The Incidence of "MediScam:" Effects of Medicaid Provider Taxes

Joseph Battles
University of Chicago
Department of Economics

Michelle Zheng
University of Chicago
Booth School of Business

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Motivation: Medicaid Financing and "MediScam"

- Medicaid: Health ins. for 78M low-income Americans, administered at state level.
- Federal govt pays 70% of overall costs by matching percentage of state spending.
  $\rightarrow$ Incentivizes states to inflate matchable spending.
- One common tool: **provider taxes**
  1. State levies tax on hospitals / nursing homes.
  2. Uses revenue to raise Medicaid reimbursements.
  3. Collects additional federal matching funds on this higher spending.
- New Hampshire officials coined the term "MediScam" for these schemes.

Provider Taxes: Policy Context and Incidence

- By 2024, all states except Alaska levy health care provider taxes.
  - Provider taxes grew from 7% to 17% of state Medicaid spending (2008–2018).
- Federal rules require taxes to be "uniform" across payer types.
  - Cannot be levied only on Medicaid-funded care.
  - Raises payments for Medicaid relative to privately-insured / self-pay patients.
- Incidence and welfare:
  - Shifts Medicaid costs from states to the federal government.
  - Changes relative prices and reallocates net-of-tax revenue across providers.
  - May chg amount, intensity, and quality of care for Medicaid patients and others.

This Paper

Setting: Hospital and nursing home provider taxes.

Questions

- Do provider taxes increase health care use by Medicaid patients?
- Which providers respond?
  - Especially: hospitals with high vs. low Medicaid exposure ex ante.
- How do these schemes redistribute resources across payers and providers?

Setting and Data

Policy variation: Staggered roll-out of provider taxes

- Hospital taxes: 16 states implementing between 2008–2013
  - Excludes early Medicaid expansion states.
- Nursing home taxes: 11 states in the same period.

Data

- KFF annual survey of state Medicaid programs $\rightarrow$ Timing of provider taxes.
- Hospitals: Hospital Cost Report Information System (HCRIS).
- Nursing homes: OSCAR/CASPER data from LTCFocus.
- Ongoing work on effects on spending, quality, and heterogeneity analysis:
  - Using: Medicaid claims, DSH audit reports, Hospital Compare

Empirical Strategy: Dynamic DiD

Units and treatment

- Unit of analysis: hospital.
- Treatment: first year a state's hospital provider tax is in place.
- Comparison group: not-yet-treated states in each period.

Staggered adoption DiD estimation

- Group-time ATT framework of Callaway & Sant'Anna (2021).
- Doubly robust DID estimator of Sant'Anna & Zhao (2020).

$$\widehat{ATT}_{g,t} = \left(\bar{Y}_t^{G=g} - \bar{Y}_{g-1}^{G=g}\right) - \left(\bar{Y}_t^{C} - \bar{Y}_{g-1}^{C}\right),$$

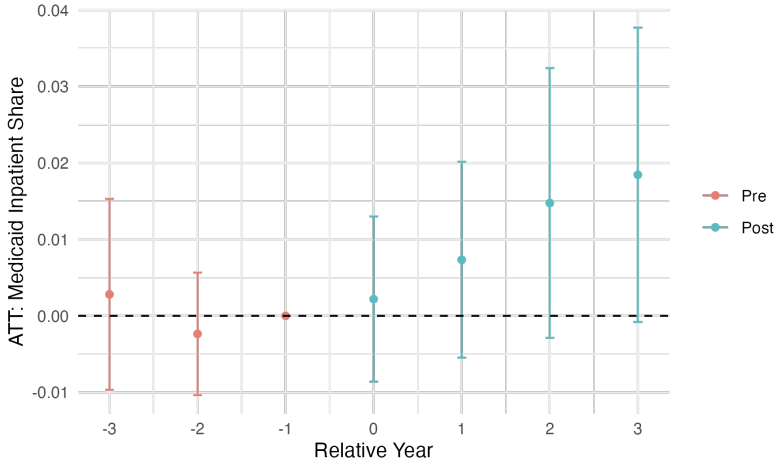
where g indexes treatment cohort.

Identification

- Parallel trends for treated vs. not-yet-treated states.
- Future work: richer tests using Medicaid claims.

Dynamic ATTs on Medicaid Inpatient Share

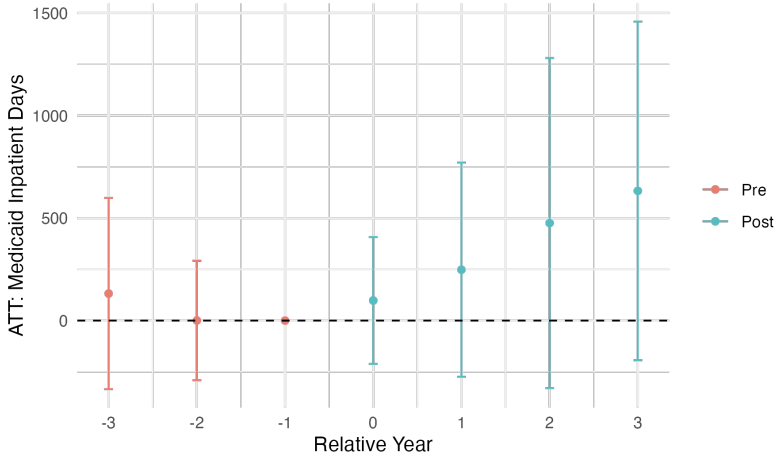
Baseline average: 17%



Panel years = 2007-2013

Dynamic ATTs on Medicaid Inpatient Days

Baseline average: 6,400 days



Panel years = 2007-2013

Which hospitals drive the overall result?

