeze eliminates this option. ***States must now find funding through general revenue appropriations or by reallocating existing Medicaid spending from other priorities.***

General revenue appropriations face political and practical obstacles. State budgets are constrained by competing priorities, existing commitments, and revenue limitations. ***Medicaid already consumes 20 to 30 percent of state general fund budgets in most states.*** Governors and legislators resist new general fund commitments for Medicaid administration when provider taxes previously enabled such expansions without general fund impact. The fact that federal match means the state's investment leverages equal federal dollars does not overcome political resistance to new state spending.

Reallocating existing Medicaid spending requires cutting something else. The obvious targets are provider payment rates or benefits. ***Reducing provider rates to fund navigation infrastructure creates provider backlash and threatens network adequacy. Reducing benefits affects enrollees directly.*** Neither option is politically palatable, particularly when the reductions finance administrative infrastructure rather than direct services.

The timing makes the constraint more acute. States need navigation infrastructure operational by December 2026. Building this infrastructure requires procurement, contracting, hiring, training, and system integration. These processes require eighteen to twenty-four months under normal circumstances. States are already behind schedule. Securing financing should have happened in 2025. Provider tax increases would have been the traditional mechanism for generating the needed state revenue. That mechanism is now unavailable.

Some states maintain rainy day funds or budget reserves that could temporarily finance navigation infrastructure. But these are one-time resources. Navigation infrastructure requires ongoing annual funding. Using reserve funds to launch navigation in 2026 does not solve how to sustain it in 2027, 2028, and beyond. States need permanent financing solutions, not temporary patches.

State Variation in Exposure

States' vulnerability to the provider tax freeze varies based on their reliance on these mechanisms and their fiscal capacity to find alternatives. ***States that used provider taxes extensively to finance high Medicaid match rates face severe constraints.*** States that relied primarily on general revenue, or that maintain robust fiscal reserves, have more flexibility.

California's situation illustrates severe constraint. California operated under a uniformity waiver allowing differential hospital tax rates. Hospitals serving higher proportions of Medicaid patients paid higher tax rates, generating substantial revenue that California used to increase Medicaid hospital payments. This arrangement generated approximately $3.7 billion annually in state

revenue, drawing down billions more in federal match. OB3 /H.R.1 prohibits such differential rate structures. ***California must unwind this financing arrangement while simultaneously building work requirement infrastructure, creating a fiscal crisis that will likely require general fund appropriations the state budget cannot easily accommodate.***

Texas presents a different profile. Texas did not expand Medicaid under the ACA, so its exposure to work requirements is limited to traditional disabled and parent populations who already face various program requirements. Texas used provider taxes but not as aggressively as expansion states. The state's relatively strong fiscal position and conservative approach to Medicaid creates more room for general revenue appropriations if political will exists.

Michigan expanded Medicaid and used provider taxes extensively. The state's Medicaid program grew substantially after expansion, and provider taxes helped finance the increased state share. ***The provider tax freeze hits Michigan hard, compounded by the state's modest fiscal reserves.*** Michigan must build work requirement infrastructure for approximately 750,000 expansion adults while losing its traditional financing tool, creating acute budget pressure.

Georgia's position reflects both opportunity and constraint. Georgia did not expand Medicaid until 2023, implementing a limited waiver program requiring work requirements from inception. The state's more modest expansion means fewer people facing requirements. ***However, Georgia's provider tax structure included elements that OB3 /H.R.1 restricts, forcing financing adjustments.*** The state's implementation experience with work requirements since 2023 creates operational knowledge but does not solve financing challenges.

New York faces massive fiscal impact. ***New York used provider taxes aggressively, with the MCO tax alone generating over $3.7 billion annually.*** CMS correspondence in 2025 indicated the federal government would approve only $2.1 billion in matching funds under new policy standards, creating a $1.6 billion shortfall even before accounting for new work requirement costs. New York must simultaneously address this existing financing gap and find resources for navigation infrastructure serving over one million expansion adults. ***The financial magnitude strains even New York's substantial fiscal capacity.***

The December 2026 Collision

The provider tax freeze took effect July 4, 2025. Work requirements begin December 2026. This eighteen-month window should provide adequate implementation time except that the financing mechanism states would typically use no longer exists. States face parallel challenges: operationalizing work requirements while solving an unprecedented financing problem.

The operational requirements are substantial. States must develop verification systems, establish exemption processes, contract with MCOs for member outreach, partner with community organizations for navigation, integrate with employment data systems, train eligibility workers, educate providers about attestation requirements, and prepare for appeals volume. Each component requires funding. Some costs are one-time system development expenses. Others are ongoing operational costs.

The financing problem compounds throughout. One-time system development costs might total $15 million to $40 million per state depending on existing infrastructure and population size. States could potentially absorb these through normal capital budgeting if necessary. Ongoing operational costs are larger and permanent. Navigation infrastructure might cost $30 million to $80 million annually per state depending on approach and population size. Provider attestation support,

community partnerships, MCO care coordination, and state administrative capacity add tens of millions more.

