[0-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 433

[CMS-2448-F]

RIN 0938-AV58

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule addresses a loophole in a regulatory statistical test applied to State proposals for Medicaid tax waivers. The test is designed to ensure, as required by statute, that non-uniform or non-broad-based health care-related taxes, authorized under a waiver, are generally redistributive. The inadvertent loophole currently allows some health care-related taxes, especially taxes on managed care organizations, to be imposed at higher tax rates on Medicaid taxable units than non-Medicaid taxable units, contrary to statutory and regulatory intent for health care-related taxes to be generally redistributive. The final rule closes the loophole by finalizing the policies in the proposed rule to add additional safeguards to ensure that tax waivers that exploit the loophole because they pass the current statistical test, but are not generally redistributive, are not approvable. By adding these safeguards, the final rule is also implementing recently added statutory requirements for a tax to be considered generally redistributive.

DATES: These regulations are effective on April 3, 2026.

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Related Taxes.

I. Background

A. Overview

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs to provide medical assistance to people with limited income and resources. While Medicaid programs are administered by the States, the program is jointly financed by the Federal and State governments. The Federal government pays its share of Medicaid expenditures to the State on a quarterly basis according to a formula described in sections 1903 and 1905(b) of the Act. The amount of the Federal share of Medicaid expenditures is called Federal financial participation (FFP). The State pays its share of Medicaid expenditures in accordance with section 1902(a)(2) of the Act. As described in more detail in the next section, the State may raise its non-Federal share obligation in various ways, subject to certain requirements, including through health care-related taxes (generally, taxing health care items or services, or providers of such items and services).

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234, enacted December 12, 1991) amended section 1903 of the Act to specify limitations on the amount of FFP available for medical assistance expenditures in a fiscal year when States receive certain funds donated from providers or certain related entities, and revenues generated by certain health care-related taxes. The Centers for Medicare & Medicaid Services (CMS) issued regulations to implement the statutory provisions concerning provider-related donations and health care-related taxes in an interim final rule (with comment period) published in November 1992 (57 FR 55118, November 24, 1992). CMS issued the final rule in August 1993 (58 FR 43156, August 13, 1993). The Federal statute and implementing regulations were intended to prevent States from shifting a disproportionate amount of the tax burden to entities with a high percentage of Medicaid business, thus shifting the State responsibility for financing of the program to the Federal government. In these financing-shifting scenarios, Medicaid

payments to providers would be made up of the Federal share plus non-Federal share raised from the providers themselves, rather than obtained from general revenue or other permissible source of non-Federal share. In part, the statute addresses this concern by requiring that health care-related taxes be broad based (generally, applicable to an entire permissible class of health care items and services, or to providers of the same) and uniform (generally, applied at the same rate to all health care items and services, or providers, in a permissible class). The statute does permit waivers of the broad-based and uniform requirements under certain circumstances, including that the Secretary of Health and Human Services (Secretary) must determine that the net impact of the tax and associated Medicaid expenditures as proposed by the State would be generally redistributive in nature, which is an issue in these provisions and which we discuss more fully later. However, since that time, we have discovered that, due to an unintended loophole in the statistical test used to determine if a health care-related tax is generally redistributive, as specified in the August 1993 final rule, some States are still able to shift the financial burden of the non-Federal share of Medicaid program expenditures to entities with a high percentage of Medicaid business, and thus ultimately to the Federal government, contrary to the statutory framework.

B. Medicaid Program Financing

Shared responsibility for financing lies at the foundation of the Medicaid program. Sections 1902(a), 1903(a), and 1905(b) of the Act require States to share in the cost of medical assistance and in the cost of administering the State plan. Under this statutory framework, Medicaid expenditures are jointly funded by the Federal and State governments. Section 1903(a)(1) of the Act provides for payments to States of a percentage of medical assistance expenditures authorized under their approved State plan. Generally, FFP is available when a covered Medicaid service is provided to a Medicaid beneficiary, which results in a Federally matchable expenditure that is funded in part through non-Federal funds from the State or a non-

State governmental entity.[1] The share of Federal funding for medical assistance expenditures is determined by the Federal medical assistance percentage (FMAP), which is calculated for each State using a formula set forth in section 1905(b) of the Act, or other applicable FFP match rates specified by the statute.

Section 1902(a)(2) of the Act and its implementing regulations in 42 CFR part 433, subpart B requires States to share in the cost of Medicaid expenditures, with financial participation by the State of not less than 40 percent of the non-Federal share of expenditures. These requirements also permit other units of non-State government to contribute to the financing of the non-Federal share of medical assistance expenditures up to the remaining 60 percent of the non-Federal share. As a result, States must participate in operating an efficient and fiscally responsible system for providing health care services to eligible beneficiaries. Because States must invest some of their own dollars to pay for the program, they have an incentive to monitor and operate their programs competently to ensure the best value for the dollars that they spend.

There are several manners in which States can finance the non-Federal share of Medicaid expenditures, including: (1) State general funds, typically derived from tax revenue appropriated directly to the Medicaid agency; (2) revenue derived from health care-related taxes when consistent with Federal statutory requirements at section 1903(w) of the Act and implementing regulations at 42 CFR part 433, subpart B; (3) provider-related donations to the State which must be "bona fide" in accordance with section 1903(w) of the Act and implementing regulations at 42 CFR part 433, subpart B; (4) intergovernmental transfers (IGTs) from units of State or local government that contribute funding for the non-Federal share of Medicaid expenditures by transferring their own funds to and for the unrestricted use of the Medicaid agency; and (5)

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[1] See the Medicaid and CHIP Payment and Access Commission's (MACPAC) list of "Federal Match Rate Exceptions" for a comprehensive list of higher FMAPs at https://www.macpac.gov/federal-match-rate-exceptions/.

certified public expenditures whereby units of government, including health care providers that are units of government, incur FFP-eligible expenditures under the State's approved State plan, consistent with section 1903(w)(6) of the Act and § 433.51(b).

C. Health Care-Related Taxes

Section 1903(w) of the Act specifies certain requirements to which permissible health care-related taxes must adhere. Specifically, section 1903(w)(1)(A) of the Act states that the Secretary will reduce a State's medical assistance expenditures, prior to calculating FFP, by the sum of any revenues from health care-related taxes that do not meet the requirements under section 1903(w) of the Act. This reduction in a State's claimed expenditures is codified in regulation at § 433.70(b). Because of the way that the statute is constructed, the baseline assumption is that all health care-related taxes are impermissible with limited exceptions for health care-related taxes that satisfy the parameters specified by the statute.

Health care-related taxes may only be imposed permissibly on certain groups of health care items or services known as permissible classes, which are outlined in section 1903(w)(7) of the Act and expanded upon in § 433.56. In general, and as discussed in the introduction to this section, such health care-related taxes must be broad-based or apply to all non-governmental providers within such a class as specified by section 1903(w)(3)(B) of the Act and § 433.68(c). They generally must also be uniform, such that all providers within a class generally must be taxed at the same rate or dollar amount as specified by section 1903(w)(3)(C) of the Act and § 433.68(d). Additionally, the tax must not have in effect any hold harmless provisions, as specified in section 1903(w)(4) of the Act and implementing regulations in § 433.68(f).

There is no possibility under the statute of waiving the permissible class or the hold harmless requirements. However, a State can request a waiver of the broad-based and/or uniformity requirements. As discussed earlier, section 1903(w)(3)(E) of the Act states that the Secretary shall approve a health care-related tax waiver for the broad-based and/or uniformity requirements if the net impact of the tax and associated expenditures is "generally redistributive"

in nature and the amount of the tax is not directly correlated to Medicaid payments for items and services with respect to which the tax is imposed. As previously stated, in the preamble of the August 1993 final rule, CMS interpreted "generally redistributive" to mean "the tendency of a State's tax and payment program to derive revenues from taxes imposed on non-Medicaid services in a class and to use these revenues as the State's share of Medicaid payments," (58 FR 43164). The preamble stated that assuming a State imposes a non-Medicaid tax and uses the funds solely for Medicaid payments, we believe a complete redistribution would exist.

States are not required to use health care-related taxes to finance the non-Federal share of Medicaid payments; in practice, it is frequently done. When this occurs, taxes that are generally redistributive have some entities that benefit financially as a result of the tax and the associated payment(s) funded by the tax, and some entities that lose money because the amount of tax they pay is greater than the amount of tax-funded payments they receive. Under a health care-related tax that is generally redistributive, entities that have more Medicaid business would expect to receive greater Medicaid payments than entities with less Medicaid business. Although the entities with a higher percentage of Medicaid business may also pay the tax, they often receive more total Medicaid payments than they pay in tax and therefore benefit from these arrangements. By contrast, entities that serve a relatively low percentage of Medicaid beneficiaries or no Medicaid beneficiaries often do not receive Medicaid payments in an amount equal to or higher than their cost of paying the tax. These entities do not benefit financially because they do not receive Medicaid payments that are sufficient to cover their tax payments. These results are inherent in a system of Medicaid payments supported by a health care-related tax that is generally redistributive, as discussed in the preamble to the August 1993 final rule.

Entities that do not benefit from a tax, such as through tax-supported payments, are unlikely to support a State or locality establishing or continuing a health care-related tax because the tax would have a negative financial impact on them. Hold harmless arrangements often either eliminate this negative financial impact or turn it into a positive financial impact for most

or all taxpaying entities, likely leading to broader support among the taxpayers for legislation establishing or continuing the tax. Hold harmless arrangements often result in the Federal government as the only net contributor to Medicaid payments that are supported by the tax program, since the non-Federal share is both sourced from and paid back to the taxpaying providers. This circumstance allows States and/or local governments to garner widespread support among taxpayers to successfully enact or continue tax programs that support increased payments to providers.

As stated earlier, tax programs can result in taxpayers receiving relatively lower Medicaid payments (typically because they furnish a lower volume of Medicaid services) than they pay in taxes, experiencing a negative financial impact. States and providers have sought out ways to avoid this result and to ensure greater support among taxpayers for tax programs. For example, groups of providers may collaborate to ensure that no provider is financially harmed for the cost of the tax. We described an example of this type of this arrangement, known as a redistribution arrangement, in a February 17, 2023, Center for Medicaid and CHIP Services Informational Bulletin (CIB) entitled, "Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments."[2] In these redistribution arrangements, entities that benefit financially (because their Medicaid payments that are financed by the tax are greater than their tax amount) will redirect a portion of their Medicaid payments to those that are harmed financially, to achieve the effect of holding providers harmless for the cost of the tax.

States are aware that arrangements which explicitly guarantee to hold taxpayers harmless, whether directly or indirectly, such as through the aforementioned redistribution arrangements, are unallowable. If CMS identifies such an arrangement, it would then reduce the State's total

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[2] https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf.

medical assistance expenditures by the amount of revenue collected from the impermissible tax before the calculation of FFP, as mandated by section 1903(w)(1)(a)(iii) of the Act.[3] These types of arrangements are problematic as they improperly shift the burden of financing the Medicaid program to the Federal government, and have been identified as such by oversight entities including the Governmental Accountability Office (GAO) and the HHS Office of Inspector General (OIG).[4,5] In an effort to achieve a similar effect as a hold harmless arrangement, some States have attempted to impose taxes using variable rates or provider exclusions (described in further detail later in this final rule) to increase the tax burden on the Medicaid program, thus mitigating or eliminating the tax burden on entities with relatively lower Medicaid business that may not be able to receive the amount of the tax they paid through increased Medicaid payments funded by the tax. Essentially, health care-related taxes designed to tax Medicaid business more than its fair share make it easier for States to guarantee taxpayers are reimbursed their tax payments through increased Medicaid payments. Due to the current regulations governing health care-related tax waiver determinations, this can occur in certain circumstances despite the regulatory statistical test designed to ensure that non-uniform or non-broad-based health care-related taxes meet the statutory requirement to be generally redistributive.

As previously discussed, a State seeking a broad-based and/or uniformity waiver for a tax must demonstrate the tax is "generally redistributive," which we have established in this context means 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

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[3] As we stated in the 2008 tax rule described below, "We chose to use the term reasonable expectation because we recognized that State laws were rarely overt in requiring that State payments be used to hold taxpayers harmless." https://www.govinfo.gov/content/pkg/FR-2008-02-22/pdf/E8-3207.pdf.

[4] See, for example, "Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight," Governmental Accountability Office (GAO), November 1, 2007; "Medicaid: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight," GAO, December 7, 2020.

[5] https://oig.hhs.gov/oas/reports/region3/31300201.pdf.

payments. A tax that does the opposite, by establishing lower tax rates on entities that serve relatively lower percentages of Medicaid beneficiaries or on non-Medicaid items or services (compared to entities that serve relatively higher percentages of Medicaid beneficiaries) is clearly not generally redistributive or consistent with the statutory requirement that a tax program be generally redistributive to qualify for a waiver.[6]

To enforce the requirement that taxes have a net impact that is "generally redistributive" in accordance with section 1903(w)(3)(E)(ii)(I) of the Act, CMS established certain tests when a State is seeking a broad-based and/or uniformity waiver. If a State is seeking a waiver of the broad-based requirement for its health care-related tax, the tax must comply with § 433.68(e)(1) to be considered generally redistributive, which establishes the test known as the P1/P2 test. If the State seeks a waiver of the uniformity requirement, whether or not the tax is broad based, the tax must comply with § 433.68(e)(2) to be generally redistributive, which establishes the test known as the B1/B2 test. These tests, where applicable, are intended to demonstrate that the State's tax program does not impose a higher tax burden on the Medicaid program compared to a broad-based and uniform tax.[7]

The P1/P2 test applies on a per-class basis to a tax that is imposed on all items or services at a uniform rate but is not broad based because it excludes certain providers. The State must divide the proportion of the tax revenue applicable to Medicaid if the tax were broad based (applied to all providers or activities within the class), called P1, by the proportion of the tax revenue applicable to Medicaid under the tax program for which the State seeks a waiver, called P2. The resulting quotient is the P1/P2 figure. Generally, to be granted a waiver of the broad-

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[6] See Congressional Record-House, November 26, 1991, 35855 https://www.congress.gov/102/crecb/1991/11/26/GPO-CRECB-1991-pt24-1-2.pdf.

7 "The Federal statute and implementing regulations were designed to protect Medicaid providers from being unduly burdened by health care-related tax programs. Health care related tax programs that are compliant with the requirements set forth by the Congress create a significant tax burden for health care providers that do not participate in the Medicaid program or that provide limited services to Medicaid individuals." 73 FR 9685 (February 22, 2008).

based requirement, this figure must be at least 1, with some exceptions noted in §§ 433.68(e)(1)(iii) and (iv). For taxes enacted and in effect prior to August 13, 1993, States may pass the P1/P2 test if they have a value of at least 0.90 and only exclude one or more of the following provider types: providers that furnish no services within the class in the State, providers that do not charge for services within the class, rural hospitals as defined at § 412.62(f)(1)(ii), sole community hospitals as defined at § 412.92(a), physicians practicing in medically underserved areas as defined in section 1302(7) of the Public Health Service Act, financially distressed hospitals under certain circumstances, psychiatric hospitals, and hospitals owned and operated by Health Management Organizations (HMOs). For taxes in effect after that date, the same exceptions would apply, and the passing value is 0.95 rather than 0.90.

The B1/B2 test also applies on a per-class basis to a non-uniform tax (whether or not it is broad based) that applies different rates to different tax rate groups of providers within the permissible class. Under the B1/B2 test, the State calculates and compares the slope (designated as B) of two linear regressions. Univariate linear regression attempts to find the line that best fits a series of points, plotted on a graph using two variables: an independent variable X and a dependent variable Y.[8] In the B1/B2 test, the independent variable or X-axis, for both regressions, represents "the number of the provider's taxable units funded by the Medicaid program during a 12-month period," also referred to as the "Medicaid Statistic."[9] The regression measures how much impact for the average provider a one-unit increase in the Medicaid Statistic has on how much that provider is taxed. For example, if the tax were based on provider inpatient days, the number of providers' inpatient Medicaid days during a 12-month period would be its "Medicaid Statistic." Or, if the tax were based on member months, the number of Medicaid

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[8] Linear regression attempts to model the relationship between two variables by fitting a linear equation to observed data. One variable is considered to be an explanatory variable, and the other is considered to be a dependent variable. Linear Regression (yale.edu) http://www.stat.yale.edu/Courses/1997-98/101/linreg.htm.
[9] 42 CFR 433.68(e)(2)(A).

member months for a managed care organization (MCO) would be the Medicaid Statistic. The Y variable, or the dependent variable, is the percentage of the tax paid by each provider in the tax program compared to the total tax amount paid by all providers during a 12-month period. Through this test, CMS seeks to ensure that, as Medicaid units increase, the tax paid by the provider does not increase more under the State's waiver proposal (the B2 regression) than it would in a broad-based and uniform tax (the B1 regression).

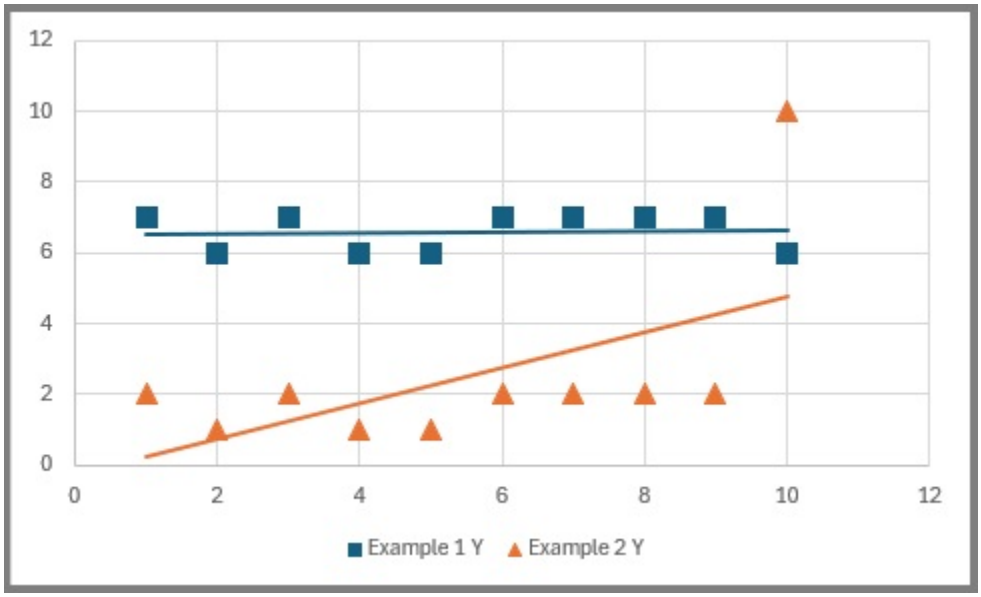
The first linear regression represents the slope of the line for the tax if it were broad-based and applied uniformly (B1). In other words, a State would submit data regarding all taxable payers in the permissible class for the tax and apply a uniform tax rate. The B1 is the slope of the line for that data. The second linear regression represents the slope of the line for the tax program for which the State is requesting a waiver (B2). To calculate the test value figure, B1 is divided by B2. If the quotient is at least 1, the tax passes the test, as specified in § 433.68(e)(2)(ii), with certain limited additional flexibility under § 433.68(e)(2)(iii) and (iv). This B1/B2 test was intended to indicate that when the B1/B2 figure is equal to or greater than one (1), the State's proposed tax is not more heavily imposed on the Medicaid program compared to a tax that is levied on all providers at the same rate.

D. Concerns About the B1/B2 Test

Since the early 1990s, the B1/B2 test has generally worked well to ensure health care-related taxes for which States seek waivers of the uniformity requirement (whether or not the tax is broad based) are generally redistributive. However, over the last decade, CMS became aware that some States are manipulating their health care-related taxes to impose tax structures that the State intends not to be generally redistributive, but that are still able to pass the B1/B2 test. In these cases, the State does not impose taxes on non-Medicaid services in a class to then use the tax revenue as the State's share of Medicaid payments. Instead, the States derive the vast majority of their tax revenue from Medicaid services, which they then use to fund the non-Federal share of Medicaid payments. In essence, this process results in a simple recycling of

Federal funds to unlock additional Federal funds. Generally, health care-related tax programs can accomplish this by taking advantage of linear regression analyses' statistical sensitivity to outliers.[10] See Figure 1.

FIGURE 1: Effect of an Outlier on the Slope of a Line



In Figure 1, the two data sets, represented by squares (example 1) and triangles (example 2), have similar data with the exception of the last data point. In example 2, this data point is an outlier. As a result, the line that fits the triangle data set is at a different angle, or slope, from the square data set. We note that this example uses basic data, not a B1/B2 analysis, to show the effect of an outlier on a linear regression.

Using these approaches, this loophole counterintuitively allows a tax program to place a much higher tax burden on Medicaid activities compared to commercial activities while still passing the B1/B2 test. Health care-related taxes that exploit the loophole effectively permit a State to shift most of the tax burden disproportionately onto the Medicaid program, which is the

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[10] In statistics, an outlier is "an observation that lies an abnormal distance from other values in a random sample from a population." Information Technology Laboratory National Institute of Standards and Technology (NIST) Engineering and Statistics Handbook 7.1.6 "What Are Outliers in Data?" https://www.itl.nist.gov/div898/handbook/toolaids/pff/prc.pdf.

exact result the B1/B2 test was intended to prevent. The State may then use the tax revenue to fund the non-Federal share of Medicaid payments to the same Medicaid entities subject to the health care-related tax. As a result, the Federal government pays an artificially inflated percentage of Medicaid expenditures on health care services, far beyond the Federal matching rates that Congress has specified in statute. Therefore, payments to providers consist of Federal funds and funds the providers have contributed themselves through taxes, without the full contribution of non-Federal share the statute requires from the State.

At its core, the B1/B2 test is centered on averages. As noted previously, the regression measures how much impact a one-unit increase in the Medicaid Statistic has on how much a provider is taxed. The rate at which each entity's tax changes with every unit of change to the entity's Medicaid Statistic is based on the average rate of change for all the entities in the regression analysis. In many cases, taking an average of all the points does not necessarily give a useful picture of the typical participant or the general nature of the population. Averages can be misleading when they include outliers or other irregularities. Similarly, outliers can distort the regression model, masking important deviations within the data.

For instance, imagine that one wanted to assess the relationship between education level and annual salary for a group of employees at a corporation. At this corporation, employees with a high school diploma make between $40,000 to $45,000. Employees with a bachelor's degree make between $65,000 to $70,000. Employees with a master's degree make between $80,000 to $90,000. Employees with a doctoral degree make between $100,000 to $115,000. The founder of the company's highest education level is a high school diploma, but they make $1.6 million per year. If one were to exclude the company founder from the linear regression, the line would have a positive upward slope indicating an increase in salary with each increasing level of education. However, if one were to include the founder, the regression line would be diverted sharply to accommodate the $1.6 million salary. The founder only represents one data point in the regression analysis, but since this point is drastically different than the rest, it potentially

distorts the relationship that the regression analysis is trying to assess. In this example, the average value, while accurate, only represents a mathematical mean in the data that is not necessarily useful for the purpose of assessing the relationship between level of education and salary among the corporation's employees. Likewise, in the case of the B1/B2 linear regressions, outliers can skew our ability to use the data to assess effectively if a tax is generally redistributive.

We have found that States can manipulate B2 by excluding from the tax a few larger providers with much higher Medicaid taxable units than the average provider in the taxable universe. Doing so drastically affects the B-coefficient value for B2. Because the Medicaid taxable units are not evenly distributed among all providers, States can effectively charge higher rates on the remaining Medicaid taxable units that make up most of the tax without running afoul of the B1/B2 test. In other words, excluding a few large providers with high Medicaid utilization from the tax, but including them in the regression calculation alters the slope of the line of the regression in a way that allows the State to pass the statistical test, while simultaneously imposing outsized burden on the Medicaid program. In these cases, the proportional percentage of the tax imposed on the Medicaid program becomes greater than Medicaid's proportion of the total taxable units.

There are several other mechanisms that States have used to undermine the efficacy of the B1/B2 test. Some States create tax programs with extraordinary differences in tax rates within a provider class based on a taxpayer mix of Medicaid taxable units versus non-Medicaid taxable units. Tax rates imposed on Medicaid-taxable units are often much higher, sometimes more than one hundred times higher, when compared with similar commercial taxable units (for example, Medicaid member months are taxed $200 per member month compared to $2 for comparable non-Medicaid member months). The "tiering" structure on some of these tax waivers enable States with these disparate tax rates to pass the B1/B2 test. Consider an MCO tax with tax rates that vary by an MCO's member months. Medicaid member months from zero to

1,000,000 are excluded from the tax. Medicaid member months from 1,000,001 to 2,000,000 are taxed $300 per member month. Medicaid member months in excess of 2,000,000 are excluded from the tax. Commercial member months from zero to 1,000,000 are excluded from the tax. Commercial member months from 1,000,001 to 2,000,000 are taxed $3 per member month. Commercial member months in excess of 2,000,000 are excluded from the tax. The "middle tier" of member months, the only one that is taxed at all, has a tax rate of 100 times on Medicaid-member months compared to their commercial counterparts. The State passes the B1/B2 test because certain Medicaid-paid member months in excess of 2,000,000 artificially "pull" the slope of B2 down making it appear as though the State is giving a larger break to Medicaid-member months than it actually is.

Historically, these taxes that targeted Medicaid first began with MCO taxes, one of the permissible classes for health care-related taxes. We note that in all of these arrangements, Federal rules prohibit States from taxing Medicare Advantage (MA) Plans,[11] or certain plans that contract with the Office of Personnel Management to provide health care for Federal employees through the Federal Employee Health Benefits (FEHB) program[12] or plans that contract with the Department of Defense to provide care to military personnel, retirees, and their families under the TRICARE system.[13] According to § 422.404, States are prohibited from imposing premium taxes, fees, or other charges on payments made by CMS to MA organizations, payments made by MA enrollees to MA plans, or payments made by a third party to an MA plan on a beneficiary's behalf.

Over several years, the Congress and CMS have actively attempted, through Federal

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[11] Under Medicare regulations at § 422.404(a), States are prohibited from taxing Medicare MCOs. Therefore, a State's taxation of MCO services is limited to commercial payers and Medicaid. As a result, taxes that exclude or sharply curtail the tax amount paid by commercial payers fall exclusively on Medicaid and to a lesser extent BHP if applicable.

[12] 5 U.S. Code 8909 - Employees Health Benefits Fund.

[13] 5 U.S.C. 8909(f). 32 CFR 199.17 (a)(7).

statutes and regulations, to prevent States from designing MCO taxes to target Medicaid MCOs or Medicaid activities. Before the Deficit Reduction Act of 2005 (DRA), the statute included a permissible class, under which States could only tax services of Medicaid MCOs, but not other MCOs. In the DRA, the Congress broadened the permissible class to include all MCO services (no longer limited to Medicaid MCO services). Realizing that States would need time to address financial impacts within their State budgets and enact potentially necessary legislative modifications to health care-related tax programs, the DRA provided a grace period to allow States to come into compliance by October 1, 2009. CMS issued a final rule entitled "Medicaid Program; Health Care Related Taxes" (73 FR 9685) that implemented the changes in the DRA. After the DRA and the 2008 final rule, States were no longer permitted to assess health care-related taxes only on Medicaid MCOs. Instead, States must assess health care-related taxes on the services of all MCOs, not just Medicaid MCOs, to qualify as broad based within the amended permissible class, except for those excluded by Federal rules from taxation.

