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CLIENT ALERT

CMS Releases Provider Tax Proposed Rule

By Manatt Health

On July 21, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule *Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes* (CMS-2452-P), implementing the limits on health care-related taxes (also called "provider taxes" in this summary) enacted under H.R. 1 (P.L. 119-21).

All states except Alaska use provider taxes to fund a portion of the non-federal share of Medicaid program expenses, a practice dating back to the 1980s. CMS estimates that in Calendar Year (CY) 2026, provider taxes generated almost $100 billion, or more than a quarter of the total non-federal share of Medicaid. Taxes on hospitals ($61 billion) and managed care organizations (MCOs) ($28 billion) represent 90 percent of all state provider taxes.

CMS enforces provider tax requirements separately for individual classes of health care services (e.g., inpatient hospital or MCO services) defined in federal regulations. Prior to H.R. 1's passage, states could levy provider taxes at a rate of up to 6 percent of provider net patient revenue without CMS considering the tax a prohibited "indirect hold harmless" arrangement (i.e., that the state returns the tax revenue to the taxed providers through Medicaid or other payments). To establish compliance with the 6 percent indirect hold harmless threshold, states divide the total tax collected during the relevant fiscal period by net patient revenue during the same period for the applicable class. In addition, federal law requires that provider taxes are "broad-based and uniform," meaning they apply to all providers in the class and are imposed at the same rate. States are entitled to waivers of the broad-based and uniformity requirements if they demonstrate to CMS that they meet a complex statistical test set out in regulation.

H.R. 1 established several major constraints on provider taxes:

- **Effective October 1, 2026** (the start of federal fiscal year (FFY) 2027), the law effectively bars states from imposing new or increased provider taxes. Taxes that were enacted and imposed as of July 4, 2025 are "grandfathered"—they may continue at their pre-H.R. 1 level, capped at the indirect hold harmless threshold (the tax amount divided by net patient revenue) in effect before the law passed. For states that expanded Medicaid to low-income adults under the Affordable Care Act (expansion states), that cap then declines over time.

- **Effective October 1, 2027** (FFY 2028), in expansion states, the law reduces the maximum 6 percent threshold by 0.5 percentage points per year until the cap reaches 3.5 percent in FFY 2032.[1]

H.R. 1 also bars taxes that impose higher rates on Medicaid volume and/or high-Medicaid providers, even if those taxes otherwise meet the long-standing uniformity waiver standard in federal regulations. (For more on the provider tax final rule implementing the new broad-based and uniformity limits, see the Manatt Health analysis).

The proposed rule provides significant new details on which provider taxes would be grandfathered under the law; how CMS would establish the new hold harmless thresholds for grandfathered provider taxes to replace the 6 percent threshold; and how CMS would implement the phase down for expansion states and monitor compliance.

Note: For purposes of this summary, we refer to the 6 percent indirect hold harmless threshold in place prior to H.R. 1 as the "6 percent threshold" or "6 percent cap", and the new indirect hold harmless thresholds that will replace the 6 percent cap as the "H.R. 1 threshold" or "H.R. 1 cap." For issues relevant to both the 6 percent and H.R. 1 thresholds, we use the term "threshold."

The proposed provider tax rule aligns more closely with the intent and plain language of H.R. 1 than CMS's November 2025 preliminary provider tax guidance, which if finalized would have invalidated a significant number of provider taxes enacted in the months leading up to H.R. 1's passage. CMS emphasizes throughout the preamble that the proposed rule's changes are intended to grandfather a greater number of taxes under H.R. 1 and that it intends to work collaboratively with states to establish the new H.R. 1 thresholds and monitor compliance. At the same time, the proposed rule introduces new provisions (e.g., a retrospective compliance framework and scrutiny of intergovernmental transfers (IGTs)) which, if finalized, could create new Medicaid financing risks for states.

Specifically, the proposed rule would:

- **Expand the number of provider taxes that would be grandfathered under H.R. 1 compared to preliminary guidance issued in November 2025.** To qualify for grandfathering, the preliminary guidance would have required states to obtain tax waiver approval from CMS and, in most cases, actively collect a tax prior to July 4, 2025. The proposed rule would remove both requirements, lowering the bar for grandfathering and preserving a greater number of taxes—including many implemented in the run-up to H.R. 1's passage—compared to the guidance.

[1] In Medicaid expansion states, taxes on nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IID) that were already in effect as of the date of enactment are *exempt* from the phase down. Social Security Act (SSA) § 1903(w)(4)(D)(iv).

- **Preserve longstanding informal guidance on the calculation of net patient revenue, minimizing potential disruption to states and providers.** The proposed rule confirms that the denominator of the threshold calculation must include all net patient revenue for the class—including revenue from providers not subject to the tax (for example, public hospitals or critical access hospitals are sometimes exempt from a tax on inpatient and/or outpatient hospital services). States have long relied on this approach to demonstrate compliance with the 6 percent threshold. Had CMS instead counted only revenue from providers that actually paid the tax, the smaller denominator could have pushed many states above 6 percent and exposed them to significant reductions in federal financial participation (FFP).

- **Establish a standardized measurement period for calculating the new H.R. 1 thresholds (prior to reductions in expansion states**), **departing from prior informal CMS guidance that gave states greater flexibility to calculate the 6 percent cap.** CMS would require that states use the state fiscal year (SFY) in which July 4, 2025 falls to calculate the new thresholds that will replace the 6 percent limit, meaning that for most states, SFY 2026 will serve as the measurement period. CMS had previously given states more flexibility, including establishing compliance with the 6 percent threshold on a rolling four-quarter or partial-year basis. For states with taxes that fluctuate substantially by quarter, the standardized SFY 2026 window could produce an H.R. 1 threshold that differs from what the prior methodology would have produced.

