1) Executive summary (what CMS did and why it matters)

CMS finalized a rule that **closes an "inadvertent loophole"** in the long-standing statistical test used to evaluate State requests for waivers of the **broad-based** and/or **uniformity** requirements that normally apply to Medicaid health care-related provider taxes. CMS concludes that, due to this loophole—particularly in the **B1/B2 regression test**—some State tax structures (especially **managed care organization (MCO)** taxes) could **pass** the existing test while still **imposing substantially higher effective tax rates on Medicaid taxable units than on non-Medicaid taxable units**, contrary to the statutory "generally redistributive" standard.

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The practical significance is that CMS is tightening Federal guardrails around how States can use provider taxes to finance Medicaid. CMS describes these exploitative structures as effectively **recycling federal dollars to draw down more federal dollars**, shifting Medicaid's non-federal share burden away from States and onto the federal government.

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Key takeaways:

- **New "additional safeguards"** are added so that waiver requests that exploit the loophole are **"not approvable."**
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- CMS formally defines key terms used to evaluate whether a tax is truly "generally redistributive," including **"Medicaid taxable unit," "non-Medicaid taxable unit," and "tax rate group."**
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- CMS finalizes **transition periods** (with special timing rules for MCO vs. non-MCO taxes) and states explicitly that, after transition, CMS may **deduct** revenues from non-compliant taxes from medical assistance expenditures (reducing FFP).
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- CMS frames the rule as also **implementing** statutory changes enacted in Section 71117 of the **Working Families Tax Cuts (WFTC) legislation**, which "closely mirrors" the proposed regulatory text.
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- CMS estimates the total annual collections from taxes exploiting the loophole are about **$24.0 billion per year**, underscoring the fiscal stakes.
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Effective date: April 3, 2026.
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2) Background: how provider taxes are supposed to work, and what the "loophole" is

A. Medicaid's financing structure and the role of provider taxes

Medicaid is jointly financed; States must supply the non-federal share, and the federal government provides FFP based on FMAP formulas. CMS reiterates that Congress and CMS have long sought to prevent financing arrangements that **shift an inappropriate share of Medicaid costs to the federal treasury**.
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Health care-related taxes are permitted only if they meet statutory and regulatory requirements (permissible class, no hold harmless, and usually broad-based and uniform), with limited waiver authority for broad-based and/or uniformity requirements if the tax's net impact is **"generally redistributive."**
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CMS has historically interpreted "generally redistributive" to mean a tax and payment structure tends to **derive revenues from non-Medicaid services** and use those revenues as the State's share of Medicaid payments.
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B. The two tests (P1/P2 and B1/B2) and why B1/B2 became vulnerable

- If a State seeks a **broad-based waiver** (but remains uniform), it uses the **P1/P2** test.
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- If a State seeks a **uniformity waiver** (whether or not broad-based), it uses the **B1/B2** regression test, which compares slopes of regression lines to ensure Medicaid utilization isn't effectively overtaxed versus a uniform baseline.
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CMS explains that the B1/B2 test, centered on regression averages, can be manipulated because linear regression is **sensitive to outliers**. In practice, some States allegedly structured taxes to **exclude** certain high-Medicaid outlier entities from taxation (or tier taxable units in a way that creates artificial slope effects), allowing the tax to "pass" while still taxing Medicaid units far more heavily than comparable non-Medicaid units.

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CMS reports a marked increase in the number and scale of these taxes, with total collections from loophole-exploiting taxes estimated at **~$24.0B annually**.
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3) The most significant policy changes in the final rule

A. New regulatory definitions to operationalize "generally redistributive"

CMS adds definitions in **42 CFR § 433.52** that are central to implementing the new safeguards:

- **Medicaid taxable unit**: a taxed unit applicable to the Medicaid program (examples CMS lists include Medicaid bed days, Medicaid revenue, Medicaid charges, etc.).
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- **Non-Medicaid taxable unit**: a taxed unit not applicable to Medicaid (e.g., non-Medicaid bed days/revenue, other non-Medicaid units).
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- **Tax rate group**: entities within a permissible class taxed at the same rate.
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Why this matters: these definitions create common "measurement units" that CMS can use to determine whether a tax structure is effectively **Medicaid-targeting** even if it can still pass the traditional regression math.

B. "Additional requirement" to demonstrate a tax is generally redistributive (the core safeguard)

CMS finalizes a new requirement under **§ 433.68(e)(3)** intended to prevent approval of waiver requests where the tax's structure results in Medicaid taxable units bearing a higher burden than non-Medicaid taxable units—even if the tax passes P1/P2 or B1/B2.

In explaining the safeguard, CMS states that if a State **taxes a taxpayer or "tax rate group" more heavily based on Medicaid taxable units/utilization than non-Medicaid units/utilization**, and it **expressly identifies** the taxpayer or group by reference to "Medicaid" (or equivalent), that would implicate the new requirement; and if a State tries to achieve the same effect without using the word "Medicaid" (a proxy/circumvention approach), that can implicate an anti-circumvention provision as well.
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Notably, CMS emphasizes that it is not replacing B1/B2; rather, it is **supplementing** it so that passing the statistical test is no longer sufficient when the tax is structured to be non-redistributive in substance.
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Practical effect: States can still request and obtain waivers, but they must show that their non-uniform/non-broad-based tax is not simply shifting the burden onto Medicaid units through tiering, exclusions, or other design features that functionally "target" Medicaid.