In response to these changes, several States attempted to "mask" health care-related taxes on Medicaid MCOs within broader taxes that included non-health care items and activities. See, for example, the OIG Report, "Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears To Be an Impermissible Health Care-Related Tax," issued on May 28, 2014.[14] Some States did this to continue taxing only Medicaid MCOs and thereby maximizing the burden on Medicaid without needing to tax additional MCO lines of business. Section 1903(w)(3)(A) of the Act and § 433.55(b) establish that a tax is considered to be a health care-related tax if at least 85 percent or more of the burden of the tax revenue falls on health care providers. Section 1903(w)(3)(A)(ii) of the Act and regulations in § 433.55(c) further specify

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[14] Department of Health and Human Services Office of the Inspector General, "Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears to be an Impermissible Health-Care Related Tax" Issued May 2014 (A-03-13-00201). https://oig.hhs.gov/documents/audit/6720/A-03-13-00201-Complete%20Report.pdf.

that taxes will still be considered health care related even if they do not reach the 85 percent threshold if the treatment of individuals or entities providing or paying for health care items or services is different than the tax treatment provided to other taxpayers. Some States with these taxes in place stated that, since the percentage of the tax imposed on health care items and services fell below the 85 percent threshold and the State did not treat health care items or services differently than other items being taxed, the portion of the tax imposed on Medicaid MCOs was not considered health care related and was not governed by section 1903(w) of the Act. In a 2014 State Health Official Letter (SHO),[15] CMS explained that taxing a subset of health care services or providers at the same rate as a Statewide sales tax, for example, does not result in equal treatment if the tax is applied specifically to a subset of health care services or providers (such as only Medicaid MCOs), since the providers or users of those health care services are being treated differently than others who are not within the specified universe. These taxes were attempting to continue to tax a subset of services within a permissible class when paid for by Medicaid, but not when the same services were not paid for by Medicaid.

Oversight agencies, including the OIG, have noted health care-related taxes as a program integrity concern in Medicaid financing several times. On January 23, 1996, the Director of Health Systems at the GAO wrote a letter to the Ranking Member of the United States House Commerce Committee that outlined some of the ways that States use "creative financing mechanisms," including health care-related taxes, to finance the non-Federal share of Medicaid expenditures.[16] In 2014 and 2017, the OIG issued reports highlighting concerns about State taxes that target Medicaid MCOs or Medicaid MCO business.[17] Although the 2017 report discussed a

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[15] *SHO #14-001*, "Health Care-Related Taxes," issued on July 25, 2014, available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-001.pdf.

[16] Letter from Dr. William J. Scanlon to Representative John Dingell written on January 23, 1996. GAO/HEHS-96-76R State Medicaid Financing Practices. https://www.gao.gov/products/hehs-96-76r.

[17] See Department of Health and Human Services Office of the Inspector General "Pennsylvania's Gross Receipts

different approach that States used to target taxes on Medicaid MCOs, it reflects the same State motivations and implicates the same concerns for Federal fiscal integrity.

As the agency responsible for Federal oversight over the Medicaid program, CMS attempted to address the concerns raised by the OIG, which mirror our own concerns based on recent experience with particular health care-related taxes that target Medicaid with a disproportionately high tax burden. In 2019, we issued a proposed rule with many financial provisions, one of which proposed to address the B1/B2 statistical loophole issue (2019 proposed rule (84 FR 63722). The 2019 proposed rule was much broader in scope in terms of the number of financial topics than this final rule. In addition, the terminology in this final rule is more precise and technical than the terminology used in the corresponding provisions in the November 2019 proposed rule. While the entirety of the November 2019 proposed rule was subsequently withdrawn in January 2021, we indicated at the time that the withdrawal action did not limit CMS' prerogative to make new regulatory proposals in the areas addressed by the withdrawn proposed rule, including new proposals that may be substantially identical or similar to those described therein (86 FR 5105).

Since then, as CMS has reviewed State proposals involving these problematic tax structures, we have advised States, and in some instances notified States in writing, regarding our concerns. In some cases, because a State's health care-related tax waiver proposal satisfied current regulatory requirements to be considered generally redistributive, we approved the proposal as required under the current regulations that include the loophole but gave the State written notice of our concerns. Specifically, CMS sent States with problematic taxes

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Tax on Medicaid Managed Care Organizations Appears to be an Impermissible Health Care-Related Tax" Issued May 2014 (A-03-13-00201).
https://oig.hhs.gov/documents/audit/6720/A-03-13-00201-Complete%20Report.pdf.
and "Ohio's and Michigan's Sales and Use Taxes on Medicaid Managed Care Organization Services Did Not Meet the Broad-Based Requirement But Are Now In Compliance" issued on April 2017 (A-03-16-00200)
https://oig.hhs.gov/documents/audit/6782/A-03-16-00200-Complete%20Report.pdf.

"companion letters" to their most recent tax waiver approvals outlining why CMS believed that their taxes did not meet the spirit of the law in terms of being "generally redistributive" because of the much higher tax burden they imposed on Medicaid taxable units compared to comparable non-Medicaid taxable units. In addition, we put these States on notice through these letters that CMS was contemplating rulemaking in this area and that those States should prepare for this possibility in their budget planning.

Recently, we noticed an increase in both the number of health care-related taxes that exploit the statistical loophole as well as an increase in the revenue raised by those taxes. Before Federal fiscal year (FFY) 2024, CMS was aware of five States with six taxes that exploited the statistical loophole. The estimated total dollar revenue collected by States related to these taxes at that time was approximately $20.5 billion annually. In FFY 2025, CMS approved two additional States' MCO tax waiver proposals that exploit the statistical loophole that total $3.5 billion in estimated tax revenue for the States. Notably, the State with the largest MCO tax that exploits the statistical loophole submitted an update to its previously approved MCO tax waiver, which increased the tax revenue from approximately $8.3 billion per year to about $12.7 billion per year. CMS estimates the total tax collection by States for all taxes that exploit the loophole currently is approximately $24.0 billion per year. To address this ongoing and increasing exploitation, in May 2025 we issued the proposed rule, "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule" (90 FR 20578, May 15, 2025) hereafter referred to as the "proposed rule."

Since issuance of the proposed rule, one State has formally submitted a waiver request for a tax on MCO services that would exploit the loophole. This proposed tax is estimated to generate $1.2 billion in revenues. We are also aware that other State legislatures have been considering similar proposals.

Recent examples illustrate what occurs when the B1/B2 test alone does not ensure that the tax is generally redistributive. In one MCO tax that exploits the loophole (and that was

approved by CMS because it passed the B1/B2 test and met other applicable regulatory requirements), Medicaid member months comprise 50 percent of all member months subject to taxation, but bear more than 99 percent of the tax burden due to the difference in tax rates for Medicaid and non-Medicaid member months. In a different State, Medicaid member months comprise 53 percent of the total member months taxed but bear over 94 percent of the tax burden. Instead of raising revenue by equally taxing non-Medicaid and Medicaid services in a class, these tax programs raise only a *de minimis* amount of revenue from non-Medicaid member months while imposing a much greater tax burden on Medicaid member months. They are examples of States maximizing taxation of Medicaid items and services by design to minimize the impact for entities that serve relatively lower percentages of Medicaid beneficiaries. This has an effect similar to taxing only Medicaid MCOs (as opposed to all MCOs), which is the practice the DRA amendments sought to eradicate, as discussed previously. Allowing States to achieve something at odds with the DRA amendments by exploiting a statistical loophole in the current regulations undermines the cooperative Federalism central to the structure of the Medicaid statute, as GAO has noted.[18] For this reason, we believe that it is necessary to address the statistical loophole to ensure fiscal integrity of the Medicaid program.

When taxes in the Medicaid program are not generally redistributive, it can result in the Federal government as the only net payer for payments funded by those taxes (generally, the non-Federal share is generated by a tax on entities that receive at least their total tax cost back in the form of increased Medicaid payments, with no net contribution of any funds that are not Federal funds). Without any net cost to the entities paying the tax, States and entities in the tax class have an incentive to maximize health care-related tax collections and maximize Medicaid payments possibly without regard to the Medicaid services delivered or programmatic goals or

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[18] GAO-08-650T "Medicaid Financing Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight" April 3, 2008.

outcomes, such as quality or patient outcomes. This creates a substantial risk to the fiscal integrity and effective operation of the Medicaid program, as reflected in the impacts calculated in section V of the proposed rule and this final rule.

Given recent State proposals and technical assistance requests, national proliferation of taxes that utilize the B1/B2 statistical test loophole presents a substantial and urgent risk to the fiscal integrity of the Medicaid program. We stated in the proposed rule that, absent the regulatory changes described therein, we were concerned that there will be significant increases in Medicaid expenditures and shifting of State Medicaid costs onto the Federal government, all without commensurate benefit to the Medicaid program or its beneficiaries.

As previously noted, CMS has witnessed the proliferation of MCO taxes that exploit the statistical loophole and, in some instances, drastically increase the revenues raised by existing MCO taxes. As a result, CMS was greatly concerned that such increases will continue and similar tax structures would be developed, further exacerbating the impact on the Federal government. Moreover, CMS learned as part of our review of tax waiver proposals and communication with States that certain States are using the revenue to fill shortfalls that exist in their State budgets as opposed to reinvesting this money in the Medicaid program. Furthermore, this influx of Federal share to State general funds could be used as State-only financing for services not eligible for FFP, such as the provision of non-emergency medical care for non-citizens without satisfactory immigration status. Although States are permitted to use health care-related tax revenue for other general revenue purposes, it nevertheless highlights the importance of ensuring Federal matching dollars are limited to the appropriate Federal share of financing the Medicaid program, or else the Federal Medicaid contribution is effectively financing these other endeavors.

While CMS has found taxes on MCOs to be the predominant class of health care items and services utilizing this loophole, CMS is also aware of other permissible classes vulnerable to this approach. CMS is concerned that absent regulatory action, additional similar tax programs

that exploit the loophole may be developed. We believe that this final rule will address concerns of CMS and Federal oversight agencies by curtailing non-Federal share financing arrangements that are counter to the statute and do not serve the best interests of Medicaid beneficiaries, the Federal treasury, Federal taxpayers, nor the long-term health and fiscal stability of the Medicaid program as a whole. Health care-related taxes that use the regulatory B1/B2 loophole create a substantial financial risk to the Medicaid program (see section V of the proposed rule and this final rule). This rule will mitigate this risk, safeguard the fiscal health of Medicaid, and ensure appropriate use of Federal Medicaid dollars.

E. Working Families Tax Cuts Legislation

During the comment period of the proposed rule, Congress passed what is commonly known as the "One Big Beautiful Bill Act" (Pub. L. 119-21, July 4, 2025) (herein after referred to as the Working Families Tax Cuts (WFTC) legislation). Section 71117 of the WFTC legislation enacted changes to section 1903(w) of the Act to add a new clause detailing when a tax would not be considered generally redistributive, along with accompanying definitions, and the new clause closely mirrors the text of the proposed regulations and definitions from the proposed rule. The revised section 1903(w) of the Act and the proposed regulation had limited organizational differences, and the statute does not include the examples listed in the proposed regulation. Therefore, in borrowing the language of the proposed rule to draft the WFTC legislation, Congress affirmed that CMS' proposed changes to § 433.68(e) are necessary to better implement the statutory mandate in section 1903(w)(3)(E) of the Act that taxes must be generally distributive for a waiver to be approved. This final rule addresses the concerns CMS described in the proposed rule, and, at the same time, codifies in regulation the new statutory requirements.

CMS acknowledges that the statutory requirement the proposed rule would address (that is, health care-related taxes for which a waiver of the broad-based and/or uniform requirements is approved must be generally redistributive in nature) has been amended by the WFTC legislation since the proposed rule. However, as the changes required by statute are

substantively identical to the contents of the proposed rule, we do not believe a further round of notice and comment is necessary to proceed with finalizing the proposal, which implements the new statutory requirements. Under section 553(b)(B) of the Administrative Procedure Act (APA), an exception from the generally applicable notice and comment requirement is available where it would be unnecessary, as is the case here despite the change in underlying statutory authority, since the proposed rule in a potential second cycle of notice and comment would merely re-propose the same revisions to the regulation that CMS proposed initially, as would be required to implement the statute. We further note that a large number of comments were received after the enactment of the WFTC legislation and made reference to it.

II. Provisions of the Regulations and Analysis of and Responses to Public Comments

We proposed that if any provision of this rule is determined to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further action, it shall be severable from the remainder of the final rule, and from rules and regulations currently in effect, and not affect the remainder thereof or the application of the provision to other persons not similarly situated or to other, dissimilar circumstances. If any provision is held to be invalid or unenforceable, the remaining provisions which could function independently should take effect and be given the maximum effect permitted by law. In this rule, we finalize several provisions that are intended to and will operate independently of each other, even if each serves the same general purpose or policy goal. Where a provision is necessarily dependent on another, the context generally makes that clear.

We received approximately 257 timely pieces of correspondence, which included comments from individuals, State government agencies, non-profit health care organizations, advocacy groups, and hospital associations.

We thank and appreciate the commenters for their consideration of the proposed requirements for addressing this loophole and ensuring the fiscal integrity of the Medicaid program. In this section, arranged by subject area, we summarize the proposed provisions, the

public comments received, and our responses. For a complete and full description of the proposed requirements, see the 2025 proposed rule. We also received several out-of-scope comments that are not addressed in this final rule.

The following is a summary of the public comments we received on the proposed rule and our responses.

Comment: Several commenters raised concerns that the proposed rule is not aligned with the recent statutory changes in the WFTC legislation since the proposed rule was drafted to ensure compliance with the statutory language in place prior to enactment of the WFTC legislation. These commenters urged CMS to revise or withdraw the proposed rule to better reflect the variations included in the WFTC legislation. A few commenters raised that the proposed rule does not align with Congressional intent to allow for this type of provider tax financing and a certain degree of non-uniformity in health care-related taxes in that it afforded the opportunity to have the broad based and/or uniformity requirements waived. Several other commenters recommended that CMS not finalize the proposed rule and maintain the existing regulatory structure and requirements governing health care-related taxes. Another commenter requested that CMS extend the comment period for the proposed rule to afford commenters time to analyze the impact of the WFTC legislation. A few commenters requested an additional 60 days, while another suggested an extension of 30 days should be considered.

Response: We disagree with the commenters regarding the alignment of the proposed rule with the new provisions of the WFTC legislation. This final rule and the WFTC legislation are aligned in that they both provide more explicit direction regarding the generally redistributive requirement for health care-related taxes. The proposed rule and final rule's regulatory language is consistent and aligns with the language and purpose of section 71117 of the WFTC legislation. In addition, the examples we provide in regulation text that are not included in the statutory language reflect a level of detail more typical for implementing regulations and generally are not expected to be found in statute. Therefore, we do not find it inconsistent that there is additional

language in the regulations and, given the alignment of the proposed rule's provisions to the amendments made by section 71117 of the WFTC legislation, we do not believe it is necessary to provide a comment period extension. As always, CMS is available to work with States expeditiously as they make any necessary changes to comply with the statute and this rule.

Comment: Most commenters were opposed to the proposed rule. Commenters expressed general opposition to the rule on the basis that it would impact services and beneficiary access to care by harming supplemental payments or other payment mechanisms funded by taxes that will be impermissible. Specifically, several commenters stated concerns regarding the impact this rule will have on access to care and the quality of care received by Medicaid beneficiaries, particularly children, seniors, and individuals with disabilities. Other commenters stated that with decreased funding available to support Medicaid payments, covered Medicaid services and benefits would be reduced, and States may limit coverage of optional Medicaid eligibility groups. Commenters were concerned about the impact the proposed rule would have on State budgets and processes, including impacts to non-Medicaid spending and non-health State spending as a result of having to reconfigure State general funds to cover funding gaps. Many commenters stated that the proposed rule likely would require States to undertake significant administrative efforts, including development of new legislation, revising rate methodologies and related State plan amendments, and conducting extensive actuarial modeling.

Numerous commenters expressed concerns that reductions in health care-related tax revenues would lead to lower Medicaid payment for providers. They stated that this impact would be most acute in rural communities, where individuals rely on a limited number of local facilities for both primary and specialty care and that provider participation in Medicaid would be impacted due to the unsustainable financial margins. The commenters specifically mentioned pediatric care at children's hospitals, specialty care for people with developmental disabilities, pregnancy and post-partum care, Federally Qualified Health Center (FQHC) services, and mental health care. Another commenter expressed concern that reductions in health care-related tax

revenues may also impact Medicaid Graduate Medical Education investments (which are not a distinct Federally matchable Medicaid expenditure type but with respect to which some States make Medicaid supplemental payments in connection with services furnished) designed to address physician workforce shortages, which some States use health care-related tax revenues to fund.

Numerous commenters stated that the impact of the rule will be realized by all providers, but noting specifically hospitals, nursing facilities and long-term care facilities. The commenters further elaborated that without tax-funded payments to offset uncompensated care costs, such providers will bear increasing costs, further straining their financial sustainability. Further, the financial strain may result in providers closing, resulting in an impact on unemployment and local communities.

Response: We acknowledge the commenters' concerns. The goal of this final rule is not to cause disruption in access to any health care services for Medicaid beneficiaries or to jeopardize the financial stability of health care providers or health systems. The purpose of this final rule is to ensure compliance with section 1903(w) of the Act as discussed in the proposed rule, and, since the amendments made by the WFTC legislation, to implement new statutory requirements. This final rule promotes the sustainability of the Medicaid program for all States by reducing wasteful and abusive financing practices perpetuated by a subset of States that have been able to use as non-Federal share revenue from health care-related taxes that are not generally redistributive as required by statute. States may still utilize health care-related taxes to support their share of Medicaid program costs, provided that they meet all statutory and regulatory requirements, including being generally redistributive. Nothing about this final rule changes the ability of a State to collect health care-related tax revenue and to use such revenue from permissible taxes as the non-Federal share of Medicaid expenditures, or to make Medicaid payments at existing levels. This change ensures that State Medicaid programs are financed by permissible sources, while preventing impermissible cost shifting to the Federal government by

certain States.

Comment: Several commenters urged CMS to monitor access to services to avoid unintended consequences for care delivery, and to develop tools to assess outcomes for Medicaid beneficiaries. Another commenter recommended that CMS consult with interested parties to understand the scope of the proposed rule's impact, particularly with respect to section 1902(a)(30)(A) of the Act.

Response: As with all changes, we intend to monitor the impact of this final rule and provide necessary technical assistance to States for them to meet its requirements, as well as all applicable statutory and regulatory requirements. We have existing requirements for analyzing access through the review of State plan amendments, managed care contract requirements, section 1915 waivers, and section 1115 demonstrations, as applicable. Our goal is to assist States in designing and operating their Medicaid programs in a manner that ensures access to high quality care for Medicaid beneficiaries. Based upon our review of existing State programs and our discussions with several of the impacted States, we have a significant understanding of both provider and State concerns regarding the impact of this final rule. However, this final rule is not designed to reduce funding in the Medicaid program, but rather to ensure Medicaid funds are financed by permissible sources, while preventing inappropriate cost shifting to the Federal government by certain States.

Comment: We received some comments in support of the proposed rule overall. These comments cited concerns shared by CMS, such as the inequity between States created by those exploiting the loophole, and the harm to the fiscal integrity of the Medicaid program that results from overburdening the Federal government. A commenter stated their concern that States' use of provider taxes inflates a State's Federal funding beyond what is authorized under statute through the FMAP formula. Other commenters supported the proposed rule as necessary to encourage healthy competition across States in development of models to finance their Medicaid programs. The commenters stated that the proposed rule would ensure equal treatment of States

as some did not exploit the loophole. A few commenters supported the proposed rule on the basis that it fulfills the original intent of the generally redistributive requirement and promotes and maintains the financial stability of Medicaid programs and Medicaid provider networks. Several commenters stated these changes are necessary to protect Federal tax dollars and American taxpayers by preventing States from shifting their share of Medicaid program expenditures to the Federal government. Another commenter stated that the existing statistical test permits non-uniform taxes on MCOs to seem compliant with the statutory generally redistributive requirement while designed specifically to disproportionately impact Medicaid providers.

Response: We thank commenters for their support of our proposals, which we generally are finalizing as proposed in this rule with minor wording modifications, and adjustment to the transition period. We agree that taxing models that exploit the loophole distort the Federal-State fiscal partnership with respect to Medicaid and improperly shift costs to the Federal government.

Comment: A commenter expressed concern that the proposed rule could undermine "legitimate" tax arrangements. Another similarly expressed concern that the proposed rule would unintentionally impact States that were not previously identified as having problematic tax structures and requested that CMS add language to ensure the rule does not negatively affect those States. A commenter was concerned that, because of slow State legislative processes, ensuring State compliance with the proposed rule will take several years.

Response: We drafted the proposed rule to focus on preventing States from adopting tax structures that are impermissible based on the statute. To the extent a health care-related tax on a permissible class satisfies recently amended statutory requirements regarding what is considered "generally redistributive" and complies with all other Federal requirements, including that it does not involve a hold harmless arrangement, it is likely to be permissible; we are available to provide technical assistance to States to discuss individual health care-related tax programs to ensure compliance with all applicable Federal requirements. Regardless, all States are

responsible for ensuring compliance with all applicable Federal statutes and regulations. Even if the State has not affirmatively identified an impermissible health care-related taxing structure, it still bears the ultimate responsibility of ensuring compliance with all Federal statutory and regulatory requirements governing health care-related taxes, including those newly enacted in the WFTC legislation and implemented in this final rule.

We are confident that all affected States with loophole taxes are aware of CMS' concerns with the tax loophole and our intent to address it through communications with us, this proposed rule, and recent Congressional action, but we expect some States may need to convene special legislative sessions to address this final rule and the WFTC legislation (and may need to regardless of other WFTC legislation provisions). Most States with health care-related taxes that exploit the loophole received formal notice with their most recent waiver approval that we were concerned the tax was not generally redistributive within the meaning of the statute, which we discuss more in section II.D. For those States that were not formally notified, we believe they are aware due to significant press attention on this topic but nevertheless are providing transition periods.

Comment: A commenter stated that the flexibility of current provider tax structures fosters innovation in care delivery and that restricting the availability would stifle innovation, hinder States' ability to develop and sustain effective care models and limit access to care. Another commenter stressed the importance of health care-related taxes to a State's Medicaid program and requested that CMS provide a list of permissible funding sources if the funding sources that States had been using are now deemed impermissible.

Response: There is nothing in this final rule that should result in the stifling of State innovation. Rather, this final rule is intended to strengthen the Medicaid program by enhancing the financial stability of the program by ensuring dollars are available to support services, as well as help ensure that Medicaid dollars are spent appropriately and for the benefit of Medicaid beneficiaries through the availability of Medicaid services without placing disproportionate

burden of financing onto the Federal government. While some States or entities may have realized certain benefits from tax structures that exploit the loophole, those tax structures do not align with the generally redistributive requirement in the statute (before the amendments made by the WFTC legislation, and certainly after).

Health care-related taxes remain a permissible source of funding. Nothing in this rule would affect the ability of States to establish health care-related taxes and use them as the source of non-Federal share, provided they meet all Federal requirements. Therefore, there is not a need to provide a list of permissible funding sources, because they are unchanged by this rule. This rule (and the related amendments made by the WFTC legislation) merely provide that certain tax structures will not satisfy the generally redistributive requirement, without changing the principle that health care-related taxes that require a waiver but that are generally redistributive and meet all other applicable Federal requirements will continue to be permissible.

Comment: Several commenters indicated that the WFTC legislation or the proposed rule will lead to decreased Medicaid benefits and lower payment rates. A few commenters also pointed to Medicaid eligibility changes and work requirements contained in the WFTC legislation and stated that the proposed rule should not be finalized due to the cumulative effect. They also stated CMS should guarantee that primary care payment rates will not fall below current levels due to the proposed rule. A few commenters recommended that CMS provide implementation funding to States for both this final rule as well as the WFTC legislation.

Response: We acknowledge these concerns and as always are available to provide technical assistance to States aiming to avoid service disruption and to develop innovative care delivery models to ensure access to care for Medicaid beneficiaries. We also acknowledge that the cumulative effect of changes established by the WFTC legislation may have varying impacts on States; however, the WFTC legislation codified the requirements we proposed in statute, and thus as such, it would be counter to section 1903(w) of the Act to not finalize the proposed rule. Specific authority for funding to States under the WFTC legislation was not provided or

authorized with respect to the amendments made by section 71117 of the WFTC legislation. However, FFP is available for certain State Medicaid administrative expenditures that meet statutory and regulatory requirements. Finally, we emphasize again that we maintain our commitment to States through our review of State program proposals to ensure that all statutory requirements are met, including access to care requirements.

Comment: Some commenters suggested that CMS postpone finalization to allow CMS time to gather additional information on how States are using provider taxes and to conduct further analysis of the impact of the rule on providers. A commenter was concerned that certain States will not have sufficient time to update their managed care preprints and submit to CMS for approval, and that where managed care State directed payments are supported by health care-related taxes they will no longer be permissible under the provisions of this proposed rule.

Response: Most States with health care-related tax waivers that exploit the loophole have received formal notice regarding the structure of such programs, but in general States have been aware for years that we intended to take action on this topic. We have advised States of our concerns, often in writing, and, as discussed later in this final rule, a transition period has been established. Finally, we note that as of the effective date of this final rule, States will have had nearly a year since the proposed rule, and more than 6 months since the enactment of the WFTC legislation, to consider and make appropriate adjustments to sources of non-Federal share.

Comment: A commenter recommended that CMS require States to report detailed information on how they raise the State share of Medicaid funding. They further stated that linking provider-level data would allow CMS to assess whether provider taxes are, in practice, generally redistributive, and if providers are being held harmless.

Response: We agree about the importance of transparency in how States finance their share of Medicaid program costs. Through our analysis of health care-related taxes, we have identified distortions of health care-related taxes that shift the burden to the Medicaid program. We review health care-related taxes both when a State applies for a waiver, and when a State

submits a preprint or SPA regarding a payment funded by a health care-related tax. This final rule allows us to take necessary action for taxes that are not generally redistributive that we were able to identify through existing oversight but did not have the regulatory authority to disapprove until now due to the statistical loophole in the regulation. We will continue to explore all available avenues to improve transparency, further protect Medicaid program dollars and ensure that Federal taxpayer dollars are being spent appropriately.

Comment: A few commenters indicated that the proposed rule could benefit from clarifications. Some requested that language be added to clarify which tax structures remain compliant, notwithstanding the proposed requirements. One specifically requested that language be added to clarify that tax structures not subject to a waiver are presumed compliant. Another commenter stated that nursing home tiers (that is, taxing nursing facilities with different characteristics such as number of beds, rural or non-State government at different rates) may be used for tax purposes that are not to exploit the loophole and requested that CMS clarify that these tiering structures are not those tiering practices referenced in this rule. These commenters stated that absent these clarifications, the proposed rule could have a negative impact on the use of compliant tax structures to support Medicaid financing, particularly for rural and safety net providers, including nursing homes.

We received other similar comments expressing this same concern about nursing facility taxes. Commenters stated that nursing homes, due to their high proportion of residents for whom Medicaid is the payer, face unique challenges in meeting "generally redistributive" requirements. They stated that longstanding, compliant tiered tax structures could now face undue scrutiny, and that excluding Medicare revenues from the tax base, as currently allowed, should continue. A commenter requested that CMS preserve established and permissible provider assessment practices, emphasizing that these allow States the flexibility to design Medicaid programs that best meet the needs of their populations. Several commenters requested that nursing homes be excluded from the regulation entirely. A commenter requested that we exclude children's

hospitals from the regulation entirely due to the critical services they provide. A commenter requested that all hospitals be exempted from the regulation. A commenter requested that nursing homes be given the same flexibilities as hospitals in the regulation.

Response: Regardless of whether a health care-related tax waiver is necessary, State tax programs must meet all Federal statutory and regulatory requirements. Although the statute and regulations do not require a demonstration that a health care-related tax is generally redistributive in nature when the State is not seeking a waiver of the broad-based and/or uniformity requirements, the absence of a need for a health care-related tax waiver does not presume that the tax meets all other Federal requirements related to permissible class and hold harmless requirements. States must evaluate their individual tax programs and work with CMS to review for allowability. The final rule clearly describes what it means for a health care-related tax to be considered generally redistributive, which test under the final rule and the amendments made by section 71117 of the WFTC legislation now ensures will not result in disproportionate burden on Medicaid.