- **Move from a prospective to retrospective compliance approach, putting states at risk of exceeding the H.R. 1 threshold years after collecting a tax.** Under CMS's current informal guidance, states may trend data from a prior period to prospectively demonstrate compliance with the 6 percent threshold. The proposed rule would instead adopt a retrospective compliance framework for the H.R. 1 thresholds based on actual data from the relevant fiscal year, similar to CMS's Medicaid Disproportionate Share Hospital (DSH) monitoring framework. States will inherently lack real-time visibility into whether they are above the H.R. 1 threshold, since actual net patient revenue will not be known until after the end of the fiscal year. Net patient revenue is generally unstable but will be even less predictable in the coming years, as other H.R. 1 provisions—including Medicaid work reporting requirements and state directed payment (SDP) reductions—slow hospital net patient revenue growth. States will effectively need to project against a moving target, which will make it challenging to know how much tax can be collected in a given quarter. Because compliance would be assessed on a multi-year lag, states could be found to exceed the threshold and face a penalty long after the federal fiscal year concludes. The stakes are highest for states that finance the non-federal share of Medicaid expansion through provider taxes and cannot, under state law, substitute general fund appropriations. Such states that are retroactively found to exceed the threshold would need to either refund tax revenue they have already spent

or be subject to even larger federal penalties for noncompliance, creating a funding gap that could put expansion coverage at risk.

- **Give CMS discretion to invalidate state financing arrangements involving public providers, even where a state complies with its new H.R. 1 thresholds.** CMS signals it will scrutinize states that, after their H.R. 1 thresholds are set based on a tax that includes public providers, later exempt those providers from the tax and instead fund their non-federal share through IGTs. Because the public providers' tax revenue was counted when the H.R. 1 threshold was established but would no longer be counted against it for monitoring purposes, the approach would effectively create additional room under the threshold. Importantly, CMS does not identify the authority it would rely on to invalidate such an arrangement or the standards it would apply when assessing the appropriateness of an arrangement.

- **Abolish the "75/75" test, an alternative pathway for states to demonstrate compliance with the indirect hold harmless requirement if the tax exceeds 6 percent of net patient revenue.** Under the test, states must demonstrate that no more than 75 percent of the providers subject to the tax receive more than 75 percent of their taxes back through enhanced Medicaid or other state payments. Because provider taxes often fund the non-federal share of Medicaid payments made to the same class of providers, states are typically unable to satisfy the 75/75 test and have used it only in limited circumstances. CMS proposes to prohibit use of the 75/75 test going forward, meaning states will need to remain under the H.R. 1 threshold to demonstrate compliance.

- **Add "services of health insurers" as another provider tax class and applies the H.R. 1 limits to the class,** with the goal of establishing a new regulatory framework for certain taxes on health insurers that previously fell into a gray area.

A detailed summary of the provisions of the proposed rule follows. A timeline of the key milestones proposed in the rule is included at the conclusion of the summary.

Comments on the proposed rule are due September 21.

Classes of Health Care Services and Providers Defined (§ 433.56)

Current regulations identify 19 permissible classes of health care providers and services that states may tax, one of which is services of MCOs. The MCO category includes health maintenance organizations (HMOs) and preferred provider organizations (PPOs).[2]

[2] The 19 classes of health care services and providers defined in § 433.56(a) include: inpatient hospital services, outpatient hospital services, nursing facility services, intermediate care facility services for individuals with intellectual disabilities, physician services, home health care services, outpatient prescription drugs, services of managed care organizations, ambulatory surgical center services, dental services, podiatric services, chiropractic

CMS proposes adding "services of health insurers" as a new class, distinct from the existing MCO class. Examples of insurers that would be covered under the new definition include certain insurers that issue policies for the group and/or individual market and are not included in the MCO category—such as insurers with general state health insurance licenses offering non-PPO products; and nonprofit hospital, medical, and health service corporation products.

CMS states that this addition is intended to address longstanding concerns that state taxes on health insurer services function as provider taxes in practice and bring them into compliance with statutory requirements. If finalized, taxes on this new class would be subject to the same legal requirements as other permissible classes—including the broad-based and uniformity requirements and hold harmless provisions—as well as the new requirements under H.R. 1: states would be prohibited from establishing new taxes on the health insurer class, and taxes in place prior to H.R. 1 would be frozen and reduced in expansion states.

While CMS frames the proposal as an attempt to provide greater clarity for states, distinguishing which entities fall into the new health insurer class versus the existing MCO class is not straightforward, because insurance licensure is conducted at the state level and differs by state. The confusion is greatest regarding PPO plans. Many states license HMOs separately, making it relatively straightforward to impose a tax and calculate the threshold for HMOs. By contrast, PPO plans are not typically licensed separately but instead sold as a product by insurance companies holding a general health insurance license (the specific licensure categories differ by state). These companies typically sell many different products across multiple lines of business under one license—individual market, small group plans, and others—some of which are PPOs and some of which are not. Because PPOs are often not their own regulatory category, states cannot easily determine which portion of a general health insurer's revenue is attributable to its PPO products. This has created confusion regarding which revenue to include in the MCO class for the purpose of the threshold calculation. Introducing a separate "health insurer" tax class on top of the existing MCO class risks compounding this confusion. For example, a company licensed as a general health insurer selling PPO products could conceivably be classified under either class, creating a risk that PPO revenue is captured inconsistently across and within states. By contrast, had CMS elected to add health insurers to the MCO class, implementation would be more straightforward.

