Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes [CMS-2452-P]
Proposed Rule Summary

On July 23, 2026, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (91 FR 46562) a proposed rule to revise standards for determining whether an indirect hold harmless arrangement exists for a health care-related tax (sometimes referred to as a provider tax).[1] The rule would implement section 71115 of P.L. 119-21, herein referred to as the "Working Families Tax Cut (WFTC) legislation," which established new indirect hold harmless thresholds for health care-related taxes.[2]

Currently, the threshold for a State's collection of tax revenues is no more than 6 percent of net patient revenue attributable to the assessed permissible class of health care items or services. Under the WFTC legislation:

- Effective October 1, 2026:
  - If a State has not enacted and imposed a tax on a provider class as of July 4, 2025, the hold harmless threshold for taxes on that provider class is zero.
  - If a State enacted and imposed a tax on a provider class as of July 4, 2025, the hold harmless threshold is equal to the applicable percent of net patient revenue attributable to the taxes imposed on that class in that State as of July 4, 2025.
- Beginning October 1, 2027, for expansion States, further reductions, or "phase-down," of the maximum hold harmless threshold may apply.

CMS also proposes to sunset a secondary prong of the regulatory indirect hold harmless determination "to ensure the thresholds determined as of July 4, 2025, serve as the maximum permissible level."[3] In addition, the rule proposes to add a new permissible class—"Services of health insurers."

Comments on the proposed rule are due by September 21, 2026.

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[1] On July 21, 2026, when CMS placed this rule on public display, it also released a fact sheet, "Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes Proposed Rule."
[2] The WFTC legislation is also known as the "One Big Beautiful Bill Act." CMS published guidance on this provision (1) in a "Dear Colleague" letter ("Section 71115 and 71117 of Working Families Tax Cuts Legislation on Provider Taxes") on November 14, 2025, and (2) as part of a broader summary of WFTC provisions affecting Medicaid and CHIP on November 18, 2025 (CMCS Informational Bulletin (CIB), p. 14).
[3] This summary uses CMS' descriptions and terms—generally without quotations marks, for ease of reading.

I. Background

A. Overview

Federal Medicaid funds are Federal grants to States for Medicaid programs to provide medical assistance to persons with limited income and resources. The dollar amount of the Federal share of Medicaid expenditures is called Federal Financial Participation (FFP). The share of Federal funding for medical assistance (benefit) expenditures is determined by the Federal medical assistance percentage (FMAP), which is calculated for each State using a formula in statute, or other applicable FFP match rates specified by the statute. For administrative claims, the Federal matching rate is 50 percent.

States may raise their "non-Federal share" in various ways, including through health care-related taxes—that is, taxing health care items or services, or the providers of those items and services, consistent with Federal statutory requirements in section 1903(w) of the Social Security Act ("the Act") and implementing regulations at 42 CFR part 433, subpart B.[4]

B. Health Care-Related Taxes

Since 1991, Federal law has included limitations on the amount of FFP that States may obtain when they generate their non-Federal share from funds donated from providers or related entities, and revenues generated by certain health care-related taxes. Since 1992, CMS has issued related regulations, which the agency reviews.

Section 1903(w) of the Act provides for a reduction of Federal Medicaid matching funds based on State health care-related taxes unless those taxes meet general statutory requirements:

(1) Imposed on a permissible class of health care items and services;[5]
(2) Broad-based, or apply to all non-Federal, nonpublic providers within a class of health care items and services;
(3) Uniform, such that all providers within a class must be taxed at the same rate; and
(4) Not part of impermissible hold harmless arrangements in which collected taxes are returned to the taxpayer, whether directly or indirectly.

[4] Henceforth, all regulatory citations in this summary will be to title 42 of the Code of Federal Regulations (CFR) unless noted otherwise.
[5] Nineteen classes are listed at 42 CFR 433.56(a). As already mentioned and described in greater detail in section II.B, CMS proposes to add another class for "Services of health insurers" excluding Medicaid MCOs.

