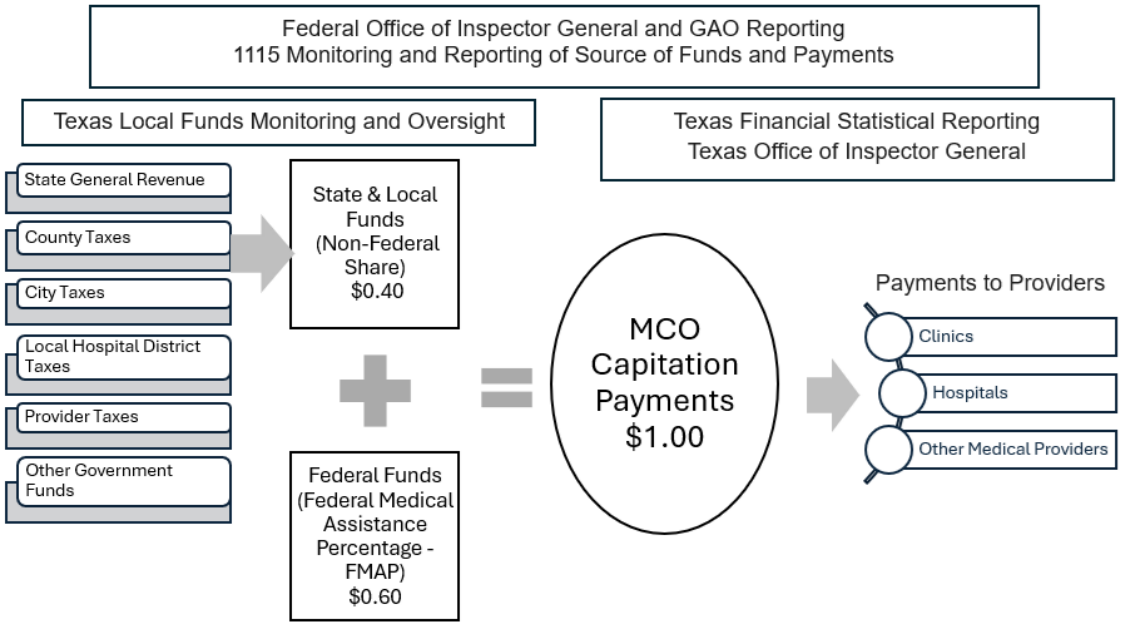
Federal Law Permits Provider Taxes in Medicaid, Which Are Essential to Fund Lifesaving Care for Children in Texas

Medicaid is funded jointly by the state and federal governments (matching percentages are Texas-specific):



Federal and state governments oversee and regulate the collection of funds, the use of funds, and the reporting of funds and payments in Medicaid.

Federal and state oversight includes:

- the General Accountability Office, which has published and presented reports in multiple Congressional hearings.
- the Centers for Medicare and Medicaid Services, which requires various transparency requirements in the sources of funds in the Texas 1115 Waiver as well as in resulting payments in annual reporting.
- additional reporting requirements in the MCO Financial Statistical Reporting related to directed Medicaid payments.

Federal law expressly permits states to use provider taxes to fund a portion of the non-federal share of Medicaid payments.

Beginning in the 1980s, states began using provider taxes and provider donations to fund the non-federal share of their Medicaid payments. In 1991, Congress addressed some unintended consequences, referred to as "loopholes," by passing the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments to significantly restrict the use of provider donations in financing Medicaid. This law provided more guidance and limitations for states' ability to draw down federal Medicaid matching funds with provider tax revenue. CMS has also instituted extensive regulations and reporting requirements on those taxes. The federal parameters include:

- **States must fund at least 40% of the non-federal share of Medicaid payments with general revenue, as required by federal law.** In state fiscal year 2024, states reported that state general revenue accounted for about 68% of the state share of Medicaid costs. The remaining 32% of financing originated from other state or local sources, including local government funds, provider taxes, fees, permissible donations, assessments, and tobacco settlement funds.

- **Provider taxes must be broad-based and uniform.** This means that the tax must be imposed on **all** providers within a specified provider class, and it must be the **same** tax rate for all providers within a specified class of providers. CMS can waive these requirements if the state meets certain statistical tests to indicate the tax remains generally redistributive.
- **States cannot hold providers harmless for their taxes**; in other words, the state cannot guarantee that the providers will receive their tax payments back.

Texas' provider taxes fund payments under the state's 1115 waiver. To receive federal approval of a waiver, a state must demonstrate that Medicaid payments under the waiver would not exceed payments without the waiver. Thus, there is an additional limit on Texas' provider taxes.

Texas' provider taxes comply with federal law, and MACPAC has recognized Texas as a model of transparency for other states.

On June 30, 2023, the Federal District Court for the Eastern District of Texas granted Texas an injunction against CMS, finding that Texas is interpreting federal law as Congress expressly stated, and that Texas is likely to succeed on the merits of its claim that its provider taxes comply with federal law.

Further, in its June 2024 report to Congress, the Medicaid and CHIP Payment and Access Commission recognized Texas' transparency in provider taxes reporting and recommended Texas' reporting as a model for other states. The Texas Legislature directed these reporting efforts beginning in 2019. In 2023, Texas released its first public report of Medicaid financing for FY 2022 that includes information on provider taxes and other government funds used to support Medicaid expenditures.

Texas' provider taxes fund quality improvement in state directed payment programs.

Texas' Directed Payment Programs (DPPs) create financial alignment among the state, the Medicaid managed care organizations (MCOs), which deliver care to 97% of the Medicaid enrollees, and providers. Texas has pay-for-performance (P4P) metrics, reporting, and evaluations within the DPPs.

DPPs must be evaluated annually to test whether the payment arrangement advances the goals of the Texas Managed Care Quality Strategy. Figure 1 shows how Texas performed on these metrics as of October 2023.

Figure 1: DPP Quality Objective Dashboard October 2023 (see **Appendix D**)

Reducing the DPPs will disrupt Texas' trajectory of improving outcomes, reducing costs, and driving innovation in the Medicaid program.

Provider taxes are a critical financing source for Medicaid reimbursement to children's hospitals in Texas.

Texas Medicaid generally covers only the federally-mandated populations, with more coverage for pregnant women and individuals needing long-term care. More than three million children are enrolled in Medicaid. Medicaid pays for **60% of all days in care** on average at a children's hospital. Thus, children's hospitals are especially reliant on Medicaid payments. **Without the DPPs, children's hospitals would be underfunded by up to 28%**, impacting access to care for all children in the state. As base Medicaid payments do not fully cover the cost of care, states have created supplemental and directed payment programs to help mitigate losses hospitals incur from treating this low-income population. HHSC has structured these programs in Texas in such a way that **provider taxes now fund over half (56%) of the total Medicaid payments to children's hospitals in Texas**. Any change that further limits the use of provider taxes as a source for the non-federal share will have devastating impacts on these hospitals.