C. Conforming edits to § 433.68(e) waiver mechanics (P1/P2 and B1/B2 remain, but with an added gate)

CMS revises § 433.68(e)'s introductory structure to make explicit that:

- For a **broad-based waiver only**, a State must demonstrate compliance with **(e)(1) and (e)(3)**.
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- For a **uniformity waiver** (with or without broad-based), a State must demonstrate compliance with **(e)(2) and (e)(3)**.
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In other words, the "additional generally redistributive requirement" becomes a required element for waiver approval in both pathways (P1/P2 and B1/B2).

D. Transition periods and compliance deadlines (highly consequential for State budgets)

CMS adopts explicit transition parameters and finalizes a regulatory transition framework in § 433.68(e)(4). The final rule distinguishes among:

1. **MCO taxes with a most recent loophole waiver approval ≤ 2 years before April 3, 2026**
   - Transition ends **December 31, 2026**.
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2. **MCO taxes with a most recent loophole waiver approval > 2 years before April 3, 2026**

- Transition ends **the day before the first day of the first State fiscal year beginning at least 1 year from April 3, 2026** (effectively providing at least a full State fiscal year).
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3. **Non-MCO permissible classes (regardless of most recent approval date)**
   - Transition ends **the final day of the State fiscal year that ends in calendar year 2028**, but **no later than Sept. 30, 2028**.
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Compliance obligation at end of transition: by the transition's expiration, States must submit a compliant waiver (or otherwise modify the tax) with an effective date **no later than the day after** the transition ends.
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Enforcement consequence after transition: once the transition expires, CMS may **deduct** revenues from taxes that don't meet (e)(3) from the State's medical assistance expenditures, as contemplated by statute and § 433.70(b).
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CMS explains that it modified transition policies from the proposal to generally align with parameters described in a "Dear Colleague" letter and to reflect the view that the most "egregious" examples are in MCO taxes—while still providing longer transition time for non-MCO taxes.
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4) Interaction with recent legislation (WFTC § 71117) and why CMS emphasizes it

CMS devotes attention to the fact that, during the comment period, Congress enacted WFTC legislation and that **Section 71117** amended the Medicaid statute to add language describing when a tax is *not* generally redistributive, along with definitions that "closely mirror" the rule's proposed regulation.
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Two important implications:

1. **Legal durability / statutory alignment.** CMS frames the final rule as implementing a now-explicit statutory standard, not merely a discretionary policy preference.
2. **Regulatory baseline in the impact analysis.** CMS states that, under OMB Circular A-4, where a rule codifies a statutory change, the analysis uses a "pre-statute" baseline and CMS believes the effects of the statute and the proposed regulation are "effectively the same," though CMS updated estimates due to modified transition periods and identification of an additional tax.
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5) Regulatory and fiscal impact: what CMS says will change in the real world

A. Scale of the issue CMS is targeting

CMS states that before FFY 2024 it was aware of five States with six loophole-exploiting taxes (~$20.5B annually), then approved two additional States' MCO tax waiver proposals in FFY 2025 (another ~$3.5B), and

observed a major increase in the largest MCO tax (from ~$8.3B to ~$12.7B per year). CMS estimates total collections exploiting the loophole are now **~$24.0B per year**.
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B. What CMS expects States to do

CMS explicitly says the rule **does not prohibit** MCO taxes or provider taxes generally; rather, it targets designs that are **not generally redistributive** and shift financing burden in ways "beyond what is contemplated" by statute and regulation.
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CMS acknowledges States may respond in multiple ways (redesign taxes, find other revenues, or reduce Medicaid spending), but also states it is not possible to quantify state-by-state provider effects.
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C. Budget and operations: transition timing is the "pressure valve"

For States currently relying on these structures, the transition timelines are arguably the most operationally important part of the rule because they determine when a non-compliant tax begins risking FFP deductions. The final rule's differentiated timeline—shorter for certain MCO taxes, longer for non-MCO taxes—signals CMS's judgment about where the fiscal integrity risk is greatest.
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6) Bottom line: why this rule is "most significant" for stakeholders

1. **It changes the waiver approval "floor."** Passing P1/P2 or B1/B2 is no longer enough; States must also clear a substantive screen intended to prevent Medicaid-targeting designs.
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2. **It formalizes concepts that will shape future negotiations and CMS reviews** (Medicaid vs non-Medicaid taxable units; tax rate groups).
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3. **It creates enforceable compliance deadlines** with an explicit post-transition enforcement mechanism (FFP-related deduction).
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4. **It is reinforced by new statutory language** (WFTC § 71117), making the policy less likely to be treated as merely discretionary.
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5. **It is about big money:** CMS pegs loophole-related collections at about $24B/year, so even partial redesigns could have meaningful downstream effects on State financing strategies, provider payment arrangements, and managed care rate setting.
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