CMS notes that if the class is not established, existing health insurer taxes that function as provider taxes may be subject to the same penalty as provider taxes that exceed the threshold for established classes.

Permissible Health Care-Related Taxes (§ 433.68)

services, optometric/optician services, psychological services, therapist services, nursing services, laboratory and x-ray services, emergency ambulance services, and other health care items or services for which a state has enacted a licensing or certification fee.

The proposed rule includes important new details on how CMS would determine which provider taxes qualify for grandfathering as taxes enacted and imposed as of July 4, 2025; how the H.R. 1 thresholds that replace the 6 percent limit would be calculated; and how CMS would monitor states' compliance with the new limits.

Calculation of the Threshold

"Enacted" and "Imposes" Criteria (§ 433.68(f)(3)(ii)(A)(1))

H.R. 1 allows a provider tax to remain in effect if, as of the date of H.R. 1's enactment (July 4, 2025), the state "has enacted such tax and imposes such tax on such class," and "the Secretary determines that the tax is within the hold harmless threshold as of that date."[3] In November 2025, CMS released preliminary guidance that—by narrowly interpreting the "enacted" and "imposes" criteria—seemed designed to invalidate state provider taxes implemented shortly before H.R. 1's enactment. CMS changed course in the proposed rule, instead opting for broader definitions designed to preserve a greater number of provider taxes implemented in the run-up to H.R. 1. Specifically, CMS proposes the following definitions:

- ***Enacted*.** CMS would consider a tax enacted if the state had completed the entire legislative process necessary to authorize the tax—including implementing a new tax or increasing the rate of an existing tax—by July 4, 2025.
    - Unlike CMS's November 2025 guidance—which would have also required that a tax needing a broad-based or uniformity waiver had received waiver approval by July 4, 2025—the proposed rule does not include waiver requirements in the definition of enacted. (Waivers are instead addressed in the "imposes" criterion, described below).
    - A tax would not be considered enacted if the legislative process was completed after July 4, 2025 but the tax was made effective retroactive to a time period before July 4, 2025. For example, a tax enacted on October 1, 2025 but made retroactively effective to July 1, 2025 would not qualify for grandfathering under CMS's proposal.
    - In addition, states that increased tax rates for existing taxes after July 4, 2025 would not be permitted to count the revenues of the increased tax in the numerator of the H.R. 1 threshold calculation. For example, a state that increased its tax from 2.5 percent to 3 percent of net patient revenue on October 1, 2025 would not be permitted to count the incremental amount of revenue (i.e., the 0.5 percent between 2.5 percent and 3 percent) in the numerator of the calculation.

[3] SSA § 1903(w)(4)(D)(i).

- ***Imposes.*** CMS would define "imposes" to mean that the tax was in effect as of July 4, 2025, meaning that the state (or locality) imposed a legally enforceable obligation to pay as of July 4, 2025. The proposal differs substantially from CMS's November 2025 guidance, which in most cases would have required a tax to be collected before July 4, 2025 to be considered imposed.

    - In addition, CMS proposes that to qualify as imposed, a tax requiring a broad-based or uniformity waiver needs to have a waiver effective date on or before July 4, 2025. Under federal rules, waivers are effective retroactive to the start of the calendar quarter in which they are submitted to CMS. As a result, states would need to have submitted a waiver to CMS by September 30, 2025 to qualify for a July 1, 2025 effective date. As CMS notes in the preamble, this revised approach to waiver approval would have the effect of grandfathering a larger number of taxes enacted in the run up to H.R. 1 compared to the November 2025 guidance.

    - CMS also clarifies that a tax would not be considered imposed if, prior to July 4, 2025, a state legislature had given a state administrative agency standing authority to impose a tax of an unspecified amount at an unspecified time. In this case, while the tax would be considered enacted, it would not be considered imposed because it did not establish a legally enforceable requirement to pay before July 4, 2025.

    - The proposal, while substantially more flexible than the November 2025 guidance, raises questions about whether certain taxes enacted in the months preceding H.R. 1 would be grandfathered. For example, consider a state that enacted a tax increase prior to July 4, 2025 but made the tax effective after that date (for example, October 1, 2025). This tax would likely not qualify as imposed under CMS's proposal because the legal obligation for providers to pay the higher rate was not in effect prior to H.R. 1's passage.

    - As another example, consider a state legislature that directed a state Medicaid agency to increase the rate of an existing provider tax to fund the non-federal share of a pending SDP—without specifying the new tax rate or the timing of the increase. While the legal obligation was in effect as of July 4, 2025, the tax increase and amount were not known prior to H.R. 1's passage. It is not clear whether CMS would consider this type of tax imposed, nor if CMS would take a different position if the state legislature permitted, but did not require, the Medicaid agency to increase the tax rate.

Threshold Calculation Methodology (§ 433.68(f)(3)(ii)(A))

The proposed rule would codify the basic formula for calculating the indirect hold harmless threshold that CMS previously shared with states through informal guidance. To establish the threshold, states divide the total tax amount collected (the numerator) by the net patient revenue for the permissible provider class (the denominator). Consistent with prior guidance, CMS notes that the threshold is calculated separately for each permissible class—for example, because inpatient and outpatient hospital services are two separate classes under CMS rules, the threshold for each is calculated separately.

