



Charles N. Kahn III
President and CEO

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Via electronic submission at <http://www.regulations.gov>

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244-8016

RE: Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole Proposed Rule (CMS-2448-P)

Dear Dr. Oz:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. The FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the above-referenced Proposed Rule on "Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole Proposed Rule," published in the Federal Register (90 Fed. Reg. 20,578) on May 15, 2025.

The FAH shares CMS' goal of preserving Medicaid funding for the vulnerable populations covered by the program. For decades, provider taxes have been used by states to sustain funding for their Medicaid programs as they attempt to meet the federal statutory requirement "to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under [Medicaid] at least to the extent that such care and services are available to the general population . . ." (42 U.S.C. 1396(a)(30)(A), known as the Equal Access clause).

All states except the state of Alaska utilize some form of a provider tax to support their Medicaid program. We are concerned that this proposed rule as currently drafted, leaves tremendous uncertainty for states regarding future approvals of provider taxes and, as such, could have significant consequences on state budgets and access to care for Medicaid's vulnerable populations. **Therefore we urge the agency to:**

- **Rescind the proposed rule and reissue it to reflect the related provisions of and interactions with the recently passed OBBBA.**
- **Use the statutory authority to narrowly focus provisions on MCO taxes; and**
- **Allow for the maximum transition period to ensure states have time to comply while working to mitigate provider and patient impacts.**

Executive Summary

In general, health care-related taxes (often referred to as provider taxes) that fund the non-federal share of Medicaid expenditures must be broad-based and uniform. When they are not, CMS must approve (per the statute) certain waiver applications from states if the tax is “generally redistributive” and “the amount of the tax is not directly correlated to payments under [Medicaid] for items or services with respect to which the tax is imposed.”¹ A final rule from 1993 implemented tests for assessing whether a provider tax is generally redistributive, which has worked effectively for 30-plus years using two statistical tests, known as the B1/B2 test and the P1/P2 test.

Under this proposed rule, CMS says it is addressing what it calls a “loophole” in the statistical tests as used by seven states—in all but one case pertaining to taxes on managed care organizations (MCOs). In the preamble, the agency stated (90 Fed. Reg. 20,589):

“CMS does not intend for [the proposed] § 433.68(e)(3) to target any taxes other than those that utilize the loophole in the B1/B2 test. CMS 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 done explicitly, would violate § 433.68(e)(3)(i) or (ii) of the proposed rule.”

Nevertheless, under this proposed rule, it appears all state applications for waivers of broad-based and uniformity requirements must meet additional standards, with the associated burden of proving that those requirements are met without the predictability of knowing with certainty what will and will not violate the new requirements.

Since this rule was proposed, P.L. 119-21, One Big Beautiful Bill Act (OBBBA), has been enacted. Section 71117 of OBBBA is entitled “Requirements regarding waiver of uniform tax requirement for Medicaid provider tax” and contains provisions similar to this proposed rule but with important differences, as well as potential interactions with other provisions in the legislation (described below).

States need additional time to consider the impacts of the legislation as it relates to this proposed rule and CMS should take the additional time to process all of the changes and interactions with OBBBA. As a result, **the FAH requests that CMS rescind the current proposed rule.** The proposed rule on this topic needs to be reissued to reflect the related provisions of and interactions with OBBBA.

¹ Section 1903(w)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1396b(w)(3)(E)(ii))

To the extent the provisions of this rule (and section 71117 of OBBBA) take effect, **the FAH requests that CMS use its statutory authority² to focus its effect “narrowly” (to use CMS’ word) on relevant MCO taxes.** Consistent with longstanding waiver approvals and legitimate public policy goals of ensuring access to essential healthcare services, CMS should also clarify that it will not prohibit a state from excluding or discounting inherently low-Medicaid hospital classes, such as psychiatric hospitals, rehabilitation hospitals, critical access hospitals, and long-term acute care hospitals, given that these hospitals are already distressed and are an important component of the state’s healthcare safety net.

If CMS proceeds in finalizing this rule, **the FAH requests that CMS provide any affected taxes the maximum transition period.** States will need additional time to address compliance issues while mitigating the impact on plans, providers, and beneficiaries.

Rescind Rule, Address Interactions with Enactment of ‘One Big Beautiful Bill Act’

For more than 3 decades, CMS regulations have required the Secretary to “automatically approve the waiver request” of any applicable broad-based or uniform tax requirement if it satisfies the applicable statistical test. Under the proposed rule, the state’s tax proposal would instead be “approvable”³ if it met the applicable statistical test and if it satisfies the requirement of a new paragraph (3) in § 433.68(e). Language similar to the proposed regulatory language at 42 C.F.R. § 433.68(e), entitled “Additional requirement to demonstrate a tax is generally redistributive,” was included in section 71117 of OBBBA as an addition to the Medicaid statute at 1903(w)(3)(E)(iii) of the Social Security Act.

