Summary of CMS Proposed Rule: Methodology to Determine Provider Taxes as Generally Redistributive

May 13, 2025

Key Resources: CMS Press Release; Proposed Rule Fact Sheet; Proposed Rule

Background

The proposed rule is intended to address concerns from CMS about a current methodology used to determine whether a provider tax is "generally redistributive." In general, health care-related taxes must be broad-based, or apply to all non-governmental providers within a class, and generally must also be uniform, such that all providers within a class generally must be taxed at the same rate or dollar amount. A State can request a waiver of the broad-based and/or uniformity requirements if they can demonstrate the tax to be "generally redistributive," meaning the tax program "generally generates tax revenues from entities that serve relatively lower percentages of Medicaid beneficiaries and uses the tax revenue as the State's share of Medicaid payments." Currently, some health care-related taxes, especially taxes on managed care organizations, can be imposed at higher tax rates on Medicaid taxable units than non-Medicaid taxable units, which CMS asserts as contrary to statutory and regulatory intent for health care-related taxes to be generally redistributive.

To enforce the requirement that taxes have a net impact that is "generally redistributive," CMS established certain tests when a State is seeking a broad-based waiver (known as the P1/P2 test) and/or uniformity waiver (known as the B1/B2 test). CMS is proposing to clarify and strengthen the criteria used to evaluate health care-related tax waivers by retaining these existing statistical tests and introducing an additional standard to ensure tax structures are substantially redistributive.

The proposal includes the following key provisions:

- Prohibiting states from taxing Medicaid units at higher rates than non-Medicaid units and setting taxing groupings that result in taxing higher Medicaid providers at higher tax levels than low Medicaid providers;
- Banning the use of proxy terms that indirectly target Medicaid;
- Requiring all future waivers to satisfy the new redistributive standard in addition to existing statistical tests; and
- Offering a transition period for states with existing waivers that do not satisfy new requirements for those that were approved more than 2 years prior to the rule's effective date.

CMS Rationale (p.6 -23): CMS argues that states are exploiting a statistical loophole in regulatory tests to structure health care-related taxes that appear compliant but are not truly redistributive. According to CMS, these tax structures may result in providers that serve more Medicaid patients appearing to contribute more, while the overall design limits the extent to which those contributions represent a meaningful non-federal share. CMS suggests this creates incentives for states and providers to prioritize maximizing tax collections and federal matching funds, rather than aligning with program goals related to access, quality, or efficiency. The agency also raises concerns that in some cases, tax revenues have been inappropriately used to support general funding gaps, including services that are not eligible for federal funding, such as non-emergency care for non-citizens.

Practices CMS describes as problematic include:

- Excluding large Medicaid-heavy providers from taxation to influence regression outcomes.
- Tiered rate structures that drastically tax Medicaid units higher than commercial ones—up to 100x more in some cases.
- Use of "proxy" terminology (e.g. income level or geographic area) to indirectly target Medicaid units at higher rates without using the term "Medicaid"

A comment from Dr. Oz in a May 12, 2025, CMS Press Release is as follows: "States are gaming the system—creating complex tax schemes that shift their responsibility to invest in Medicaid and rob federal taxpayers. This proposed rule stops the shell game and ensures federal Medicaid dollars go where they're needed most—to pay for health care for vulnerable Americans who rely on this program, not to plug state budget holes or bankroll benefits for noncitizens."

Scope and States Impacted (p.27, 37-41): Under the core proposal, CMS is targeting seven states with currently approved MCO tax waivers that do not meet the new redistributive standard. Of those, four states with waivers approved within the past two years would be excluded from a transition period and required to comply immediately on the effective date of the final rule. The remaining three states, whose waivers were approved more than two years prior, would be eligible for a 1-year transition period to bring their tax structures into compliance.

- While enforcement is focused on these seven states, the proposed new standard in § 433.68(e)(3) would **apply to all provider taxes (even if CMS has not yet flagged them) and for future waiver requests**. It covers **any permissible provider class**, raising the bar for how CMS evaluates whether a tax is genuinely redistributive. CMS notes that although these issues have so far been found in MCO taxes, other provider classes may also be vulnerable to similar risks.
- CMS emphasizes that the rule is not intended to disrupt or target compliant tax programs that are already broad-based, uniform, and meet federal standards. CMS further clarifies that the proposed provision would be applied narrowly and is specifically aimed at tax structures that utilize methodology using the B1/B2 in a manner inconsistent with legitimate public policy goals that would otherwise violate the new redistributive standards if stated explicitly. CMS also makes clear it would not interfere with a state's ability to implement otherwise permissible state and locality taxes, specifically those imposed by units of local government such as counties.