The proposed rule includes important new details on how the numerator and denominator would be established and how the threshold would be calculated.

Numerator Calculation (Tax Amount Collected). CMS clarifies that the tax amount in the numerator of the H.R. 1 threshold calculation should include the amounts actually collected by the state, including amounts involuntarily collected through Medicaid payment offsets or other collection efforts. However, the tax amount should not include taxes that were owed by a provider but never paid. As a result, the tax included in the numerator of the threshold calculation may be less than the total tax liability. States differ significantly in both the volume of unpaid provider taxes and the aggressiveness of their collection efforts. Because CMS proposes to base the calculation on actual tax and net patient revenue data and provide a multi-year remediation period after the end of the federal fiscal year (described on page 12), states would still have an opportunity to collect taxes owed from a prior period. States with a substantial amount of unpaid provider taxes are likely to be motivated to collect as much of the tax liability as possible for the period in which the H.R. 1 threshold is calculated—including through Medicaid payment offsets or other involuntary collection efforts—to increase the thresholds that will serve as the new cap on provider taxes going forward (prior to reductions in expansion states).

Denominator (Net Patient Revenue). In many states, certain types of providers are exempted from provider taxes. For example, public and critical access hospitals are often exempted from taxes on inpatient and outpatient hospital services. Consistent with longstanding informal CMS guidance, the proposed rule would define "net patient revenue" as all net patient revenue from the permissible provider class, including revenue from providers not subject to the tax. This means that the threshold calculation may differ from the state's tax rate, even if both are based on net patient revenue from the same year. For example, consider a state that imposes a 2 percent tax on inpatient hospital services, but exempts critical access hospitals from the tax. Net patient revenue for all inpatient hospital services is $1 billion – of that amount, $100 million is for critical access hospitals. The state collects $18 million from the tax (2 percent multiplied by $900 million). However, the hold harmless threshold is 1.8 percent, because the $18 million is divided by $1 billion – that is, all inpatient net patient revenue for the class inclusive of critical access hospitals. This means that the threshold will be set and taxes will be assessed against the threshold using this larger, more inclusive denominator.

CMS considered, but did not propose, limiting net patient revenue to providers within the permissible class that are actually taxed. CMS declined to move forward with this alternative, citing it as inconsistent with both its longstanding interpretation of the term and with two statutory references that use the term in the broader sense. This alternative would narrow the denominator and increase the effective tax threshold, pushing states closer to, or above, the 6 percent cap.

For inpatient and outpatient hospital services—which are separate permissible provider tax classes—states often extract net patient revenue figures from Medicare cost reports, which only include aggregate net patient revenue for inpatient and outpatient hospital services combined. As a result, states have developed approaches to disaggregate inpatient and outpatient revenue using different allocation methodologies – for example, using the proportional distribution of inpatient and outpatient hospital charges, which are reported separately on the Medicare cost report. CMS notes that it will continue to work with states on appropriate allocation methodologies, and in general, does not intend to take enforcement actions against states based on misattributions.

H.R. 1 Threshold Rounding Approach.[4] CMS proposes to round the H.R. 1 threshold percentage to nine decimal places. That approach, combined with the more extensive reporting that would be required (see page 15), could be cumbersome for states and CMS, particularly where states have provider taxes across multiple classes.

H.R. 1 Threshold Limit. CMS explains that the H.R. 1 threshold must be less than 6 percent, unless the state demonstrates to CMS that it met the "75/75" test (described further on page 13) prior to July 4, 2025. In that case, CMS would permit the state to maintain a tax that exceeds the 6 percent threshold but notes that it does not expect any states to meet these criteria.

***H.R. 1 Threshold Measurement Period*.** CMS proposes to use the SFY in which July 4, 2025 falls as the measurement period for calculating the new H.R. 1 thresholds. In most states, the measurement period would be SFY 2026 (which is July 1, 2025 - June 30, 2026 for most states). In circumstances where the measurement period includes tax amounts that were not enacted and imposed as of July 4, 2025—for example, a tax that was increased on October 1, 2025—states would need to deduct that revenue from the numerator of the calculation. In states where the tax amount declined during SFY 2026, CMS would work with states to identify an alternative measurement period. CMS also clarifies that taxes in effect as of July 4, 2025—but that required a subsequent tax waiver renewal after that date—for example, on October 1, 2025—would be considered continuous (that is, the tax would not be considered new solely because it required tax waiver reauthorization).

[4] 91 Fed. Reg. 46562, 46570 (July 23, 2026).

The proposal to use one standardized SFY as the measurement period differs from current CMS practice, which gives states more flexibility. For example, CMS currently permits states to use the most recent four quarters—or alternatively, the most recent tax period (e.g., quarter or six-month period)—to calculate the threshold. In the preamble, CMS explains that it also considered alternative measurement periods such as FFY 2025, CY 2025, or four consecutive quarters that include July 4, 2025. For most states—including those that enacted and imposed new or increased taxes in the run-up to H.R. 1—CMS's proposal to use SFY 2026 as the measurement period would accurately capture the threshold in place prior to H.R. 1's enactment. For example, a state that enacted and imposed a higher hospital tax on June 1, 2025 would have the increased tax fully included in the SFY 2026 measurement period.