The WFTC legislation provision that closes the loophole does not specify exemptions from the new generally redistributive requirements based on provider type or tax class, nor did we propose such exemptions. We also want to affirm that, while we will examine all tax rate groups and tiering tax structures on all non-uniform taxes, we are aware that there are many appropriate and permissible tax rate practices that involve the use of tiers and groups. We note that of the many nursing facility taxes, we are only aware of two that appear to utilize the loophole. As such, we disagree that there is a need for special consideration for nursing facilities, since many States have developed permissible health care-related taxes on nursing facility services without exploiting the loophole and inappropriately cost shifting to the Federal government. This final rule does not limit the flexibility of States to develop tax programs that meet Federal program requirements. Nothing in the current rule, this final rule, or the WFTC legislation would prohibit or preclude States from excluding Medicare revenue from taxation. In

addition, due to the interests of ensuring consistency of administration, fiscal stewardship over the Medicaid program, and the statute as amended by section 71117 of the WFTC legislation, we decline to adopt the commenters' suggestion of excluding specific providers or permissible classes of services from the requirements of this final rule. We agree with the commenter that every permissible class should be treated and evaluated similarly in the new regulation, including the services of nursing facilities.

Comment: Several commenters urged CMS to incorporate special considerations and exemptions into the proposed rule, emphasizing the need for targeted flexibility, clear guidance, and recognition of unique provider circumstances to ensure fair and workable provider tax policies. A few commenters recommended that CMS establish a safe harbor for taxes with modest non-uniformity, stating this would respect Congressional intent and established practices that allow reasonable variation in provider taxes. A commenter highlighted how current regulations allow exemptions for certain hospitals (that is, rural hospitals, sole community hospitals, financially distressed hospitals and psychiatric hospitals), but not for nursing homes, and urged CMS to extend similar exemptions to nursing homes facing financial and demographic pressures. A commenter called for CMS to clarify the requirements for when provider taxes will be considered generally redistributive and permissible, to avoid confusion and ensure compliance.

Response: We disagree that special exemptions should be included in this final rule. Providing safe harbors or exemptions for taxes that do not meet statutory and regulatory requirements jeopardizes the fiscal integrity of the Medicaid program. Exemptions such as these do not support using Federal taxpayer dollars appropriately. Finally, we note that the WFTC legislation did not include exceptions, and we are finalizing without exceptions both for the fiscal integrity reasons stated and to implement for alignment with the updated statutory requirements.

Comment: A few commenters requested that specific types of organizations such as

governmental and non-profit emergency medical services agencies be exempted from the proposed rule.

Response: We appreciate the commenters' concerns and understand the desire to exempt certain provider types, such as governmental and non-profit emergency medical services agencies, from the provisions of the proposed rule. However, in the interest of consistent fiscal policy, it is not feasible to exempt specific categories of providers from the rule's requirements. Uniform application of the rule ensures that all health care-related taxes are administered fairly and without preferential treatment. In addition, the WFTC legislation does not authorize exceptions for specific provider types. As a Federal agency, we are obligated to implement regulations to effectuate applicable laws.

Comment: A commenter expressed concern regarding the rule's application to licensure programs. Specifically, the commenter was concerned that the proposed rule could inadvertently make Medicaid certification fees impermissible. This commenter requested that CMS clarify that State licensure and certification program fees are exempt from the requirements of the proposed rule.

Response: We disagree with the commenter's recommendation. A certification fee solely based on Medicaid participation would not be permissible as it would not meet the existing regulatory requirements at § 433.56(a)(19). For a licensing or certification fee to be permissible, it must meet the provisions of § 433.56(a)(19)(i)-(iii). There were no proposed revisions to this language. These types of fees must still be broad based and uniform (or the State must receive a waiver of these requirements), the payer of the fee cannot be held harmless, and the amount of the fee cannot exceed the cost of operating the licensing or certification program.

Comment: A few commenters stated that the proposed rule would eliminate or severely restrict the flexibility Congress intended for States to design non-uniform provider taxes, undermining statutory intent and established practice. A few commenters stressed Congress's expressed intent for flexibility, with a commenter stating that it runs contrary to statutory intent

and violates the APA. A commenter emphasized how the vast majority of State provider taxes are not designed to exploit the loophole identified in this proposed rule, stating that this structural overhaul and additional threshold is not necessary.

Response: The proposed rule and our response to public comments received reflect the APA process. We agree that there are health care-related taxes that meet statutory and regulatory requirements, including as amended by section 71117 of the WFTC legislation and under the requirements of this final rule. However, as we discuss throughout this rule, there are some health care-related taxes that take advantage of an inadvertent loophole in a regulatory statistical test which has allowed States to circumvent the statutory requirement for a health care-related tax to be generally redistributive. As Congress stated through the plain language of section 1903(w)(3)(E) of the Act, the Secretary shall approve a health care-related tax waiver for the broad-based and/or uniformity requirements if the net impact of the tax and associated expenditures is "generally redistributive" in nature and the amount of the tax is not directly correlated to Medicaid payments for items and services with respect to which the tax is imposed. The health care-related taxes taking advantage of the inadvertent loophole circumvent the statutory requirement for health care-related taxes seeking to be approved via a waiver to be generally redistributive. The circumvention of the statutory requirement results in shifting the burden of financing the Medicaid program to Medicaid providers and ultimately to the Federal government. The statutory intent was further reinforced by section 71117 of the WFTC legislation, which requires by statute the very changes we proposed under the preexisting authority of section 1903(w)(3)(E) of the Act.

Comment: Several commenters stated that States' ability to tax is essential to their sovereignty, and that provider taxes are a legally permissible and essential way to raise revenue to pay for the State share of Medicaid payments. These commenters indicated the proposed rule creates Federalism concerns and infringes on State sovereignty by limiting State taxing authority. Some commenters believed that CMS' suggestion that the proposed rule did not raise Federalism

or preemption concerns was based on the agency's narrow view of the benefits provider tax programs provide to the Federal government. A few commenters pointed to Department of Revenue of Ore. v. ACF Industries, Inc., 510 U.S. 332, 345 (1994) to support their position that State taxing authority is "central to State sovereignty" and should not be limited beyond the "evident scope" of any Federal law that limits that authority.

Response: We do not disagree that the ability to levy taxes is within a State's sovereign power. Nothing in the Medicaid statute restricts a State's ability to impose taxes and collect tax revenue, although the statute does place certain limitations on which tax revenues may be used to draw down Federal Medicaid matching funds. In this regard, we agree that States have the ability and authority to impose health care-related taxes without the Medicaid expenditure reduction in statute at section 1903(w)(1)(a)(2) of the Act and § 433.70(b) as long as they meet the applicable requirements of Federal law. This final rule is not changing that fact. However, Federal statute and regulation, and further reinforced most recently by the WFTC legislation, have established parameters to ensure that Medicaid providers and the Medicaid program are not unduly harmed by such taxes. This final rule is not limiting States' ability to utilize health care-related taxes; rather, it provides necessary parameters to ensure the statutory provisions are maintained and met.

Comment: Numerous commenters requested that CMS provide clear guidance and technical assistance to States and providers, in particular to those States that will need to restructure their health care-related taxes. They stated that this is necessary to allow States to phase out impermissible taxing structures with minimal disruption to their Medicaid program. Commenters suggested CMS provide examples and templates of acceptable tax structures, have a centralized team to support tax waiver redesign and modeling, and work with impacted States to identify alternate funding sources.

Response: We have staff assigned to review health care-related taxes, including waiver requests, and provide technical assistance to States on non-Federal share sources. We again

assure the commenters that we are available to provide technical assistance. We also remind States that FFP is available for certain State Medicaid administrative costs that meet statutory and regulatory requirements.

Comment: A few commenters disagreed with the language from the background section of the proposed rule regarding the purpose and value of health care-related taxes. These commenters stated that health care-related taxes do in fact support stable funding for the Medicaid program. Some of these commenters discussed specifics about their State's Medicaid program financing structure, how taxes supplement rather than supplant Medicaid funding, and the healthcare this funding supports. One other commenter noted that even though almost every State imposes some type of health care-related taxes, CMS does not have precise data on how much State funding is derived from provider taxes due to opaque financial reporting. This lack of clear data makes it challenging for CMS to evaluate how much providers are actually paid, net of taxes, and how much of the State's share is effectively shifted back to the Federal government.

Response: This rule does nothing to stifle the use of permissible health care-related taxes; it merely ends an abusive practice that threatens the fiscal integrity of the Medicaid program at large. It is both the States' and CMS' responsibility to ensure that Medicaid dollars are spent appropriately and in compliance with Federal requirements, including the statutory requirement that taxes for which a waiver is approved be generally redistributive in nature. This final rule addresses health care-related taxes that run counter to statutory requirements intended to ensure the Medicaid program is not unduly burdened. This is necessary to protect Federal taxpayers, and to protect Medicaid providers from bearing the cost of financing the Medicaid program or other programs within a State that utilize the health care-related tax revenues. Although this final rule is not focused specifically on transparency, and therefore comments about additional financial reporting are beyond the scope of the provisions of this final rule, it does mirror the new statutory requirements enacted in the WFTC legislation, and will enable us to provide better oversight and ensure the fiscal integrity of the Medicaid program.

Comment: A few commenters disagreed with CMS referring to the provider tax structure addressed in the proposed rule as a "loophole." Some commenters stated that health care-related taxes are legal mechanisms structured within strict parameters and approved by the Federal government. These commenters expressed frustration with CMS' depiction of health care-related taxes when, in the past, CMS had acknowledged health care-related taxes being a critical source of Medicaid program funding. A commenter suggested that CMS put guardrails in place to ensure Medicaid tax revenue is used properly, rather than broadly disallowing certain taxes. Some commenters mentioned State accountability policies that ensure health care-related tax revenue is spent on relevant areas of Medicaid and health care, promoting quality care and a better joint Federal and State partnership in administering the Medicaid program.

Response: The purpose of this final rule is to provide necessary oversight of health care-related tax waivers to align with applicable Federal statutory provisions. This final rule contains necessary guardrails – now required by statute – to ensure that health care-related tax revenue is generated in a permissible manner without circumventing the purpose of the statutory "generally redistributive" requirement to not overly burden Medicaid providers. The previous regulations addressed this same issue through the statistical test that we are maintaining, but unfortunately that test was vulnerable to exploitation by certain States seeking to increase revenue from the Federal government. This vulnerability has allowed a tax program to place a much higher tax burden on Medicaid activities compared to commercial activities, which allowed a State to effectively shift a disproportionate burden of the tax onto the Medicaid program. As previously stated, this was the very outcome that the statistical test – as well as the statute, even before the amendments made by section 71117 of the WFTC legislation – were intended to prevent States' circumventing the intent of the test in this manner is fairly characterized as a "loophole," which is defined by Merriam's Dictionary as "a means to escape, especially an ambiguity or omission in the text through which the intent of a statute, contract or obligation may be evaded."

Comment: Without referencing specific provisions in the proposed rule, many

commenters expressed concern regarding general ambiguity and subjectivity of generally redistributive requirements and proxy language provisions. A commenter stated the language of the provision is vague and creates uncertainty. A few commenters stressed the need for CMS to provide clear, objective, and consistent standards to guide States in demonstrating that a tax is generally redistributive. A commenter recommended that CMS work with Medicaid agencies to develop a new statistical test or other objective measure. A commenter recommended that CMS establish a framework with clear, quantitative benchmarks and reproducible thresholds to guide States in demonstrating that taxes are generally redistributive. A commenter stated that the rule should allow reasonable and clearly defined uses of Medicaid statistics to set non-uniform tax rates, as long as safeguards are in place to prevent unfair tax burdens and gaming.

Response: We disagree with the commenters that the rule is ambiguous, subjective, or unclear. First, § 433.68(e)(3)(i) prohibits States from imposing a higher tax rate on any taxpayer or tax rate group based on a provider's Medicaid taxable units than the tax rate imposed on any taxpayer or tax rate group based on a provider's non-Medicaid taxable units except for excluding Medicare revenue or payments as described at § 433.68(d). Whether one tax rate is higher than another is a straightforward comparison that requires comparing two tax rates to determine which rate is higher. Second, § 433.68(e)(3)(ii) prohibits States from taxing any taxpayer or tax rate group defined by its relatively higher level of Medicaid utilization compared to any other taxpayer or tax rate group defined by its relatively lower level of Medicaid utilization. The example provided demonstrates how this is also a straightforward comparison: one tax rate group is for facilities with $200 million or more in Medicaid revenue while the other tax rate group is for facilities with less than $200 million in Medicaid revenue. These groups, clearly defined based on Medicaid utilization, have vastly disparate tax rates of $250 and $20 per bed day, respectively, which is again a straightforward comparison. In addition, the preamble of this rule provides several additional examples to illustrate for commenters how these standards work.

While § 433.68(e)(3)(iii) may appear less straightforward than the first two provisions, it

is essentially the same as the first two, just without explicitly naming Medicaid. We believe this provision is crucial to stop efforts to circumvent the first two provisions by not explicitly stating the term "Medicaid" (or the State-specific name for the program). This provision has been narrowly tailored to achieve this result and is now required by statute. Additionally, for all three of these provisions, we encourage States to approach us for technical assistance as early as possible to help them ascertain whether their particular provision could possibly run afoul of any of these provisions.

We discussed in the proposed rule and elsewhere in this final rule why we did not choose to establish a new statistical test: our desire not to be disruptive, the fact that the B1/B2 test generally works well for most health care-related tax waiver requests, and the fact that a new statistical test could mean a new loophole. A State may use Medicaid statistics as part of the development of a non-uniform tax rate, as long as the tax rates are not disparate based on Medicaid utilization, with the higher burden placed on Medicaid business. For example, we discuss later in response to a comment where it may be appropriate to use Medicaid data as an available data source, provided the effect is not impermissible. A State may not use Medicaid statistics to have non-uniform rates that tax Medicaid providers more heavily, as that use would be counter to the letter and intent of the final rule, the longstanding statutory generally redistributive requirement, and the amendments made by section 71117 of the WFTC legislation.

Comment: Several commenters recommended that CMS limit the proposed rule to just MCO taxes, as they account for the majority of the tax burden targeted by the proposed rule. In addition, commenters recommended that since taxes on hospitals are not as burdensome on average to the Medicaid program as taxes on MCOs, hospital taxes should not be included.

Response: We disagree that it is appropriate to only limit this policy to taxes on MCOs. While it is true that most of the loophole taxes we are aware of are taxes on the services of MCOs, the permissible class defined at § 433.56(a)(8), we have also identified taxes on other permissible classes, including inpatient hospital services and nursing facility services, that pose

similar risks to the Medicaid program. One of our guiding principles for addressing the loophole was to close it entirely. To exclude certain permissible classes from this policy would not achieve that goal. We believe it is more appropriate and effective to address the issue comprehensively rather than partially. Limiting the rule to MCO taxes could leave other problematic tax arrangements unaddressed and potentially allow similar issues to spread in non-MCO permissible classes. As a result, we want to prevent future issues by addressing the situation proactively and comprehensively. Additionally, the WFTC legislation does not limit the requirements to MCO taxes only, nor was the longstanding statutory "generally redistributive" requirement limited to MCO taxes before the amendments made by the WFTC legislation. Therefore, we also decline to adopt the commenters' suggestion for consistency with Federal statute as well. However, in recognition that MCO loophole taxes impose a greater burden on the Medicaid program, we have provided, through the authority under the WFTC legislation, a longer transition period for non-MCO taxes that violate the loophole. This is detailed with greater specificity in section II.D.

Comment: A commenter noted that the proliferation of Medicaid managed care plans has made it difficult for physicians to focus on patient care due to differing requirements. This commenter also stated that there needs to be increased oversight on Medicaid managed care.

Response: We agree with the commenter that effective and efficient oversight of Medicaid managed care is a laudable goal. However, the relationship between the proliferation of managed care plans and the ability of physicians to provide adequate patient care is outside the scope of this rule.

Comment: A commenter pointed out that existing regulations at § 433.68(e)(2)(iii)(B) permit States to develop less redistributive taxes if the tax entirely excludes or reduces the tax burden on specified entities. They suggested that essential hospitals be added as one of the providers listed for this lower threshold.

Response: The proposed rule did not propose any changes or additions to the existing

types of providers that can be excluded from a State's tax program and still be deemed as generally redistributive in nature with a lower statistical test threshold. Therefore, this comment is out of scope of the proposed rule. We also did not propose any changes to the language in § 433.68(d). The option for health care-related tax programs to permissibly exclude Medicare revenues is still maintained in regulation. However, it is important to note that any State health care-related tax program must meet all applicable statutory and regulatory requirements.

Upon review of comments, and consistent with the WFTC legislation, we are finalizing the rule as proposed, with a couple minor wording changes and adjustments to the transition period, which are noted in the respective provision sections.

A. General definitions (§ 433.52)

We proposed adding new definitions at § 433.52. We proposed to add and define "Medicaid taxable unit" to mean "a unit that is being taxed within a health care-related tax that is applicable to the Medicaid program." This includes units that are used as the basis for Medicaid payment, such as Medicaid bed days, Medicaid revenue, costs associated with the Medicaid program such as Medicaid charges, or other units associated with the Medicaid program. Although we had previously established the use of "taxable unit" in preamble of prior rulemaking,[19] we stated our belief in the proposed rule that formalizing a definition in regulation will allow us to better specify the inclusion of factors in our consideration of whether a tax is generally redistributive, which we discuss in section II.B.

We proposed to add and define "non-Medicaid taxable unit" to mean "a unit that is being taxed within a health care-related tax that is not applicable to the Medicaid program." This includes units that are the basis for payment by non-Medicaid payers, such as non-Medicaid bed days, non-Medicaid revenue, costs that are not associated with the Medicaid program, or other

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[19] See 57 FR at 55128 ("By the term "Medicaid Statistic,["] we mean the number of the provider's taxable units applicable to the Medicaid program.").

units not associated with the Medicaid program.

We proposed to add and define "tax rate group" to mean "a group of entities contained within a permissible class of a health care-related tax that are taxed at the same rate." Our work on the subsequent provisions of § 433.68(e)(3)(i), (ii), and (iii) led to the development of this term to illustrate this concept succinctly, and we therefore decided it would be beneficial to define it formally in regulations as well. These provisions referred to groups of providers or health care items and services taxed at the same rate. For the sake of clarity and simplicity, we believed it was easiest to use a single term to refer to these types of groupings.

We invited comments on the inclusion of these terms, the definitions we proposed, and if there are any other terms used in the proposed rule that should be included in the regulatory definitions as well.

The following is a summary of the public comments on our proposed definitions, and our responses.

Comment: We received several comments that expressed concern that the proposed definitions were too vague, lacked clarity, or were subjective. Some commenters stated that this was very concerning with the use of the term "could include" in the definitions of Medicaid taxable unit and non-Medicaid taxable unit. They commented that the use of this phrasing would be extremely difficult to implement.

Response: The intent of the definitions was not to be limited by the use of the phrase "could include." The phrasing was merely intended to reflect that the list of examples was not exhaustive. However, since that meaning can be conveyed by simply stating "include," we are amending the regulation to remove the word "could" for clarity. Furthermore, the WFTC legislation section 71117 included these definitions, and did not include the phrasing "could include," so this update creates precise alignment with the current statutory language.

Comment: A few commenters commended CMS for developing clear definitions in § 433.52 and for the examples of permissible tax groupings.

Response: We appreciate the commenters' feedback regarding the clarity of the definitions provided in § 433.52. We agree that clear definitions are essential to support understanding and compliance with the final rule.

Following review of public comments, we are finalizing the definitions as proposed with the modification to remove the word "could" in the definitions of Medicaid taxable unit and Non-Medicaid taxable unit.

B. Permissible Health Care-Related Taxes – Generally redistributive (§ 433.68(e))

Section 1903(w)(3)(E)(ii)(I) of the Act provides that the Secretary shall approve a State's application for a waiver of the broad-based and/or uniformity requirements for a health care-related tax, if the State demonstrates to the Secretary's satisfaction that the tax meets specified criteria, including that the net impact of the health care-related tax and associated Medicaid expenditures as proposed by the State is generally redistributive in nature.

In section II.C., we discuss new regulatory language in § 433.68(e)(3) we are finalizing to better implement the statutory mandate that a tax be generally redistributive, and the changes made by the WFTC legislation. The new regulatory language necessitates conforming changes to the preceding regulatory language, that is, § 433.68(e)(1) and (2), to reflect the new requirement at § 433.68(e)(3). Accordingly, we proposed to amend § 433.68(e) to provide that a proposed tax must satisfy new paragraph (e)(3), in addition to, as applicable, paragraph (e)(1) or (2) of that section. The addition of paragraph (e)(3) is discussed in section II.C. of this rule.

We further proposed to amend paragraphs (e)(1)(ii) through (iv) and (e)(2)(ii) and (iii) to add that the waiver must satisfy the requirements of paragraph (e)(3) and (f), in addition to existing requirements, for the waiver request to be approvable. Paragraph (f) refers to the current regulatory implementation of limitations on hold harmless arrangements in connection with health care-related taxes, which we did not propose to modify in the proposed rule. The addition of this reference to paragraph (f) in various places in paragraph (e) is intended to enhance clarity, but not to make any substantive change concerning hold harmless limitations. We note that

paragraph (e)(1)(iii) references taxes enacted prior to August 13, 1993. Although a new waiver submission for a tax in effect prior to August 13, 1993, would be unlikely, it is still possible, (for example, if a State makes a non-uniform change to its longstanding tax and needs a waiver), and this proposal accounts for that possibility.

We sought comment on our proposed amendments to § 433.68(e), (e)(1)(ii) through (iv), and (e)(2)(ii) through (iv) and on any additional conforming regulatory edits that may be needed to reflect that paragraph (e)(3) is a requirement for a waiver of the broad-based and/or the uniformity requirement to be approved.

The following is a summary of the public comments on the proposed changes to § 433.68(e), (e)(1)(ii) through (iv), (e)(2)(ii) and (iii), and our responses:

Comment: Some commenters were concerned regarding the varying usage of the phrase "is approvable" and "will be approved" in the changes proposed to § 433.68(e)(1) and (2). They requested that CMS clarify the intent of the differing languages, with one stressing the importance of clear standards for States and providers.

Response: The language referenced by the commenters refers to places where CMS changed existing regulatory language and where we did not. In the regulatory text for both § 433.68(e)(1)(ii) and (e)(2)(ii), we use the phrase "the tax waiver is approvable" where we were replacing text that previously stated CMS "will automatically approve." Conversely, in § 433.68(e)(1)(iii), (iv), and (e)(2)(iii), the phrase "will be approved" appears where it did in the previous regulations, because here we were not changing that, but instead adding the language "in addition to satisfying the requirement at paragraphs (e)(3) and (f)." We believe that the phrases "is approved" and "will be approved" convey the same meaning as "is approvable" that we are finalizing in this regulation. We are finalizing these changes as proposed.

Comment: A few commenters supported the rule's efforts to curb "gaming" and exploitation of the loophole in provider tax structures. A few commenters stressed their support for changes to the B1/B2 test to prevent gaming. A few commenters urged CMS to take

additional steps such as applying the additional requirements to demonstrate a tax is generally redistributive, which the commenter called a requirement not to unduly burden the Medicaid program, to both the B1/B2 and P1/P2 tests to limit future gaming.

Response: We thank the commenters for their support. With the enactment of the WFTC legislation, we have determined that the final rule's provisions are sufficient at this time, and it currently is not necessary to propose changes to the application of the B1/B2 and P1/P2 tests. Under this final rule, the requirements we are establishing are not based on an undue burden on Medicaid but rather ensure proper application of the statute. However, we note that the change to paragraph (e)(1)(ii) and (iii) ensure the requirements of paragraph (e)(3) are met when a State is only seeking a broad-based requirement waiver using the P1/P2 test, as well as when a State is seeking a uniform requirement waiver using the B1/B2 test. This is consistent with the amendments made by section 71117 of the WFTC legislation.

Comment: A commenter supported the proposed changes to § 433.68(e) as necessary clarifying and technical edits to account for the new requirements.

Response: We thank the commenters for their support.

After reviewing the comments, we are finalizing the changes to § 433.68(e)(1)(ii) through (iv) and (e)(2)(ii) and (iii), as proposed.

C. Permissible Health Care-Related Taxes – Additional requirement to demonstrate a tax is generally redistributive (§ 433.68(e)(3))

CMS sought to address health care-related taxes that do not have the effect of being generally redistributive despite being able to pass the P1/P2 or B1/B2 test, as applicable, as previously discussed. In the proposed rule, we explained our belief that, in large part, the B1/B2 test has served its function as a straightforward mathematical implementation of the statutory requirement under section 1903(w)(3)(E)(ii)(I) of the Act that to be granted a waiver a tax must be generally redistributive. Although the linear regression used in the B1/B2 analysis is vulnerable to certain kinds of manipulation by States, as discussed in section I.D. of this final

rule, CMS' experience has shown that the B1/B2 test usually works as intended. In the proposed rule, we aimed to eliminate the possibility these vulnerabilities will be exploited. As a result, we proposed to retain the B1/B2 test based on the long-term reliance of many States on the test and its overall utility in accomplishing its purpose of ensuring that taxes for which waivers are requested are generally redistributive. However, as demonstrated by the problematic taxes discussed earlier that are designed to target Medicaid with increased tax rates compared to other taxpayers, it is necessary to take our analysis a step beyond the mathematical result of the B1/B2 test to ensure we uphold the statutory mandate that a tax for which a waiver is approved be generally redistributive, which we proposed to do through the addition of the requirements in paragraph (e)(3). In addition, as specified in existing statute and by cross reference in regulation at section 1903(w)(1)(A)(iii) of the Act and § 433.70(b), respectively, even if a tax passes the applicable statistical test, it is still considered impermissible if it contains a hold harmless arrangement prohibited by section 1903(w)(4) of the Act and § 433.68(f). Therefore, we proposed to add cross-references to § 433.68(f) in regulatory language we proposed to update in § 433.68(e)(1)(ii), (1)(iv), (2)(ii), and (2)(iii) regarding the approvability of a tax waiver proposal.

As previously discussed, § 433.68(e) specifies the applicable statistical test for evaluating whether a proposed tax is generally redistributive: if the State is seeking only a waiver of the broad-based requirement, paragraph (e)(1) specifies that a State must meet the test referred to as "P1/P2" described in section I.C. of this rule, while a State seeking a waiver of the uniformity requirement or both the broad-based and uniformity requirements must meet the test specified in paragraph (e)(2), referred to as "B1/B2," also described in section I.C. of this final rule.

We proposed adding a new paragraph, § 433.68(e)(3), to ensure that a health care-related tax is generally redistributive by preventing taxes that impose higher tax rates on providers that primarily serve Medicaid beneficiaries than on other providers that serve a relatively smaller number of such beneficiaries. Specifically, in paragraph (e)(3), we proposed that the new

requirements would apply on a per class basis. We also proposed that regardless of whether a tax meets the standards in paragraphs (e)(1) and (2), the tax would not be "generally redistributive" if it has certain described attributes that are contrary to the tax program being generally redistributive in nature.

The provisions of this final rule specify the attributes of a tax that would violate the generally redistributive requirement in paragraphs § 433.68(e)(3)(i), (ii) and (iii). The applicability of these provisions, and the associated analysis of whether a tax violates the generally redistributive requirement, would differ based on whether the tax or waiver indicates Medicaid explicitly. We discuss each of these in turn. We note that this policy will not interfere with a State's ability to implement otherwise permissible State and locality taxes (that is, taxes imposed by units of local government such as counties).

The following is a summary of comments received about the additional "generally redistributive" requirement, in general, and our responses.

Comment: A few commenters recommended that CMS adopt a presumption in favor of provider taxes being generally redistributive, with the burden placed on CMS to demonstrate noncompliance only if specific regulatory requirements are not met. A commenter stated that applying both the B1/B2 and P1/P2 tests would better prevent future gaming of provider tax rules.

Response: The Social Security Act clearly places the obligation on States to operate their Medicaid program in compliance with Federal requirements. The final rule's regulatory provisions describe what is necessary for a health care-related tax to be considered generally redistributive. In developing the proposed rule and considering the enactment of the WFTC legislation with its amendments to section 1903(w) of the Act, we have determined that the final rule's provisions are sufficient at this time and there currently is not a need for changes to the application of the B1/B2 and P1/P2 tests. The effect of requiring all waivers to meet both the B1/B2 and the P1/P2 tests would be to eliminate the statistical loophole. However, it would also

be more restrictive than the option of adding requirements in § 433.68(e)(3)(i) through (iii) that we proposed and would affect more States with more taxes. In addition, it would encompass some taxes where there is no evidence that they are out of compliance with Federal requirements. Because of the comparatively greater burden that would be involved in addressing a wider variety of States and taxes, which generally do not merit increased concern, CMS did not believe that this option would be desirable. For this reason, we did not choose it. Rather the requirements finalized in this rule, particularly in section § 433.68(e)(3), provide the tools necessary for us to effectively evaluate health care-related tax waiver proposals and determining whether they are in fact generally redistributive. A health care-related tax cannot be presumed to be generally redistributive if it has not been established that all requirements in statute and regulation are met. This work requires analysis of the State's tax program and proposal. Finally, we note that the suggestion of the commenters would not align with the requirements under the WFTC legislation, which we have endeavored to align with.