As a result of the enactment of OBBBA, there are a number of questions that remain unaddressed and interacting issues that should be considered before finalizing the proposed rule, giving stakeholders additional time to comment and states to prepare for transitions to be compliant. They include but are not limited to the following:

- OBBBA (section 71117(a)) includes the same additional requirement as the proposed rule but does not modify the current regulation’s “automatically approve” provision. Will CMS maintain this existing regulatory language, in contrast to the proposed rule?
- OBBBA (section 71117(c)) allows for a transition period of up to three years—significantly longer than what is proposed. Will CMS consider aligning its transition timeline to account for the diverse classes of provider taxes that could fall under this

² For example, in the last sentence of 1903(w)(3)(E)(i) of the Social Security Act (42 U.S.C. 1396b(w)(3)(E)(i))

³ This proposed rule focuses, in part, on the meaning of “generally redistributive” in section 1903(w)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1396b(w)(3)(E)(ii)). That clause specifies the waiver-application criteria that, if met, the “Secretary shall approve such an application” However, in this proposed rule, CMS’ change of “will automatically approve the waiver request” to “is approvable” at 42 C.F.R. § 433.68(e)(1)(ii) and (e)(2)(ii) appears to give the Secretary further, unspecified ability to deny the application, notwithstanding having met the applicable requirements. We believe this change to be contrary to law. (As described in greater detail below, another provision (section 1903(w)(3)(E)(i) of the Social Security Act (42 U.S.C. 1396b(w)(3)(E)(i)) gives the Secretary broader scope for “[p]ermissible waivers” but not for denying waivers.)

requirement and ensure the rule’s scope is appropriately tailored under the Secretary’s authority?

- OBBBA (section 71115) reduces the safe harbor threshold to zero percent, (essentially creating a moratorium), freezes hold-harmless thresholds at their current rate for non-expansion states while reducing provider taxes gradually to 3.5 percent for expansion states. This narrows state flexibility and limits the policy tools to mitigate financial disruption from section 71117(a), including potential unintended consequences. How will CMS address this constraint?
- Prior to CMS’ creation of Medicaid State Directed Payments (SDPs), states with substantial Medicaid managed care programs struggled to effectively target enhanced funding to high-need hospitals. After creating SDPs, states were able to expand their use of comprehensive managed care programs, to cover a greater portion of healthcare, including inpatient hospital care. Because OBBBA (section 71116) limits states provider reimbursement to Medicare rates under these programs, hospitals will continue to be challenged, putting many at further financial risk. States may have to consider whether or not managed care remains a sustainable option for their state.

Given the multitude of complex Medicaid policies in OBBBA, CMS should rescind the current proposed rule and reissue it after considering how the agency and the states can address the interactions of this particular policy (that is, requirements regarding waiver of uniform tax requirement) with other provisions in OBBBA. Stakeholders will also be better able to provide informed comment in response to CMS’s proposed policies.

For all the reasons above, we request that CMS rescind this proposed rule. CMS should propose a new rule based on a thoughtful evaluation of the policies in section 71117 of OBBBA and its interactions with other policies in the legislation. It would be administratively burdensome for all involved for CMS to finalize this rule without considering policy changes in OBBBA without providing a separate opportunity for notice and comment. Thus, we request CMS continue to rely on the longstanding rules and practices for waivers of broad-based and uniformity requirements for health care-related taxes until such time as rule making can be undertaken.

Limit the Policy to Managed Care Organizations

CMS has pointed to a limited number of state MCO taxes as the rationale for proposing this rule citing a “loophole” used on health care-related taxes that states place on managed care organizations (MCOs). According to CMS, “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” (90 Fed. Reg. 20,578).

Federal regulations at 42 C.F.R. § 433.56(a) list 19 classes of health care items and services to which health care-related taxes may separately apply—for example, inpatient hospital services and physician services. However, one stands out not as a direct service *per se* but generally as a payment for a service: “Services of managed care organizations” (42 C.F.R. §

433.56(a)(8)). With respect to health care-related taxes, the separate MCO class is also called out in federal statute (1903(w)(7)(A)(viii) of the Social Security Act).

Given the scenarios outlined in the proposed rule regarding health care-related taxes on MCOs, we believe CMS should narrowly tailor the scope of the rule to apply only to MCOs. Importantly, this explicit change to narrow the proposed rule to health care-related taxes on MCOs would directly align with CMS' own "Summary of Burden Estimates For Proposed Requirements" where CMS estimated an impact to only seven states (all of which have MCO taxes that would be affected). As discussed elsewhere in this comment letter, given the recent enactment of OBBBA and the related language contained at Section 71117, the FAH believes this narrowing of the proposed rule is both prudent and warranted action. The FAH strongly urges CMS to take a measured and targeted approach to this proposed rule so it can fully understand any broader interaction and associated complexities between this proposed rule and Section 71117 of OBBBA. The provider tax structures affecting hospitals and other providers of health care services have not demonstrated a repeated effort to "exploit the loophole because they pass the current statistical test, but are not generally redistributive . . ." (90 Fed. Reg. 20,578). Congress intended to allow some non-uniform provider taxes, including those based on Medicaid-specific characteristics. This remains unchanged by recent Congressional action. CMS should consider some modest degree of non-uniformity under the flexibility provided in the statute for "exemptions" for other "[p]ermissible waivers" in section 1903(w)(3)(E)(i) of the Social Security Act (42 U.S.C. 1396b(w)(3)(E)(i)).