However, there are circumstances where a calculation based on SFY 2026 may not accurately capture a state's historical tax threshold. For example, some states impose taxes based on a formula that varies substantially by tax period (for example, a tax based on hospital costs that fluctuates each quarter). For states that have historically used a rolling four-quarter measurement period to calculate the threshold, using the SFY 2026 measurement period could differ substantially from prior calculations. CMS invites comment on the proposal to use SFY 2026 as the measurement period.

Retrospective Approach to Establish H.R. 1 Thresholds and Monitor Compliance. CMS proposes a standardized process for calculating the new thresholds based on actual taxes collected and actual net patient revenue for the applicable period. (The specific reporting process and relevant examples are described on page 12, and the proposed data submission requirements are described on page 15.) This approach differs from CMS's current process, which gives states greater flexibility to prospectively trend tax amounts and/or net patient revenue from a prior period to a more current period for purposes of demonstrating compliance with the threshold. If the standardized process produces an H.R. 1 threshold that slightly exceeds the 6 percent limit but would have been below the 6 percent cap using CMS's prior guidance, CMS does not intend to pursue a reduction in FFP.

CMS notes that it could consider reductions in FFP in cases where the standardized methodology produces a hold harmless threshold in "significant excess" of the 6 percent cap, or where the state cannot demonstrate that it would have remained under the 6 percent cap using the prior guidance. CMS does not clarify how it would determine that a rate is "slightly" versus "significantly" above the 6 percent cap, creating uncertainty around when it could penalize states for non-compliance.

Finally, CMS also proposes that the calculation methodologies described in this section would also apply to the new health insurer provider tax class described on page 4.

Application of the Threshold

Timing (§ 433.68(f)(3)(ii)(B))

Under H.R. 1, the moratorium on new or increased provider taxes goes into effect October 1, 2026. While CMS proposes to calculate H.R. 1 tax thresholds using SFY data (described above), it proposes to monitor and enforce compliance with these new thresholds (as well as the phase-down thresholds for expansion states described below) on a FFY basis. CMS notes that a FFY monitoring approach will simplify its administrative processes compared to monitoring compliance for different time frames depending on the state. CMS proposes that states would report the necessary information for monitoring through quarterly CMS-64 submissions, which will allow CMS to analyze the four quarters of the FFY (for more information on proposed reporting requirements, see page 15).

State provider tax programs typically operate on a SFY basis, which in most cases differs from the FFY. As a result, state tax collections are likely to be misaligned with the federal enforcement window. When H.R. 1 thresholds first go into effect, as well as during the phase down in expansion states, new thresholds will often apply mid-SFY, meaning states may need to decrease tax rates mid-SFY. For example, in a state with a July 1, 2026 – June 30, 2027 SFY, the state would still need to ensure that taxes attributable to the October 1, 2026 – September 30,2027 period do not exceed the threshold for that federal fiscal year.

Phase Down for Expansion States (§ 433.68(f)(3)(ii)(B)(1)–(3))

The H.R. 1 threshold calculated above will decrease over time for expansion states for all taxed provider classes, excluding nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IID), such that the threshold is the lower of the threshold calculated (see page 7), and:

- 5.5 percent for FFY 2028
- 5 percent for FFY 2029
- 4.5 percent for FFY 2030
- 4 percent for FFY 2031, and
- 3.5 percent for FFY 2032 and each subsequent FFY.

In the case where states must make mid-SFY tax changes during the phase down to align with the FFY monitoring window, CMS provides two options for how states could operationalize the change. As an example, consider a state that imposes a tax on an SFY basis and must operate within a 4.5 percent net patient revenue threshold for FFY 2030 and 4 percent for FFY 2031. Under the first option, the state could impose a tax of 4.5 percent of net patient revenue tied to July-September 2030, and 4 percent of net patient revenue tied to October 2030-June 2031. Alternatively, states could prorate net patient revenue across the FFY and identify a maximum tax amount (in dollars) that could be imposed during the FFY.

Interim Indirect Hold Harmless Threshold Process (§ 433.68(f)(3)(ii)(B)(4))

Because CMS plans to calculate the H.R. 1 thresholds using actual tax collection and net patient revenue data from the SFY overlapping with July 4, 2025 for each permissible class, CMS will need to allow sufficient time for claims run-out, collection delays, and other data availability lags before establishing the final thresholds. CMS notes that the time frame between (1) the end of the SFYs overlapping with July 4, 2025 (in many states, this would be June 30, 2026), and (2) the moratorium on new or increased taxes (effective October 1, 2026) is insufficient for establishing complete and accurate H.R. 1 threshold calculations prior to the moratorium's effective date.

Therefore, CMS proposes an "interim" H.R. 1 threshold process, where CMS would provide states with an interim, non-binding H.R. 1 threshold, to serve as an early indication of each state's H.R. 1 thresholds effective October 1, 2026, allowing states to adjust their taxes in advance of that date. However, CMS proposes that states would submit data to inform the interim threshold by December 31, 2026 and does not specify when CMS will communicate the thresholds, meaning even the interim threshold will not be available to states prior to the October 1, 2026 effective date. States will therefore need to proactively estimate their own thresholds in advance of October 1, 2026 to inform any needed tax changes.

CMS would publish final thresholds no later than September 30, 2028, at which time CMS would require that any state with taxes exceeding the final H.R. 1 threshold (even if the state remained under the interim H.R. 1 threshold) to retroactively take corrective action (i.e., refunding a portion of the tax to tax-paying providers), or face FFP penalties described below. CMS notes it does not intend to enforce penalties until states have had an opportunity to take those corrective actions and would only penalize states that "engaged in excessive or intentional overcollections."

