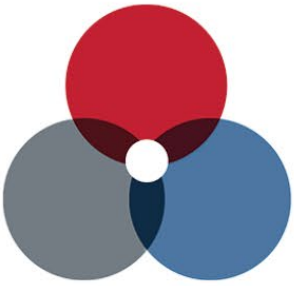

Fragile Financing

Provider taxes, state directed payments, and Ohio Medicaid

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Fragile Financing:

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Medicaid is the single largest payer for health services in Ohio, covering more than three million residents and accounting for over $43 billion in combined state and federal spending in FY 2025—about five percent of the state's economy. Meeting the state's obligation to draw down federal matching dollars has always been a challenge.

Ohio relies heavily on two financing tools that are largely invisible outside of policy circles: provider taxes and state directed payments (SDPs). Recent federal policy changes place billions of these financing streams at risk; estimates suggest that Ohio could lose $6.5 to $13 billion in Medicaid funding over the next decade if restrictions on provider taxes and SDPs take full effect.

How do provider taxes work?

Provider taxes raise billions of dollars each year from hospitals, nursing facilities, managed care organizations, and other providers. These dollars are then used as the state share to leverage additional federal funds. State directed payments, in turn, route much of this money back to providers through Medicaid managed care contracts. Together, these tools now underpin much of Ohio's Medicaid program—but both raise important questions about sustainability, transparency, and accountability. Nationally, SDP use has exploded, with spending more than doubling in less than two years, and provider taxes face renewed scrutiny from federal policymakers.

Payment arrangements under pressure

Recent federal developments sharpen those concerns. H.R. 1, the federal budget bill, levied new restrictions on provider taxes, and CMS has finalized rules requiring states to show greater transparency and cap SDP rates at Medicare levels. For Ohio, these changes put programs like the Health Insuring Corporation franchise fee and hospital payment arrangements under pressure, highlighting just how much the state depends on financing mechanisms that could soon face tighter limits. This paper explains how provider taxes and SDPs work in Ohio, how they interact, and why their future is critical to the state's Medicaid policy debates.

Medicaid financing basics

Medicaid is a joint federal–state program, but the financing balance tilts heavily toward federal dollars. In Ohio, the federal government pays close to two-thirds of all Medicaid costs through the Federal Medical Assistance Percentage (FMAP). The state provides the rest, with certain groups such as the ACA expansion population receiving enhanced federal support.

Most of Ohio's nonfederal Medicaid is financed through provider taxes and fees

What is striking in Ohio is that state tax dollars make up only a small share of the program's budget. According to the Health Policy Institute of Ohio's Medicaid Basics 2025, most of the state's nonfederal share is financed through provider taxes and fees—on hospitals, nursing facilities, and managed care plans—as well as transfers from public entities. These sources have become essential because they allow the state to draw down billions in federal matching funds without relying heavily on general revenue.

Another important distinction is how extra payments flow back to providers. In fee-for-service systems this occurs through supplemental payments, but as most beneficiaries are now in managed care, states like Ohio rely more heavily on SDPs. These must be written into managed care contracts and approved by CMS in advance.

Understanding how provider taxes and SDPs work is critical to understanding both the stability of Ohio's Medicaid program and the risks posed by new federal oversight.

Provider taxes in Ohio

Ohio depends heavily on provider taxes to finance its share of Medicaid spending. Together, these taxes generate several billion dollars each year, making them one of the largest sources of state support for the program. Without them, Ohio would have to rely much more heavily on general tax revenue or face difficult choices about cutting Medicaid benefits, eligibility and or payments.

Hospital franchise fee

The hospital franchise fee is the largest of Ohio's provider taxes, but it is also one of the newest. It was created in 2009 during the Great Recession, when state revenues collapsed and lawmakers sought new ways to sustain Medicaid spending (I served as Ohio's Medicaid Director during this period). The fee is assessed on hospitals based on their

inpatient and outpatient revenues and today it raises well over a billion dollars annually. These dollars are then matched with federal funds and flow back to hospitals through Medicaid payments. Hospitals have generally supported the fee because much of what they pay comes back to them in the form of Medicaid reimbursement.