Before OB3 /H.R.1, states would have financed these costs through modest provider tax increases generating adequate state revenue to draw down federal match. A state needing $40 million in state funds annually to cover its share of $80 million in navigation costs would have increased hospital taxes perhaps 0.3 to 0.5 percentage points. Providers would pay the additional tax and receive it back through higher rates or supplemental payments. The state's net general fund position barely changes. Federal match covers half the cost. The infrastructure gets built and operated.

After OB3 /H.R.1, this path is closed. States must find the $40 million in state funds through general appropriations or reallocate from existing Medicaid spending. General appropriations require legislative action in tight budget environments. Reallocation requires cutting provider rates or benefits, creating political and operational backlash. Neither option is attractive. Both face significant obstacles. Time is running out to implement either before December 2026.

The Impossible Choice

The provider tax freeze forces states to choose between maintaining provider payments and building work requirement infrastructure. Without new revenue sources, they cannot do both.

Maintaining provider payments preserves network adequacy. Hospitals and nursing homes operating on thin margins cannot absorb reductions without cutting services or limiting Medicaid participation. Provider groups lobby effectively against rate cuts. Cutting rates to fund work requirement infrastructure triggers opposition campaigns and political backlash.

Building work requirement infrastructure prevents coverage losses among eligible people. Without adequate navigation support, coverage losses will exceed policy intent. People qualifying for exemptions will lose coverage because they cannot document them. People who are working will lose coverage because they cannot verify hours.

Each choice carries consequences. States maintaining provider payments will see coverage losses. States cutting provider rates will see network problems and provider protests. States attempting to muddle through will achieve neither objective well.

Federal policy created this dilemma by mandating work requirements while eliminating states' traditional financing mechanism in a single act.

Alternative Financing Mechanisms

States facing provider tax constraints have explored ***alternative financing approaches.*** None fully replaces provider tax capacity, but combinations might partially close the gap.

Enhanced federal match for health information technology provides one avenue. CMS regulations allow 90 percent federal match for Medicaid information technology development and 75 percent ongoing match for operations. Some work requirement infrastructure components might qualify. Verification systems, data exchange platforms, member portals, and case management systems with health IT components could draw enhanced match. States pursuing this avenue must carefully categorize spending to maximize HIT qualification while ensuring compliance with federal requirements.

The challenge is that ***enhanced HIT match covers technology but not human infrastructure.*** Navigation staff, community partnerships, exemption clinics, and provider support cannot be

classified as health information technology. These human components often represent the larger cost categories. Enhanced HIT match helps but does not solve the financing problem.

Federal administrative match for eligibility operations provides standard 50 percent federal participation. Work requirement activities qualify as eligibility functions. ***States can claim federal match for eligibility worker time, outreach activities, and verification systems.*** The limitation is that states must contribute their 50 percent share to access federal match. Without provider taxes to generate state revenue, the constraint remains finding the state's half.

Medicaid managed care contracts offer another mechanism. States can require MCOs to provide navigation support as a contractual obligation. MCO costs flow through capitation rates, which include federal match. This shifts navigation costs from state administrative budgets to MCO contracts, effectively financing navigation through capitation rather than administration. The federal match percentage may differ slightly, and states must ensure adequate capitation rates to cover MCO costs without creating actuarial issues.

MCO contract requirements face practical limits. ***MCOs can absorb some incremental administrative costs within existing capitation.*** Large-scale navigation infrastructure exceeds what capitation can support without rate increases. States requesting significant capitation increases face federal scrutiny about actuarial soundness and must demonstrate the increases reflect legitimate cost increases rather than financing gimmicks. The flexibility exists but is constrained.

Community benefit obligations for non-profit hospitals create potential partnerships. Tax-exempt hospitals must demonstrate community benefit to maintain 501(c)(3) status. Navigation assistance helping community members maintain health coverage qualifies as community benefit activity. Hospitals could fund navigation programs that both serve community benefit requirements and protect hospital revenue by maintaining patient coverage.

This approach requires hospitals to use operating revenue to fund navigation rather than receiving state payments financed through provider taxes. ***Hospitals facing margin pressure may resist diverting revenue to navigation even when navigation protects against uncompensated care increases.*** The mechanism provides theoretical capacity but depends on voluntary hospital participation driven by self-interest alignment rather than government financing.

Workforce Innovation and Opportunity Act funding supports workforce development activities that overlap substantially with work requirement navigation. WIOA grants fund job search assistance, skills training, supportive services, and employment counseling. ***States can braid WIOA resources with Medicaid administrative funding to support dual-purpose navigation that serves both workforce development and health coverage goals.***

WIOA funding comes with different match rates and eligibility criteria than Medicaid administrative funds. Integrating these funding streams requires coordination across agencies, aligned outcome measures, and careful cost allocation. States with well-developed workforce boards and strong interagency collaboration can leverage this opportunity. States with siloed agencies face administrative barriers to braiding resources effectively.

Rural Provider Implications

The provider tax freeze hits rural providers particularly hard. Rural hospitals and nursing homes operate on narrow margins. Many depend on Medicaid revenue for financial viability. Approximately 300 rural hospitals are currently at immediate risk of closure. Provider tax freezes

reduce the financing available for Medicaid payment rates precisely when states face pressure to fund work requirement infrastructure.