Data Remediation

CMS proposes to allow up to two years after each FFY for states to finalize the actual tax amounts collected as a percentage of net patient revenue and take corrective actions (i.e., make tax refunds to providers) if taxes exceeded the threshold. After this two-year period, CMS would have the discretion to apply penalties, described below. For example, for FFY 2029 (October 1, 2028 – September 30, 2029), states would have until September 30, 2031 to report compliance.

This proposal would create an ongoing process where states must retroactively ensure they are under their thresholds and refund taxes as needed to stay under those thresholds. Any unanticipated fluctuation in collected tax amounts, the tax rate, or net patient revenue could push a state above its threshold unintentionally—even in years when the H.R. 1 thresholds themselves do not change. CMS's proposed approach is likely to affect a significant number of states, because net patient revenue is inherently unstable—it shifts with changes to payment

rates, utilization, and other market forces such as hospital closures or expansions. Several H.R. 1 provisions outside the provider tax context will also likely slow net patient revenue growth over the coming years, including cuts to SDPs and coverage losses tied to work reporting requirements, meaning that historical net patient revenue growth rates may not accurately reflect future growth. The practical result is that a state could attempt to comply in good faith based on the best available net patient revenue estimate at the time and still exceed the threshold based on retrospective, actual data from the rate year.

For example, consider a state that taxes inpatient hospital services at a fixed amount per inpatient day. In the SFY 2026 measurement period, hospitals in the class reported 100,000 inpatient days and $1 billion in net patient revenue, and the state collected $50 million in taxes—producing an H.R. 1 threshold of 5 percent. For the next year, SFY 2027, the state projects that net patient revenue will again be $1 billion, with 100,000 bed days. The state therefore does not change its tax rate, collects $50 million in taxes, and expects to stay at the 5 percent threshold. In actuality, inpatient days hold steady, but SDP cuts result in a reduction of $100 million in net patient revenue, so the actual net patient revenue for SFY 2027 is $900 million. This change pushes the state above the 5 percent threshold ($50 million in taxes divided by $900 million in net patient revenue equals 5.6 percent).

Under CMS's proposal, states that retroactively identify taxes that exceeded the H.R. 1 threshold must issue refunds to taxed providers to avoid federal recoupment, as described on page 15. States would need to either identify a new source of state revenue to backfill the taxes that were returned, or would need to retrospectively reduce Medicaid payments that the over-collected tax had financed. Either option would be complicated and could require a combination of new state legislative authority and amendments to previously approved state plan amendments (SPAs) or SDP preprints. In many cases, SDP preprint amendments would not be allowed under federal rules, raising questions around how states would secure federal authority to retrospectively reduce payments.

The exposure is greatest for states that finance the non-federal share of Medicaid expansion through provider taxes and are barred by state law from using general fund appropriations for the expansion population. Consider a state whose statute requires that the non-federal share of expansion be financed entirely by a tax on hospitals, deliberately insulating the general fund from expansion costs. If that tax was later found to exceed the state's H.R. 1 threshold, the state would need to refund tax dollars it had already spent on expansion—with no lawful source to replace them. Resolving the gap would require the legislature to amend the financing statute, which in some states could be challenging. And because the H.R. 1 thresholds phase down annually in expansion states, states will face this cycle—adjusting collections to a new threshold, then retroactively assessing and correcting over-collections—year after year. In the proposed rule, CMS does not address the scenario where a state retroactively determines that it is below the H.R. 1 threshold and wishes to retroactively increase the tax up to the threshold.

Revision of the Second Prong of the Indirect Hold Harmless Test (§ 433.68(f)(3)(i)(B))

The proposed rule would discontinue application of the second prong of the indirect hold harmless test, known as the "75/75 test," effective in federal fiscal years beginning on or after October 1, 2026. Under the 75/75 test, taxes exceeding the 6 percent threshold could avoid classification as a hold harmless arrangement if no more than 75 percent of taxpayers in the class received 75 percent or more of their total tax costs back in enhanced Medicaid payments or other state payments. For example, consider a hypothetical state with 12 hospitals that imposed an outpatient hospital service tax of 10 percent of net patient revenue, exceeding the 6 percent cap. Each of the 12 hospitals paid $8 million in outpatient hospital taxes in a given year. Under the current second prong of the indirect hold harmless test, CMS would allow such a tax if fewer than nine hospitals (75 percent of hospitals) received more than $6 million (75 percent of their tax) back in the form of Medicaid payments or other state payments.

Under the proposed rule, CMS would no longer apply the 75/75 test if a tax exceeded the H.R. 1 cap, eliminating the option for states to impose provider taxes above the H.R. 1 thresholds that were not enacted and imposed as of July 4, 2026. CMS frames this change as responsive to a 2018 Office of Inspector General (OIG) report on hospital tax programs; while this OIG report recommended reconsideration of the 75/75 test, it was in the broader context of reconsideration of the full indirect hold harmless framework, including the 6 percent cap.[5]

In effect, the test has been applied very infrequently since its establishment in 1993 regulations.[6] In the proposed rule, CMS asserts that only one state has ever had a provider tax exceeding the 6 percent limit by passing the second prong 75/75 test. While CMS notes its understanding that no state currently has enacted and imposed a tax exceeding the 6 percent threshold, the proposed rule would permit a provider tax exceeding that cap if CMS had previously approved it under the second prong as of July 4, 2025, subject to the H.R. 1 phase-down requirements. No new taxes could be established exceeding the H.R. 1 caps under the proposed rule, even if they would have passed the 75/75 test.

