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MEDICAID FINANCING: CMS PROPOSED RULE RELATED TO H.R. 1'S PROVIDER TAX RESTRICTIONS

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PART I: RECAP OF H.R. 1'S PROVIDER TAX RESTRICTIONS

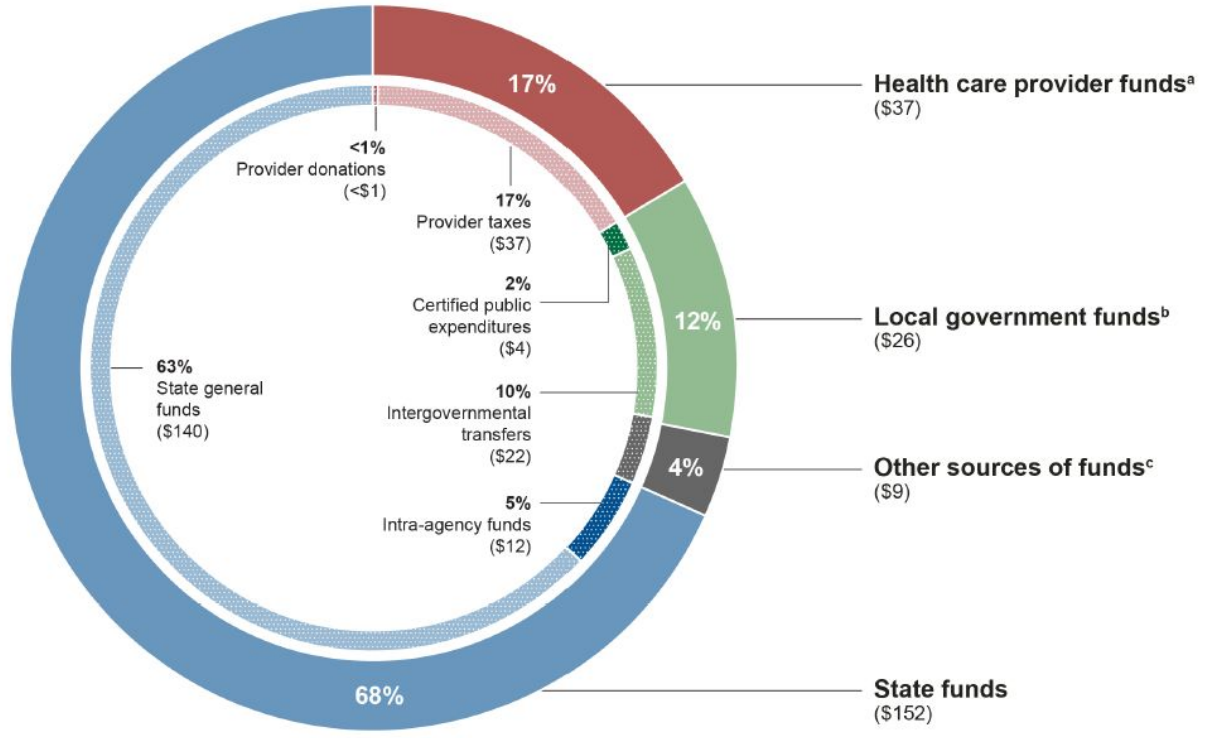
How States Finance Their Share of Medicaid Costs

- Traditional general revenues like income and sales taxes
- Provider taxes
  - Taxes, assessments and fees on hospitals, nursing homes, managed care plans and other health care providers
- Other dedicated state revenues
  - Tobacco taxes
- Other government contributions, subject to 40% state minimum
  - Intergovernmental transfers (IGTs) and certified public expenditures (CPEs)

Financing Sources for State Share (2018)

Figure 2: Nonfederal Share of Medicaid Payments Financed with Funds from Health Care Providers, Local Governments, States, and Other Sources in State Fiscal Year 2018

Percentage (dollars in billions)



Source: GAO analysis of state questionnaire data. | GAO-21-98

H.R. 1's Provider Tax Restrictions

- All states but Alaska rely on provider taxes to help finance the state share of Medicaid costs.
- This could include taxes and assessments on hospitals, nursing homes, intermediate care facilities for people with intellectual disabilities (ICF-IDs), managed care plans, and others
- Three provider tax restrictions in budget reconciliation law
- $225 billion/10 years in federal spending cuts and 1.2 million more uninsured by 2034 according to Congressional Budget Office estimates