HIC franchise fee

The Health Insuring Corporation (HIC) franchise fee, created in 2016 and codified in ORC 5168.76, applies to managed care plans based on their enrollment. It uses a tiered structure that charges higher rates on Medicaid member months than on non-Medicaid member months. In the current state budget for FY 2026–2027, lawmakers projected the HIC tax will raise about $880 million per year in state revenue. This revenue supports capitation payments to the Medicaid managed care plans, which in turn fund state directed payments to providers.

While the tax has been approved by CMS, it faces new uncertainty under Section 44134 of and under CMS's recent guidance, which warns that taxes charging higher rates on Medicaid than commercial services are unlikely to remain permissible. Ohio could be required to redesign this tax structure well before the end of the federal transition period in 2028.

Nursing facility and ICF/IID franchise fees

By contrast, the nursing facility and ICF/IID (historically ICFMR) franchise fees have been in place much longer, dating back to the 1990s. These are daily per-bed assessments that raise several hundred million dollars annually. They are considered relatively stable financing sources because they are flat per-bed charges that apply uniformly to all facilities, regardless of payer mix. Unlike the HIC fee, they do not vary between Medicaid and non-Medicaid residents, which may make them less vulnerable to federal scrutiny under .

Each of these taxes is subject to a federal ceiling: the total amount collected from a given class of providers cannot exceed six percent of that class's net patient revenue. Ohio, like many states, has structured its franchise fees to remain under these class-specific caps. This means that while the state can continue to rely on them, there is limited room to raise rates further in the largest provider classes without bumping up against federal limits.

Providers taxes amount to about $20 billion in federal funds each year

Taken together, Ohio's provider taxes supply much of the state share that allows Medicaid to draw down more than $20 billion in federal funds each year. They remain the backbone of Ohio's Medicaid financing strategy, but also a potential pressure point as federal oversight tightens and as the state explores whether its HIC franchise fee can survive under new federal rules.

State directed payments in Ohio

As Ohio shifted nearly all Medicaid beneficiaries into managed care, the state also had to adapt how it supports providers. In the old fee-for-service system, states used supplemental payments—often called upper payment limit (UPL) programs—to make additional payments to hospitals, nursing facilities, and other providers above standard Medicaid rates. But as enrollment in managed care grew, fee-for-service supplemental payments reached fewer providers and became less effective.

To address this gap, CMS created the option of state directed payments (SDP). Under this approach, states instruct managed care plans to make specific types of payments to providers, but the payments still flow through the managed care contracts. Each SDP must be submitted to CMS for approval, including detailed actuarial documentation, provider-level impact analysis, and evidence that payments are consistent with Medicare's upper payment bound. Capitation rates must remain actuarially sound once the SDP is included.

SDPs are a central part of Ohio's Medicaid financing

For Ohio, SDPs have become a central financing tool. They allow the state to channel revenue raised through provider taxes back to hospitals, nursing facilities, and other providers in ways that resemble the old UPL programs but are tailored to a managed care environment. This has made SDPs the backbone of Ohio's Medicaid payment policy, complementing the provider tax structure described in the previous section.

Ohio has developed several directed payment programs that channel billions of dollars each year back to providers through Medicaid managed care contracts. These programs are designed both to stabilize provider finances and to advance policy goals such as improving quality or supporting specific types of institutions.

One of the largest is the set of hospital additional payments, which supplement base managed care reimbursements for inpatient and outpatient services. These payments are

closely tied to the hospital franchise fee, ensuring that hospitals receive back much of the revenue they contribute through the tax. The program has grown into a central element of hospital financing in Ohio, particularly for safety-net and teaching hospitals.

SDPs at teaching hospitals

Ohio also operates the Improvements for Priority Populations (OIPP) program. This SDP was initially targeted at smaller university-affiliated hospitals but has since evolved into a broader vehicle for making additional hospital payments. In the FY 2026–2027 budget, OIPP and the Care Innovation and Community Improvement Program (CICIP) were consolidated with other hospital directed payments, reflecting an effort by the state to streamline its SDP portfolio.