Comment: A commenter highlighted an example of a relevant State proposition directing tax revenue generated from MCO-based taxes to fund designated services benefiting all State Medicaid beneficiaries. The commenter suggested that CMS should amend the rule to enable States to impose non-uniform taxes if they use the funds to supplement reimbursements or enhancing services for Medicaid beneficiaries. A few commenters urged CMS to introduce mechanisms to determine whether the revenue was being used in a supplemental manner rather than just supplanting other State general fund obligations in determining whether to approve a waiver for a particular tax structure.

Response: We appreciate the commenter's recognition of how health care-related taxes, including those on MCOs, can be used to fund Medicaid services. We acknowledge that many States rely on such taxes to support a wide range of Medicaid payments. Nothing in this final rule prohibits States from continuing to impose health care-related taxes on services of MCOs. This rule is not intended to prevent States from making new investments in their Medicaid

programs through any permissible means of financing allowed under statute and regulation. However, taxes designed to exploit the loophole are not generally redistributive in nature as required by statute, and they place an undue financial burden on the Medicaid program and the Federal government beyond what is contemplated by statute and regulation. After the finalization of the additional generally redistributive requirement, and with the statutory changes made by section 71117 of the WFTC legislation, States with currently non-compliant MCO taxes may redesign their health care-related taxes to ensure compliance with Federal requirements. Additionally, States have the option to finance these services from sources other than health care-related taxes on services of MCOs.

Comment: A commenter recommended CMS publish clear guidance on the process for evaluating proposed tax waivers. A commenter recommended CMS maintain the B1/B2 test due to the subjectivity of the proposed rule's provisions and the States' longstanding reliance on the test. A commenter stated that these provisions were too broad in scope because they would capture and implicate a wider variety of taxes than is necessary.

Response: The provisions of the proposed rule provide clear standards for tax waivers. If a State taxes a taxpayer or tax rate group more heavily based on its Medicaid taxable units or utilization than its non-Medicaid taxable units or utilization and expressly identifies the taxpayer or tax rate group by reference to “Medicaid” or an equivalent name, that will implicate § 433.68(e)(3)(i) or (ii). If a State does the same thing, but to circumvent the additional generally redistributive requirement under this final rule (and as required by the amendments made by section 71117 of the WFTC legislation) does not use the word “Medicaid” or an equivalent name, but instead identifies the taxpayer or tax rate group differently to achieve the same result, that would implicate § 433.68(e)(3)(iii). Nothing about the way the B1/B2 currently works will change; for waivers of the uniformity requirement, States will still need to pass the B1/B2 test. To address the statistical loophole, we are supplementing the existing B1/B2 test with a new additional generally redistributive requirement, as proposed and as required under the

statutory amendments made by section 71117 of the WFTC legislation. By employing these two methods together (that is, the existing B1/B2 test and the new generally redistributive requirement), the analysis of proposed tax waivers will help ensure that we only approve tax waivers that are generally redistributive because they tend to use non-Medicaid revenue to pay for Medicaid payments, as required by statute. Likewise, we disagree that the new provisions do not provide clear guidance. Section 433.68(e)(3)(i) and (ii) fundamentally rely on straightforward measures of whether one amount is greater or less than another amount. Section 433.68(e)(3)(iii) does involve a consideration of a wider variety of factors that are not strictly speaking statistical or numeric, but that only forms the first step of the proxy analysis, which then concludes with whether the tax has the same effect as described in paragraph (e)(3)(i) and (ii). Despite the wider variety of factors that are under consideration, our analysis at this stage will remain objective since the proxy is only limited to capturing States that are attempting to circumvent the requirements in § 433.68(e)(3)(i) and (ii) through using alternative language and not other situations.

Section 433.68(e)(3)(iii) is necessary to prohibit States from attempting to circumvent the additional "generally redistributive" requirement by not using the word "Medicaid" or an equivalent name. While we have considered relying solely on a new statistical test, we declined to propose doing so at this time because the alternative tests we considered would have caused unnecessary disruption for States with existing approved tax waivers that are functioning appropriately. In addition, we disagree with the commenter that the regulation is too broad in scope. The regulation is narrowly tailored to accomplish its purpose of ensuring that tax programs are generally redistributive, while still retaining State flexibility in designing their tax programs. We have repeatedly emphasized these policies only affect a small number of known loophole taxes. As a result, we decline to adopt the commenters' suggestions. Finally, we note that the WFTC legislation enacted these provisions, substantially as we proposed, with limited organizational differences between the regulation and statute and without including the examples

listed in the proposed regulation. Therefore, apart from the fact that we determined the policies we finalized are the most effective, least disruptive, pathway to close the statistical loophole, we also determined it is appropriate to finalize as proposed to align with the amendments made by the WFTC legislation.

Comment: A few commenters provided specific examples of their State's tax arrangements and sought clarity on whether or not they would be deemed permissible.

Response: As with many new regulations, we understand that States may require technical assistance in interpreting how the regulation applies to their unique circumstances. While the notice and comment rulemaking is not the appropriate venue to discuss the specifics of each State's particular situation, we encourage States to contact us directly if they have any questions or concerns regarding how the regulation might affect them. We also intend to communicate directly with the small number of likely impacted States regarding the status of their tax waiver(s) and the new requirements under this final rule and the amendments made by section 71117 of the WFTC legislation. We are committed to supporting States and providing technical assistance as needed. Furthermore, we recommend States contact us as early as possible if they have questions or are concerned about whether their health care-related taxes may conflict with the new Federal requirements.

Comment: A few commenters suggested edits to the proposed rule in areas of the proposed rule's provisions that commenters indicated were ambiguous or with which the commenters otherwise disagreed. These included removing the examples from the regulatory text, applying the policy only to MCO taxes, and to limit the applicability of § 433.68(e)(3)(i), (ii), and (iii) to States that have received companion letters from CMS informing them that their tax may be problematic. Finally, a commenter suggested that the "legitimate public policy goal" apply to all of § 433.68(e)(3)(i), (ii), and (iii).

Response: We are not making any edits based on these suggestions. We discussed in earlier responses why it would not be appropriate to limit the scope of this rule to MCO taxes.

We also believe the examples in regulatory text demonstrate the agency's commitment to the interpretation of the regulations that we described in preamble to the proposed rule, and we have made it clear these examples are not exhaustive. We are also not limiting the applicability to States that have received companion letters, because then there would still be loophole taxes. We have addressed the issue of whether a State has received a companion letter through the different transition periods, where all States that did not receive a formal companion letter have at least a full State fiscal year to come into compliance under this final rule. We decline to adopt the suggested edit that the legitimate public policy language applies to all the additional requirement regulations, as this is only a consideration for § 433.68(e)(3)(iii), borne out of the fact that Medicaid is not being named explicitly. This difference requires a greater examination of intent, to ensure inadvertent associations are not inappropriately penalized. Finally, as we have stated, we are finalizing all changes to § 433.68(e)(3) as proposed, with one wording change to paragraph (e)(3)(iii) noted in the relevant section for consistency with section 71117 of the WFTC legislation.

Comment: A few commenters in support of the proposed rule pointed to how MCO taxes that exploit the loophole in particular disproportionately impact Medicaid tax burden.

Response: We appreciate the commenters' support and agree that taxes on services of MCOs, as described at § 433.56(a)(8), that also exploit the loophole, present the most egregious examples of this problem. We believe that the provisions of the proposed rule would effectively address these taxes so as to prohibit this issue from recurring.

After consideration of the public comments overall on the establishment of an additional requirement to demonstrate a tax is generally redistributive, and consistent with section 71117 of the WFTC legislation, we are finalizing all changes to § 433.68(e)(3) as proposed, with one wording change to paragraph (e)(3)(iii) noted in the relevant section.

1. Taxes that Refer to Medicaid Explicitly

In § 433.68(e)(3)(i), we proposed that if, within the permissible class, the tax rate

imposed on any taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable units (except as a result of excluding from taxation Medicare or Medicaid revenue or payments as described in paragraph (d) of this section) the tax would not be generally redistributive. We also proposed to specify an example of a tax that would violate this provision, although the example is not the only example of how a tax might be structured to violate this requirement. The example we proposed in regulations text specifies that an MCO tax where Medicaid member months are taxed $200 per member month whereas the non-Medicaid member months are taxed $20 per member month would violate this requirement. Medicaid would, in this context, also include descriptions of where a State uses its proper name of its State-specific Medicaid program.

In § 433.68(e)(3)(ii), we proposed that if within a permissible class, the tax rate imposed on any taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer or tax rate group defined by its relatively higher volume or percentage of Medicaid taxable units, it would not be generally redistributive. We also proposed to specify two examples of taxes that would violate this provision, although the examples were not intended to be the only examples of how a tax might be structured to violate this requirement. The first example specifies that a tax on nursing facilities with more than 40 Medicaid-paid bed days of $200 per bed day while nursing facilities with 40 or fewer Medicaid-paid bed days are taxed $20 per bed day would violate this requirement. The second example describes a tax on hospitals with less than 5 percent Medicaid utilization at 2 percent of net patient service revenue for inpatient hospital services, while all other hospitals are taxed at 4 percent of net patient service revenue for inpatient hospital services; this tax structure also would violate this requirement.

Health care-related taxes with the attributes described in the examples in § 433.68(e)(3)(i) and (ii) are designed to generate less tax revenue from non-Medicaid sources

and more tax revenue from Medicaid sources for the same amount of taxable services or revenue, which is inconsistent with a generally redistributive tax. This is contrary to the Congressional intent and statutory direction that non-broad based and non-uniform taxes that are granted a waiver must be generally redistributive. Based on our analysis, existing State taxes that use the B1/B2 loophole described previously would all fail the requirement in the proposed § 433.68(e)(3)(i). One of these existing State taxes that uses the loophole would also fail the requirement in § 433.68(e)(3)(ii).

These scenarios illustrate examples of taxes that target Medicaid taxable units with higher tax rates when compared with non-Medicaid taxable units. As a result of this targeting, the tax ensures that taxed entities that serve no, or relatively low percentages, of Medicaid beneficiaries are not financially harmed as a result of the tax. This is important because providers with low Medicaid utilization would be less able to be made whole by additional Medicaid payments. As a result, these providers are not burdened by any, or more than a de minimis, tax liability. Because of this tax structure, the State, its localities, and taxpayers do not appear to shoulder a significantly reduced net non-Federal share. As a result, the Federal government is the only net payer or a substantially higher net payer than contemplated by statute in its specification of the applicable Federal matching percentage. In addition to this being counter to the statutory framework, as described above, the scenarios presented by the rule are illustrative of taxes that present a significant fiscal integrity risk to the Medicaid program without any benefit to the Federal taxpayer. When non-Federal entities do not incur a net non-Federal share cost (or incurring a reduced non-Federal share cost), there is a reduced incentive for States to propose payment methods that are efficient, economic, and consistent with other applicable Federal requirements.

The following is a summary of the public comments on the provisions when a waiver explicitly names Medicaid under § 433.68(e)(3)(i), and our responses:

Comment: A commenter urged CMS to omit the examples included in this section, both

because they are non-exhaustive (and according to the commenter, therefore cause uncertainty), and because they overlook situation-specific nuances. The commenter challenged the example that a higher tax rate on nursing facilities with more than 40 Medicaid-paid bed days than the tax rate on nursing facilities with 40 or fewer bed days would be considered not generally redistributive, asserting that a State may use Medicaid-paid bed days as a proxy for total bed days, because Medicaid data is timely and less volatile over time, rather than increase the share of tax burden on Medicaid taxable units.

Response: We are maintaining the examples in the regulation text. The inclusion of these examples allows readers of the regulations to have clear insight into the meaning of the regulations. This also provides examples on which a State can reasonably rely, as these have been codified in regulation. We believe it is clear that these examples are not exhaustive, and maintain that that they are valuable reference points for States as they interpret and implement the regulation.

We acknowledge the commenter's point that the examples do not capture the nuances of each specific situation, and we are available to provide technical assistance on different circumstances. With respect to the example in the comment, to provide the data necessary to pass the B1/B2 test initially, States must already be collecting data on Medicaid units as distinct from total taxable units. A State would be unable to calculate the B1/B2 test if the only data they had was Medicaid bed days. As a result, we do not believe that the situation suggested by the comment would be possible, given how States must calculate the B1/B2 test. States often use lagged data from a few years prior in their health care-related tax waiver requests. We expect this practice to continue. Nothing in the final rule would preclude States from continuing to do this. We continue to encourage States to provide the best, most accurate, most recent data they have for health care-related tax waiver submissions to us.

Comment: A commenter stated that the language of this provision was too vague and creates uncertainty. Another commenter requested that CMS provide guidance to States, given

that their intentions for the tax and rate may need to be considered.

Response: We respectfully disagree with the commenter's assertion that the language of § 433.68(e)(3)(i) is vague or creates uncertainty. As discussed in response to general comments that indicated the same, § 433.68(e)(3)(i) prohibits States from imposing a tax rate on any taxpayer or tax rate group based on Medicaid taxable units higher than the tax rate on any taxpayer or tax rate group based on a provider's non-Medicaid taxable units (except for excluding Medicare revenue or payments as described at § 433.68(d)). It is readily apparent if one tax rate is larger than another tax rate. Then, to aid States further, we provided multiple examples of potential violations, and we encourage States to seek technical assistance early in the design of their tax programs. We appreciate the commenter's request for additional guidance and is available to engage with States individually to address any concerns related to § 433.68(e)(3)(i).

The following is a summary of the public comments on proposed § 433.68(e)(3)(ii), and our responses:

Comment: A commenter recommended that CMS allow tiered assessment models that use lower tax rates on small Medicaid providers or high-volume Medicaid providers, when the model supports access and meets Federal requirements.

Response: Nothing in this rule would prohibit States from establishing lower tax rates for small Medicaid providers or high-volume Medicaid providers. In fact, a tax that provides lower tax rates for providers with higher Medicaid taxable units or utilization aligns with the "generally redistributive" concept. The regulation would permit this while not allowing lower tax rates for providers with lower Medicaid taxable units or utilization. Providers defined by comparatively higher Medicaid business cannot be taxed more than providers defined by their comparatively low Medicaid business. We would likely need to examine the details of the commenter's particular situation to make a definitive judgement on permissibility under Federal requirements.

Comment: A commenter cautioned that taxes on nursing homes in many States use tiers,

and that some States impose health care-related taxes by referencing providers that serve multiple levels of care as "definitions" for tax rate tiers, though these "definitions" are not codified in State statute or regulation. The concern the commenter has is that these practices will be viewed as impermissible proxies.

Responses: For the purposes of § 433.68(e)(3)(iii), CMS will not decide based on one sole factor, such as how the "definitions" are codified in State statute or regulation. We will initially review how the State describes the tax to CMS, and then also consider surrounding circumstances and information about the tax. When States submit health care-related tax waiver requests to CMS, they must submit a letter describing, among other things, the structure of the tax, and the tax rates. CMS refers to this as the health care-related tax request letter. In its health care-related tax request letter, if the State uses the word "Medicaid" or its State-specific equivalent, § 433.68(e)(3)(i) or (ii) may come into effect. If not, § 433.68(e)(3)(iii) may still apply. CMS would need to look at the example in question in greater detail, as we will be making these assessments on a case-by-case basis.

Comment: A few commenters claimed that § 433.68(e)(3)(i) and (ii) would make it difficult for States to impose multiple tax rates. One such commenter stated that this could occur because CMS is considering the tax portion only and is not considering payments supported by the tax.

Response: We respectfully disagree with the commenters assertion that § 433.68(e)(3)(i) or (ii) will make it difficult for States to impose multiple tax rates. The additional analysis to determine whether a tax is generally redistributive finalized in this rule will only occur when a State is proposing multiple tax rates and therefore is not a uniform tax. However, these policies do not prohibit non-uniform taxes. These specific provisions only apply if the State uses "Medicaid" in their description of the tax to us and then would only further trigger these provisions if the Medicaid-associated tax rate is higher.

Additionally, we agree with the commenter that the regulation is focused mainly on the

structure of a tax program as opposed to the methodology used to make Medicaid payments; however, this is not because we do not consider the associated payments. Section 1903(w)(3)(E)(ii)(I) of the Act specifies that whether a tax is generally redistributive in nature considers the net impact of the tax and associated expenditures; as such, the generally redistributive analysis must necessarily consider the payments that the tax will fund, including whether they are not being used for Medicaid payments. However, our policies have historically focused on the tax structure because we expect and have found that health care-related taxes are generally used to fund Medicaid payments, and we ensure our policies reflect that likelihood.

We further note that no part of assessing the permissibility of taxes exists in a vacuum. Our analyses of provider taxes also consider payments supported by these taxes; for example, the analysis we conduct to determine whether a hold harmless arrangement is in place. As such, although the changes we are finalizing at § 433.68(e) focus mainly on the structure of the tax itself, this is through the knowledge that the tax is likely used for Medicaid payments, and in conjunction with a closer examination of the payments for the hold harmless analysis.

After consideration of the public comments, and consistent with section 71117(a)(1) of the WFTC legislation, which added the proposed language as section 1903(w)(3)(E)(iii)(I) and (II) of the Act, we are finalizing § 433.68(e)(3)(i) and (ii) as proposed. However, we note that the WFTC legislation reversed the order of the two provisions from what we proposed. We are maintaining the order as proposed, as we view this difference as immaterial and want to prevent any confusion from the proposed rule and the way the information was organized at the greater level of detail contained in rulemaking.

2. Waivers that Do Not Refer to Medicaid Explicitly

In § 433.68(e)(3)(iii), we proposed to prohibit a State from imposing a tax that excludes or imposes a lower tax rate on a taxpayer or tax rate group defined by or based on any characteristic that results in the same effect as described in paragraph (e)(3)(i) or (ii). In other words, there does not need to be an explicit reference to Medicaid in the State's tax program if

the State is using a substitute definition, measure, attribute, or the like as a proxy for Medicaid to accomplish the same effect. By "the same effect," we mean imposing a higher tax rate on Medicaid taxable units than on non-Medicaid taxable units, even if this is accomplished with less mathematical precision under an approach that does not explicitly reference Medicaid than would be possible under an approach that violates proposed paragraph (e)(3)(i) or (ii).

The proposed rule specified two examples of taxes that would violate this provision but does not provide an exhaustive list of ways a tax might be structured to violate it. The first example involves the use of terminology to establish a tax rate group based on Medicaid without explicitly mentioning "Medicaid" (or the State-specific name of the Medicaid program) to accomplish the same effect as described in paragraph (e)(3)(i) or (ii). This example specifies that a tax on inpatient hospital service discharges that imposes a $10 rate per discharge associated with beneficiaries covered by a joint Federal and State health care program and a $5 rate per discharge associated with individuals not covered by a joint Federal and State health care program would violate this requirement, because joint Federal and State health care program describes Medicaid, and a higher tax rate is imposed on Medicaid taxable units. The second example concerns the use of terminology that creates a tax rate group that closely approximates Medicaid, to the same effect as described in paragraph (3)(i) or (ii). This example specifies that a tax on hospitals located in counties with an average income less than 230 percent of the Federal poverty level of $10 per inpatient hospital discharge, while hospitals in all other counties are taxed at $5 per inpatient hospital discharge, would violate this requirement, because the distinction being drawn between tax rate groups is associated with a Medicaid eligibility criterion (income) with a higher tax rate imposed on the tax rate group that is likely to involve more Medicaid taxable units.

The intent of the proposed provision in paragraph (e)(3)(iii) is to address potential efforts by States or local units of government to mask a health care-related tax that falls more heavily on Medicaid taxable units using some other terminology or defining factor to circumvent the

requirements in paragraph (e)(3)(i) and (ii) by avoiding explicitly targeting Medicaid taxable units with higher tax rates. For the same reasons described previously regarding taxes that would violate paragraph (e)(3)(i) or (ii), such taxes would not meet the statutory generally redistributive requirement and would have a substantially negative impact on the fiscal integrity of the Medicaid program. Absent this provision, we explained our concern that if we only finalized the requirements in § 433.68(e)(3)(i) and (ii), States might choose to pursue taxes that would otherwise be prohibited under § 433.68(e)(3)(i) and (ii) through the use of a proxy for Medicaid. Following the enactment of the WFTC legislation, we are also finalizing paragraph (e)(3)(iii) for consistency with the new statutory language.

We proposed to codify this regulatory language with this level of detail directly in response to feedback we received to a similar proposal in the November 2019 proposed rule. Although we remain committed to addressing the statistical loophole, as we were in the November 2019 proposed rule, we acknowledge that the level of detail in the November 2019 proposed rule might not have provided enough context to give commenters an accurate picture of our intent. Under the analogous provision of the 2019 proposed rule, we would have determined a tax program not to be generally redistributive if it imposed an "undue burden" on the Medicaid program because the tax "excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the tax rate group having no Medicaid activity or relatively lower Medicaid activity than any other tax rate group." (84 FR 63778). The 2019 proposed rule may not have presented a clear idea of how we would apply the requirement to avoid imposing an undue burden on the Medicaid program. In the proposed rule, we added language to § 433.68(e)(3) to provide reassurance to interested parties that these current proposals are intended only to shut down the loophole to better effectuate the statutory directive that health care-related taxes for which the broad-based and/or uniform requirement is waived must be generally redistributive, and not impact permissible State health care-related tax programs

unrelated to this goal. For example, in section II.A., we proposed to define "Medicaid taxable unit" to narrow the scope from "Medicaid activity" as used in the November 2019 proposed rule. We also chose, in all of paragraph (e)(3), to propose specific illustrative examples that demonstrate our commitment to a clear, specific, and predictable application of our regulations. We believe that the illustrative examples will provide the public with a better understanding of what these provisions do and how we will apply it in practice when evaluating State tax waiver proposals, compared to the November 2019 proposed rule.

We invited comments on other examples we could provide, whether in the final rule preamble or in regulation text, that could make even clearer how we will implement the proposed policies. We address comments received on the examples we proposed at the end of this section with other comments and responses pertaining to waivers that do not refer to Medicaid explicitly.

Since the scenarios described in § 433.68(e)(3)(iii) would not name Medicaid explicitly, we explained that CMS would need to assess whether Medicaid is nevertheless implicated, and then whether the tax results in the same effect as described in paragraph (3)(i) or (ii). Under this assessment, we would examine the tax and waiver submission, including the characteristics of each tax rate group description, the entities in the tax rate group, and the Medicaid taxable units and non-Medicaid taxable units associated with each tax rate group and entities in each tax rate group. No single factor would result in an automatic determination by CMS that the tax rate groups have been designed to target Medicaid when it is not explicitly named. However, a series of overlapping descriptions or characteristics that appear to point toward Medicaid utilization, without using the word Medicaid, would probably lead to a heightened level of scrutiny. For example, we explained that, if CMS analyzes a Medicaid utilization table in a tax waiver submission (which lists providers, their tax rates, and their Medicaid utilization) and observes that a certain group of excluded providers described as "Provider Group A" has little to no Medicaid utilization, we would further scrutinize "Provider Group A" to ascertain whether it is a proxy for lack of Medicaid utilization, as discussed further later in this rule.

Accordingly, we proposed that CMS may examine whether the tax or waiver uses terminology that describes Medicaid implicitly without using the term itself, such as the "joint Federal and State health care program," used in our example in the proposed rule.[20] We would also examine if the tax rate group is defined based on criteria that mirror Medicaid eligibility or other defining characteristics, such as a data point that is associated with Medicaid or a Medicaid eligibility criterion like income (such as percentages of low-income individuals in a geographic area), or a particular provider type that is associated with high Medicaid utilization (such as State or other public facilities and university/teaching hospitals).

This analysis would fit into our regular review work and interactions with States. When CMS reviews a tax waiver submission, we assess the waiver for compliance with all applicable statutes and regulations. This assessment is not necessarily limited to the waiver submission itself, or to the materials as first submitted by the State. Upon review, we generally tailor a set of questions for the State to obtain any additional information necessary to adjudicate the waiver request or request revisions necessary for the submission to meet Federal requirements. For example, we might ask for clarification based on something we did not understand, that we want to confirm, or that may be in error. We regularly have additional discussions with the State, which may include technical assistance phone calls, and review of State submission of updated or additional health care-related tax waiver request materials. The process is both collaborative and iterative, to allow States to vary their taxes in ways appropriate for their individual circumstances as supported by statute and regulations, and to allow CMS to arrive at an appropriate approvability decision based on Federal requirements.

We explained that an assessment of whether or not a State is utilizing a proxy in violation of proposed paragraph (e)(3)(iii) would be conducted under this same process. If we analyze a

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[20] 90 FR 20587.

Medicaid utilization table and observe a disparate set of rates for higher and lower Medicaid utilization tax rate groups despite the tax passing B1/B2, and we cannot readily determine how the tax rate groups have been constructed, we will ask the State for additional information as is part of our standard practice. Consistent with our existing practice, this allows the State to identify for CMS any necessary clarifications or explanations that informed the development of the tax rate groups. The additional information we obtain from the State could allow us to determine that the tax rate groups were not constructed to target taxation to higher Medicaid utilization tax rate groups or away from lower Medicaid utilization tax rate groups, but instead for a legitimate public policy purpose not directed at manipulating relative tax burden.

Section 433.68(e)(3)(iii) is not intended to prevent States from designing tax rate groups to achieve legitimate public policy goals, when these do not prevent the tax from being generally redistributive.[21] In this context, by "legitimate," we mean any public policy goal that the State may lawfully pursue, which is the State's actual purpose and not a spurious or fictive purpose offered to conceal or negate a true purpose of directing higher relative tax burden to the Medicaid program. This type of assessment is already historically reflected in the consideration CMS gives to certain non-uniform taxes under § 433.68(e)(2)(iii)(B), where CMS permits a lower threshold to pass the B1/B2 test for taxes that provide more favorable tax treatment only for specified types of entities, including sole community hospitals as defined in § 412.92. A "sole community hospital" (SCH) generally is a hospital that is the only hospital in its geographic area and therefore serves as the sole source of inpatient hospital services for the vulnerable population in the area. Because these hospitals play vital roles in providing access to care to beneficiaries, they were included in the statutory and regulatory flexibilities built into the statistical test in recognition of their importance to recipient access to services (57 FR 55118

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[21] See reference in proposed rule at 93 FR 20588.

through 55129).

For example, a State establishing a nursing facility tax program, within which a tax rate group for a provider type such as continuing care retirement communities (CCRCs) is subject to a lower tax rate for public policy reasons, would not, in and of itself, violate paragraph (e)(3)(iii), even if the CCRC tax rate group happens to have lower Medicaid utilization than other tax rate groups in the tax program. In this case, we would consider that the designation of CCRC exists outside of the health care-related tax domain, and, for taxation purposes within the CCRC designation, the tax rate is not differentiated between Medicaid and non-Medicaid taxable units. CCRCs are licensed by the States in which they are located. They are not a classification or designation that the State created for the purposes of establishing health care-related tax provider groups or otherwise to minimize the impact on non-Medicaid providers or taxable units.

As another example, a State might seek to exclude providers located in rural areas from taxation. States often afford special consideration for rural providers as a means of helping preserve beneficiary access to services in rural areas that otherwise might not have a sufficient number of qualified providers to serve the needs of Medicaid beneficiaries. Like sole community hospitals, the existing regulations in § 433.68(e)(2)(iii)(B) currently provide additional flexibility for States in designing non-uniform tax waivers that favor rural hospitals. A tax structure that excluded rural providers without any explicit reference to Medicaid would likely not fall within the proxy provision. Generally, because the provider group would be defined by a pre-existing classification that exists for various public policy purposes apart from taxation (rural location) and because the tax treatment within the classification of rural providers would not vary between Medicaid and non-Medicaid taxable units, there would not appear to be an indication that the State is using the taxpayer rate group to direct tax burden to the Medicaid program or away from providers with relatively lower Medicaid utilization.