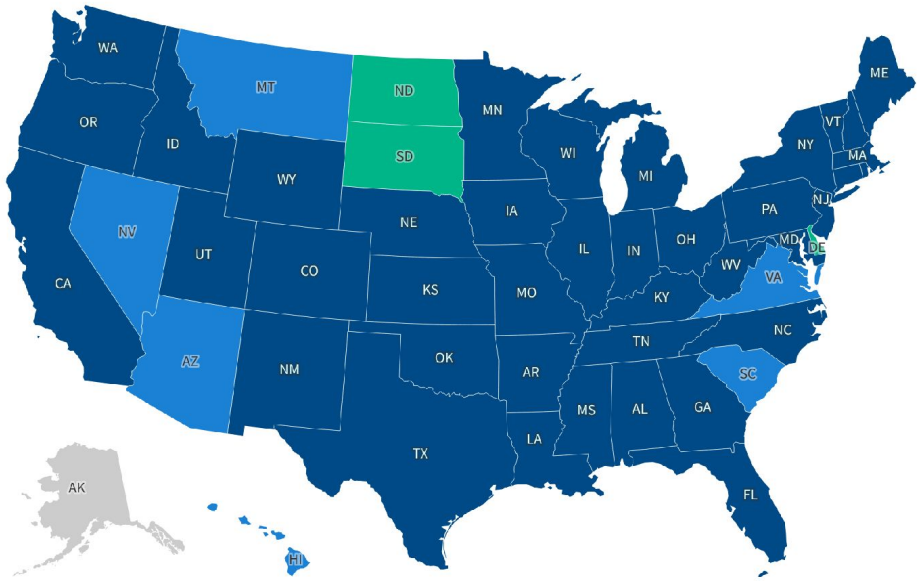
Which States Have Provider Taxes?

Figure 1

All States but Alaska Use Provider Taxes To Help Finance the State Share of Medicaid Spending

Number of provider taxes or fees in place in FY 2025

- 3+ Provider Taxes/Fees (41 states including DC)
- 2 Provider Taxes/Fees (6 states)
- 1 Provider Tax/Fee (3 states)
- No Provider Taxes/Fees (1 state)



Note: FY = state fiscal year. Includes Medicaid provider taxes as reported by states. FL, KS, and MS did not respond to the 2025 survey; publicly available data used to verify taxes in place (reported in previous surveys) but not the size of these taxes.

Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, November 2025

KFF

Overview of Provider Tax Rules

- Statutory and regulatory rule framework governing provider taxes in place since 1991-1992
- Taxes must be uniform and broad-based and must not hold providers harmless
  - Waivers allowed for uniform and broad-based requirements if state can show mathematically that tax is proportionately assessed on Medicaid/non-Medicaid revenues
  - Two prong test to show no indirect hold harmless arrangement: (1) under prior law, safe harbor if tax does not exceed 6% of net patient revenues or (2) 75/75 test

Section 71115 of H.R. 1: No New or Increased Provider Taxes

- Permanent prohibition on any new provider taxes or increases in existing provider taxes as of date of enactment (with penalties enforced starting October 1, 2026)
- Whether there is an increase in an existing tax depends on size of existing tax (as measured as a % of net patient revenues)
- Existing taxes are grandfathered if they were both enacted and imposed before July 4, 2025

Section 71115 of H.R. 1: Provider Tax Restrictions Targeting Expansion States Only

- Reduces permissible size of most existing provider taxes but only in Medicaid expansion states
- Current “safe harbor” limit of 6% of net patient revenues phased down starting October 1, 2027
- Affects all taxes except for taxes on nursing homes and ICF-IDs
- Phase down in limit by 0.5 percentage points each year
  - FFY 2028: 5.5%
  - FFY 2029: 5%
  - FFY 2030: 4.5%
  - FFY 2031: 4%
  - FFY 2032 and thereafter: 3.5%

Section 71117 of H.R. 1: Provider Tax Restrictions Affecting "Uniformity Waiver" States

- States have always been able to satisfy the uniformity requirement by demonstrating compliance with a mathematical test and obtaining a uniformity waiver from CMS
- Upon enactment, H.R. 1 prohibits certain existing provider taxes operating under uniformity waivers that use differential tax rates between Medicaid and non-Medicaid providers
- Affects at least 7 expansion states (CA, IL, MA, MI, NY, OH and WV) with 9 taxes (primarily managed care organization taxes) but *additional* states and taxes still could be implicated
- Final regulations from January 2026 implementing provision include transition periods for affected states. Varies based on type of provider and by timing of most recent approval