More specifically, taxes on hospitals, physicians, nursing homes, and other providers play a critical role in supporting adequate reimbursement for services delivered and in maintaining the financial stability and sustainability of a state's Medicaid managed care program. Unlike MCOs that serve exclusively Medicaid beneficiaries, hospitals serve all patients, regardless of health insurance coverage. Hospitals as well as nursing homes and physicians do not pose the same level of risk to program integrity. As CMS proceeds with implementation of OBBBA, the FAH requests that this policy apply only to services of MCOs specified in 42 C.F.R. § 433.56(a)(8).

This request is consistent with current Medicaid law and as amended by OBBBA. Section 71117 of OBBBA amends 1903(w)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1396b(w)(3)(E)(ii)), which addresses situations where "[t]he Secretary shall approve such an application" for a waiver of the uniform tax requirement. In addition, section 1903(w)(3)(E)(i) of the Social Security Act (42 U.S.C. 1396b(w)(3)(E)(i)) states the following: "Permissible waivers may include exemptions for rural or sole-community providers." This clause (i) makes clear that other waivers are permissible, outside of those that Congress says the Secretary "shall approve" in accordance with clause (ii). The Secretary should use his flexibility to target any additional regulatory burden and requirements with respect to a waiver of the uniform tax requirement on only the MCO taxes primarily at issue.

Furthermore, CMS should also clarify that it will not prohibit a state from discounting or excluding inherently low-Medicaid hospital classes, such as psychiatric hospitals, rehabilitation hospitals, critical access hospitals, and long-term acute care hospitals, as reflected in many longstanding waiver approvals, given that these hospitals often are already distressed and are an

important component of the state’s healthcare safety net. Such treatment would be similar to other exceptions regarding provider taxes — for example, rural and financial distressed hospitals (among others) in 42 C.F.R. § 433.68(e)(1)(iii)(B).

Provide Maximum Transition Period for Affected Taxes

In the proposed rule, a new 42 C.F.R. § 433.68(e)(4) permits for transitioning some previously approved taxes that would not satisfy the proposed (e)(3). The dates would be based on the effective date of the rule, if finalized, as follows:

- No transition period would be available for healthcare-related tax waivers that do not satisfy the new (e)(3) that were approved 2 years or less before the final rule effective date.
- For healthcare-related tax waivers that do not satisfy the new (e)(3) that were approved more than 2 years before the final rule effective date, states would have two options—
 - Submit a revised waiver proposal that complies with (e)(3), with an effective date no later than the start of the first state fiscal year beginning at least one year from the final rule effective date, or
 - Modify the tax to comply with this rule and all other applicable federal requirements, also with an effective date no later than the start of the first state fiscal year beginning at least one year from the final rule effective date.

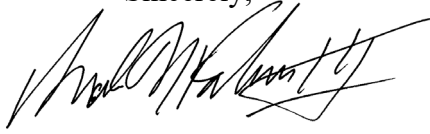
As previously mentioned, (1) this transition period is substantially shorter than that permitted under OBBBA, and (2) OBBBA substantially limits states’ ability to modify provider taxes as it simultaneously institutes other limitations (section 71115 of OBBBA). This is particularly important as so many provider taxes support the sustainability of Medicaid managed care in many states through state directed payments. The proposed accelerated transition period is inconsistent with past CMS transition period precedent such as in last year’s managed care final rule at 89 Fed. Reg. 41002, 41109-10 (May 10, 2024). In that final rule, CMS provided for a three-year transition for states to be in compliance with the prohibition of separate payment terms for Medicaid managed care capitation rates where CMS stated:

*“Therefore, we are not finalizing §438.6(c)(6) as proposed and will instead, as we invited comments on, adopt a new provision at paragraph (c)(6) requiring that all SDPs be incorporated into Medicaid managed care capitation rates as adjustments to base capitation rates and prohibiting the use of separate payment terms. In §438.6(c)(8)(iv), we establish that this new prohibition is applicable beginning with the first rating period for contracts with MCOs, PIHPs and PAHPs **beginning on or after 3 years after July 9, 2024** (emphasis added), which will provide three rating periods for States to transition from use of separate payment terms.”*

We are very concerned with the current timeline laid out in the proposed rule to implement such a transition (even with a more limited scope) that will have significant impacts on states’ Medicaid programs and budgets. Thus, CMS should provide the maximum allowable transition period for states for any new requirements regarding a waiver of uniformity.

The FAH appreciates this opportunity to submit these comments. If you have any questions or if we can assist CMS as it considers these recommendations, please contact me or any member of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "A. M. ...". The signature is fluid and cursive, with a large initial letter 'A' and a long horizontal stroke extending to the right.