When, by chance, a State's effort to design a tax program in support of a public policy purpose like promoting health care access results in a tax rate group that happens to have lower

Medicaid utilization ending up with a tax break, some States may balance this with a corresponding break for higher Medicaid utilization providers. Nothing in the proxy provision would prevent States from being able to balance tax rate groups in this way as they have in the past. Other possible examples of tax rate groups that States may wish to give a tax break to for policy reasons not related to directing higher relative tax burden to the Medicaid program include psychiatric hospitals and rural hospitals, among others. These instances would be permissible under proposed paragraph (e)(3)(iii)(B) because the State has a legitimate public policy reason not related to directing relative tax burden toward the Medicaid program for giving preferential tax treatment to the tax rate group for the type of provider in question.

As noted, the groupings discussed in the previous paragraphs exist for policy reasons outside of the context of taxation, indicating they were not created solely for the purpose of the tax and waiver under review. Conversely, a possible signal that a State is trying to exploit the loophole for a reason that is not tied to legitimate public policy would be the State's use of groupings that do not appear to have a connection to a reasonable policy purpose. This would indicate to CMS that we need to investigate further to determine if the State's proposal would lack a legitimate policy purpose and would impose disproportionate burden on Medicaid. Examples of groupings that could have a legitimate policy purpose include grouping providers within a permissible class by number of bed days for an inpatient hospital services tax and member months for managed care plan services tax. In these instances, the grouping uses health care-associated quantification measures. We note that this would not be the sole factor to determine whether a State has a legitimate public policy interest when establishing tax groupings; groupings like this would simply not raise the same red flags as groupings unrelated to health or tax policy.

An example of a grouping that does not appear to have a connection to a legitimate policy purpose (and that would prompt further inquiry) could include a feature of the physical plant of facility in question. For example, if a State was targeting a specific hospital with very high

Medicaid utilization, and that hospital was unique in having two separate exterior entrances to the emergency department, the State might construct inpatient hospital tax rate groups based on the number of exterior entrances to the emergency department. CMS might see this on review of a waiver submission, and it would prompt additional questions to the State as part of our typical practice of assessing waiver submissions to understand the rationale for assigning tax rates in this manner, because it is not evident how incentivizing hospital emergency departments through taxation to have (or not to have) a particular number of separate exterior entrances to the emergency department would advance a legitimate State public policy goal.

As stated, CMS does not intend for § 433.68(e)(3) to target any taxes other than those that utilize the loophole in the B1/B2 test. We explained in the proposed rule that we would apply this proposed provision narrowly, to reach only those situations where, based on considerations not related to a legitimate public policy goal as discussed previously, CMS determines that a State is attempting to mask that it is seeking to apply a higher tax rate based on a taxpayer's or tax rate group's Medicaid taxable units in a manner that, if it had been done explicitly, would violate § 433.68(e)(3)(i) or (ii).

The following is a summary of the public comments on the proxy provisions located at § 433.68(e)(3)(iii), and our responses.

Comment: Many commenters expressed concern regarding a perceived lack of clarity in the proxy criteria for terminology equivalent to Medicaid. Several commenters expressed concern with a lack of standards for how CMS will determine the "same effect as Medicaid" or what the agency will consider as constituting a proxy for Medicaid. Several commenters recommended CMS define explicit standards, outside of illustrative examples, for the proxy classification criteria in the final rule. These commenters sometimes noted that these standards would provide additional clarity on the provision. Several commenters stated that the vague standard for the proxy provisions would make State revenue sources less predictable since they would not know if CMS would consider their descriptions a proxy or not. In addition, a

commenter stated that because of the lack of clarity for the proxy provision States may not develop tax programs because their taxes could be disapproved retroactively. A commenter described the proxy as overly complex. Finally, some commenters stated that the ambiguity of the proxy provision will cause CMS to expend additional resources to determine if a tax rate group uses a proxy or not.

Response: We respectfully disagree with the commenters that § 433.68(e)(3)(iii) and its associated preamble language lacks clarity. While we acknowledge that we did not provide a comprehensive list of every possible way that States could design proxy language, which would not be a feasible task, we believe that the overall purpose and intent of the provision is clear. The regulation is intended to prevent States from circumventing the new, additional requirement to demonstrate that a tax is generally redistributive by creating provider group designations intended to be able to tax the Medicaid program more. This is not a baseless concern. There have been instances in the past where States have appeared to interpret Federal requirements in ways that, while not explicitly stated, may have had the effect of circumventing clear Federal statutes and regulations. For example, the permissible classes upon which States may impose health care-related taxes are listed at section 1903(w)(7) of the Act and § 433.56. States may not impose a health care-related tax upon health care items and services other than those listed in those places without experiencing a penalty spelled out in statute at section 1903(w)(1)(a)(2) of the Act and § 433.70(b). A health care-related tax, as defined by section 1903(w)(3)(a) of the Act and § 433.55, in part, is a tax where at least 85 percent of the burden falls on health care providers, or under which the treatment of individuals or entities providing or paying for health care items or services is different than the tax treatment provided to other individuals or entities. In the past, there have been instances where States have structured broad taxes in ways that included health care items or services (as well as non-health care items and services, and non-health care providers) which, when the health care items and services included in the tax are considered independently, did not meet the criteria for a permissible tax class under Federal

requirements. After identifying such arrangements, we issued a letter to all States reminding them of statutory and regulatory requirements, outlining future compliance expectations, and issued a disallowance to one State to enforce compliance that continued non-compliance even after the all-State letter.[22] Without the proxy provision we are finalizing at § 433.68(e)(3)(iii), States may likewise attempt to circumvent Federal requirements on health care-related taxes by describing Medicaid without using the word Medicaid for the purpose of evading the additional requirements to demonstrate a tax is generally redistributive. We use the word "defined by" in § 433.68(e)(3)(i) and (ii) to encompass only those situations where the State uses the word Medicaid or its State-branded equivalent (that is, the proper name of the State's Medicaid program and/or State Medicaid agency). We do not wish to leave the door open to this kind of manipulation.

Regarding the request to provide "explicit standards" outside of illustrative examples, as noted, such a list would be impossible to create. The proxy provision precludes States from adopting synonyms for Medicaid without using the word Medicaid to evade the additional requirement to demonstrate a tax is generally redistributive. There may be innumerable ways someone could describe something without using the proper name of the thing itself, but achieve the same effect. Any attempt to produce a definitive list would be inherently incomplete. We disagree that States would have uncertainty or confusion about whether a tax violates the proxy provision or not. States that develop a proxy for Medicaid would do so to circumvent the additional requirement to demonstrate a tax is generally redistributive. Because of this, these States would, necessarily, be aware that the proxy provision could apply to their tax rate group. By contrast, if a State begins with a legitimate public policy purpose (as discussed earlier in this preamble) in mind when designing its tax program, we expect that that purpose will be evident

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22 *SHO #14-001*, "Health Care-Related Taxes," issued on July 25, 2014, available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-001.pdf.

on the face of the State's waiver request or will be elaborated during our collaborative waiver review process, such that the State need not be concerned that its tax program design would be regarded inaccurately as a proxy for targeting disproportionate tax burden to Medicaid. If States have additional questions about how the proxy provision may affect them, we encourage States to request technical assistance from us.

While we appreciate the commenter's concern for the time and resources that our staff will spend implementing the new proxy provision, the addition of the provision will not substantially increase the workload that we already have when processing waiver requests. We currently engage with States on a wide variety of issues related to their health care-related tax waiver submissions, and as stated, the information we would gather to make our assessment is part of this standard work.

Comment: A few commenters expressed concern that the proposed provision would create confusion for States looking to modify existing or design new provider taxes and would allow the agency to alter what it would consider to be a proxy. A few commenters noted this rule moves away from the reliance on statistical tests to determine broad-based and uniform waiver compliance. Some commenters expressed specific concern that the rule is directly in contrast to the agency's original implementation of the B1/B2 and P1/P2 tests. A commenter urged CMS to base proxy determinations solely on data rather than subjectivity. A commenter expressed concern that the proposed rule would prohibit a long-standing Medicaid proxy terminology in the State's health care-related tax program even though the tax program's goal is to align Medicaid financing with delivery system needs. Another commenter urged CMS to allow States to demonstrate their compliance with this rule by using a comprehensive review process. A commenter believed the lack of objective standards may lead to an arbitrary application of this rule.

Response: We respectfully disagree with commenters who assert that the proposed provision would create confusion for States looking to modify existing or design new provider

taxes. If a taxpayer group is defined using proxy for Medicaid and has the same effect as § 433.68(e)(3)(i) and (ii), avoiding the word "Medicaid" in an attempt to evade the additional requirement to demonstrate a tax is generally redistributive, this would violate § 433.68(e)(3)(iii). Conversely, if it does not use a proxy in this manner (or have the same effect as § 433.68(e)(3)(i) and (ii)), it would not. We concede that the determination of what does and does not constitute a proxy under this provision necessarily lies with the agency. However, we have an obligation, in this and all requirements, to apply standards consistently. Therefore, we have attempted to provide as many examples and as much logic as possible to help States understand the standards we will apply.

We respectfully disagree with commenters that the rule, as a whole, moved away from statistical tests. States are still required to pass the P1/P2 or B1/B2 test as applicable. The regulations finalized in this rule are additive. Section 433.68(e)(3)(i) and (ii) rely on straightforward comparisons.

Section 433.68(e)(3)(iii) is not a statistical test because the novel element that paragraph (e)(3)(iii) introduces beyond the straightforward comparison is an assessment of language. There is no statistical test to determine whether an alternative description is being used to circumvent the additional requirement to demonstrate a tax is generally redistributive. However, although we anticipate many cases will be clear, this does not make the assessment somewhat subjective. As a result, we believe that the proposed approach offers flexibility to States while preserving the fiscal integrity of the Medicaid program.

We do not agree with the commenter that simply because the State has had "Medicaid proxy terminology" in place for a long time, that we should provide for some sort of waiver for this arrangement. First, while we are not currently aware of any States that exploit the loophole using proxy terminology to do so, States have not needed to use proxy terminology as the current regulations permit direct use of Medicaid terminology so long as the waiver passes the statistical test. Next, States will have adequate periods of transition outlined in the transition period of this

final rule. In addition to the transition period, we also issued a letter discussing the transition periods after the enactment of the WFTC legislation. These transition periods are described in greater detail in section II.D. We also believe that the commenter may be misunderstanding what constitutes a prohibited proxy methodology under § 433.68(e)(3)(iii). The rule does not prohibit States from adopting lower tax rates for provider groups that happen to have lower Medicaid utilization—provided there is a legitimate public policy reason unrelated to directing tax burden to Medicaid. For example, many States exclude nursing facilities services provided by CCRCs from nursing facility taxes based on non-Medicaid policy considerations. If the commenter wishes to receive a definitive assessment of their State's particular methodology, we will need to review the specific arrangement in detail.

We agree with the commenter that States and CMS should look at the entire tax program comprehensively when determining if a proxy is present as defined by § 433.68(e)(3)(iii). We believe that our rule as proposed does this. We disagree with the commenter that there is a "lack of standards" or that this will lead to arbitrary applications. While there does not, and cannot, exist a definitive set of elements that need to be present for the proxy provision to apply, we believe that the examples we have provided and the legitimate public policy purpose standard we have laid out in the proposed rule gives States an understanding of the rules that apply under this final rule and the amendments made by section 71117 of the WFTC legislation. Finally, we strive to consistently maintain equal treatment for all States, and we generally take into consideration past precedents in determining future action. We believe this approach provides a sound framework to prevent arbitrary application of Federal legal requirements while preserving necessary flexibility.

Comment: A few commenters urged CMS not to codify examples in regulation text, in particular examples of impermissible taxes, as it may lead to uncertainty or confusion.

Response: The aim of the examples provided in the proposed rule at § 433.68(e)(3)(iii) was not to provide a list of taxes that would definitively be either permissible or impermissible.

In general, we would need to examine the specific tax in question to make a definitive determination. Rather, these examples were intended to be illustrative of the types of taxes that may serve as proxies versus those that may not. We agree with the commenters that providing an exhaustive list of such proxies would not be possible. For this reason, we have declined to do so in this rule.

Comment: A commenter requested that CMS align the proposed rule with the WFTC legislation, specifically by replacing "any characteristic that results in the same effect" with "any description that results in the same effect." The commenter believed a "characteristic" of a tax design may be distinct from a "description" used within a tax design.

Response: We agree with the commenter's suggestion to align the regulatory language with the language in the WFTC legislation that uses the term "description" and not "characteristic," and we are finalizing that change. However, we do not believe that there is a substantive difference between the word "description" as used in the WFTC legislation and the word "characteristic" as used in the proposed rule. In the health care-related tax waiver narrative letters that States submit to us, they must describe to us the characteristics of their various tax rate groups for CMS to make appropriate determinations, so in practice these terms are functionally the same. However, we wish to clarify that the word "description" does not only include the words that the State uses in the letter but can also include any supporting information or documentation that it provides to us during our consideration of the health care-related tax in question. As a result, whether the regulation contains the word "characterization" or the word "description," the same result is achieved. States may not circumvent the additional requirement to demonstrate a tax is generally redistributive by using alternative language to achieve the same prohibited result as explicitly referencing Medicaid or its State-specific equivalent. To conform with the language of the statute, we are finalizing the language of § 433.68(e)(3)(iii) with a revision that replaces "characterization" with "description."

Comment: A commenter expressed concern that CMS identified teaching hospitals for

scrutiny as a tax rate group because they are defined based on criteria that mirror Medicaid eligibility or other defining characteristics.

Response: Section 433.68(e)(3)(iii) does not create a blanket prohibition on States establishing separate tax rates for "a particular provider type that is associated with high Medicaid utilization (such as State or other public facilities and university/teaching hospitals.). It also does not suggest that these facilities will be subject to any special scrutiny in and of themselves. The "teaching hospital" example in question would only be potentially problematic if a State places a higher rate on these facilities than on other facilities with relatively lower Medicaid utilization rates. This is because one could conceive how "teaching hospitals" would constitute a legitimate public policy purpose. States may continue to impose relatively lower tax rates on these providers (with relatively higher Medicaid utilization) or tax them at the same rate as other providers. Additionally, we remind commenters that there may not be a singular factor that will be dispositive of the existence of a proxy for Medicaid. Rather, we will analyze all available information, considering the overall design of the tax, provider classifications, and the practical effect of the tax across provider types. The goal is to ensure compliance with statutory and regulatory requirements—not to penalize providers or States for permissible rate structures that accomplish legitimate policy goals. We would likely need to examine the commenter's State's specific situation before making definitive determinations on the permissibility or impermissibility of any specific arrangement related to a health care-related tax.

Comment: A commenter expressed support regarding the interpretive leeway afforded to States and CMS' permission of certain instances of proxy terminology discussed in the proposed rule's preamble.

Response: We appreciate the commenter's support. We agree that these provisions afford States and CMS sufficient flexibility to address the application of the provisions to specific situations.

Comment: A commenter indicated there is room for interpretation in the provision and

commended CMS for allowing this interpretive space for nursing home provider taxes.

Response: We thank the commenters for their supportive feedback and agree that this standard provides States with some flexibility.

Comment: Many commenters expressed concern regarding the lack of clarity on the criteria used to determine legitimate public policies. Several commenters urged CMS to provide additional information about the process and criteria for defining legitimate public policy. Several commenters recommended CMS allow greater flexibility in defining legitimate public policy due to unintended ramifications the rule may have on legitimate public policies that may not meet CMS' standards. A commenter requested that CMS confirm that the definition of "legitimate" does not prescribe the nature, subject matter, or rationale of a public policy for the purposes of § 433.68(e)(3)(iii). Another commenter recommended that CMS revise the rule to define a tax as generally redistributive if it serves a legitimate public policy goal and suggested the specific factors CMS described for considering this determination should be codified in regulation.

Response: The term "legitimate public policy purpose" does not appear in the regulatory text of § 433.68(e)(3)(iii). Instead, we introduced this concept in the proposed rule preamble to provide helpful guidance to States in assessing when the provision may apply because we have determined that the State is using a proxy methodology to single out Medicaid. As a reminder, § 433.68(e)(3)(iii) only comes into play when two conditions are met. First, the State must create taxpayer groups defined without explicitly referencing "Medicaid" in the description of the taxpayer groups but using a proxy that nevertheless singles out Medicaid. Second, the State must impose a tax on a taxpayer group that has the same effect as § 433.68(e)(3)(i) or (ii). That is, there must be a higher tax rate on a taxpayer group that serves a generally higher level of beneficiaries in the Medicaid program. Acknowledging that inadvertent associations may result from permissible tax structures requires the analysis to determine whether the State is using a proxy methodology to single out Medicaid. This provision was designed to strike the

appropriate balance between fiscal oversight and State flexibility. We provided several illustrative examples of proxy descriptions that we believed may fall within the scope of this provision. We stated, "[o]ther possible examples of tax rate groups that States may wish to give a tax break to for policy reasons not related to directing higher relative tax burden to the Medicaid program include psychiatric hospitals and rural hospitals, among others." (90 FR 20589). We noted that States may want to give breaks to these types of facilities for what we called a "legitimate public policy purpose." We contrasted that with, "grouping that does not appear to have a connection to a legitimate policy purpose."

Our intent is not to restrict States from offering any tax breaks or exclusions to providers with relatively low Medicaid utilization, as long as those decisions are based upon legitimate public policy considerations; where they are, we anticipate that we would not determine that the State is using a proxy in the manner prohibited by § 433.68(e)(3)(iii). However, if a State creates a tax rate group that does not have a legitimate public policy justification and that was created solely for the purpose of designing a health care-related tax that exploits the Medicaid program, we may consider such a grouping a proxy for Medicaid taxable units or utilization.

We do not believe that it would be possible to provide a comprehensive list of "legitimate public policy purposes" as suggested by the commenters. States may have a wide variety of legitimate policy purposes in mind that relate to different State circumstances. These factors could relate to differences in public health priorities, State fiscal administration, or the health insurance marketplaces in respective States. For example, some States may have more tribal health considerations, others may have more rural health concerns, others may have more urban health concerns. We have frequently encountered differences among States regarding how they spend money on their Medicaid programs, which programs they choose to fund, in what amounts, and using what methodologies. We believe that it would be overly prescriptive and not sufficiently respectful of States' prerogatives and the principles of cooperative Federalism to provide States with a list of such principles. Additionally, we generally defer to States when

judging the legitimate nature of their public policy purposes unless we have specific reasons to question them. If a State's justification is rational and does not appear to be designed to avoid complying with a Federal requirement, we are likely to accept it. Our goal is to ensure that health care-related taxes for which a waiver is approved are generally redistributive in nature, as required by statute. Within that framework we are committed to providing States with as much flexibility as possible.

The use of the word "legitimate" is not meant to be a value judgement on the sagacity of a State's choices in its public health and other public policy priorities. We are aware that States have many, often competing priorities within the State when it comes to their Medicaid programs and serving their Medicaid beneficiaries. As the entity that is generally more familiar with the local concerns, the State has invaluable insight in determining its public health and other public policy priorities. As a result, States are free to balance these interests against one another and make decisions that are in the best interests for their populations, provided that they stay within the confines of Federal law and regulations. The term is intended to contrast with a tax rate group created for the purpose of enabling the State to circumvent the requirement to demonstrate a tax is generally redistributive located at § 433.68(e)(3)(i) and (ii).

We do not believe that "legitimate" requires a specified definition in this context separate from its plain language meaning, as we are using it descriptively rather than as a term of art. It is an actual, real, not fictional, group that a State has a public policy or public health reason to treat in a certain way. It is not something contrived or spurious that has been concocted or fabricated for the purpose of evading the requirements to be generally redistributive. We also believe the preamble is the appropriate place for this discussion and decline to adopt the commenter's suggestion to add the legitimate public policy considerations to the regulation. We do not want to be overly restrictive to States by adopting a special definition of what "legitimate" is. If CMS defined the term in regulation, this would constrain States more than necessary. In order to preserve State policy flexibility, we have decided to not include such a definition in the

regulatory text.

Comment: When considering if something is a "legitimate public policy" purpose, a commenter suggested that CMS should focus on allowing States to determine that a given provider tax structure supports access, continuity of care, and Medicaid providers in underserved areas. Another commenter suggested that States be allowed to tailor tax rate groups specific to their State.

Response: We agree with the commenter that access to care is a critical consideration for the future of the Medicaid program. In addition, we agree with the commenter that, in certain instances, access to care may be a "legitimate public policy purpose" that the State uses to define its tax rate groups. For that reason, we gave several examples of providers that are critical in maintaining access to care in the proposed rule, such as sole community hospitals and psychiatric hospitals. In addition to access to care, States may have other purposes such as quality of care and efficiency of care. These are just a few of several legitimate public policy purposes that States could point to in this situation. What matters is not what order the State places for its healthcare or other public policy priorities, but that the purpose itself is legitimate and not contrived for the purpose of evading the requirement to demonstrate a tax waiver is generally redistributive. Finally, we agree with the commenter that States often may tailor tax rate groups in line with legitimate public policy priorities specific to their State, provided they do not violate any Federal requirements. States have considerable leeway in this matter as long as they do not violate Federal statute and regulations.

Comment: A few commenters recommended CMS allow States to demonstrate policies aligning with public policy goals and promoting objectives of the Medicaid program.

Response: We appreciate the commenters' recommendation, which aligns with our standard review practices. In cases where we have questions or concerns about the tax rate for a specific tax rate group, we would generally follow the approach suggested by the commenters and provide States the opportunity to explain the rationale behind their tax structure. If a State

can demonstrate that its policy supports legitimate public policy goals, certainly including Medicaid program goals, and presents a clear and reasonable rationale, we will consider this explanation when making its determination. Additionally, we note again that there may be no one dispositive factor, but a combination of multiple factors taken as a whole that are likely to guide our determination on the applicability of § 433.68(e)(3)(iii) to a specific tax rate group. We encourage States to provide us with detailed and relevant information that supports their position, while avoiding unnecessary or excessive documentation that may not aid in the evaluation.

Comment: Many commenters agreed with preamble language regarding tax structures relevant to skilled nursing facilities, community hospitals, intermediate care facilities, and rural hospitals that may be permissible when designed to advance a legitimate public policy purpose.

Response: We appreciate the commenters' positive feedback and support. We attempted to provide a list of illustrative examples of legitimate public policy purposes in the proposed rule. We are glad that commenters found the examples helpful. Our goal was to clarify that we do not intend to interfere with a State's efforts to promote important policy objectives—such as supporting access to care in rural areas or for populations with specialized needs—so long as those efforts are not designed to circumvent Federal requirements. We will continue to consider such legitimate policy goals when evaluating the permissibility of health care-related tax structures.

Comment: Many commenters requested similar consideration for tax structures relevant to a variety of facility and care types, including safety-net hospitals, teaching hospitals, essential hospitals, community health centers, emergency medical services, behavioral health facilities, and children's hospitals. A commenter suggested that CMS place these provider types in the text of the proposed rule as opposed to the preamble only, which we presume meant placing the provider types in regulation text as opposed to the preamble only.

Response: As we noted in the proposed rule, the examples provided were intended to be

illustrative only. They do not represent a comprehensive or exhaustive list of permissible groupings. We remain committed to work directly with States to evaluate their specific tax structures. We encourage States to seek technical assistance early in the process if they are unsure whether their proposed tax structure could be affected by § 433.68(e)(3)(iii). While the rule includes illustrative examples of provider tax rate groupings, these were not intended to represent a definitive list of "permissible tax groupings." Rather, the examples reflect groupings that we have observed in the past and that, based on prior experience, generally have not raised concerns under the standard described in § 433.68(e)(3)(iii)—specifically, the prohibition on using tax rate group descriptions as a proxy for low or high Medicaid taxable units or utilization to circumvent the additional requirement to demonstrate a tax is generally redistributive. In addition, the main focus of the provision is not to provide examples of groupings that would be permissible, but to provide a list of groupings that would likely be impermissible if used as a proxy for Medicaid utilization. As a result, we decline to include specific types of "legitimate" provider groupings in the text of the regulation as suggested by the commenter.

Comment: A few commenters recommended CMS leverage their proposed definitions to conduct a 1-year, data-driven analysis of current health care-related tax revenue allocation. The commenters pointed out that there is often a disconnect between the sources of non-Federal share, including health care-related taxes, on the one hand and the programs that the payment actually funds on the other. The commenter stated that further study is needed in this area.

Response: We conduct oversight to trace the flow of funds from health care-related taxes to the actual payment mechanisms that they fund when reviewing State payment proposals. These include asking States to tie their taxes to specific State plan amendments and State-directed payments that are funded by the tax. In addition, we have asked States to provide dollar amounts paid to providers funded by the health care-related tax for which they are requesting a health care-related tax waiver. However, while we support enhanced data collection and payment transparency, the goal of the commenter to tie the sources of funding more directly to

the sources of non-Federal share is beyond the scope of the present rule. We remain committed to close collaboration with States and other interested parties to ensure compliance with the regulation and to support transparency in how health care-related taxes are designed and implemented.

As a result of the public comments, and based on section 71117(a)(1) of the WFTC legislation, which added the proposed language of the regulation with limited changes as section 1903(w)(3)(E)(iii)(III) of the Act, we are finalizing § 433.68(e)(iii) as proposed with the minor modification of substituting "description" for "characterization."

D. Permissible Health Care-Related Taxes – Transition Period (§ 433.68(e)(4))

We made every effort to ensure the impact of the proposed rule would be limited to those health care-related taxes that exploit the statistical loophole. Moreover, we understand that the updated requirements proposed in previous sections of the proposed rule and now finalized in this rule will require those States with such taxes to modify or end them to prevent a reduction in medical assistance expenditures eligible for FFP. Our aim is to close the loophole as soon as possible, while acknowledging State circumstances. Therefore, we proposed to provide a transition period only for those States with currently approved tax waivers that exploit the loophole that would be out of compliance with § 433.68(e)(3) that have not received the most recent approval within the past 2 years. We had also sought comment on various alternatives (discussed in more detail later in this section), including whether to provide different transition periods based on permissible class, or a transition period that is longer than 1 year for taxes that qualify for a transition period, or no transition period for all tax waivers that exploit the loophole. We are finalizing alternatives to the proposed transition periods to distinguish MCO taxes that exploit the loophole from other permissible classes and to provide additional time, given the relatively recent release of guidance, discussed in the next paragraph.

On November 14, 2025, CMS released a "Dear Colleague" letter[23] providing guidance to States on the provider tax provisions in the WFTC legislation, including the transition periods for section 71117 the Secretary was permitting, as authorized under the WFTC legislation. This letter stated that tax waivers in the MCO permissible class would have at least until the end of the State fiscal year that ends in 2026 to comply with the new requirements added by the WFTC legislation. Taxes within all other permissible classes would have until the end of the State's fiscal year that ends in 2028. We are finalizing policies that in all instances provide as much, and sometimes more, time than the transition parameters in the "Dear Colleague" letter. Table 1 sets forth the compliance dates (that is, the timeframe by which a tax must comply), based on transition periods finalized under this final rule:

TABLE 1: Compliance Dates Based on Transition Periods for WFTC legislation and This Final Rule

Tax Permissible Class	Most Recent Waiver Approval	Compliance Date
MCO	2 years or less	January 1, 2027
MCO	More than 2 years	State Fiscal Year 2028
Non-MCO	Any length of time	State Fiscal Year 2029

Consistent with the other policies finalized in this rule, this will not affect any non-loophole taxes. The transition period length will be the length of time between the effective date of this final rule and when the State's health care-related tax waiver that no longer conforms to regulatory requirements would have to be modified or discontinued to avoid a reduction in medical assistance expenditures. The compliance date, in turn, represents the time after the transition period, when a State must be in compliance. We proposed to determine eligibility for a transition period based on the most recent approval date of the waiver in which the State utilizes the loophole.

