Not All Provider Taxes Are the Same: Why Correctly Designed Provider Taxes Keep Rural and Small Urban Hospitals Open

Across the country, rural hospitals face persistent financial pressure driven by low patient volume, high Medicaid utilization, and limited alternative revenue sources. As a recent Defend Forgotten America report documented, in 2025 alone, at least 90 hospitals have experienced credit rating downgrades, service eliminations, or full closures. These distress events reveal a patterned, multi-signal collapse with credit downgrades often preceding a loss of essential services.

Directed payment programs play a key role in keeping these hospitals open. Medicaid is jointly financed by states and the federal government, with federal matching rates ranging from 50 percent to 83 percent. To finance their share, states rely on a combination of general revenue and provider taxes, which allow them to draw down additional federal Medicaid funding. These funds are often deployed through directed payment programs, which increase reimbursement to hospitals and other providers, particularly those serving high volumes of Medicaid patients.

Today, provider taxes are a core component of Medicaid financing. As of 2025, at least 46 states and the District of Columbia have implemented a hospital provider tax program, either through statewide structures or more targeted, locally supported models.

A recent paper by the Paragon Health Institute explores how rural hospitals are impacted in states with and without statewide provider taxes. The questions raised by the paper are important and worth careful examination. The analysis, however, lacks essential context. Its methodology was limited to just 12 states with statewide hospital provider taxes, comparing rural hospital closures in those states to 7 states that never adopted one. The remaining 31 states are excluded entirely, including those where provider tax policies have been implemented, modified, or tailored over time.

Texas, for example, which has operated a rural-focused directed payment program funded by local provider taxes for years, is excluded from the report because it does not meet the criteria of a statewide tax.

While Ohio is included in the analysis, it is evaluated based on its longstanding statewide provider tax structure, the Hospital Franchise Fee Program, without accounting for more recent efforts to develop a targeted, locally structured approach through the Rural Hospital Tax Pilot Program.

By focusing only on states that either consistently had statewide provider taxes or never adopted them, the analysis cannot capture how rural hospitals are affected when provider tax models are implemented, adapted, or structured to meet local needs.

Locally structured provider taxes offer a more precise and fiscally responsible way to support rural hospitals than broad, statewide approaches that may not reflect their financial realities. When designed around similarly situated providers, these models can better align financing with actual need.

Design Matters: Statewide vs. Local Provider Taxes

All provider taxes must meet federal requirements, including being broad-based and uniform. Within those parameters, states retain flexibility in how programs are structured.

Statewide provider taxes apply a single rate across hospitals with very different financial profiles. These rates are often influenced by larger systems and may not reflect the margins, payer mix, or service demands of smaller rural hospitals.

Locally structured provider taxes take a different approach. By focusing on hospitals with similar characteristics, they allow states to better match financing tools to actual conditions.

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STATEWIDE PROVIDER TAXES	LOCALLY STRUCTURED PROVIDER TAXES
Structure Single rate applied across all hospitals in a state	**Structure** Targeted to a defined group of hospitals with similar characteristics
Rate Setting Influenced by large systems with broader financial capacity	**Rate Setting** Aligned with the financial realities of participating hospitals
Fit for Rural Providers May not reflect rural margins or Medicaid reliance	**Fit for Rural Providers** Designed around rural-specific financial pressures
Use of Funds Distributed broadly across provider types	**Use of Funds** Targeted to participating hospitals
Financial Impact Can vary widely across hospitals	**Financial Impact** More closely aligned with actual need
Flexibility Limited ability to tailor to subgroups	**Flexibility** Greater ability to adjust based on local conditions

Case Study: Ohio's Rural Hospital Tax Pilot Program

Ohio offers a clear example of how this approach can work in practice. Ohio's Rural Hospital Tax Pilot Program demonstrates how provider tax design can be aligned more closely with rural hospital needs. After years of relying on a statewide provider tax, the state developed a more targeted model focused specifically on rural hospitals:

Defined Group - The program applies to a specific set of rural hospitals facing similar financial pressures.

Common Characteristics - Participating hospitals share comparable payer mix, service offerings, and operating margins.

Tailored Rate Setting - The structure allows this group to establish a tax rate that reflects their actual financial capacity.

