CMS PROPOSED RULE ON MEDICAID PROVIDER TAXES

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Overview

The Centers for Medicare & Medicaid Services (CMS) proposes major changes to the Federal rules governing provider taxes and other health care-related taxes used by States to finance the non-Federal share of Medicaid. The rule implements section 71115 of the Working Families Tax Cut legislation by replacing the longstanding 6 percent indirect hold harmless "safe harbor" with State- and provider-class-specific limits tied to the taxes that were enacted and imposed as of July 4, 2025. The new framework would apply beginning October 1, 2026. CMS also proposes stronger reporting, reconciliation, and enforcement processes; elimination of the secondary 75/75 test; and a new permissible tax class for health insurers. Comments are due 60 days after publication—September 21, 2026, if the rule is published as scheduled. (Public Inspection PDF, pp. 1-2, 11-14.) Click here for the proposed rule.

Core Policy Changes

1. Class-specific tax ceilings replace the general 6 percent threshold. For each permissible provider or service class, CMS would calculate a maximum percentage by dividing the total tax revenue attributable to that class by the net patient revenue of all providers in the class, using the tax structure in effect on July 4, 2025. A State that had no enacted and imposed tax for a class on that date would generally have a zero-percent threshold for that class. Multiple State and local taxes within the same permissible class would be aggregated. CMS proposes to define net patient revenue as patient-care revenue from all payers for the particular taxed service, including Medicare revenue, but excluding unrelated revenue such as parking, cafeteria, and gift-shop receipts. The State fiscal year containing July 4, 2025 would generally be the measurement period, with adjustments to exclude post-July 4 increases. (pp. 14-16, 30-43.)

2. Expansion States face a scheduled phase-down. Beginning in Federal fiscal year 2028, the applicable limit in an expansion State would be the lower of its July 4, 2025 class-specific percentage or 5.5 percent. The ceiling would then decline to 5.0 percent in FFY 2029, 4.5 percent in FFY 2030, 4.0 percent in FFY 2031, and 3.5 percent in FFY 2032 and later years. Taxes on nursing facility and intermediate care facility for individuals with intellectual disabilities services would be exempt from this annual phase-down, although their limits would remain capped at the July 4, 2025 level. Non-expansion States would not be subject to the statutory phase-down but would still be restricted by their July 4, 2025 class-specific ceilings. (pp. 10-11, 47-51.)

3. The 75/75 test would end prospectively. Under current rules, a tax above the safe-harbor percentage can sometimes remain permissible if fewer than 75 percent of taxpayers receive at least 75 percent of their tax costs back through Medicaid or other State payments. CMS proposes to discontinue this second prong for Federal fiscal years beginning on or after October 1, 2026, reasoning that it could be used to circumvent the new statutory ceilings. A previously approved percentage above 6 percent that was valid as of July 4, 2025 could theoretically be preserved, subject to the expansion-State phase-down, although CMS states that it does not expect any State to fall into this category. (pp. 61-65.)

4. Health insurers would become a new permissible tax class. CMS proposes to add "services of health insurers" as a permissible class, excluding managed care organizations—including HMOs and PPOs—already covered by the existing MCO class. The new class could include insurers in the individual and group markets, short-term limited-duration coverage, certain excepted-benefit policies, and specified Medicare insurance products. Taxes on this class, such as premium-revenue or covered-life assessments, would have to satisfy the same broad-based, uniformity, waiver, and hold harmless requirements as other provider taxes. This change would bring existing State insurer taxes into a clearer and more consistent Federal review framework. (pp. 16-23.)

Implementation, Reporting, and Enforcement

CMS proposes a staged process because complete tax and net patient revenue data will not be immediately available. States would submit estimated information with the CMS-64 report for the quarter ending December 31, 2026, including each tax's authorizing law, implementing documents, waiver history, evidence of when the tax was imposed, estimated revenue and net patient revenue, and the Medicaid payments supported by the tax. Enhanced quarterly reporting would begin October 1, 2026. Actual data needed for final threshold calculations would be due by June 30, 2028, and CMS intends to announce final State- and class-specific thresholds by September 30, 2028. Failure to report a tax could cause CMS to exclude it from the final calculation, potentially producing a lower permissible threshold. (pp. 42, 52-56, 68-78.)

During the transition, CMS would issue interim thresholds for State monitoring and waiver review. CMS generally would defer penalties until final thresholds are available and States have had an opportunity to correct excess collections, but it expressly retains authority to act against intentional or excessive overcollections dating back to October 1, 2026. States would generally have two years after the end of an applicable reporting period to reconcile data and remediate excess collections, potentially by returning proportionate amounts to taxpayers or making other permitted adjustments. If a tax remains impermissible, CMS may reduce the State's claimed medical assistance expenditures before calculating Federal financial participation. CMS also proposes authority to defer or disallow Federal funds and to withhold approval of State payment proposals when missing tax data prevents CMS from verifying that the non-Federal share is permissible. (pp. 53-60, 74-78.)

Financial and Operational Impact

Provider taxes are a central Medicaid financing mechanism: CMS reports that 49 States and the District of Columbia use them and estimates 2026 collections of $98.6 billion. Hospitals account for the largest share—approximately $61.8 billion—followed by managed care organizations at $28.1 billion, nursing facilities and ICFs at $7.3 billion, and all other classes at $1.4 billion. CMS estimates that the effective freeze on new or increased taxes would reduce State provider-tax revenue by $51.0 billion from 2026 through 2035, while the expansion-State phase-down would reduce it by an additional $147.7 billion, for a combined $198.7 billion reduction. (pp. 86-89.)

In its stand-alone base-case model, CMS projects that lower provider-tax financing would reduce Federal Medicaid spending by $245.8 billion and State Medicaid spending by $138.2 billion over 2026-2035—a $384.0 billion total decrease. CMS expects the largest payment reductions to affect hospitals because hospital taxes generate most provider-tax revenue. The actual provider impact is complicated: hospitals and other providers would pay less in taxes, but States could also reduce Medicaid base rates, supplemental payments, benefits, or enrollment, or substitute general-fund revenue. CMS assumes States replace 30 percent of lost financing with other revenue. After accounting for overlap with separate statutory and regulatory limits on State-directed payments, CMS estimates the additional reduction in provider payments attributable to this rule at approximately $142.1 billion, rather than the full $384.0 billion. (pp. 90-96.)

Practical Significance for States and Providers

The proposal effectively locks each State's Medicaid tax-financing capacity to its July 4, 2025 position and, in expansion States, progressively reduces most class limits to no more than 3.5 percent. States will need to inventory every State and local health care-related tax, validate the legal enactment and imposition dates, standardize net patient revenue calculations, and model future collections against both interim and final ceilings. Hospitals should evaluate how much of their Medicaid reimbursement—including supplemental and State-directed payments—depends on provider-tax financing and should prepare for State-specific restructuring. The most consequential comment issues are likely to include the calculation of net patient revenue; treatment of waivers and taxes enacted but not fully operational by July 4, 2025; the scope of the health-insurer class; the phase-down methodology; the elimination of the 75/75 test; and the feasibility of the reporting, remediation, and enforcement timelines.