We invited comment on the length of time since a waiver was most recently approved

23 Available at https://www.medicaid.gov/medicaid/downloads/providertax_dcl_11142025.pdf.

and the time of the transition period applicable to those lengths of time, including whether the transition periods should be shorter or longer, and specifically whether the lengths of the transition periods should be adjusted to account for States that have a 2-year legislative cycle (see related discussion later in this section). We also solicited comments on whether the final rule should instead include transition period lengths for each category of State waivers by permissible class, such as different lengths of time for inpatient hospital taxes versus MCO taxes.

We also invited comments on whether different permissible classes would be more or less burdensome to rectify a tax waiver that utilized the loophole. We did not receive any comments on this request for feedback. While we did not distinguish between MCO and non-MCO taxes in the proposed rule, we did discuss as an alternative policy under consideration whether different transition period lengths should be given for MCO taxes and taxes on other permissible classes (90 FR 20591). Due to how interrelated many of the comments on this section were, we respond to all comments received on the transition periods and proposed alternatives at the end of this section.

First, we specifically proposed that States with health care-related tax waivers that do not meet the requirements of paragraph (e)(3), where the date of the most recent approval of the waiver that violates paragraph (e)(3) occurred 2 years or less before **April 3, 2026**, would not be eligible for a transition period. Any collections made under that waiver following **April 3, 2026** could have been subject to deduction from medical assistance expenditures as described in § 433.70(b). For example, if a State's most recent approval for a tax loophole waiver was received on December 10, 2024, under our proposal, regardless of permissible class, the State's waiver would no longer be valid on April 3, 2026 under this policy, because the effective date is less than 2 years after December 10, 2024.

We did not propose a transition period for waivers with the most recent approval date 2 years or less before the effective date of the final rule for several reasons. States that fall into this category obtained their most recent approval knowing that CMS intended to undertake

rulemaking in this area, as was communicated in a companion letter with their approval. We recommended that impacted States carefully consider how to mitigate or avoid possible challenges that could result from rulemaking. Although this circumstance could be administratively burdensome for States to address, an affected State would have risked that burden by requesting the exploitative waiver, and by not taking corrective action sooner, and with no guarantee of any type of transition period. Under the policies finalized in this rule, these taxes will now have a transition period that ends December 31, 2026. In other words, the tax would need to comply with the new requirements by January 1, 2027. Disallowances for taxes that remain noncompliant with the requirements of this final rule may have associated revenues deducted from expenditures eligible for FFP, starting with revenues collected on the first day after the end of the transition period. As noted, for this first transition period, that date will be January 1, 2027. As discussed previously in this final rule, the transition periods finalized in this rule, in all instances, either maintain or add to the transition parameters in the "Dear Colleague" letter. This is also more generous than the proposed rule, which proposed no transition period for these taxes with recently approved waivers.

Second, we proposed that States with health care-related tax waivers that do not meet the requirements of paragraph (e)(3), where the date of the most recent approval of the waiver that violates paragraph (e)(3) occurred more than 2 years before April 3, 2026, must either submit a health care-related tax waiver proposal that complies with paragraph (e)(3) with an effective date no later than the start of the first State fiscal year beginning at least 1 year from April 3, 2026, or otherwise modify the health care-related tax to comply with this rule and all other applicable Federal requirements with an effective date not later than the start of the first State fiscal year beginning at least 1 year from April 3, 2026.

Under this final rule, MCO taxes that exploit the loophole with approvals more than 2 years before the effective date of the final rule will still have until their first State fiscal year beginning at least 1 year from April 3, 2026, as proposed. For example, if a State's last waiver

approval for an MCO tax was more than 2 years prior to April 3, 2026, and the State's fiscal year begins April 1, 2026, the final day of that State's transition period is March 31, 2027, and that State would need to submit a compliant health care-related tax waiver, or otherwise address the tax waiver's noncompliance, with an effective date no later than April 1, 2027. The regulatory language we are finalizing now reflects that this transition period is specific to MCO taxes approved more than 2 years before the effective date of the final rule.

We believe providing at least 1 full State fiscal year for MCO taxes with a most recent approval of more than 2 years before the effective date of the final rule is an appropriate timeframe for several reasons. As discussed in the proposed rule, we considered that past rulemaking that involved transition periods often had longer transition times in consideration of States that might have biennial legislative sessions. Out of all the affected States (that is, States that have currently approved tax waivers that take advantage of the statistical loophole and do not comply with paragraph (e)(3)), all States have annual legislative sessions, which should give them sufficient time for their respective legislatures to enact any necessary changes. There is one State that has a biennial budget cycle, and this State will receive a transition period of at least a full State fiscal year. Also, we noted that § 433.72(c)(2) specifies that a waiver will be effective for tax programs commencing on or after August 13, 1993, on the first day of the calendar quarter in which the waiver is received by CMS. For instance, in the event of an April 1, 2026, effective date for the final rule, a State with a 1-year transition period and a State fiscal year that begins July 1 would have until September 30, 2027, to submit a waiver package with an effective date of July 1, 2027. In this case, the State has nearly 3 extra months to submit a compliant waiver. Depending on when a State's fiscal year begins relative to this rule's effective date, a State eligible for the transition period may have approximately 2 years to remedy a noncompliant tax waiver under our policy.

We are modifying this final rule from the proposed to generally align with (and in some cases, add to) the transition parameters in the "Dear Colleague" letter, consistent with alternative

transition policies discussed in the proposed rule. As reflected in Table 1, the last category of taxes affected by this rule, non-MCO taxes, will have until the end of the State fiscal year that ends in calendar year 2028 to bring their taxes into conformity with the new Federal requirements. This maximum allowable time is different than the proposed rule and consistent with what was communicated in the "Dear Colleague" letter. Following the enactment of section 71117 of the WFTC legislation, when deciding whether and in what capacity to grant a transition period under the section 71117(c) authority, we determined it was appropriate to provide additional transition period time for non-MCO tax waivers that exploit the loophole. In our work with States to identify and understand the taxes that exploit the statistical loophole, we have found that the most egregious examples of shifting the burden of financing Medicaid to the Federal government exist in MCO taxes. As just one example, one approved MCO tax waiver that exploits the loophole imposes a rate on Medicaid taxable units that is 117 times higher than comparable commercial business. Conversely, a hospital tax that exploits the loophole taxes Medicaid 3.5 times higher than comparable commercial business. As such, CMS oversight prioritized quickly identifying MCO taxes that appear to exploit the loophole, and we have expressed concerns to States with such taxes, in most cases before State implementation of the loophole tax. Consistent with CMS' findings that MCO taxes are the permissible class of tax that most commonly implicates the loophole, we believe that shorter transition period for such taxes is necessary to allow States and CMS to remedy the most egregious MCO-taxes.

We also stated in the proposed rule that States with new tax loophole waiver proposals pending before CMS as of the effective date of this final rule would not be eligible for a transition period. This remains true in the final rule and is consistent with the transition period policy discussed in the "Dear Colleague" letter. Additionally, we note that after the July 4, 2025, enactment date of the WFTC legislation, CMS does not have authority to approve taxes that use the loophole closed by section 71117 of the WFTC legislation, and this final rule. In the time since the proposed rule, we have received another tax waiver request that proposes a tax that

exploits the loophole. We noted in the proposed rule that in the event that additional States submit waivers that exploit the loophole, and these waivers were approved prior to the effective date of this final rule, CMS would issue a companion letter with their tax waiver approval letter, and the State would not receive a transition period for its tax. This recently received loophole tax waiver request is still pending. As just noted, due to the passage of the WFTC legislation, CMS is unable to approve the waiver. The waiver is also not eligible for the transition periods that are being implemented via this final rule or that are discussed in the "Dear Colleague" letter.

We previously signaled in the November 2019 proposed rule that this is a policy area we wanted to address. As part of our standard health care-related tax waiver approval letters of the broad-based and/or uniformity requirements, CMS informs States that "any changes to the Federal requirements concerning health care-related taxes may require the State to come into compliance by modifying its tax structure." Given that CMS has signaled it intended to address the loophole in the November 2019 proposed rule, health-care related tax waiver approval letters, and the proposed rule, we believe that States should be sufficiently aware of our intent to make changes in this area and their responsibility to adjust accordingly.

Furthermore, of the seven States with existing loophole waivers that we have identified as of the date of the proposed rule, four have been issued companion letters with their most recently approved tax waiver letters, and all four waivers have approval dates within 2 years of this final rule's effective date. These companion letters were intended to formally notify these States that we viewed their tax structures as problematic and intended to address the issue through notice and comment rulemaking soon.

There are three States that have not been issued companion letters that we expect to be affected by this final rule. Given CMS' actions described previously in this final rule, we believe that they should still be sufficiently informed through previous actions that signaled our intent to address the loophole issue; moreover, we have communicated with these States directly, as part of our standard practice of offering technical assistance to States. These States also will all be

eligible for longer transition periods under the policies finalized in this rule, with none receiving the shortest transition period. Likewise, we are offering technical assistance to all States that we anticipate might be impacted by this rule to ensure all are aware of the requirements and timeframes and will be well positioned to meet them.

Regardless of the length of transition period a State will receive for its waiver, we will consider a tax waiver proposal to be in compliance with the requirements in this rule if (and when) the tax in question is generally redistributive as described in section 1903(w)(3)(E)(ii)(I) of the Act and § 433.68(e). We note that the proposal would also need to meet all other requirements for tax waiver proposals and health care-related taxes in general, which still includes the P1/P2 test and B1/B2 test, where applicable, in addition to the new requirements in paragraph (e)(3). It does not mean CMS will automatically approve a waiver renewal or amendment request. CMS will still closely examine any renewals or amendments associated with taxes that exploit the loophole for any other violations of statutory and regulatory requirements, including hold harmless. CMS routinely provides technical assistance to States prior to the formal submission of a tax waiver proposal and would provide similar assistance to affected States upon request.

Rather than ending health care-related tax waivers that do not meet the requirements of this final rule and section 71117 of the WFTC legislation, States are also permitted to adjust the taxes in question in such a way as to be compliant with Federal requirements without needing to submit a new tax waiver proposal. Specifically, States are permitted to make the structure of a tax uniform, which would then not require the submission of a new tax waiver (on the basis of uniformity; a tax that is not broad based would still require a waiver). For example, a State may wish to adjust its tax to be imposed on all non-Federal, non-public entities, items, and services within a permissible class and to be applied consistently in amount/rate across all taxable units. The tax would also need to comply with the hold harmless provisions specified at § 433.68(f), but we would consider such a tax to be broad-based and uniform, and it would not require a

waiver at all. CMS intends to monitor the individual circumstances of States that would be affected by this rule to ensure that affected taxes have been amended if we do not receive a new tax waiver request for review and approval. As another example, a State could make a uniform change to a tax, while still not making the tax uniform overall, without requesting a new waiver. A uniform change might be a change to a tax that reflects the same percentage tax rate change for every tax rate group of providers. However, we note that based on the scale of the difference in rates in loophole taxes, it may not remedy the loophole issue to change the tax uniformly.

As stated, this rule is not intended to be disruptive to States' health care-related tax programs. We acknowledge that this rule will require some States to make changes, with different applicable timeframes. However, we believe the rule will likely have a minimal impact on the total amount of tax revenue States could collect because a State's ability to collect taxes will remain unchanged. In other words, affected States would have the opportunity to modify their existing taxes to come into compliance with all requirements and maintain the same or similar level of revenue collection, if that is the State's policy choice. Further, it is possible that tax waivers that exploit the loophole that are modified to comply with the proposed rule would result in increased financial benefit to taxpayers that serve relatively high percentages of Medicaid beneficiaries because those taxpayers would no longer bear a disproportionate tax burden in relation to taxpayers that serve relatively lower percentages of Medicaid beneficiaries.

Finally, we proposed that, once the transition period for a tax waiver that qualifies under paragraph (e)(4) has expired, CMS may deduct from a State's medical assistance expenditures revenues from health care-related taxes that do not meet the requirements of paragraph (e)(3) as specified by section 1903(w)(1)(A)(iii) of the Act and § 433.70(b). Under § 433.70(b), CMS can deduct from a State's medical assistance expenditures, before calculating FFP, revenues from health care-related taxes that do not meet the requirements of § 433.68. However, we assured States that payments made with revenue collected during the transition period in accordance with an approved existing tax waiver that exploits the loophole would not be subject to disallowance

on the basis of these new regulatory requirements.

We proposed multiple alternatives to the transition period policies proposed in this section. First, we proposed, alternatively, that waivers that do not comply with proposed § 433.68(e)(3) approved within the past 3 years before the effective date of the final rule would not receive a transition period. As compared to the proposed policy, this 3-year period would include an additional, currently approved tax waiver that exploits the loophole, for a total of five loophole tax waivers that would not receive a transition period, instead of four waivers. We did send a companion letter with the most recent approval for this additional loophole tax waiver, so under this alternative transition period, all States with loophole tax waivers that would not receive a transition period still would have received a companion letter expressly notifying the State of our concerns about its tax structure with the most recent waiver approval. We further proposed, alternatively, to extend this either 2 or 3-year timeframe since the last approval as may be needed in the final rule to capture the four most recently approved loophole tax waivers (if we finalized a 2-year transition period) or five most recently approved such waivers (if we finalized a 3-year transition period), to ensure that these specific waivers (with which most recent approval we sent the State a companion letter) do not receive a transition period. Finally, we considered an alternative to our proposal of no transition period for more recently approved loophole tax waivers and a 1-year transition period for loophole tax waivers with longer-standing most recent approvals. Specifically, we alternatively proposed to offer no transition period for any loophole waiver, regardless of the time since the most recent approval of the waiver. Next, we alternatively proposed that loophole waivers approved in the 2 years (or 3 years) before the effective date of the final rule would receive a 1-year transition period instead of no transition period, and the longer-standing most recent waiver approvals (more than 2 or 3 years before the effective date of the final rule) would receive a 2-year transition period. We discussed previously the transition periods outlined in the "Dear Colleague" letter, as well as the modified transition timeframes provided to States for their waivers to come into compliance with the new

Federal requirements under this final rule.

We invited comments on the transition periods, including whether any of the proposed cutoff timeframes and/or transition period lengths should be shorter or longer. We also invited comments on whether any of the policies in the proposed rule would be disruptive to existing State tax waivers that do not exploit the statistical loophole. The following is a summary of the public comments on the proposed transition periods and our responses:

Comment: Almost all those who commented on the transition period section did so to indicate that the transition periods were insufficient. Many of these commenters also disagreed generally with the proposed bifurcation of transition periods. Several commenters stated that the proposed transition periods seem arbitrary and do not provide adequate time for States to transition. A few commenters stated the transition period must minimize harm to providers and Medicaid beneficiaries. Several commenters recommended a transition period that provides States with a reasonable or adequate amount of time to comply with the proposed requirements. Many commenters that requested CMS provide longer transition periods, such as the 3 years authorized in the WFTC legislation, pointed to prior transition periods CMS had afforded to States. A few commenters pointed to the DRA of 2005 and suggested CMS adopt a similar 48-month compliance period. A few commenters stated that CMS had historically incorporated longer transition periods such as a 10-year phase out of pass-through payments from 2016 through 2027. A few commenters stated that CMS had provided 3-year transition periods in last year's Medicaid managed care final rule regarding State-directed payments. A few commenters stated that when CMS changed its method of calculating upper payment limits in 2001, CMS provided transition periods of 3, 5, and 8 years depending on the length of time a State had its approved amendments in place. A few commenters suggested varying lengths of time such as a 5-year transition period. A commenter recommended a 10-year transition period and a commenter recommended a 3- or 4-year transition period.

Many of these commenters stated that without longer transition periods, States would be

unable to revise their provider tax structures, resulting in reduced provider services and reduced access to care for beneficiaries. Several commenters stated that the financial stability of hospitals and hospital services would be impacted, and a few commenters specified that safety net hospitals would be particularly affected by the proposed rule. Commenters stated that the financial pressure would lead States to implement changes that adversely impact Medicaid beneficiaries and providers, such as restricting Medicaid coverage, and cutting services and programs. Some commenters that expressed concern about how this would affect hospitals and nursing homes stated it would be particularly felt in rural areas.

Response: We understand the concern about the length of time affected States will have to remedy their tax structure to no longer exploit the loophole. However, as we described in the proposed rule, we want to emphasize again here that impact of this rule is on a narrow subset of taxes that collect revenue via a structure that is not generally redistributive. The circumstance with this policy is distinct from other transition periods referenced by commenters, which were implemented as the result of large programmatic changes. In contrast, with this final rule, we are amending the statute to align with the text and intent of section 1903(w)(3)(E)(ii)(I) of the Act rather than implementing a significant change to Medicaid. The tax waivers that exploit the loophole and do not comply with the provisions of this final rule were inconsistent with the statute requiring taxes for which waivers are approved be generally redistributive in nature both before the amendments made by section 71117 of the WFTC legislation, and explicitly so after.

We also note there was nothing preventing a State from undertaking the necessary steps to change its tax. If a State chooses to reduce payments or services in response to this rule, then that State is making that choice knowingly in the face of other options. Nothing about this rule changes the ability of a State to collect revenue; rather, the rule ensures that a State's tax meets the statutory definition of "generally redistributive" as provided in section 1903(w)(3)(E)(ii)(I) of the Act. However, as discussed previously in this rule, we are finalizing transition periods that provide States additional time from what was proposed. We note that we do not have

statutory authority, under section 71117 of the WFTC legislation, to provide for any transition period over 3 fiscal years in duration, as was suggested by some commenters.

Comment: A few commenters recommended extending the transition period to 3 fiscal years to ensure adequate time is given to phase out non-compliant taxes without jeopardizing the stability of the Medicaid program, continuity of care and affordability of commercial coverage. The commenters stated that when adjusting tax programs to be compliant, States will have to increase tax rates for commercial health plans, which will increase premiums for individual market coverage. One such commenter stated that these increased tax assessments could result in insufficient premium rates that could place financial strain on health insurers and reduced health plan availability. The commenters opined that by allowing 3 years, States will be able to align changes to commercial plan taxation with individual and employer market rate cycles and avoid market disruption. The commenters stated that without sufficient transition, 2026 premium rates could be insufficient and lead to reduced health plan availability, with a commenter noting that insurers and State regulators are now finalizing 2026 premium rates in various markets. A few commenters suggested more generally that a transition period should be adequate to accommodate rate setting cycles and avoid disruptions to consumers in insurance markets in affected States.

Response: We appreciate the important and constructive feedback of the commenters who shared their concerns and experiences with us. We want to emphasize the assurance we provided in the proposed rule that this rule is narrowly tailored to affect only those State taxes that exploit this loophole and thus harm the stability of the Medicaid program. We further want to emphasize that all States impacted by this rule have engaged in this practice knowing it was not aligned with the intent of the Medicaid program and with awareness that we intended to remedy the situation, either due to the issue arising in prior rulemaking, or because we communicated with them directly about this during the most recent waiver approvals.

While we understand that the amendments in this final rule may not be ideal from the

perspective of some interested parties, the "generally redistributive" requirement is written in statute, and taxes that exploit the loophole discussed in the proposed and this final rule fail to meet this requirement. Furthermore, the many States and taxes that do not exploit the loophole serve as evidence that exploiting the loophole is not necessary to run a Medicaid program. As the Federal steward of Medicaid, we must ensure that all health care-related taxes comply with the Medicaid statute. In recognition of the changes that certain States will need to make to their taxes and the potential time required to implement those changes, we are finalizing transition policies that are more generous than those described in the proposed rule. Otherwise, we are finalizing the policies proposed, apart from minor wording changes, in order to protect the fiscal stability of Medicaid.

Comment: We received numerous comments regarding the authority for the Secretary to grant a transition period of up to 3 years in section 71117(c) of the WFTC legislation. Several commenters stated that allowing a transition period for States with waivers approved 2 years or less before the final rule's effective date was aligned with Congressional intent and specifically stated the WFTC legislation. Several commenters stated that anything other than alignment with the WFTC legislation for State transition periods would cause confusion and distress for hospitals, providers, and beneficiaries. A commenter added that the WFTC legislation did not contemplate the immediate termination of currently approved taxes. Many commenters requested that CMS use its authority under the WFTC legislation to afford all States with a transition period. A few of these commenters stated that aligning the transition period in the proposed rule with the transition period described in the WFTC legislation would provide States with a clear and consistent transition period, ensure complete compliance, and avoid serious budget impacts to those States with more recent waiver approvals.

Response: When the WFTC legislation was enacted on July 4, it was after the proposed rule had been published on May 15. The nearly exact overlap in language between the proposed regulations and the bill text demonstrates the legislative intent for the bill to align with what we

had proposed. As such, we want to draw commenter attention to the specific language of section 71117(c) of the WFTC legislation, which states "subject to *any* applicable transition period" (emphasis added). This language is not a requirement to establish a particular transition period, but merely the authority to do so. Section 71117(c) of the WFTC legislation goes on to state that the transition period is "not to exceed 3 fiscal years," rather than stating that the transition period must be 3 years. If we were required to provide 3 years, the plain text of section 71117(c) of the WFTC legislation would have reflected this intent. Instead, Congress granted the Secretary discretion to determine an appropriate transition period to be afforded to States.

As previously discussed, on [DATE], we circulated a letter to our State colleagues describing the transition period the Secretary was granting under the authority in the WFTC legislation, of at least through the end of the State's fiscal year that ends in 2026, and more in some instances. Our intent with the letter was to provide prompt notice to States about the minimum transition period the Secretary would offer under the WFTC legislation, while allowing us to finalize the transition period via the rulemaking process. There still remains the urgent need to make sure tax waivers no longer exploit the loophole. Therefore, we are finalizing that all affected health care-related taxes that exploit the loophole with waivers approved before July 4, 2025, will receive a transition period, and the length of that period will depend on the permissible class taxed and the length of time since the most recent waiver approval for that tax.

Comment: A few commenters stated that more time was needed so that States could obtain detailed technical assistance and guidance from CMS on the interaction between the proposed rule and the WFTC legislation. These commenters pointed out a potential conflict in which the proposed rule allows States to modify their provider taxes, but the moratorium in section 71115 of the WFTC legislation may prevent States from modifying their existing provider taxes. A commenter stated a longer transition period would allow States to obtain more guidance from CMS about what is permissible under the proposed rule.

Response: States with loophole taxes that need to modify their tax will be able to do so

without violating section 71115 of the WFTC legislation, provided that the tax meets all Federal statutory and regulatory requirements. Section 71115 of the WFTC legislation generally prevents new or increased provider taxes that would cause tax collection for a permissible class in a State to exceed the new indirect hold harmless threshold, but it does not prevent modifications. Moving forward, States will be able to adjust their taxes so long as they do not exceed the relevant tax collection limits. Therefore, we do not currently see a need for technical guidance on the interaction between these provisions, as they are not strictly in conflict.

Comment: Many commenters who recommended the need for a longer transition period cited the insufficiency of notice to affected States as a basis for this need. A few commenters stated that the companion letters sent with recent waiver approvals to States were insufficient notice for the proposed rule's provisions. Some of those commenters went on to say the letter indicated only an intent to develop new regulatory requirements but that those requirements were not specified. Other commenters stated that the companion letters were inconsistent with principles of fair notice and regulatory consistency. In their view, all States are informed at the time of approval that future Federal law changes may require prospective revision. Also, in their opinion, these documents did not provide the minimum necessary information States needed to make informed decisions, such as the possibility that CMS would not honor the already approved waiver timeframe, allow a transition period, or explain what States would have to do to bring the taxes into compliance if Federal legal requirements changed. Furthermore, some of these commenters added that setting these issues aside, those letters were not broadly disseminated to the public, so interested parties were not provided notice or an opportunity to comment.

A few commenters stated that the 2019 proposed rule is also inadequate notice to States that CMS intended to propose this rule due to the eventual withdrawal of the 2019 proposed rule and the amount of time that has passed since its publication. A few commenters stated that States could not have known when and exactly how CMS would update its statistical tests and the related regulatory criteria to assess provider tax waiver requests. A commenter stated that

pointing to a proposed rule from years earlier that was not finalized is not adequate or appropriate regulatory guidance.

Some commenters offered suggestions for how to mitigate the issue of notice to States. A commenter recommended waivers already in place, approved with or without companion letters, should remain active through the end of the transition period. A commenter stated that at a minimum, CMS should honor already approved waivers. A commenter also recommended CMS inform States if they have tax structures out of compliance after the finalization of this rule.

Response: We disagree with the commenters that noted that States have not had sufficient notice as to how we would address the loophole. As described previously in this final rule, we have communicated to States that we have intended to address the loophole, and we are finalizing this policy through notice and comment rulemaking. Between the proposed rule, the comment process, and the subsequent publication and delayed effective date of the final rule, we have met our obligations for notice and comment rulemaking. However, we do acknowledge that there are times we have delayed implementation, and often this is to mitigate administrative burden on States needing to make changes. For example, in the 2024 Ensuring Access to Medicaid Services final rule, we delayed implementation on many provisions, at different times, in recognition of the number of new requirements States would need to address and develop processes to implement in a rule of that scale. That is not the case in this final rule.

This rule finalizes a policy that reflects the conceptual basis that a tax must be generally redistributive. We emphasize again that this rule only affects a few States and their taxes. We also believe that the 2019 proposed rule, although not finalized or identical to this rule, provides a clear signal of our intent and our view that a tax is problematic if it is not generally redistributive within the meaning of the statute, even if it passes the B1/B2 test. It is not new information that we are announcing in this rule that those practices are not aligned with statutory intent, which has been made even plainer by the amendments made by section 71117 of the WFTC legislation.

Apart from issuing the companion letters to the States with the most recent approvals, we also discussed with them prior to the issuance of the approval that the tax exploited the loophole. We further note that, when the shortest transition periods granted in this final rule expires, States will have had almost a year or more than a year since the proposed rule, and nearly 9 months since the passage of the WFTC legislation.

In response to commenter concern, we want to assure that currently approved waivers for loophole taxes will remain in force and effect until the expiration of the applicable transition period. However, we want to further clarify that some tax waivers themselves do not currently have a specified expiration date that we would otherwise honor. We further note that we cannot honor an approved waiver, despite the fact that the waiver does not by its own terms specify an expiration date, if the waiver becomes inconsistent with Federal law due to subsequent statutory and regulatory changes. We also want to confirm that we intend to affirmatively notify (or more accurately, re-notify) affected States, and work closely with them to ensure timely compliance.

Comment: A few commenters agreed with CMS and stressed that States have had adequate notice and time to prepare for compliance. One such commenter went further to say no States should have a transition period. The commenter also stated that any delay in finalizing the proposed rule would allow further loophole utilization and qualify more States for the transition period than currently estimated. A few commenters expressed general support for having no transition period and immediately implementing the rule. A commenter stated their belief that no transition period would benefit the most vulnerable Medicaid populations.

Response: We appreciate the support of commenters. While we believe it may have been possible and appropriate not to offer a transition period, and proposed this as an alternative, we determined it would be most beneficial for all involved to focus on the most recent and most egregious tax waivers first. Although the passage of WFTC legislation addressed the concern about delays expressed by the commenter, we do note that in the proposed rule we addressed and accounted for no transition period for additional waiver submissions.

Comment: Several commenters appeared to share the same misunderstanding that CMS intended to apply these new policies retroactively. Several stated that it is common practice for tax "collections" to occur months (if not years) after a provider owes the tax. Thus, these commenters stated that the rule would penalize these States for not complying with requirements that were not in place at the time their waivers were approved, and it would effectively apply new regulatory requirements retroactively. A few commenters stated that CMS lacks the statutory authority to impose the proposed requirements retroactively, as section 71117(c) of the WFTC legislation requires CMS to apply them prospectively. In addition, a few commenters stated that the retroactive application they perceived in our proposed rule was not legally permissible under the APA, that it would be arbitrary and capricious under 5 U.S.C. 706(2)(A), and that it would compromise principles of fair notice, regulatory consistency, and good-faith reliance. In addition, a few commenters stated that while the US Supreme Court upheld a retroactive tax statute in United States v. Carlton, 512 U.S. 26 (1994), CMS cannot retroactively apply the proposed requirements as they fail both prongs of the Carlton test. A commenter stated that disallowing FFP for uncollected taxes would invalidate actuarial certifications. A commenter requested that financial penalties only apply to collections for taxes incurred after the effective date of the final rule, not retroactively. The commenter requested that CMS consider language that would limit the application of the penalty to collections of taxes incurred for those periods that occur after the effective date of the final rule.