Section 1903(w)(3)(E) specifies that the Secretary shall approve a health care-related tax waiver for the broad-based 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 for which the tax is imposed.[6] To enforce the "generally redistributive" requirement of a waiver of the broad-based or uniformity requirements, CMS applies specific tests. For the tax to be considered generally redistributive, a State must satisfy:

- §433.68(e)(1) and (3) for a broad-based waiver only, or
- §433.68(e)(2) and (3) for a uniformity waiver (whether or not a broad-based waiver is also requested).

These tests 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.

Under section 1903(w)(1)(A), prior to calculating FFP, the Secretary will reduce a State's medical assistance expenditures by the sum of any revenues from health care-related taxes that do not meet the requirements of section 1903(w).[7]

C. Direct and Indirect Hold Harmless Arrangements

Section 1903(w)(4) and §433.68(f) describe hold harmless arrangements with respect to health care-related taxes. According to section 1903(w)(4)(C)(i), a hold harmless provision exists where—

> "[t]he State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax."

Similar language exists in §433.68(f)(3).

There are two general types of hold harmless arrangements: direct and indirect.

Direct Hold Harmless Arrangement. Under a direct hold harmless arrangement, CMS says the State provides a payment (Medicaid or non-Medicaid), offset, or waiver to the providers (whether through direct or indirect payments, including payments redistributed through an intermediary) that guarantees to repay the providers for part or all of the cost of the tax and thereby holds them harmless for the cost of the tax. CMS states, "It is the payment, not necessarily the unit of government, that guarantees to hold the provider harmless for the cost of the tax." In the preamble to a 2008 final rule ("Medicaid Program; Health Care-Related Taxes" (73 FR 9685) (2008 final rule)) amending §433.68(f)(1) through (3), CMS explained that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments)."

[6] The permissible class and hold harmless requirements cannot be waived.
[7] This reduction in a State's claimed expenditures is codified in §433.70(b), which CMS proposes to amend.

Indirect Hold Harmless Arrangement. If no direct hold harmless arrangement is found, CMS tests for an indirect hold harmless arrangement, which was first implemented in the 1992 IFC[8] at §433.68(f)(3)(i)(A), where it is referred to as an "indirect guarantee." In that rule, CMS explained that a hold harmless exists if the State or other unit of local government imposing the tax provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax. If an explicit guarantee (direct hold harmless) did not exist, a two-prong test for an indirect hold harmless arrangement would apply, described below.

CMS says it is possible for a State to indirectly provide a payment within the meaning of section 1903(w)(4)(C)(i) of the Act that directly guarantees to hold taxpayers harmless for all or any portion of the costs of the tax, if some or all of the taxpayers receive those payments through an intermediary (for example, a hospital association or similar provider affiliated organization).[9] In the 2008 final rule, CMS said that hold harmless arrangements may not be overtly established through State law but can be based instead on "reasonable expectations" that certain actions will take place among participating entities that will result in taxpayers being held harmless for all or a portion of their health care-related taxes.

First Prong. Under the first prong, CMS compares the revenues from a tax imposed on a permissible class to the revenue attributable to the assessed permissible class of health care items or services (net patient revenue). If the tax produces revenues of more than 6 percent of the net patient revenue,[10] CMS may determine that an indirect hold harmless exists, depending on whether the tax passes the second prong.

In the 1992 IFC, CMS said it chose the threshold of 6 percent because it was the average level of taxes applied to other goods and services in the States. Thus, if tax collections exceed a certain amount of taxpayers' revenue, there likely exists a means of providing money (through Medicaid payments or otherwise) back to those taxpaying entities to repay tax costs.

This first prong is commonly known as the "6 percent test" or the "safe harbor threshold."

Second Prong. If the tax exceeds the 6 percent threshold, CMS evaluates the tax under the second prong of the test, referred to as the "75/75 test": If, in the aggregate, 75 percent of taxpayers receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments, CMS will determine that an indirect hold harmless

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[8] 57 FR 55118, November 24, 1992.