Financial pressure on rural hospitals in Ohio is already translating into service reductions and limited access to care. Rural hospitals are reimbursed at roughly 73% of the cost of Medicaid care, leaving a persistent gap that must be absorbed elsewhere. At the same time, one in four rural hospitals is operating at a loss, and nearly 20% are considered vulnerable to closure.

These pressures show up first in the services hospitals can no longer sustain. Only 24% of Critical Access Hospitals in Ohio continue to offer labor and delivery, and entire regions now lack local access to maternity care.

The Ohio General Assembly approved the Rural Hospital Tax Pilot Program through the state budget, recognizing that programmatic investments alone do not address the underlying financial pressures facing rural hospitals. The program is currently pending federal approval, underscoring the importance of ongoing policy decisions related to Medicaid financing and provider tax flexibility.

By allowing a defined group of rural hospitals to generate the state share needed to draw down federal Medicaid funding, the pilot creates a targeted, provider-funded financing mechanism that increases reimbursement and stabilizes operations.

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State Examples of Targeted Rural Support

States across the country have implemented directed payment programs, financed through provider taxes, that reflect more targeted approaches to supporting rural providers.

STATE	PROGRAM	TARGETED PROVIDERS	DESCRIPTION	ESTIMATED SCALE
Texas	Rural Access to Primary and Preventive Services (RAPPS)	Rural Health Clinics	Provides enhanced Medicaid payments through locally supported financing structures	~$700 million annually
New Hampshire	Critical Access Hospital Directed Payment Program	Critical Access Hospitals	Provides uniform increases in inpatient and outpatient payments to CAHs	Up to ~$95 million annually
Georgia	Rural Obstetric Services Directed Payment Program	Hospitals providing rural obstetric services	Provides targeted support to maintain obstetric services in rural communities	State-directed payment program

These examples reinforce a consistent theme: when financing mechanisms are structured with intention, they can better support rural providers operating under similar constraints.

Implications for the Paragon Analysis

The Paragon paper evaluates provider taxes based on statewide models and measures their impact primarily through rural hospital closure rates. That framing does not reflect how provider taxes are used in practice today.

Statewide provider taxes apply a uniform structure across diverse hospital systems, which can dilute their effectiveness for rural providers. Locally structured models take a different approach by aligning financing with a defined group of hospitals that share similar financial conditions. By focusing only on statewide provider taxes, the analysis does not capture how locally structured approaches can more directly address the financial pressures rural hospitals face.

The distinction is important. Financing tools that are not tailored to provider characteristics may not produce the same outcomes as those designed specifically for rural hospitals. Evaluating provider taxes without accounting for these differences risks overlooking the models that are most responsive to rural healthcare needs.

Federal Policy Context

Recent federal efforts, including the Rural Health Transformation Program established under the One Big Beautiful Bill Act, represent an important investment in rural healthcare. These initiatives are a meaningful step toward addressing long-standing challenges, particularly in areas such as workforce, access, and care delivery.

At the same time, they do not replace the role of provider taxes in Medicaid financing, particularly locally structured models that directly address hospital reimbursement. Provider taxes support ongoing, system-wide funding that hospitals rely on to sustain operations year after year. Locally structured provider taxes, in particular, allow states to target that financing more precisely to hospitals facing similar financial pressures. Federal programs are often more limited in scope, duration, or targeting. Provider tax financing operates continuously within the Medicaid program and can be structured to respond to local conditions.

Both approaches play a role. Sustaining access to care in rural communities requires not only programmatic investment, but also stable and flexible financing mechanisms that can be tailored to the providers delivering that care.

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Conclusion

Rural hospitals need additional support. That much is clear, and there is growing alignment around the importance of strengthening rural healthcare infrastructure.

Provider taxes remain a central part of Medicaid financing in most states, but their effectiveness depends on how they are designed. Statewide approaches may not fully reflect the needs of rural providers. More targeted models, particularly those that allow for local flexibility, can better align financing with real-world conditions and provide a more fiscally responsible approach to supporting rural hospitals.

Ohio's Rural Hospital Tax Pilot Program illustrates what that looks like in practice. By focusing on a defined group of similarly situated hospitals, the state has created a model that directly addresses reimbursement gaps and supports ongoing operations.

As policymakers consider the future of Medicaid financing, preserving the ability to design and implement these targeted approaches will be critical. The issue is not whether provider taxes work or are necessary, but whether they are structured to work for the providers who need them most.