While the 75/75 test has been infrequently used to date, discontinuing application of the second prong reduces state flexibility in imposing new provider taxes that exceed the limits established in H.R. 1, even if such taxes are not hold harmless arrangements (i.e., do not return the tax costs to taxpayers via Medicaid or other payments). Such constraints may affect states that use provider taxes as true general fund taxation vehicles, but whose taxes exceed the new H.R. 1 limits. CMS could have alternatively made the test more stringent (i.e., a "50/50 test") to ensure higher tax rates were not hold harmless arrangements, which would have provided states with flexibility to generate revenue via taxes on health care organizations unrelated to Medicaid payments that flow to the same providers.

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[5] Department of Health and Human Services Office of Inspector General, "Although Hospital Tax Programs in Seven States Complied with Hold-Harmless Requirements, the Tax Burden on Hospitals was Significantly Mitigated," 2018, https://oig.hhs.gov/documents/audit/6785/A-03-16-00202-Complete%20Report.pdf.

[6] 58 Fed. Reg. 43156 (August 13, 1993).

Ending the 75/75 test and adding the new health insurer class described on page 4, could also constrain taxes on carriers offering Marketplace coverage. For example, all states with a state-based Marketplace SBMs use these taxes to fund Marketplace operations. While many existing health insurer taxes would be grandfathered under H.R. 1 and the proposed rule, states would have few pathways to increase taxes or impose new ones as Marketplace operating costs grow. In addition, taxes in expansion states above 3.5 percent of net patient revenue would also be subject to reductions as H.R. 1 cuts phase in.

FFP Limitation and Enforcement (§ 433.70)

The proposed rule maintains and clarifies existing enforcement standards for the indirect hold harmless threshold. Consistent with current practice, if a state provider tax is found to have an impermissible hold harmless arrangement, the state would have to return FFP associated with the impermissible tax. Specifically, the full value of the noncompliant tax would be subtracted from the state's total computable expenditures. The state-specific federal match rate (Federal Medical Assistance Percentage, or FMAP) would then be applied to the new, lower amount. For example, if a state provider tax is 6.5 percent of net patient service revenue and its H.R. 1 threshold is 6 percent, the state would have to reduce its matchable expenditures by the total amount of the tax—not just the 0.5 percent in excess of the cap—and repay CMS any resulting overage in federal funds. As such, if a state with a 50 percent match rate had an impermissible tax that generated $800 million in revenue, the $800 million would need to be removed from the state's $10 billion Medicaid total computable expenses for that year, reducing the state's federal match by $400 million for the year. States may voluntarily return such funds to CMS, or if the state refuses, CMS can recoup the funds via deferral or disallowance processes. As noted above (see page 12), states would have up to two years following a given fiscal year to retrospectively adjust their taxes prior to them being deemed impermissible and subject to repayment.

Reporting Requirements (§ 433.74)

The proposed rule establishes a new two-track reporting framework to support implementation of the indirect hold harmless threshold, including one-time reporting needed to calculate the H.R. 1 threshold and ongoing quarterly reporting to monitor compliance going forward.

One-time Reporting Requirements (§ 433.74(b)(2) and (b)(3))

CMS proposes using two one-time data submissions to support calculation of interim and final H.R. 1 thresholds:

- ***Reporting to inform interim H.R. 1 thresholds*** (due December 31, 2026). States would be required to submit tax collection amounts and net patient revenue for the SFY containing July 4, 2025 by tax and permissible class. States could utilize estimates or projections for this data submission given that actual tax collection amounts and net

patient revenue may not be available by the due date. CMS also proposes that states provide for each tax the authorizing legislation (and related State regulations/ administrative issuances) with dates and citations, the type and date of all tax waivers, documentation of when the tax was imposed, and what the tax funds, including specific Medicaid payments supported.

- ***Reporting to inform final H.R. 1 thresholds*** (due June 30, 2028). CMS proposes that states submit actual (not estimated) tax collection amounts and net patient revenue, by tax and permissible class, for all taxes enacted and imposed by July 4, 2025. CMS will use this data to calculate and notify each state of its final H.R. 1 threshold percentage by permissible class, including any applicable phase-down schedule.
    - *Treatment of local taxes.* CMS emphasizes that local provider taxes (e.g., taxes imposed by cities or counties) must be included in the calculation of a permissible class's H.R. 1 threshold, including taxes imposed by local governments that are transferred to the state Medicaid agency as an IGT. CMS proposes to aggregate revenue from all state and local taxes imposed on the same permissible class and divide the total by statewide net patient revenue for that class to calculate a statewide H.R. 1 threshold for the permissible class.

Ongoing Reporting Requirements (§ 433.74(b)(4) and (b)(5))

Beginning in FFY 2027, CMS proposes that states would report quarterly their tax collections and net patient revenue data by tax and permissible class on the CMS-64 form. In addition, states would be required to specify what each tax funds, share any updates to taxes that change whether providers that are also state or local units of government are subject to the tax, and share any other data CMS requests. Tax collection and net patient revenue data would be reported to CMS for the period in which the tax is imposed on providers, not the period collected. For example, revenues from a tax on inpatient services imposed on September 1, 2028 but collected on October 15, 2028 would be included on the state's July-September 2028 CMS-64 and included in the state's FFY 2028 tax amount. Notably, CMS proposes that states must use the same methodology for calculating net patient revenue for the one-time reporting that forms the basis of the H.R. 1 threshold in all ongoing reporting to CMS. For example, if a state uses inpatient and outpatient hospital charges to allocate aggregate hospital net patient revenue across permissible classes for the one-time reporting, the state must continue to use that methodology in ongoing reporting.