The CICIP program was created to support hospitals that train medical residents and provide services to underserved populations. Like OIPP, CICIP has relied on intergovernmental transfers from participating public hospitals to provide the nonfederal share, which the state then uses to draw down federal match.

Taken together, these SDP programs have become as important as provider taxes themselves. They ensure that the dollars raised through franchise fees are returned to providers in ways that keep the financing system politically viable, while also giving the state a tool to advance targeted policy objectives.

SDPs must be approved each year

Unlike fee-for-service supplemental payments, which are built into the Medicaid state plan, SDPs must be approved each year as part of the managed care contracting process. States are required to submit a preprint to CMS that describes the type of payment, the providers affected, the payment methodology, and the policy goals. Each preprint must be accompanied by an actuarial certification showing that the managed care capitation rates remain sound once the SDP is included.

Approval is typically granted for a single contract year, and CMS has made clear that each renewal will be reviewed under the latest standards, including the Medicare payment cap and expenditure ceiling. This rolling process gives CMS leverage to ensure compliance and allows the agency to adjust expectations over time. For states like Ohio that operate multiple large SDP programs, this annual approval cycle creates significant administrative work and introduces uncertainty about whether CMS will allow programs to continue.

Federal rules also require states to report annually on SDP spending. States must disclose how much was paid, which providers received the funds, and how the payments advanced Medicaid objectives. CMS has now committed to publishing preprint approvals and financial data, limiting states' ability to keep payment details opaque.

In practice, CMS and independent reviewers like MACPAC have noted that state reporting is often incomplete or inconsistent, and the rapid growth of SDP spending—over $110 billion in 2024—has outpaced available data on outcomes.

New federal oversight

In September 2025, CMS issued updated guidance that significantly tightens requirements for state directed payments. States must now provide detailed actuarial documentation, including provider-level impact analysis, and demonstrate that SDP payment rates are at or below Medicare levels. CMS has also imposed a hard cap on total SDP expenditures: the amount written into an approved preprint is the maximum the state can spend in that program year. If collections or utilization exceed projections, states cannot increase SDP payments without submitting an amended preprint and obtaining new CMS approval. CMS has further committed to publishing state preprint approvals and financial data, enhancing transparency but reducing states' discretion.

A new, two-layer ceiling and statutory restrictions

These changes represent the strongest federal push yet to rein in SDP growth and create immediate pressure on states like Ohio, which has built a large hospital-focused SDP portfolio tied to its franchise fees. The new "two-layer ceiling"—Medicare rate limits combined with dollar caps based on preprints—removes much of the flexibility Ohio has historically used to true up payments when franchise fee revenues or managed care utilization came in higher than expected.

At the same time, Section 44134 of H.R.1, the federal budget bill, imposes new statutory restrictions on provider taxes. The law requires uniformity between Medicaid and non-Medicaid services, ending CMS's prior flexibility to allow redistributive structures. H.R.1 took effect upon enactment, though the Secretary of Health and Human Services may grant states up to three federal fiscal years—through September 30, 2028—to bring their taxes into compliance. The law also allows provider taxes and SDPs approved before enactment to continue temporarily under prior rules, creating what is often referred to as a grandfathering provision.

In practice, however, grandfathering does not shield Ohio from CMS's regulatory process. Provider taxes like the hospital, nursing facility, and ICF/IID franchise fees benefit from the statutory transition, but SDPs must be re-approved each year through CMS's preprint process. CMS guidance confirms that each renewal will be reviewed under the new Medicare payment cap, documentation requirements, and expenditure ceiling — effectively eliminating grandfathering for these programs.

Ohio's dual challenges

On top of this, CMS has also proposed a new rule aimed at closing what it calls a loophole in Medicaid provider tax regulations. Under the proposal, any tax that explicitly references Medicaid in its base and applies a higher rate to Medicaid units than to non-Medicaid units would automatically fail the "generally redistributive" test, regardless of statistical pass rates. This standard directly threatens Ohio's Health Insuring Corporation (HIC) franchise fee, which charges Medicaid member months at a higher rate than commercial member months.