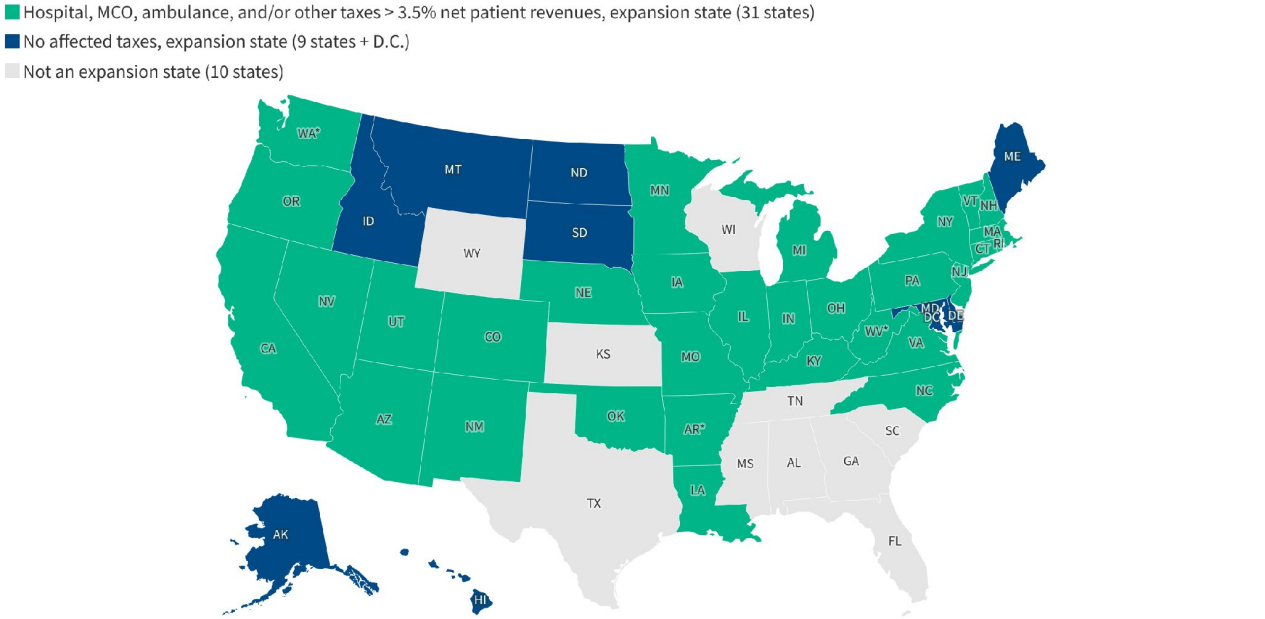
Many Expansion States Will Be Affected

- According to KFF, as many as 31 expansion states will have to lower some of their provider taxes
- Some states like North Carolina, Missouri and Arizona have explicitly used hospital provider tax increases to finance their share of the cost of Medicaid expansion

Figure 4

The Effective Prohibition on New or Increased Provider Taxes Could Impact All States, With Expected Cuts to Existing Taxes in At Least 31 States

ACA expansion states with a provider tax on hospitals, MCOs, ambulances, or other affected providers above 3.5% of net patient revenues as of July 1, 2025



Note: ACA = Affordable Care Act, MCO = managed care organization. Figure excludes health insurer taxes which would be subject to the new rules if CMS' proposed rule is finalized. Provider taxes on nursing facilities and intermediate care facilities are exempt from the new limits on provider taxes in expansion states. Other affected providers include community living supports (also known as HCBS or home care) in Kentucky and labs and x-rays in West Virginia. *Only affected tax is on ambulance and/or other providers.

Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, November 2025

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PART 2: CMS PROPOSED RULE

New CMS Proposed Rule

- Proposed rule issued July 21st
- Covers the two H.R. 1 section 71115 provider tax restrictions
- Uniformity waiver provision was already addressed in final rule from January
- *Public comments due September 21st*
- Includes numerous provisions that go far beyond H.R. 1 requirements under section 71115

Health Insurer and Other Non-Medicaid Taxes

- Inconsistent with longstanding CMS practice and state understanding
- Explicitly extends general provider tax rules (and H.R. 1 restrictions despite statutory conflict) to health insurer taxes even if not funding Medicaid
  - State-based Marketplace user fees
  - Reinsurance
  - State subsidies to supplement Marketplace premium tax credits
  - Insurance Department operations
- Clarifies that other health-related taxes that apply to entities that are not listed as permissible classes by CMS are specifically prohibited even if not funding Medicaid
  - PBMs
  - TPAs
  - Health benefit consultants
  - Manufacturers of opioid drugs