The trade-off becomes explicit in rural areas. ***States can maintain rural provider rates or fund navigation infrastructure, but constrained budgets prevent both.*** Rural hospitals and nursing homes serving high proportions of Medicaid beneficiaries cannot absorb rate cuts. Many would close. Rural communities would lose healthcare access entirely, affecting everyone regardless of insurance status.

Work requirement implementation will affect rural residents disproportionately. Rural populations face greater barriers to verification: limited internet access, greater distances to social service offices, fewer community support organizations, and higher rates of employment in seasonal or informal work that is difficult to document. Rural residents need navigation support more than urban residents, yet rural states face tighter budget constraints limiting their ability to provide it.

OB3 /H.R.1 included $50 billion over five years for rural health transformation programs, intended to mitigate rural healthcare impacts. This funding could theoretically support rural navigation infrastructure. However, the funds are distributed to states through a competitive grant process requiring state plans. States must apply, receive approval, and implement programs within federal guidelines. The process takes time that states do not have before December 2026. Rural transformation funds may eventually supplement work requirement infrastructure but will not provide immediate solutions for December 2026 implementation.

The rural dynamic creates political pressure on governors and state legislators from rural areas. Rural hospital associations, nursing home associations, and local chambers of commerce all lobby for maintaining provider payments. Rural legislators resist rate cuts that would threaten institutions critical to their districts. The politics of protecting rural providers competes with the policy imperative of building work requirement infrastructure. States led by governors with rural political bases face particularly acute pressure.

The Federal Accountability Gap

Federal policy created this financing crisis but provides no federal solution. Congress imposed work requirements knowing states would need infrastructure to implement them. Congress simultaneously eliminated the financing mechanism states traditionally used for such infrastructure. The federal government mandated the requirement, removed the financing tool, and offered no alternative.

This creates a federal accountability gap. If states fail to build adequate navigation infrastructure and coverage losses exceed policy intent, who is responsible? States had insufficient resources. Federal law prevented them from accessing their traditional financing mechanism. The federal government did not provide alternative funding. Responsibility cannot rest entirely with states when federal policy deliberately constrained their financing options.

CMS guidance emphasizes state responsibility for adequate implementation. Federal oversight will evaluate whether states have verification systems, exemption processes, and member support. Federal reviewers will note when states' infrastructure proves inadequate. But federal oversight does not provide financing. CMS can identify deficiencies but cannot resolve the resource constraints that created them.

States may argue in federal waiver applications and implementation plans that the provider tax freeze makes adequate infrastructure unaffordable. They may request flexibility, deadline

extensions, or additional federal support acknowledging financing limitations. These requests place federal administrators in difficult positions. CMS cannot waive statutory requirements. CMS cannot authorize enhanced federal match beyond what law allows. CMS can provide technical assistance but cannot provide money.

The disconnect between federal requirements and federal financing support may generate state resistance. ***Some states might intentionally implement minimal infrastructure, document that resource constraints prevented more, and argue federal policy created the conditions for inadequate implementation.*** This approach risks federal penalties but positions states to argue the penalties are unjust given resource limitations federal policy imposed.

The December 2026 Reality

December 2026 will arrive regardless of whether states solved the financing problem. Work requirements will take effect on schedule. States will launch whatever infrastructure they managed to build with whatever financing they secured. The adequacy of that infrastructure will vary dramatically based on states' success navigating the financing crisis the provider tax freeze created.

Well-resourced states with fiscal capacity may find general revenue to fund navigation despite provider tax limitations. These states will build professional navigation programs, comprehensive exemption systems, and robust provider support. Their expansion populations will experience work requirements with infrastructure making compliance achievable for eligible people.

Constrained states without fiscal capacity or political will to commit general revenue will launch with minimal infrastructure. Navigation will be under-resourced. Exemption documentation will be under-supported. Verification will depend on member self-navigation through systems designed for documentation rather than assistance. Coverage losses will exceed what policy intended as eligible people lose coverage due to system failures rather than compliance failures.

The geographic variation in infrastructure adequacy will create parallel tracks. Expansion adults in some states will experience work requirements as administrative adjustments requiring modest effort to maintain coverage. Expansion adults in other states will experience work requirements as substantial barriers that many cannot navigate successfully. The variation reflects state fiscal capacity differences that the provider tax freeze exacerbated.

The provider financing constraint guarantees sub-optimal implementation across many states. The question is not whether infrastructure will be adequate but how inadequate infrastructure will be and where coverage losses concentrate. States making different financing trade-offs will see different patterns of coverage loss. Those prioritizing provider payments over navigation will see documentation failure losses. Those cutting provider rates to fund navigation will see provider network problems. Neither outcome serves anyone well.

The federal government mandated work requirements as policy reform intended to encourage employment and self-sufficiency. The provider tax freeze undermined states' capacity to implement the requirements with infrastructure making them workable. The resulting implementation will test whether work requirements function as intended or simply create administrative barriers that eligible people cannot overcome. The test occurs in real time with real people losing coverage while policymakers argue about responsibility and resources.

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