Response: We want to clarify that the policies described in this rule will not be applied retroactively, nor did we propose that they would. The penalties will be imposed for revenues collected after the date by which a State needed to have its tax in compliance, which would be no earlier than the first day after the State fiscal year that ends in 2026. Even if the collection itself occurs later under the State's usual tax revenue collection processes, if the collection was made in accordance with a tax that was permissible with respect to the time period for which the revenue is being collected, it would not violate this requirement. Therefore, we would not

penalize that collection. For example, if a State collects tax revenue from providers in July 2026, after the effective date of the final rule, and the revenue collected is for taxable activity that occurred during the State's FY 2025, this would be permissible, as the tax was permissible at that time, before the effective date of this final rule.

We are concerned that several, discrete comments had the same incorrect interpretation that we intended to apply these requirements retroactively. We intend to work closely with affected States to determine if and why they believe a penalty, if applied, is retroactive, to clarify the effect of the final rule, as may be needed. Although we did not propose nor intend to apply these policies retroactively, we do not have full knowledge of all State revenue collection practices, and we welcome any additional information or requests for assistance.

Comment: A number of commenters opposed to the proposed transition periods referenced the specific need for State legislatures to have more time to act. Per these commenters, a truncated transition period fails to recognize the significant operational, regulatory, and legislative challenges States face in modifying complex tax and financing structures. These commenters added that changing these tax structures requires legislative action and time for the State legislatures to act. However, because the effective date of the rule is tied to the date when CMS finalizes the rule, these States may or may not qualify for a transition period depending on if/how quickly CMS finalizes the rule. Furthermore, they add, even if a State does qualify for the transition period, the effective date could fall in the middle or very close to the end of their fiscal year cycles when their legislatures are not in session. Therefore, some State legislatures may not have time to adjust to avoid the financial shortfall or find adequate alternative funding streams. Some commenters stated that this is particularly concerning for States with limited legislative calendars whose legislatures meet biannually.

Similarly, several commenters stated that the transition periods in the proposed rule would not be sufficient to allow time for States to work with CMS, their respective legislatures, and interested parties to gain support and approval of revised funding mechanisms. Several

commenters believed that longer transition periods were needed for States to navigate the complex fiscal and operational challenges involved in revising their provider taxes. A commenter stated that a voter referendum may be needed to require and implement the use of provider taxes. A commenter believed that the variation in State budget cycles underscored the need for an adequate transition period. Other commenters added that State agencies may also need to change their regulations, which will require engagement with interested parties, and time for drafting and commenting.

Response: We note that nearly every State affected by this rule has a legislature with an annual legislative cycle. We have also seen many cases where State legislatures convene special sessions to address urgent and pressing matters. Although we do not believe this situation will require States to convene special sessions, as States have been aware of the issue and could plan for this outcome, we realize that some States may end up in this position by choosing not to bring their loophole taxes into compliance with the new Federal requirements by the end of the applicable transition period under this final rule. We do not believe it is appropriate to continue this drain on the fiscal integrity of the Medicaid program by allowing ongoing cash windfalls to States so they can address this during a more relaxed schedule. We believe that the transition periods afforded in this final rule should provide sufficient time for States to adjust their health care-related taxes as needed.

Comment: Many of the general comments regarding the transition period section disagreed with treating certain States differently on the basis of how recently their waivers were approved, and stated that there should be transition periods for all affected taxes. Many commenters opined that the proposal to deny a transition period to some States was disproportionately burdensome for the affected States. Several commenters stated that CMS should provide all States with a transition period because treating States differently based on the date of approved waivers would be arbitrary, capricious, and unfair, with one saying it penalized those States unfairly for a policy that was not yet in place. Another commenter stated that it

would be equitable for CMS to provide all States the same transition period. A few commenters stated that denying a transition period to some States lacked a rational basis grounded in program design or policy impact. A few commenters stated that States acted in good faith when they received CMS approval for tax waivers and current policy structures allowing their provider tax structures. These commenters believe the relevant States should not be penalized with no transition period.

Response: The States that are receiving the shortest transition periods are not situated the same as those that are receiving more time. The States with shorter transitions have all received companion letters with their most recent approvals, and we engaged directly with these States during the waiver approval process about the loophole issue. These companion letters were intended to document formal notice to these States that we viewed their tax structures as problematic and intended to address the issue through future notice and comment rulemaking. However, as mentioned, before the issuance of the most recent approvals and the accompanying companion letters, we were communicating directly with those States about our concerns. Those States nevertheless made the decision not to modify or withdraw the tax waivers to ensure the ongoing cash windfall from the Federal government. Moreover, the most recent approvals have had the current revenue levels in place the least amount of time, and some are the result of new taxes or massive increases that greatly magnified the negative impacts of these loophole taxes and fundamentally altered the revenue a State would anticipate receiving. At no point in time have these States operated under the impression that the current funding levels were permissible or protected against imminent CMS action. It is for that reason we did not propose a transition period for the most recent waiver approvals. However, while we still stand by this reasoning, we have amended the transition periods in this final rule by giving a short transition period to those tax waivers that would have received none under the policy described in the proposed rule, to align with the "Dear Colleague" letter, which served to give a measure of certainty regarding the transition periods to States while CMS completed this rulemaking process. We believe that

aligning the duration of the transition periods in this final rule with those of the periods described in the "Dear Colleague" letter serves the best interests of the Medicaid program because alignment will help prevent potential confusion.

Comment: Many commenters expressed a need for more time specifically for those States that would not receive a transition. They cited reasons such as the length of time required to unwind or revisit existing tax structures and provider payment policies. These commenters stated that to develop provider tax or financing alternatives, it would take time to engage in interested parties' negotiations and obtain legislative approval as well as approval from CMS. A few commenters stated that not allowing a transition period would negatively impact non-Medicaid interested parties, too. A commenter stated that affected States may make hasty and suboptimal tax changes to ameliorate the lost funding, and that these changes could lead to higher commercial insurance premiums for individuals and employers. Another commenter stated that due to the reductions in Medicaid reimbursement rates, some providers may offset the financial losses by increasing the payment rates they charge to commercial plans and Medicare.

A few commenters stated that the proposal to deny a transition period to States with waivers approved 2 years or less before the final rule's effective date was particularly arbitrary considering that States do not know if or when CMS will finalize the rule. In their opinion, this would require States to preemptively dismantle, or redesign approved programs when the final contours of Federal policy are unknown. Some commenters similarly stated that it is unreasonable for CMS to expect that States should have already redesigned their tax programs to comply with requirements that are not yet defined.

A few commenters stated that not allowing a transition period unjustly puts these States in an extremely precarious financial position, as they would experience sharp budget shortfalls with serious and immediate impacts on their Medicaid programs and State budgets. They added that these States are at a major disadvantage because their waivers would be immediately out of compliance and the corresponding funding subject to deductions until they make the necessary

changes.

Response: As we stated in the proposed rule, it has been incumbent upon States to assess the risk of having a waiver deemed prospectively impermissible when determining whether to submit or proceed with a waiver request that exploits the loophole. The companion letters also made clear that we intended to act, but did not indicate there would be any type of transition period, so there was no reason a State should have chosen to maintain its exploitative tax structure on the belief of time to transition. The time to transition has already been occurring. To the extent this change results in a budget shortfall for a State, it will be the result of that State's budget being reliant on an inequitable funding stream from the Federal government, inconsistent with the statutory purpose and design. However, we also note that under the "Dear Colleague" letter and the transition periods adopted into this final rule affected States will have a transition period of a duration that is at least until the end of their respective State fiscal year that ends in calendar year 2026 whereas, under the proposed rule, we proposed that certain States would receive no transition period.

Comment: Many commenters stated that provider taxes are a critical source of funding for States. Additionally, because some affected States use or planned to use funds associated with tax waivers that exploit the loophole to increase payment rates for some providers/services, future provider reimbursement would likely be lowered. They stated this would be detrimental for the affected providers not only due to the loss of future funds, but also because they relied on the current or anticipated rate increases and have already made long-term decisions on staffing, equipment, and service capacity. Per these commenters, taken together, the cascading effect of an inadequate transition time would lead to State changes that introduce significant uncertainty and operational disruptions into Medicaid programs, and that will hinder access to care for Medicaid beneficiaries. In the case of a 1-year transition period, commenters expressed similar concerns, but also noted that payments are already unsustainably low, and this change would reduce them even further.

Several commenters stated that it was justifiable for States to rely on CMS honoring the waiver approval timeframe, and that States made meaningful budgetary and programmatic decisions accordingly. These commenters stated that these States' reliance on CMS' approval is no less valid simply because their waivers were approved more recently.

Response: We acknowledge that in many cases, the revenue generated from a tax and bolstered by the increased burden on the Federal government's share of Medicaid is used to fund additional payments to providers. However, it is the responsibility of the individual States to come into conformity with new Federal requirements under this final rule and the amendments made by the WFTC legislation, in a manner that is the least disruptive to their individual circumstances. Finally, we note again as discussed in a previous response that some waivers do not have an approval timeframe. They are open-ended approvals, where a new waiver is only required if a State wants to make a non-uniform change to the tax or if necessary to conform the tax to newly applicable Federal legal requirements. Therefore, in these cases there is not a waiver approval timeframe for us to honor. Any promises or assurances as to the timeframes for payment rates would be from States to providers.

Comment: A commenter suggested that if CMS decided to include a longer phase-out period for those States that did not receive separate companion letters, but whose waivers were approved in the last 3 years, that these States should immediately stop using funds for "FFP." This commenter also recommended a 1-year transition period for provider taxes approved more than 3 years ago.

Response: We appreciate the suggestion. As we understand it, the commenter was suggesting the transition period apply only with respect to the requirement to change the tax structure, such as by submitting a new waiver, but the State would not be permitted to use the tax revenue as its non-Federal share in the interim. Although we would support the goal to end the burden on the Federal government caused by the tax waiver that exploits the loophole as soon as possible, we believe it would add a layer of administrative complexity and furthermore, we did

not propose or otherwise contemplate this approach in the proposed rule. Therefore, we are not adopting this change.

Following review of public comments, we are finalizing the transition periods with modifications described.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 et seq.), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a "collection of information," as defined under 5 CFR 1320.3(c) of the PRA's implementing regulations, is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the proposed rule, we solicited public comment on each of the aforementioned issues for the following sections of the rule that contained collection of information requirements. We did not receive such comments, and therefore, are finalizing the burdens in this rule as proposed, with minor modifications to account for additional waivers.

A. Wage Estimates

To derive average costs, we used data from the US Bureau of Labor Statistics' (BLS') May 2024 National Occupational Employment and Wage Statistics for all salary estimates (https://www.bls.gov/oes/tables.htm). In this regard, Table 2 presents BLS' mean hourly wage,

our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 2: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Health care Support Worker	31-9099	23.44	23.44	46.88

As indicated, we adjusted our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. Collection of Information Requirements

The following sections of this rule contain collection of information requirements (or "ICRs") that are or may be subject to OMB review and approval under the authority of the PRA. Our analysis of the requirements and burden follow. For this rule's full burden implications, please see the Regulatory Impact Analysis under section IV. of this preamble.

1. ICRs Regarding General Definitions (§ 433.52)

We do not anticipate that any of the definition changes (adding and defining "Medicaid taxable unit," "non-Medicaid taxable unit," and "tax rate group") will result in the need for States to amend existing or create new State Plan or policy documents. Consequently, such changes are not subject to the requirements of the PRA.

2. ICRs Regarding Tax Waiver Submissions (§ 433.68)

The following changes will be submitted to OMB for approval under control number 0938-0618 (CMS-R-148).

Under the current regulations, States may submit a waiver to CMS for the broad-based requirements (all providers within a defined class must be taxed) and/or the uniformity requirements (all providers within a defined class must be taxed at the same rate) for any health

care-related tax program which does not conform to the broad based or uniformity requirements under § 433.68. For a waiver to be approved and a determination that the hold harmless provision (for example, guaranteeing to repay taxpayers the cost of the tax) is not violated, States must submit written documentation to CMS which satisfies the quarterly reporting and recordkeeping requirements under § 433.74(a) through (d). Without this information, the amount of FFP payable to a State cannot be correctly determined.

Uniformity Requirements Waiver: A State must demonstrate that its tax plan is generally redistributive by calculating the ratio of the slopes of two linear regressions, generally resulting in a value of 1.0 or higher. Under the changes in this final rule, States will still need to demonstrate this calculation, and the waiver proposal must reflect a tax that is generally redistributive under the requirements in new paragraph § 433.68(e)(3) (entitled, "Additional requirement to demonstrate a tax is generally redistributive").

This rule addresses an inadvertent regulatory loophole related to the current statistical test to ensure that taxes passing the test are generally redistributive. The loophole essentially allows States to shift the cost of financing the Medicaid program to the Federal government. As indicated in section II of this preamble, this rule finalizes our proposed policy to close the loophole in the statistical test by:

- Prohibiting States from explicitly taxing Medicaid units at higher tax rates than units of other payors.
- Prohibiting State gaming through "proxy" terminology.
- Including a transition period for States with existing loophole taxes.

We anticipated in the proposed rule that the provisions of this final rule may require seven States to submit a total of eight new waiver proposals (within 2 years of the effective date of this final rule) that demonstrate compliance with the updated requirements. This number is based on the number of States that had tax waivers that exploit the loophole as of the publication of the proposed rule and reflects that one State has two waivers.

We have since learned of one additional loophole tax for a total of nine waivers in the same seven States. Although the submission of a new waiver is not the only way to address the requirements of this final rule, for purposes of scoring the impact of this rule we assume all seven States will go this route, as we believe it is the most likely and we have no reliable way of knowing how each State may choose to proceed. However, we also recognize that some States may choose to restructure their taxes in a manner that does not require them to submit a new waiver request. Existing tax waivers that do not exploit the statistical loophole are not affected and, therefore, have no added requirements and burden.

Consistent with our active (or currently approved) estimates under the aforementioned OMB control number, we continue to estimate that it would take 80 hours at $46.88/hr for a healthcare support worker to prepare and submit the waiver request. In aggregate, we estimate a one-time burden of 720 hours (9 waivers x 80 hr/waiver) at a cost of $33,754 (720 hr x $46.88/hr). When taking into account the Federal administrative match of 50 percent, we estimate a one-time State cost of $16,877 ($33,754 * 0.5).

Consistent with our active collection of information request, this final rule does not provide States with a waiver form or template. Instead, instruction for preparing and submitting the waiver is provided in the aforementioned rules and what is codified in §§ 433.68 and 433.72.

Outside of the revised waiver, we do not anticipate that the finalized changes will result in the need for States to amend existing or create new State Plan or policy documents. Consequently, we are not setting out such burden.

Broad-Based Requirements Waiver: Please note that this rule's finalized policies will also apply to waivers of the requirement for taxes to be broad-based; however, because this rule affects existing waivers that exploit the loophole, we are only considering the uniformity requirements waiver in this PRA/COI section.

C. Summary of Burden Estimates

TABLE 3: One-Time Burden Estimates

Regulation Section(s) under Title 42 of the CFR	OMB Control Number (CMS ID Number)	Respondents	Responses (per State)	Total Responses	Time per Response (hr)	Total Time (hr)	Labor Costs ($/hr)	Total Cost ($)	State Cost ($)
Waiver Documentation (§ 433.68)	OMB 0938-0618 (CMS-R-148)	7 States	1 or 2	9	80	720	46.88	33,754	16,877

IV. Regulatory Impact Analysis

A. Statement of Need

The final rule will eliminate an inadvertent loophole in existing health care-related tax waiver regulations and strengthen CMS' ability to enforce section 1903(w)(3)(E) of the Act. These changes are necessary to address taxes that align with existing regulations but do not meet the requirement of the statute due to a statistical loophole that exists in the regulations. These provisions of the final rule are narrowly tailored to address this problem and enable CMS to enforce its new requirements with care to ensure that existing tax waivers that do not exploit the statistical loophole are not affected. All other changes are conforming or technical changes and related to this primary objective of closing the loophole.

As reflected further in this section, the financial impact on the Federal government of the existing problem is large, and the potential for this problem to proliferate further demands swift action.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, "Regulatory Planning and Review," Executive Order 13132, "Federalism," Executive Order 13563, "Improving Regulation and Regulatory Review," Executive Order 14192, "Unleashing Prosperity Through Deregulation," the Regulatory Flexibility Act (RFA) (Pub. L. 96354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and the Congressional Review Act (5 U.S.C. 804(2)). Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as

the Congressional Review Act, 5 U.S.C. 801 et seq.), OMB's Office of Information and Regulatory Affairs has determined that this final rule does meet the criteria set forth in 5 U.S.C. 804(2).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; and distributive impacts;). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for regulatory action as defined by section 3(f)(1) of Executive Order 12866. For the proposed rule, we prepared our estimates using a "no action" baseline, which OMB's Office of Information and Regulatory Affairs determined was significant per section 3(f)(1). For this final rule, and in light of the passage of the WFTC legislation, we are maintaining the same analysis but noting that it is now a "pre-statute" baseline. Accordingly, we have prepared an RIA that to the best of our ability presents the costs, benefits, and transfers of the rulemaking. Therefore, OMB has reviewed these regulations, and the Departments have provided the following assessment of their impact.

Executive Order 14192, titled "Unleashing Prosperity Through Deregulation," was issued on January 31, 2025. For E.O. 14192 accounting purposes, savings to the Federal government that are classified as transfers in regulatory impact analyses do not count as cost savings.

C. Detailed Economic Analysis

To enforce the requirement that taxes have a net impact that is "generally redistributive" in accordance with section 1903(w)(3)(E)(ii)(I) of the Act when a State is seeking a broad-based and/or uniformity waiver, CMS established certain tests such as the P1/P2 and the B1/B2 tests. These tests are described in detail in section I.C. of this rule.

To determine the economic impact of this rule, as we did with the proposed rule, we started with information collected by CMS on provider taxes that we anticipate will be affected by these changes. We identified nine taxes in seven States that will be affected by this final rule. This data is collected via the Form CMS-64[24] and through State submissions for waivers, and to a lesser extent, as part of State plan amendments and State-directed payment preprints. The information collected included: the type of provider or health care-related entity taxed (for example, MCOs or hospitals); the expected amount of tax revenue to be collected; the percentage of total tax revenue paid based on association with Medicaid (the Medicaid taxable units); and the percentage that Medicaid constitutes of the total tax base for the relevant permissible class for the tax. In these eight cases, the amount of tax revenue paid based on Medicaid taxable units would be used to fund higher provider payments to account for the taxes paid by the providers to the States.

While we acknowledge that there is uncertainty about how States would respond, our approach does not assume any change in the total tax revenue; we assume that the burden of the tax would shift from disproportionately taxing Medicaid taxable units to a more proportional distribution on all taxable units. We calculated the amount of tax paid under the expected percentage of the tax paid based on Medicaid taxable units and compared it to the amount that would be paid if the burden for Medicaid taxable units was the same as the Medicaid-associated

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[24] The Form CMS-64 is a collection under OMB 0938-1265 (CMS 10529).

percentage of the total tax base. For example, for MCO taxes, we calculated the current tax burden that is assessed on Medicaid tax units (premiums or member months for Medicaid enrollees) and the overall amount of tax revenue. Then we calculated the tax burden that is assessed against Medicaid taxable units assuming that the tax was assessed evenly across all units (premiums or member months). For hospital taxes, we did the same analysis using the taxable units for hospitals (which could be revenue, hospital stays, or days hospitalized). This data is shown in Table 4.

TABLE 4: Summary of Current Medicaid Tax Waiver Data (in billions of 2024 dollars)

Tax Category	Number of State waivers	2024 estimated annual revenue (billions)	Medicaid tax burden as percentage	Medicaid share of taxable units as percentage	Medicaid tax burden (billions)	Medicaid tax burden under proposed rule (billion)
Managed care organization	7	$18.5	96%	53%	$17.9	$9.8
Hospital	1	$5.1	44%	32%	$2.2	$1.6
Nursing facility	1	$0.34	67%	80%	$0.27	$0.23
Total	9	$24.0	85%	49%	$20.4	$11.7

For 2024, we estimated that these taxes accounted for $24.0 billion in revenue for 7 States. For States with waivers that started in 2025, we included the first year's revenues in 2024 for this analysis. Of this amount, we estimate that $20.4 billion was assessed against Medicaid taxable units (85 percent) and thus was ultimately paid by the Medicaid program. We also estimated that if the taxes were assessed proportionately on all taxable units, that only $11.7 billion (49 percent) would have been assessed against Medicaid taxable units.

The following example illustrates how we calculated the impact of the proposed policy change. Assume a State has a provider tax that exploits the loophole and is expected to collect $1 billion in revenue. Ninety-five percent of the taxes are assessed against Medicaid taxable units, but only 50 percent of the total taxable units are Medicaid taxable units. As a result, the Medicaid program (that is, the State and the Federal government) bears 95 percent of the tax burden, even though Medicaid only accounts for 50 percent of the basis for taxation (such as

Medicaid member months or hospital days) for this service in the State. Under existing regulations with the loophole, the Medicaid program would be expected to pay for $950 million of the tax revenue (via higher payments to providers) [95 percent * $1 billion = $950 million]. Under the proposal, the Medicaid program would be expected to pay for approximately $500 million for the tax revenue [50 percent * $1 billion = $500 million], because $500 million is 50 percent of the $1 billion collected in tax revenue, which reflects the share of the tax base attributable to Medicaid usage (or total taxable units). In that case, total expenditures made by the Medicaid program would be anticipated to decrease by $450 million [$950 million - $500 million].

We estimated that the impact on Federal Medicaid expenditures would be the difference in the taxes paid by Medicaid under current law multiplied by the average FFP matching rate. The average Federal share includes higher Federal matching rates for certain services or populations, most notably the 90 percent matching rate for expansion adults in States that expanded Medicaid eligibility under the Affordable Care Act. For example, if the average Federal share in the State for expenditures in the relevant permissible class in the previous example is 70 percent, then the Federal savings would be $315 million [$450 million * 70 percent].

To calculate the impact in future years, we made the following assumptions. We assumed no new additional waivers would be approved beyond the 9 currently in place. We also assumed that the 9 current waivers would be transitioned to new tax waivers under the transition schedule described in section II.D. We projected that the amount of tax revenues would increase at the same rate as Medicaid spending growth in the budget (based on the projections in the Mid-Session Review of the FY 2025 President's Budget). The Federal share of these impacts was estimated using the average Federal share for each State and service category by tax; this would include adjustments to the base Federal matching rates (notably, the 90 percent matching rate for costs for expansion adults). We estimated that the rule would reduce Federal Medicaid spending

by $78,2 billion from 2027 through 2036 (in real 2027 dollars). This estimate accounts for the transition period applicable as described in Section II.D. These estimates have been updated from the proposed rule to account for changes in the transition schedule. Notably, we now project the financial impacts would begin in 2027 as compared to 2026 in the proposed rule. The annual impacts are shown in Table 5. In addition to the Federal savings, we also project a reduction in State Medicaid expenditures of $46.9 billion over 2027 through 2036. The annual impacts are shown in Table 5.

TABLE 5: Projected Impact Rule on Medicaid Expenditures (in millions of 2027 dollars)

Year	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Federal	-6,000	-6,600	-7,000	-7,300	-7,700	-8,000	-8,400	-8,700	-9,100	-9,400	-78,200
State	-3,600	-3,900	-4,300	-4,400	-4,600	-4,800	-5,000	-5,200	-5,400	-5,700	-46,900

Because it is possible, and we believe likely, that additional States may implement new taxes that exploit the waiver statistical loophole if current policy is unchanged, and that States may increase the revenues raised by existing taxes, we also developed estimates for an illustrative scenario where additional States submit similar taxes over the next several years. In this scenario, we assumed that 2 States would submit new MCO tax waivers for 2026, and 4 additional States would submit MCO tax waivers each year from 2027 through 2030 (reaching 25 States by 2030). We also assumed that 2 additional States would submit hospital tax waivers each year from 2027 through 2030 (reaching 9 by 2030). We produced estimates for both MCO taxes and hospital taxes based on those for which we have already seen loophole taxes.

However, we note that we believe this loophole could be exploited on any permissible class. Tax revenue and burden on the Medicaid program is projected to increase at the same rate as the underlying service spending in Medicaid based on the mid-session review (MSR) 2025 projections. We assume that the impacts on other States are proportional to the largest MCO and hospital taxes currently approved, in the scenarios described herein. For MCO taxes, we assumed that the Medicaid program would account for 99.8 percent of the tax revenue using the loophole and would account for only 50 percent of the revenue under the proposed policy; we

also assumed that the tax revenue attributable to the Medicaid program would be equal to about 23 percent of State Medicaid managed care spending. For hospital taxes, we assumed that the Medicaid program would account for 44 percent of the tax revenue using the loophole and for only 32 percent under the proposed policy; and we assumed that that the tax revenue attributable to the Medicaid program would be equal to about 19 percent of State Medicaid hospital spending. We did not assume any additional nursing facility taxes. We note again that this scenario reflects not only the current taxes, but the impact if these taxes are allowed to proliferate. Under the illustrative estimate, the Federal government would avoid $312.7 billion in Medicaid spending over 2027 through 2036 (in real 2027 dollars) and State Medicaid expenditures would be $170.1 billion lower, as shown in Table 6.

TABLE 6: Projected Impact of Rule on Medicaid Expenditures Under Illustrative Scenario (in millions of 2027 dollars)

Year	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Federal	-7,300	-19,900	-25,900	-32,600	-34,000	-35,600	-37,000	-38,500	-40,100	-41,800	-312,700
State	-3,800	-10,600	-13,900	-17,600	-18,400	-19,400	-20,200	-21,100	-22,100	-23,000	-170,100

1. Transfers (additional discussion)

We note that the amounts described in the previous section do not necessarily represent the total Federal burden that may arise from loophole taxes, and therefore the total savings that will result from closing the loophole. As discussed in the preamble section I.C. in this final rule, States can and sometimes do use the tax revenue generated by shifting the burden to Medicaid (and therefore onto the Federal government) through the loophole to fund additional payments to providers. Those subsequent payments can again be claimed as expenditures and receive Federal match, thus further increasing Federal spending; to the extent States reduce the revenue collected by provider taxes and in turn reduce Medicaid spending, the impacts on Federal and State Medicaid expenditures may be even higher than what we have estimated here.

However, it should be noted that effects on the Federal budget (as well as the costs to States and taxpaying entities) are highly dependent on how States respond to these changes.

Broadly, we believe States generally have several ways to address these changes, and they are not mutually exclusive, with varying consequences for magnitude of regulatory effects and for who pays and receives transfers. As we estimated previously, States may decide to maintain the current level of revenue in these tax programs, with less revenue based on Medicaid taxable units and the burden distributed across other payers (which could include Medicare for non-MCO taxes —thus generating some tendency toward overestimation in the Federal budget savings estimates appearing elsewhere in this regulatory analysis—and private health insurers). States may choose to reduce or eliminate these taxes and may make up the revenue elsewhere (for example, through other taxes, health care-related or not). States may also opt to reduce spending – in Medicaid or in other parts of the State budget – to account for the decrease in tax revenue. We expect that these decisions will depend on several factors beyond our ability to predict, including: the relative impact these policies have on the State Medicaid program and overall State budgets; the response from other health care payers and providers of potentially higher tax burdens; and impacts on other entities, including on providers and beneficiaries in the State. We sought comments on how affected States would respond to these proposed changes.

The following is a summary of the public comments on our regulatory impact analyses:

Comment: A few commenters expressed concern that the proposed rule did not contain a "meaningful" RIA. A few commenters requested that CMS conduct a comprehensive impact analysis on safety net hospitals before finalizing the rule. A commenter stated the RIA fails to consider key relevant impacts of the proposed rule, including the potential for serious harm to Medicaid funding and delivery, thus falling short of RIA standards. A commenter similarly stated that the RIA was inaccurate due to the uncertainty of the proposed rule's impact on patient access. A commenter recommended that CMS seek feedback from States on the proposed rule's budgetary and programmatic impact.

