CHILDREN'S HOSPITAL ASSOCIATION

Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Final Rule

Summary

On Feb. 2, 2026, CMS finalized the "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole" final rule, which revises compliance requirements for health care-related provider taxes. The rule codifies H.R. 1's ban on certain provider taxes that meet technical federal requirements but effectively shift most of the tax burden onto providers with higher Medicaid volumes.

More specifically, the rule prohibits any provider tax that: (1) imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes, (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service, or (3) has the "same effect" as (1) or (2). Although the rule primarily targets managed care organization (MCO) taxes, it affects all provider tax arrangements that would be considered out of compliance with the new requirements.

This rule also sets extended compliance timelines for states with MCO taxes, offering more flexibility than the proposed rule and 2025 provider tax guidance. The rule takes effect on Apr. 3, 2026.

CHA commented on the proposed rule, emphasizing the role of provider taxes in Medicaid and the potential impact on children's access to care. Key provisions for children's health and hospitals are outlined below. Please reach out to Milena Berhane with any questions.

600 13th St., NW | Suite 500 | Washington, DC 20005 | 202-753-5500
16011 College Blvd. | Suite 250 | Lenexa, KS 66219 | 913-262-1436
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KEY PROVISIONS IN THE RULE

Topic	Provision	CHA Comments

Prohibition on Certain Provider Taxes
§ 433.68(e)
	The rule codifies the following prohibitions on certain provider taxes included in H.R. 1.
	
	States are <u>prohibited</u> from:
	• **Taxing Medicaid utilization at higher rates than non-Medicaid utilization.**
	  ○ For example, a tax on MCOs where Medicaid member months are taxed $200 per member month whereas the non-Medicaid member months are taxed $20 per member month would be prohibited.
	
	• **Taxing high-Medicaid providers at a higher rate than low-Medicaid providers.**
	  ○ For example, a tax on nursing facilities with more than 40 Medicaid-paid bed days of $200 per bed day and on nursing facilities with 40 or fewer Medicaid-paid bed days of $20 per bed day would be prohibited.
	
	• **Implementing tax arrangements that result in the "same effect" as the prohibited taxes described above.**
	  ○ For example, this would prohibit a tax of $10 per inpatient hospital discharge on hospitals located in counties with an average income less than 230 percent of the federal poverty level, while hospitals in all other counties are taxed at $5 per inpatient hospital discharge, because the distinction between tax rate groups is associated with Medicaid eligibility and would likely result in a higher tax rate for high-Medicaid hospitals.
		We recommended that CMS <u>clarify</u> the "same effect" language, to ensure that it is not meant to apply to situations where there is a legitimate other policy purpose that is not directed at manipulating relative tax burden toward the Medicaid program, such as excluding rural providers from a provider tax to help preserve beneficiary access.

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<td>*Note: While CMS provides examples that demonstrate this "same effect" provision, it does not state a clear definition, potentially creating confusion for states.

Prior to this final rule, taxes that met the applicable statistical test to be granted broad-based and uniformity waivers were granted automatic approval. Now, CMS states that taxes must meet pass the statistical test in addition to complying with these new requirements to be considered approvable, removing any guarantee of automatic approval.

CMS notes that it will provide technical assistance to states that need to restructure their provider taxes to be compliant with these new requirements.</td>
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<td>Timeframes for Compliance with New Requirements
§ 433.68(e)(4)</td>
<td>CMS finalized the following timeframes for states to come into compliance with these requirements:
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<tr><th>Tax Type</th><th>Most Recent Tax Waiver Approval</th><th>Compliance Deadline</th></tr>
<tr><td>MCO</td><td>After Apr. 3, 2024</td><td>By Jan. 1, 2027</td></tr>
<tr><td>MCO</td><td>Before Apr. 3, 2024</td><td>By state fiscal year (SFY) 2028, for most states.

*States must comply before the start of the SFY that begins after Apr. 3, 2027.</td></tr>
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<td>We urged CMS to provide all states with the full three-year transition period included in H.R. 1 to comply with the proposed changes, regardless of when a state's provider tax arrangement was approved.</td>
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		Other (non-MCO) provider taxes	Any approval date	By SFY 2029, for most states. *States must comply by the end of the SFY that ends in calendar year 2028, but no later than Sept. 30, 2028.
Interaction of New Requirements with Moratorium on New or Increased Provider Taxes	H.R. 1, in addition to these new requirements, also included a prohibition on new or increased provider taxes, starting in federal fiscal year 2027. In this final rule, CMS indicates, but does not explicitly state, that states may modify their non-uniform taxes to comply with the new uniformity rules and still qualify for "grandfathering" under the new tax moratorium, as long as the tax does not exceed the new indirect hold harmless threshold established under the law.			The comment period for this proposed rule closed prior to the passage of H.R. 1, therefore, this was not an issue at the time for us to provide comment.

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