Provisions of Proposal (p.24, 26 -37): CMS is proposing to add new standards/requirements to strengthen the definition of when a health care-related tax is considered generally redistributive. As part of this effort, CMS also proposes to codify definitions for terms such as "Medicaid Taxable Unit," "Non-Medicaid Taxable Unit," and "Tax Rate Group" to promote consistent interpretation of the new requirements. It clarifies that states may still design tax rate groups that support legitimate public policy goals, such as favoring rural providers, continuing care retirement communities (CCRCs), or sole community hospitals, as long as those classifications are established through existing licensure or policy and not created *solely* for tax purposes. The new standard would apply on a per-class basis and would override prior tests if the tax structure includes the following features that counter the principle of re-distributiveness:

- **Imposing higher tax rates on Medicaid units than non-Medicaid units within the same class**

Example: An MCO tax where member months for Medicaid enrollees are taxed at $200, while member months for non-Medicaid enrollees are taxed at $20, placing a disproportionate burden on Medicaid plans for the same type of service.

- **Using Medicaid volume or utilization tiers that lower rates for low-Medicaid providers**
  Example: A hospital tax that charges 2% of net inpatient revenue for hospitals with less than 5% Medicaid utilization and 4% for all others, shifting tax liability away from providers with minimal Medicaid participation.
- **Targeting Medicaid indirectly through proxy terms**
  Example: A tax that charges $10 per discharge for patients covered by a "joint Federal and State health care program" and $5 for others, where the terminology functions as a stand-in for Medicaid and results in higher rates for Medicaid-related services.
- **Using socioeconomic or demographic proxies closely tied to Medicaid eligibility**
  Example: A tax that charges hospitals in counties where the average income is below 230% of the federal poverty level $10 per discharge, while hospitals in higher-income counties pay $5, effectively targeting hospitals serving more Medicaid beneficiaries.
- **Creating unusual or arbitrary groupings that appear to isolate high-Medicaid providers**
  Example: A tax that defines provider groups based on the number of exterior entrances to a hospital's emergency department—where only one hospital with high Medicaid volume meets the criteria, raising concerns of intentional Medicaid targeting.

Implementation (p.23, 37-44): To support implementation, CMS proposes a one-year transition period for waivers approved more than two years before the final rule's effective date (i.e. pre- Summer 2023) and includes a severability clause to preserve the rest of the rule if any part is invalidated. CMS is also soliciting feedback on whether transition timelines should vary based on how recently a waiver was approved or to account for states with biennial legislative cycles.

Compliance Opportunities (p.41 -43)

- **Submit a New Compliant Waiver:** States with a currently approved waiver that no longer meets the new redistributive standard can submit a new waiver that aligns with the revised requirements.
  - This must be done with an effective date no later than the first State fiscal year beginning at least one year from the effective date of the final rule (if the state qualifies for a transition period)
- **Modify the Existing Tax to Meet New Rules:** Instead of submitting a new waiver, states may revise their tax structure to comply with all updated federal standards, including the new redistributive rule and existing requirements like the hold harmless prohibition
  - This must also take effect by the start of the first fiscal year at least one year out from the rule's effective date (if a transition period applies)
- **Make Uniform Changes Without Needing a New Waiver:** States can avoid waiver resubmission if they make uniform adjustments—meaning the same percentage change across all provider groups
  - *Example: If Hospital Type A is taxed $100 per discharge and Hospital Type B $10, both could be reduced by 10% to $90 and $9 respectively. This uniform reduction would not require a new waiver*

- **Revert to a Broad-Based, Uniform Tax That Requires No Waiver:** States may redesign their tax program, so it is broad-based and uniform across all non-federal, non-public providers within a permissible class.

Alternative Proposals Being Considered (p.43 -44)

- **3 Year Approval Lookback**: CMS proposes that waivers approved within 3 years (instead of 2) before the effective date would not receive a transition period. This would capture an additional currently approved waiver, bringing the total from 4 to 5 waivers denied a transition period under this stricter policy
- **Tiered Transition Periods:**
  - Waivers approved within 2 or 3 years before the effective date would receive a 1-year transition
  - Waivers approved more than 2 or 3 years before the effective date would receive a 2-year transition
- **No Transition Period for Any Waiver:** Eliminate transition periods entirely, regardless of when the waiver was last approved. This would apply uniformly to all waivers deemed noncompliant under the new standard

Enforcement (p.43 -44)

CMS will enforce the new redistributive standard by deducting revenues from a state's medical assistance expenditures under § 433.70(b) if a health care-related tax fails to meet the requirements of § 433.68(e)(3). CMS will assess compliance based on adherence to all federal requirements, including the new redistributive standard.

- For states without a transition period, this enforcement begins on the rule's effective date. States with a transition period will not face disallowances for revenues collected during that window, provided the tax complies with an existing waiver. After the transition, noncompliant taxes may trigger federal funding reductions, though CMS does not specify exact deduction amounts.
- New waiver approvals granted before the rule's effective date that rely on the loophole will receive companion letters and will not qualify for transition relief.
- No changes to state plan documents are anticipated; compliance is expected to occur through waiver submissions only.