Response: States have many options for how to respond to the changes made by this rule. A State may maintain payments funded by a loophole tax through other means such as general

fund revenue. The State may continue payments in a manner permitted by the tax waiver once brought into compliance with Federal law not to overburden the Medicaid program. We also acknowledge that they may, as the commenter was concerned, stop or decrease certain payments. We described these possible effects in the RIA, but continue to believe that quantifying the possible effects is especially speculative. We took the approach that best reflected the known outcomes and available data while acknowledging the uncertainty in how States will respond to these changes. We also believe it is not possible to quantify the effects on any particular providers or groups of providers, while noting it is possible that States may reduce spending that affects some providers more than others. Seeking feedback from loophole States would not have changed the rulemaking decision, since this rule, even before the passage of WFTC legislation, is addressing an action that was already impermissible.

Comment: Several commenters expressed concern regarding estimates included in the proposed rule's RIA, with a few commenters stating generally that the estimated savings specific to this rule are not accurate. A commenter stated that the estimated $33.2 billion reduction in Federal Medicaid spending is an underestimate due to CMS' assumption that all States will expand existing taxes to all payers or due to the moratorium on further adoption of similar taxes. A commenter believed the estimated savings are now inaccurate due to WFTC legislation. Similarly, a commenter expressed concern that the rule's RIA is no longer relevant due to WFTC legislation. A commenter specifically recommended that CMS clarify its estimates by distinguishing between waiver-authorized programs in Table 3 of the proposed rule and those that have not been identified as contributing to redistributive imbalance. Finally, a commenter stated that allowing more States to qualify for transition periods will undermine the savings estimates in the rule's RIA.

Response: We believe that the estimates are accurate. We do not assume new taxes or significant expansions of existing taxes as an explicit part of the baseline, and thus do not assume any cost impacts beyond the current taxes in place. To address the possibility of an increase in

the use of these taxes in the future, we did provide the alternative scenario in the RIA in the proposed rule. As noted above, while we acknowledge that States may take steps in response to this change (which could include changing the terms of the taxes to be in compliance with the statute, finding other revenue sources, or reducing Medicaid spending), we do not believe it is possible to quantify those impacts. We have noted and described these possible outcomes in the RIA.

Under OMB Circular A-4, our analysis for instances such as this, where a rule could be regarded as merely codifying a change already made in statute, utilizes a "pre-statute" baseline for our impact assessments. Therefore, we are maintaining our analysis from the proposed rule, although at that time, the baseline was "no action." In other words, the underlying circumstances have changed, but the primary impact analysis we should provide remains the same, just through another route, which is through statute. We also believe that the effects of section 71117 of the WFTC legislation and the proposed rule are effectively the same, and thus the projected impacts are the same as well. However, as the transition periods have been modified and one additional tax has been identified, we have updated the estimates in this analysis accordingly.

As a result of the public comments, we are only updating the discussion of the baseline to reflect the "pre-statute" baseline.

2. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret the proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume the following entities will review: State Medicaid Agencies, State governments, MCOs, and health care providers. We assume at least three people at every State Medicaid Agency (56) will review and two people in every State and territory government (56), for a total of 280 reviewers. We then estimate an additional 20 reviewers in every State Medicaid Agency affected by these policies (7 States, 140 reviewers), as well as 1,124 members

across seven State Legislatures, for a total of 1,544 reviewers. It is more difficult to predict how many individuals in how many MCOs and providers will review, so we are therefore doubling the number from the previous estimate, for 3,088 total reviewers. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. We also recognize that this is a relatively short rule with a single policy focus, and therefore for the purposes of our estimate, we assume that each reviewer reads 100 percent of the rule. We sought comments on this assumption. We did not receive any comments on our regulatory review cost estimates, and therefore we are maintaining our assumptions.

Using the wage information from the BLS 2024 Occupational Employment and Wage Statistics (https://www.bls.gov/oes/tables.htm) for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is $132.44 per hour, including overhead and fringe benefits. Assuming an average reading speed, we estimate that it would take approximately 2 hours for each person to review the proposed rule. For each person that reviews the rule, the estimated cost is $264.88 (2 hours x $132.44). Therefore, we estimate that the total cost of reviewing this regulation is $0.8 million ($264.88 x 3,088).

D. Alternatives Considered

We considered replacing the B1/B2 with another statistical test (discussed in more detail below) for all waivers of the uniformity requirements. Updating the statistical test to one that directly reflected Medicaid burden would have several advantages. First, it would have been administratively simple for CMS to implement, where one test would merely be replaced by another during a waiver review. Second, it would have had the clear effect of eliminating the statistical loophole. Third, it would have been a purely statistical test that would not require a separate decision-making process on the part of CMS.

This test would have measured Medicaid's proportion of the total business (numerator) compared to Medicaid's share of the expected total tax revenue (denominator). For example, suppose a tax on nursing facilities existed where there were 390,000 total bed days of which

330,000 bed days were Medicaid-paid bed days. Divide the second number 330,000 by the first number, 390,000 to receive a percentage of approximately 84.6 percent Medicaid bed days. Assume further that the total tax revenue collected was $11,000,000. Assume that the total tax amount collected based on Medicaid taxable units was $9,000,000. Divide the second number $9,000,000 by the first number $11,000,000, to receive a percentage of approximately 81.81 percent of tax revenue derived from Medicaid taxable units. Divide the first percentage, 84.6 percent, by the second percentage, 81.81 percent, to arrive at the final percentage, 103.41 percent.

We also considered various figures that would have represented a "passing" (that is, approvable) figure under this test, including 90 percent, or 95 percent, which may have allowed more existing taxes that do not exploit the loophole to pass. However, we ultimately decided against proposing this overall new statistical test option for several reasons. First, we believed that this test would have been unnecessarily disruptive to our existing approved health care-related taxes with broad-based or uniformity waivers, many of them longstanding. Several of these waivers that did not exploit the statistical loophole would have failed this test, such as some nursing facility taxes, possibly due to excluding Medicare or other permissible differences in tax structure. We realize that States have become accustomed to the B1/B2 test over a long period of time and wanted to solve the tax loophole issue while being minimally disruptive to their legislative and regulatory activities related to the Medicaid program, including their programs of health care-related taxes that do not exploit the statistical loophole. Finally, we realized that if we set the passing figure too low, several taxes that are exploiting the loophole would be able to continue with their tax programs that are not generally redistributive. We did not want to undertake a change that would not close the loophole completely or that risked opening a new one. In addition, through our experience of testing this new statistical test, we assessed the disruption to existing taxes and State processes that would result from replacing the

B1/B2 test, regardless of the specific details of that test. As a result, we did not contemplate alternate statistical methodologies or tests.

In addition to the wholesale replacement of the B1/B2 by this new statistical test for all waivers of the uniformity requirement, we also considered various limiting conditions to the universe of tax waivers to which it would apply. For example, we considered having this new test apply only to taxes on services of MCOs, since most of the loophole exploiting taxes fall in this permissible class. However, there is at least one tax that we know of on hospitals that has different, higher, tax rates for Medicaid-payable days than non-Medicaid payable days. We wanted a fix that would cover this tax as well, because we believe that the higher rate imposed on Medicaid taxable units is not consistent with the statutory requirement that health care-related taxes for which waivers are approved must be generally redistributive. Additionally, applying this test only to MCOs would have left the Federal government open to future State tax waiver proposals that used the B1/B2 loophole in other permissible classes, including but not limited to inpatient hospital services and outpatient hospital services. In the proposed rule, we aim to be as comprehensive as possible to reduce the necessity of pursuing further rulemaking in this area in the short-term.

We also considered proposing this new statistical test discussed in the prior paragraphs, but proposing to apply it only to taxes that had separate tax rates for Medicaid taxable units compared to non-Medicaid taxable units, or separate tax rates for providers with Medicaid taxable units compared to providers with taxable non-Medicaid units. For example, a tax that had a rate of $20 per Medicaid-paid bed day compared to $2 per non-Medicaid paid bed day would fall under this category. To take another example, providers with more than 100 Medicaid bed days are taxed $20 per bed day compared to providers with less than 100 Medicaid bed days are taxed $2 per bed day. This would have been similar in scope to our current proposal. First, we would have still needed to adopt some kind of "Medicaid substitute" provision similar to § 433.68(e)(3)(iii) to address situations where the State did not use the word

"Medicaid" in their descriptions but achieved the same effect. Second, we believe that this approach would have been somewhat confusing for States to implement. It would have required a longer learning process while we instructed the States how to conduct the test. We wanted to adopt the simplest, most straightforward option. As a result, we decided against adopting this test into regulation to measure whether a tax waiver is "generally redistributive" in any format at the present time.

In addition, we considered not proposing that Medicaid proxies be addressed at all in this regulation. Up until this point, we have not received any proposals that we would consider to be "Medicaid substitutes" in the context of the B1/B2 loophole. However, up until this point, States have had no incentive for taxes that use the B1/B2 loophole not to describe groups using the word "Medicaid." Under the provisions in this rule, they have that incentive since, absent the "substitute" provision, the new regulation does apply only to States that explicitly target Medicaid. While closing one loophole, we did not wish to open another one with the exact or very similar effect as the first loophole. We believe that leaving the door open to this kind of manipulation would undermine the entire purpose of this rulemaking. We attempted to be as comprehensive as possible to foreclose the necessity of future rulemaking in the near-term if we were able to identify and preemptively prevent any serious deficiencies. This helps to create a stable, level, regulatory framework, reducing the needs for updates and changes. This is beneficial for both CMS and the States. States have a clear expectation of the regulatory framework within which they operate and can plan their budgets and legislative sessions accordingly. And CMS does not need to undertake new rulemaking soon after concluding prior rulemaking on the same subject. As a result, we believed that proposing the "Medicaid substitute" provision was necessary to make sure we were capturing the full universe of problematic practices that result in tax waivers that are not generally redistributive and effectively close the regulatory loophole.

As a result, we believe that the option we chose to propose mandating that Medicaid taxable units not be taxed at a higher rate than the rate imposed on any taxpayer or tax rate group based on non-Medicaid taxable units had several advantages. First, it removes the full universe of current taxes that exploits the statistical loophole. Second, it is narrowly tailored only to those taxes that exploit the statistical loophole. Third, it is not unnecessarily disruptive on States with currently approved tax waivers of the uniformity requirement that do not exploit the statistical loophole. All those factors combined, make it the option that we have proposed.

Finally, we considered alternatives to our approach in the transition period section. Within that section, we have some alternatives on which we invited comment, including no transition period for any waivers. We are confident that all States engaged in this practice are aware they are exploiting a loophole, and no transition period aligned with our intent to close the loophole as quickly as possible. However, we ultimately decided to initially propose a short transition period for waivers we had not approved most recently and therefore had not communicated with the State about this specific issue as recently. We also considered longer timeframes for transition periods for all waivers, but we did not want to extend the time that these loopholes are burdening the Medicaid program any longer than necessary. Finally, we considered associating the length of transition periods to how long the tax has been in place. We are finalizing the transition periods with modifications discussed previously.

E. Accounting Statement and Table

Consistent with OMB Circular A-4 (available at https://www.reginfo.gov/public/jsp/Utilities/a-4.pdf), we have prepared an accounting statement in Table 7 showing the classification of the impact associated with the provisions of this final rule.

TABLE 7: Accounting Table

Category	Estimate	Year Dollar	Discount Rate	Period Covered	
Collection of Information Requirements					
Total	$33,754	2025	N/A	One-time	
State	$16,877	2025	N/A	One-time	
Regulatory Review Costs					
	$0.8 million	2025	**N/A**	One-time	
Transfers					
Annualized Monetized (Federal, $/year)	$7,617 million	2027	7 percent	2027-2036	
	$7,731 million	2027	3 percent	2027-2036	
Annualized Monetized (non-Federal, $/year)	$4,569 million		2027	7 percent	2027-2036
	$4,637 million		2027	3 percent	2027-2036
Quantitative: ● Estimated reduction in transfers from Federal government to States, ranging from $6,000 million to $9,400 million per year over 2027 through 2036, reflecting reduced Medicaid payments associated with certain health care-related taxes. ● Estimated reduction in transfers from State governments to other payers (for example, private insurance sponsors), ranging from $3,600 million to $5,700 million per year from 2027 through 2036, reflecting reduced Medicaid payments associated with certain health care-related taxes.					

F. Regulatory Flexibility Act (RFA) and Section 1102(b) of the Social Security Act

Effects on Health Care Providers

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that many of the health care providers subject to health care-related taxes are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $9.0 million to $47.0 million in any 1 year).

TABLE 8. SBA SIZE STANDARDS FOR APPLICABLE NORTH AMERICAN INDUSTRY CLASSIFICATION SYSTEM (NAICS) INDUSTRY CODES

NAICS Code	Entity Type	Description	SBA Size Standard/Entity Threshold ($) (in millions)	Total Small Business
622	Providers	Hospitals	47	1,494
6211	Providers	Physicians	16	141,446
6212	Providers	Dentists	9	119,497
6213	Providers	Other Health Practitioners	9 - 47	164,784

Source: US Census 2022 SUSB
*Note, the NAICS code for this industry changed in 2022, and now include NAICS 454110, Electronic Shopping and Mail Order Retail and 454390, Other Direct Selling Establishments; however, 2022 revenue data are not available. For this reason, 2017 revenue data will be used in this analysis.

Table 9 shows the small distribution of firms and revenues. According to this table, we can see and understand the disproportionate impacts among small firms and between small and large firms. According to the US 2022 Census Statistics of US Business, the total revenue for the four industries identified as small businesses, according to the SBA size standard and shown in table 8, amounts to $450.97 billion and average revenue amounts to $1.056 million. Recall, SBA defines a small business as having revenues of less than $9.0 million to $47.0 million in any 1 year.

TABLE 9. IMPACTS AMONG SMALL FIRMS AND BETWEEN SMALL AND LARGE FIRMS

Firm Size (by Receipts)	Firm Count	Percent of Small Firms	Total Revenue	Average Revenue
SMALL FIRMS	427,221	**100.00%**	$ 450,956,331,000.00	$ 1,055,557.50
<100,000	54,816	13%	$ 2,962,471,000.00	$ 54,043.91
100,000-499,999	173,833	41%	$ 44,646,417,000.00	$ 256,835.11
500,000-999,999	99,512	23%	$ 65,588,722,000.00	$ 659,103.65
1,000,000-2,499,999	71,438	17%	$ 118,030,155,000.00	$ 1,652,204.08
2,500,000-4,999,999	18,392	4%	$ 76,840,635,000.00	$ 4,177,937.96
5,000,000-7,499,999	5,226	1%	$ 37,971,651,000.00	$ 7,265,911.02
7,500,000-9,999,999	2,526	1%	$ 25,118,647,000.00	$ 9,944,040.78
10,000,000-14,999,999	2,324	1%	$ 30,056,356,000.00	$ 12,933,027.54
15,000,000-19,999,999	1,244	0%	$ 21,879,161,000.00	$ 17,587,750.00
20,000,000-24,999,999	273	0%	$ 5,135,306,000.00	$ 18,810,644.69
25,000,000-29,999,999	193	0%	$ 4,717,106,000.00	$ 24,440,963.73
30,000,000-34,999,999	180	0%	$ 4,959,077,000.00	$ 27,550,427.78
35,000,000-39,999,999	144	0%	$ 4,216,461,000.00	$ 29,280,979.17
40,000,000-49,999,999	191	0%	$ 8,834,166,000.00	$ 46,252,178.01
LARGE FIRMS				
Receipts > 49 million		NA		

Source: US Census 2022 SUSB

Table 10 combines the small firm's size and revenue data with the cost estimates determined in this final rule to understand the economic impact on small entities. As mentioned previously, the only costs that will be incurred as a result of this rule are the collection of information costs, at a cost of $33,754, and when taking into account the Federal administrative match of 50 percent, we estimate a one-time State cost of $16,877. The cost to review this rule, amounts to $0.8 million. Therefore, the total cost to implement this rule is $850,631. When this

cost is distributed amongst the 427,221 entities identified as being small according to the SBA, each of these small entities incurs a cost less than $2.00.

TABLE 10. ECONOMIC IMPACTS ON SMALL ENTITIES*

Firm Size (by Receipts in millions)	Average Revenue ($)	Annualized Cost ($) per Firm	Percent of Small Firms	Revenue Test (Percentage)
SMALL FIRM	1,055,557.50	1.99	**100%**	0.02%
<100,000	54,043.91	1.99	13%	0.37%
100,000-499,999	$256,835.11	1.99	41%	0.08%
500,000-999,999	$659,103.65	1.99	23%	0.03%
1,000,000-2,499,999	1,652,204.08	1.99	17%	0.01%
2,500,000-4,999,999	4,177,937.96	1.99	4%	0.00%
5,000,000-7,499,999	7,265,911.02	1.99	1%	0.00%
7,500,000-9,999,999	9,944,040.78	1.99	1%	0.00%
10,000,000-14,999,999	12,933,027.54	1.99	1%	0.00%
15,000,000-19,999,999	17,587,750.00	1.99	0%	0.00%
20,000,000-24,999,999	18,810,644.69	1.99	0%	0.00%
25,000,000-29,999,999	24,440,963.73	1.99	0%	0.00%
30,000,000-34,999,999	27,550,427.78	1.99	0%	0.00%
35,000,000-39,999,999	29,280,979.17	1.99	0%	0.00%
40,000,000-49,999,999	46,252,178.01	1.99	0%	0.00%

Source: US Census 2022 SUSB

*As a result of the costs of $850,631 (discounted at 7 percent) including regulatory review and collection of information costs, we were able to calculate the revenue impact on small businesses for the four industries discussed.

1. Number of Small Entities

We used the most recent revenue data available from the 2022 Statistics of U.S. Businesses (SUSB) from the Census Bureau to determine the number of small entities and their revenue.

TABLE 11. NUMBER OF AFFECTED ENTITIES AND THEIR PERCENTAGE OF THE OVERALL INDUSTRIES

Industry	Number of Small Entities	Percentage of Overall Industries
Hospitals	1,494	0.35%

Physicians	141,446	27.97%
Dentists	119,497	33.11%
Other Health	164,784	38.57%

Source: 2022 SUSB Census

Based on the latest available 2022 SUSB data records, we estimate that 427,221 health care provider entities may be considered small entities either because of their nonprofit status or because of their revenues, as detailed in Table 11. Approximately 0.35 percent (1,494) of these are hospitals, 27.97 percent (141,446) are physician practices, 33.11 percent (119,497) are dental practices, and 38.57 percent (164,784) are other health practitioners.

We calculated the percentage of revenue represented by the annualized cost per firm divided by the average revenue times 100, and none exceeded the 3 to 5 percent of revenue threshold, as summarized in Table 10. Therefore, according to the revenue tests, the economic impact was less than one percent. All the costs were evenly distributed among the 427,221 small entities; thus, for the purposes of this RFA, there were no disproportionate impacts among small firms, and between small and large firms.

Individuals and States are not included in the definition of a small entity. As previously stated, this rule will not have a significant impact measured change in revenue of 1 to 3 percent on a substantial number of small businesses or other small entities. We do not anticipate that States will seek to rebalance the revenues to that extent through small entities, as the permissible classes affected by this rule are not small entities. Nearly all the taxes that this policy will end are taxes on MCOs. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 1 to 3 percent. We do not believe that this threshold will be reached by the requirements in this rule. Therefore, the Secretary has certified that this rule will not have a significant economic impact on a substantial number of small entities. We sought comments on this assessment.

We did not receive any comments on this section and are finalizing our assessment as proposed.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis

if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For the purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We do not believe this rule will have a significant impact on small rural hospitals. Although as stated previously we cannot predict the ways a State may respond to the cessation of a Federal funding stream, we do not anticipate based on the requirements in this rule those revenues will be sought from small, rural hospitals, as States often seek to insulate these providers from increased costs. Therefore, the Secretary has certified that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $187 million. The UMRA's analysis requirement is met by the analysis included in section IV. of the proposed rule, conducted per EO 12866. This final rule does not mandate any requirements for local or tribal governments, or for the private sector. Costs may shift from the Federal government to States.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Allowing States to continue to exploit a loophole in current regulations undermines the statutory framework, and, as GAO has noted, undermines the cooperative

Federalism that lies at the heart of the Medicaid program.[25] For this reason, we believe that it is necessary to address the statistical loophole to ensure fiscal integrity of the Medicaid program.

Hence, this rule does not impose substantial direct costs on State or local governments, preempt State law, or otherwise have Federalism implications.

Comment: A commenter disagreed with the Federalism assessment, stating that the proposed rule would limit their State's ability to tax providers and, therefore, would infringe on their sovereignty, which they stated was inconsistent with basic principles of Federalism.

Response: Nothing in this rule changes a State's ability to establish a health care-related tax that is consistent with Federal law. Even before this change was reinforced by the WFTC legislation, the policies finalized in this rule would only affect those taxes that improperly overburdened the Medicaid program in a manner already inconsistent with the generally redistributive requirement of the Act. We are therefore not making any changes to our assessment of Federalism impacts as a result of comments.

I. Conclusion

The policies in this rule will enable us to ensure FFP is distributed equitably and as intended and contemplated by statute.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Mehmet Oz, MD, Administrator of the Centers for Medicare & Medicaid Services, approved this document on January 13, 2026.

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[25] GAO-08-650T "Medicaid Financing Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight" April 3, 2008.

List of Subjects in 42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs-health, Medicaid, Reporting, and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR Chapter IV as set forth below:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 continues to read as follows:

Authority: 42 U.S.C. 1302.

2. Amend § 433.52 by adding the definitions of "Medicaid taxable unit", "Non-Medicaid taxable unit" and "Tax rate group" in alphabetical order to read as follows:

§ 433.52 General definitions.

* * * * *

Medicaid taxable unit means a unit that is being taxed within a health care-related tax that is applicable to the Medicaid program. This includes units that are used as the basis for Medicaid payment, such as Medicaid bed days, Medicaid revenue, costs associated with the Medicaid program such as Medicaid charges, or other units associated with the Medicaid program.

Non-Medicaid taxable unit means a unit that is being taxed within a health care-related tax that is not applicable to the Medicaid program. This includes units that are used as the basis for payment by non-Medicaid payers, such as non-Medicaid bed days, non-Medicaid revenue, costs that are not associated with the Medicaid program, or other units not associated with the Medicaid program.

* * * * *

Tax rate group means a group of entities contained within a permissible class of a health care-related tax that is taxed at the same rate.

6. Amend § 433.68 by—

a. Revising paragraphs (e) introductory text, (e)(1)(ii), (e)(1)(iii) introductory text, (e)(1)(iv) introductory text, (e)(2)(ii) and (e)(2)(iii) introductory text; and

b. Adding paragraphs (e)(3) and (4).

The revision and additions read as follows:

§ 433.68 Permissible health care-related taxes.

* * * * *

(e) *Generally redistributive***.** A tax will be considered to be generally redistributive if it meets the requirements of this paragraph (e). If the State requests waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraphs (e)(1) and (3) of this section. If the State requests waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraphs (e)(2) and (3) of this section.

(1) * * *

(ii) If the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 1 and satisfies the requirements of paragraphs (e)(3) and (f) of this section, the tax waiver is approvable.

(iii) If a tax is enacted and in effect prior to August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.90, CMS will review the waiver request. Such a waiver will be approved only if, in addition to satisfying the requirement at paragraphs (e)(3) and (f) of this section, the following two criteria are met:

* * * * *

(iv) If a tax is enacted and in effect after August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.95, CMS will review the waiver request. Such a waiver request will be approved only if, in addition to satisfying the requirement at paragraphs (e)(3) and (f) of this section, the following two criteria are met:

* * * * *

(2) * * *

(ii) If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 1 and satisfies the requirements of paragraphs (e)(3) and (f) of this section, the tax waiver is approvable.

(iii) If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 0.95, CMS will review the waiver request. Such a waiver will be approved only if, in addition to satisfying the requirement at paragraphs (e)(3) and (f) of this section, the following two criteria are met:

* * * * *

(3) *Additional requirement to demonstrate a tax is generally redistributive***.** This paragraph (e)(3) applies on a per class basis. Regardless of whether a tax meets the standards in paragraphs (e)(1) and (2) of this section, the tax is not generally redistributive if:

(i) Within a permissible class, the tax rate imposed on any taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable units (except as a result of excluding from taxation Medicare revenue or payments as described in paragraph (d) of this section). 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 violate the requirements of paragraph (e)(3)(i) of this section.

(ii) Within a permissible class, the tax rate imposed on any taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer or tax rate group defined by its relatively higher volume or percentage of Medicaid taxable units. 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 violate the requirements of paragraph (e)(3)(ii) of this section. As an additional example, a tax on hospitals with less than 5 percent Medicaid utilization at 2 percent of net patient service revenue for inpatient hospital services,

and on all other hospitals at 4 percent of net patient service revenue for inpatient hospital services would also violate the requirements of paragraph (e)(3)(ii) of this section.

(iii) The tax excludes or imposes a lower tax rate on a taxpayer or tax rate group defined by or based on any description that results in the same effect as described in paragraph (e)(3)(i) or (ii) of this section. Characteristics that may indicate this type of violation exist include:

(A) Use of terminology to establish a tax rate group based on Medicaid without explicitly mentioning Medicaid to accomplish the same effect as described in paragraphs (e)(3)(i) or (ii) of this section for a tax rate group. For example, a tax on inpatient hospital service discharges that imposes a $10 rate per discharge associated with beneficiaries covered by a joint Federal and State health care program and a $5 rate per discharge associated with individuals not covered by a joint Federal and State health care program would violate this requirement, because joint Federal and State health care program describes Medicaid and a higher tax rate is imposed on Medicaid discharges than on discharges for individuals not covered by a joint Federal and State health care program.

(B) Use of terminology that creates a tax rate group that closely approximates Medicaid, to the same effect as described in paragraphs (e)(3)(i) or (ii) of this section. For example, a tax on hospitals located in counties with an average income less than 230 percent of the Federal poverty level of $10 per inpatient hospital discharge, while hospitals in all other counties are taxed at $5 per inpatient hospital discharge, would violate this requirement, because the distinction being drawn between tax rate groups is associated with a Medicaid eligibility criterion with a higher tax rate imposed on the tax rate group that is likely to involve more Medicaid taxable units.

(4) *Transition period***.** (i) The following transition periods end as follows:

(A) For States with health care-related tax waivers on the services of managed care organization permissible class that do not meet the requirements of paragraph (e)(3) of this section, where the date of the most recent approval of the waiver that violates paragraph (e)(3) of

this section occurred 2 years or less before April 3, 2026, the final day of the transition period is December 31, 2026.

(B) For States with health care-related tax waivers on the services of managed care organization permissible class that do not meet the requirements of paragraph (e)(3) of this section, where the date of the most recent approval of the waiver that violates paragraph (e)(3) of this section occurred more than 2 years before April 3, 2026, the final day of the transition period is the day before the first day of the first State fiscal year beginning at least 1 year from April 3, 2026.

(C) For States with health care-related tax waivers on permissible classes other than the services of managed care organizations class that do not meet the requirements of paragraph (e)(3) of this section, regardless of the date of the most recent approval of the waiver that violates paragraph (e)(3) of this section, the final day of the transition period is the final day of the State fiscal year that ends in calendar year 2028, but no later than September 30, 2028.

(ii) By the expiration of the transition period applicable under paragraph (e)(4)(i) of this section, States must either:

(A) Submit a health care-related tax waiver proposal that complies with paragraph (e)(3) of this section with an effective date that is no later than the day after the final day of the transition period specified in paragraph (e)(4)(i) of this section; or

(B) Otherwise modify the health care-related tax to comply with this rule and all other applicable Federal requirements with an effective date that is no later than the day after the final day of the transition period specified in paragraph (e)(4)(i) of this section.

(iii) Once the transition period for a tax waiver that qualifies under paragraph (e)(4)(ii) of this section has expired, CMS may deduct from a State's medical assistance expenditures revenues from health care-related taxes that do not meet the requirements of paragraph (e)(3) of this section as specified by section 1903(w)(1)(A)(iii) of the Act and § 433.70(b).

Robert F. Kennedy, Jr.,

Secretary,

Department of Health and Human Services.

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