Medicaid "disproportionate share hospitals" (DSH):

- Hospitals that serve high fraction of Medicaid or uninsured patients
- Entitles facility to extra Medicaid payments

Use DSH status as a binary proxy for hospitals' willingness to treat Medicaid patients.

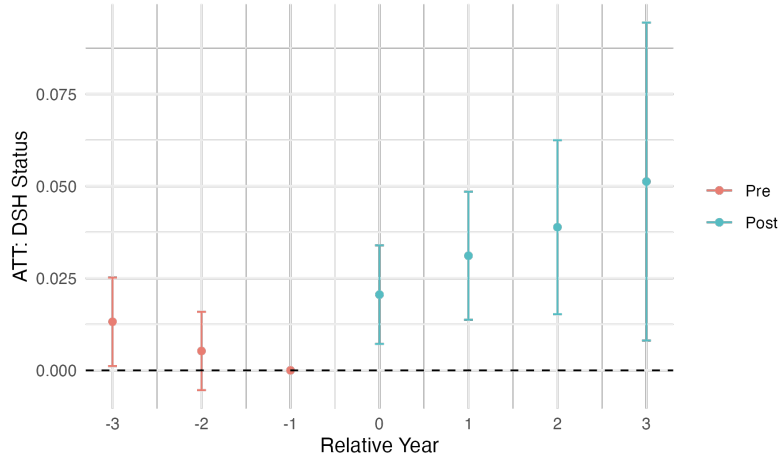
- In the pre-period, half of the hospitals in sample qualified as DSH.

Results:

- 5 percentage-point increase in hospitals qualifying as DSH due to provider tax.
- Result driven by real increase in Medicaid share of patients at these hospitals.

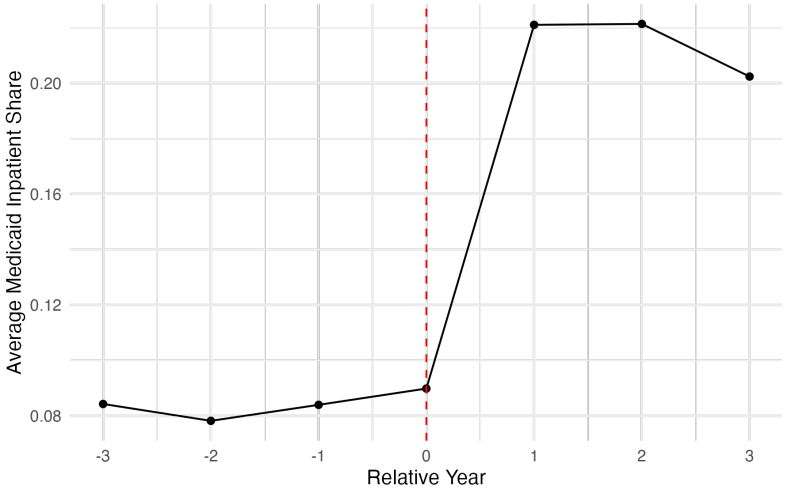
Dynamic ATTs on % Hospitals with DSH Status

Baseline average: 51%



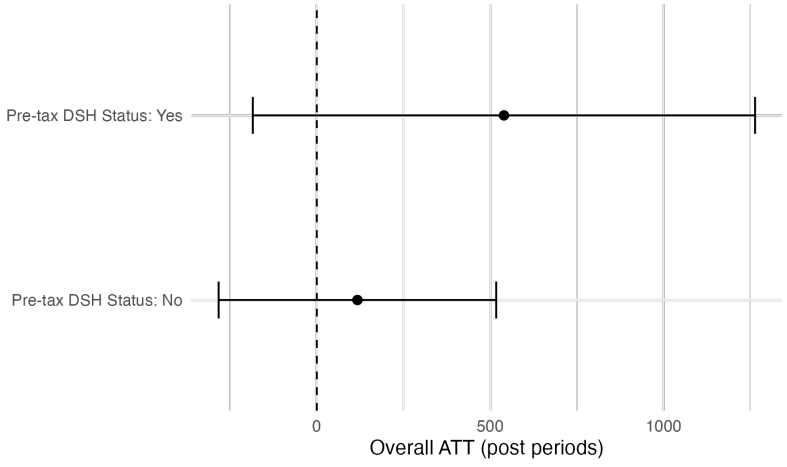
Panel years = 2007-2013

New DSH Hospitals: Medicaid Share Increases



Panel years = 2007-2013

ATT on Medicaid Inpatient Days by Pre-Tax DSH Status



Conclusions and Next Steps

Takeaways

- Provider taxes increase quantity of hospital care delivered to Medicaid patients.
- Relative price changes induce both:
  - Entry into DSH status by hospitals.
  - Larger volume responses at existing safety-net providers.

$\rightarrow$ Provider tax trade-off: fiscal externality on fed govt. vs. supply of Medicaid care.

Ongoing/Future Work

- Extend analyses to nursing homes.
- Estimate supply elasticities and quantify fiscal externality vs. supply trade-off.
- Quality of care, non-Medicaid spillovers, and patient outcomes.