Effective Date (p.37 -45)

- Ineligible for Transition – Waivers approved within 2 years of the rule's effective date become invalid immediately. States must stop collecting revenue on the effective date or face FFP deductions. *Example: Waiver approved Dec 10, 2024 → Rule effective Jan 14, 2026 → No transition period. Waiver ends Jan 14, 2026.*

- States Eligible for 1-Year Transition Period – Waivers approved more than 2 years before the rule's effective date must come into compliance by the start of the first full state fiscal year beginning at least 1 year after the effective date.

Examples:

- *Rule effective Jan 14, 2026 → FY begins Apr 1 → Comply by Apr 1, 2027*
- *Rule effective Jan 14, 2026 → FY begins Jan 1 → Comply by Jan 1, 2028*

Potential Implications (p.45 -65)

CMS assumes the proposed rule will not reduce overall Medicaid program funding because it does not limit the total amount of tax revenue states can collect, only how that burden is distributed. States retain flexibility to revise tax structures by broadening the tax base or adjusting rates while maintaining revenue levels and access to federal matching. The rule targets equity in tax design rather than funding volume, and CMS expects most states will restructure their taxes rather than reduce program funding to comply.

The agency does not expect changes to existing Medicaid State Plan documents, nor does it propose new waiver templates, and assumes providers will experience changes in tax liability depending on how states redistribute the burden.

Administrative and Compliance Burden

- CMS estimates a one-time burden of 640 hours across 8 waivers (7 states, 1 state with 2 waivers), assuming 80 hours per waiver submission at a rate of $46.88/hour, totaling $30,003.20 in labor cost, with states covering $15,001.60 after the 50% federal match.

Impact on States

CMS anticipates eight tax waivers in seven states will be affected, assuming all will need to resubmit waivers to comply with the rule, though some may have to consider alternative revenue sources or payment adjustments. The extent of the impact varies depending on whether the state is subject to the core proposal (no transition) or eligible for the 1-year transition period:

- States with no transition period (3 states under the core proposal) would have to immediately cease collecting noncompliant taxes upon the effective date of the final rule or face deductions in federal matching. This could lead to:
  - Budget disruptions, particularly for Medicaid programs relying on the tax for supplemental payments.
  - Service delivery gaps if replacement funding or structural changes are not rapidly implemented.
  - Compressed legislative or administrative timelines, as these states may lack sufficient time to redesign or reauthorize tax programs through their normal processes.
- States with a 1-year transition period may still experience strain but will have until the start of the next full state fiscal year (at least one year after the effective date) to come into compliance.

Impact on Providers

Providers in states with currently noncompliant taxes may experience changes in tax liability depending on how the burden is redistributed, particularly those in provider classes where taxes were previously concentrated on high-Medicaid providers. For high-Medicaid providers, tax-funded Medicaid payments are often essential to financial stability, helping cover uncompensated care, staffing, and operational costs that base Medicaid rates do not fully support, and their removal could significantly strain the ability of these providers to maintain services for Medicaid populations.

- In states without a transition period, providers may experience:
    - Abrupt changes to tax obligations with no phase-in, potentially affecting financial planning.
    - Disruptions to Medicaid supplemental payments or rate enhancements funded by the invalidated tax, which may lead to short-term cash flow challenges.
- Providers in states with a transition period will likely experience more stable implementation, but could still see long-term shifts in tax structure, payment models, or how Medicaid payments are justified to CMS.
- CMS expects the rule will not significantly affect small providers or rural hospitals, since most of the affected taxes apply to larger entities like MCOs and states usually avoid placing new tax burdens on small or rural providers. However, CMS is asking for public feedback on this assessment.

Public Comment Period

CMS is accepting public comments through July 14, 2025 to solicit input on the proposed rule, including the agency's interpretation of health care-related tax arrangements and any potential unintended consequences or operational impacts not fully addressed in the proposed rule.

Specifically, CMS is seeking input on:

- **Disruption to Existing Waivers:** Feedback is requested on whether any proposed policies may unintentionally disrupt existing state tax waivers that do not invalidate the statistical loophole.
- **Length of Transition Periods:** Comments are invited on whether the proposed cutoff timeframes and transition lengths (e.g., 1 or 2 years) are appropriate, or if they should be shorter or longer
    - **Tailored Transition Timelines:** Input is sought on whether different provider classes (e.g. inpatient hospitals vs. MCOs) may warrant distinct transition timelines and seeks input on whether some waiver types may be more burdensome to revise than others.
- **Definitions and Terminology:** Stakeholders are encouraged to provide feedback on the terms and definitions included in the proposed rule, and whether additional terms should be codified to improve clarity and consistency.
- **Legitimate Policy Goals:** Suggestions and examples are welcomed to help identify legitimate public policy purposes behind certain tax structures that may otherwise appear non-compliant under the new redistributive test.