For Ohio, the result is a dual challenge: redesign provider taxes, especially the HIC franchise fee, to comply with H.R.1 and CMS's proposed rule, while simultaneously recalibrating SDP programs to satisfy CMS's heightened regulatory standards on an annual basis. Together, these changes increase uncertainty and reduce flexibility at the very moment Ohio's Medicaid program is most dependent on these financing strategies.

Michigan faces similar issues

This issue is playing out with our neighbors to the north. On September 16, legislation was introduced in the Michigan House of Representatives to revise the state's insurance provider assessment to comply with new federal rules under H.R.1. It passed the House in only nine days and is now before the Michigan Senate. The bill is intended to preserve Medicaid financing by seeking a federal waiver and restructuring their current managed care tax so Michigan avoids penalties that would otherwise disallow its current funding mechanism. The speed of this effort underscores how worried states are about these new federal rules.

What might these changes cost Ohio health care providers

To approximate the impact of federal policy changes on Ohio's reliance on provider taxes and SDPs, we began with statewide projections from the Kaiser Family Foundation (KFF).

KFF projects that federal Medicaid funding for Ohio will decline by anywhere between 13 percent ($33 billion) and 16 percent (41 billion) over the next decade under H.R. 1.

Because provider taxes and SDPs together account for roughly 20 to 25 percent of Medicaid financing nationally, applying that share to Ohio's projected federal funding losses yields an estimated $6.6 to $10.3 billion in potential reimbursement reductions to Ohio health care providers over ten years, or about $660 million to $1.0 billion per year.

This is likely a conservative estimate, since H.R.1's six-month redetermination and work requirements are expected to reduce enrollment and therefore shrink the base of Medicaid claims that generate SDP dollars, and CMS's new requirement that SDP expenditures cannot exceed the amounts written into preprints may further limits Ohio's flexibility to push out additional funds when revenues or utilization come in higher than projected.

5 Things advocates should watch

State budget choices as federal dollars decline.
With billions in Medicaid financing at risk from new federal restrictions, policymakers must decide whether to backfill with general revenue, scale down provider payments, or restrict eligibility. Advocates will need to shape that debate to protect coverage and access to care as much as possible.

The future of the HIC franchise fee.
Ohio's Medicaid managed care tax raises nearly $900 million per year but is unlikely to comply with H.R.1's uniformity standards or CMS's proposed ban on taxes that charge higher rates for Medicaid services. Advocates should watch closely how ODM and lawmakers plan to redesign or replace it before the 2028 transition deadline.

Implementation of CMS's new SDP rules.
Every SDP renewal must now include provider-level impact analysis, actuarial documentation, and proof that rates are at or below Medicare's upper payment bound. CMS has also capped SDP expenditures at the amounts written into approved preprints and committed to publishing program data. These requirements will shape the size and nature of Ohio's hospital and other-directed payment programs in the coming years.

Enrollment losses from six-month redeterminations and work requirements.
H.R.1's requirement for more frequent eligibility checks and possible work requirements will increase coverage churn and reduce the base of services eligible for SDP funding.

Advocates should track enrollment changes and highlight the access implications for Ohioans.

Limits on franchise fee growth.
Even where franchise fees comply with federal rules, they cannot exceed six percent of provider class net patient revenue. This statutory ceiling limits Ohio's ability to raise additional revenue from hospitals, nursing facilities, or ICF/IID facilities as costs rise or if other financing sources shrink.

State budget choices if federal dollars decline.
With billions in Medicaid financing at risk from new federal restrictions, policymakers must decide whether to backfill with general revenue, scale down provider payments, or restrict eligibility. Advocates will need to shape that debate to protect coverage and access to care.

(Disclosure: The author sits on the Board of Directors of the MetroHealth System, which participates in the Care Innovation and Community Improvement Program (CICIP) state directed payment.)

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