New Retrospective Compliance System

- Creates onerous and punitive retrospective compliance and enforcement process
  - Required reporting by states every quarter
  - Actual data must be reported (tax revenues and net patient revenues) with projections, estimates, and other methodologies no longer permissible (despite longstanding policy and practice)
  - Tax revenues and net patient revenues will likely be volatile in coming years (e.g. impact of Medicaid and Marketplace cuts and falling provider revenues)
  - All revenues from tax are non-permissible if tax exceeds limit by any amount
  - States must refund taxpayers or pay back federal government federal Medicaid funds that would have matched that amount of impermissible revenues *2 or more years later* if state found to be out-of-compliance
  - Encourages states to further reduce size of their provider taxes (that is, stay even further below safe harbor thresholds required under H.R. 1) to avoid risk of major risks of budget hits down the road

Elimination of 75/75 Prong

- States no longer allowed to show no indirect hold harmless by satisfying 75/75 prong (no more than 75% of taxpayers receive 75% of Medicaid or other state payments that may be financed by tax)
  - Conflicts with statute (not required by H.R. 1, 75/75 prong previously codified)
  - Appears goal of this change is to simply make it harder to finance Medicaid, as any tax that satisfies 75/75 prong reasonably demonstrates no hold harmless (and why the prong was first included in original provider tax regulations)
  - CMS does not explain why 75/75 prong is suddenly a problem

Definition of Enacted and Imposed

- Whether a tax is a new or increased tax is grandfathered is based on whether the tax was already enacted and imposed before H.R. 1's enactment
- Earlier November guidance said for a tax to be imposed, the tax must already have been actively collected
- Proposed rule now requires only a legally enforceable obligation but that could potentially still affect some states
- Rule still does not clarify that a state that fixes a newly prohibited uniformity waiver tax can do so without violating prohibition on new/increased taxes (final uniformity waiver rule also did not include this clarification)

Greater Scrutiny of IGTs

- H.R. 1 did not address IGTs or CPEs at all
- Proposed rule does not explicitly impose new major restrictions on state use of IGTs or CPEs
- But states must now notify CMS of any new exemptions from provider taxes for public providers and there will be increased review and oversight of such arrangements especially if new IGTs related to exempted public providers are established (but no details/standards for that review and no explanation of why such exemptions do not continue to be permissible)

Regulatory Impact Analysis

- CMS estimates H.R. 1's provider tax restrictions and this proposed rule will reduce state provider tax revenues by $198.7 billion/10 years (17.2% reduction). By 2035, provider tax revenues will be 27.1% lower.
- CMS assumes *no* eligibility cuts so no enrollment losses unlike CBO
- Likely federal Medicaid spending cut is an underestimate. CMS estimates a cut of $245.8 billion/10 years (2026-2035), compared to the CBO estimate of $191.1 billion (2025-2034). Using same budget window, CMS estimate is only 5.4% higher. Also includes no impact on non-Medicaid state health spending

Adverse Impact on State Budgets

- States must generally balance their budgets unlike the federal government
- Combination of provider tax restrictions in H.R. 1 and additional restrictions in proposed rule mean *even less* existing revenues to support Medicaid (and other state health spending) over time and fewer revenue options moving forward
- Provider tax restrictions produce federal savings because states will likely be unable to fully replace lost revenues and be forced to cut their Medicaid programs and thereby cutting federal spending
- States have only three tools to cut Medicaid: eligibility, benefits and provider payment rates
- Provider rates and optional benefits including HCBS services are typically first to face budget cuts but Medicaid expansion in some states is specifically funded by provider taxes
- Other state health programs and initiatives now at serious risk as well

Other Cost-Shifts Facing States

- H.R. 1 also includes SNAP cost shifts from the federal government to states:
  - States must pick up greater share of SNAP administrative costs (75% instead of 50%) starting October 2026
  - States must share in 5-15% of SNAP benefit costs for first time starting October 2027 (same time as when provider tax safe harbor phasedown provision in expansion states first takes effect). Based on prior error rates

Resulting Need for Additional State Revenues

- If states want to mitigate Medicaid cuts to provider rates and optional benefits, as well as eligibility cuts and more red tape, they will need to raise additional revenues at the state level (such as through income taxes, corporate taxes, or other taxes) and/or *Congress will have to repeal the Medicaid cuts*
- Additional revenues to backfill cost-shifts will also help mitigate risk of other budget cuts affecting children like slashing/eliminating SNAP and cuts to other vital parts of the budget like K-12 education

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QUESTIONS?