CMS also proposes that states must report quarterly on any changes to a provider tax that affect whether public providers are subject to the tax, even when the change does not require submission of a tax waiver. CMS explains that it is concerned that states may respond to the new provider tax limitations by restructuring taxes and related financing mechanisms in ways that increase federal matching funds while creating a prohibited direct or indirect hold harmless arrangement. For example, CMS identifies as an area of concern situations where a

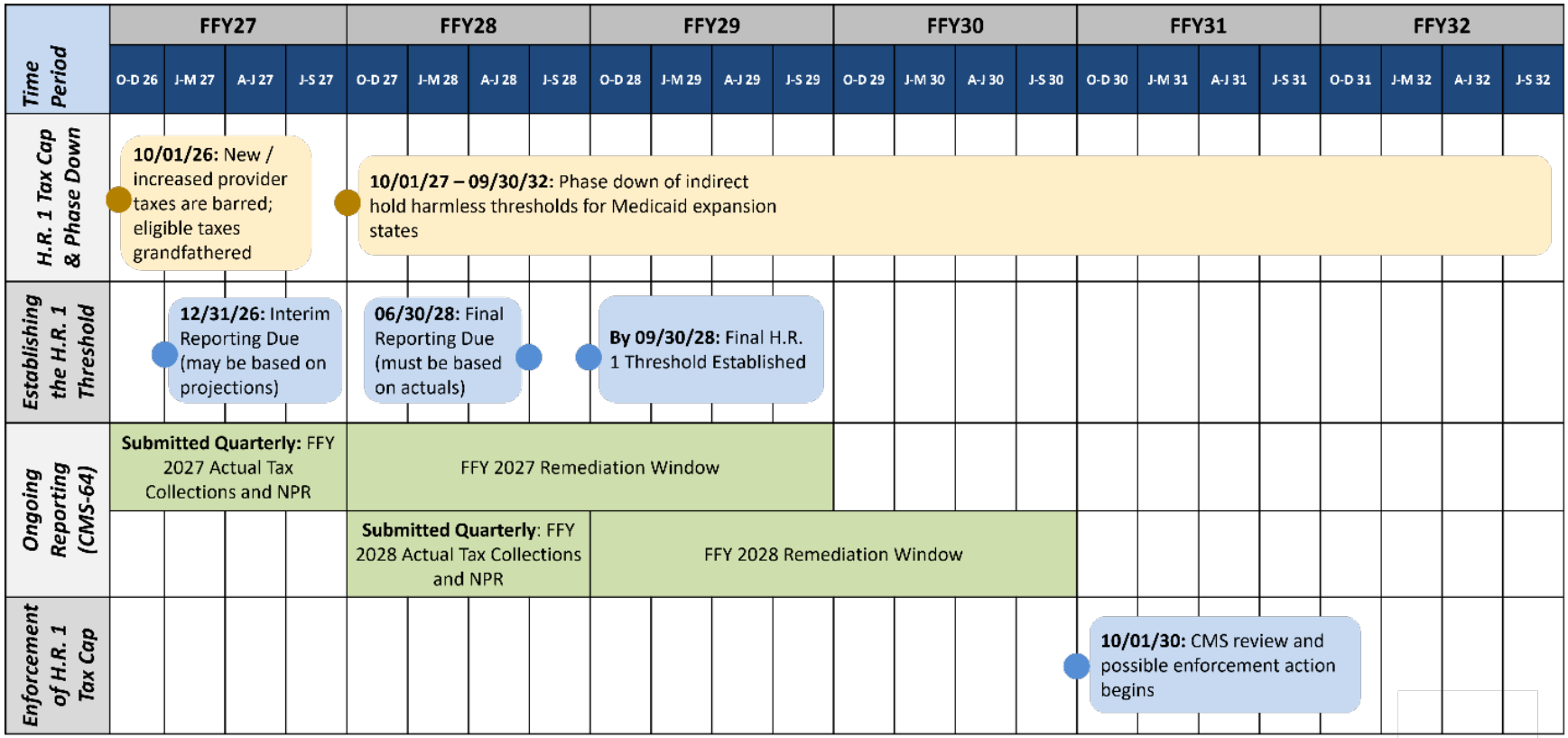
state exempts a public hospital system from a provider tax and subsequently requires that hospital system to make an IGT to finance Medicaid expenditures. Where public providers were included in a tax when a state's H.R. 1 threshold was established but are later removed from the tax base, the state could effectively create additional room under the threshold while continuing to finance the non-federal share through IGTs from those same public providers. Notably, CMS does not identify a specific statutory or regulatory authority that would prohibit these arrangements where a state otherwise complies with applicable provider tax requirements.

Looking Ahead

Taken together with the SDP proposed rule published in May, CMS is proposing major changes to the Medicaid payment and financing landscape that will shape state decision making, provider participation in Medicaid, and access to care in the years ahead.

Comments on the proposed rule are due September 21.

Proposed Rule Implementation Timeline for Key Provisions



Notes: (1) CMS notes that the timeline is illustrative and subject to change; (2) each subsequent year of quarterly reporting during the phase-down will have a two-year remediation period; FFY 2027 and FFY 2028 remediation periods are shown here as illustrative examples; (3) NPR refers to Net Patient Revenue.

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