[9] Note, there has been recent litigation dealing with "whether the hold-harmless rule prevents … private-to-private redistribution" (e.g., *Fla. Agency for Health Care Admin. v. Adm'r for Ctrs. for Medicare & Medicaid Servs.*, No. 24-10875, slip op. at 7 (11th Cir. Dec. 5, 2025) and *Texas v. Ctrs. for Medicare & Medicaid Servs.*, 805 F. Supp. 3d 734, 743-44 (E.D. Tex. 2025)). The 11th Circuit found that the State government does not need to be the party actually providing the guarantee in order for the guarantee to run afoul of the hold harmless test (*Fla. Agency*, slip op. at 25-26, 29). The Texas district court found otherwise: "In sum, CMS has no statutory authority to reach private hold-harmless arrangements or to penalize a state's failure to regulate these agreements" (*Texas v. Ctrs. for Medicare & Medicaid Servs.*, 805 F. Supp. 3d 734, 743-44 (E.D. Tex. 2025)). CMS' appeal in the Texas case is pending in the Fifth Circuit, while the Florida case was remanded to the district court for further proceedings.

[10] Under section 403 of the Tax Relief and Health Care Act of 2006 (P.L. 109-432), the indirect hold harmless threshold was temporarily reduced from 6 percent to 5.5 percent for January 1, 2008, through September 30, 2011. In the 2008 final rule, this was incorporated into regulation located at §433.68(f)(3)(i)(A).

arrangement exists and the tax will be impermissible and subject to the reduction in medical assistance expenditures.

CMS describes a 2018 report from the HHS Office of Inspector General (OIG).[11] In sum, the report found that although the provider taxes were considered permissible because they were below the indirect guarantee hold harmless threshold of 6 percent, the rate of return of Medicaid taxes in the form of Medicaid payments led the OIG to recommend that CMS "re-evaluate the effects of the health care-related tax safe-harbor threshold and the associated 75/75 requirement to determine if modifications are needed, such as the reduction or elimination of the safe harbor threshold or adjusting the 75/75 requirement and take appropriate action." CMS concurred and stated that it would evaluate both to determine if modifications are necessary. Through this proposed rule and due to the regulatory action required the WFTC legislation, CMS says it is re-evaluating the appropriateness of the 75/75 test.

D. Working Families Tax Cuts Legislation

CMS recaps section 71115 of the WFTC legislation, which amended section 1903(w)(4) of the Act by modifying the indirect hold harmless threshold for fiscal years (FYs) beginning on or after October 1, 2026. Specifically, the previous "6 percent" threshold is replaced with an amount, as of July 4, 2025, based on the percent of net patient revenue attributable to the permissible class for which the health care-related tax (1) was enacted by a State or unit of local government, and (2) that the State or locality imposes. If a State or unit of local government[12] has not enacted and imposed such a tax as of July 4, 2025, the applicable percent for that class is zero percent.

Beginning in Federal fiscal year (FFY) 2028, the methodology differs for an expansion State, which is defined in the WFTC legislation as "a State that, beginning on January 1, 2014, or on any date thereafter, elects to provide medical assistance to all individuals described in section 1902(a)(10)(A)(i)(VIII) under the State plan under this title or under a waiver of such plan." For expansion States, the indirect hold harmless threshold will be subject to a statutory phase-down beginning in FFY 2028. The applicable threshold for each permissible class will be the lower of the July 4, 2025, calculated threshold, or the applicable percent for the FFY:

- 5.5 percent in FFY 2028,
- 5.0 percent in FFY 2029,
- 4.5 percent in FFY 2030,
- 4.0 percent in FFY 2031, and
- 3.5 percent in FFY 2032 and beyond.

For example, if an expansion State has a threshold of 4.7 percent for the inpatient hospital services permissible class based on taxes enacted and imposed on July 4, 2025, the State's threshold would be 4.7 percent for FFY 2027, 2028, and 2029; 4.5 percent for FFY 2030; 4.0 percent for FFY 2031, and 3.5 percent in FFY 2032 and beyond.

[11] "Although Hospital Tax Programs in Seven States Complied with Hold-Harmless Requirements, the Tax Burden on Hospitals Was Significantly Mitigated," OIG Report A-03-16-00202, Nov. 18, 2018.
[12] Henceforth, references to the State as the taxing authority includes units of local government.

Under the WFTC legislation, this phase-down is not applicable to health care-related taxes imposed on the nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) permissible classes, although those will still be subject to the threshold calculated as of July 4, 2025.

The WFTC amendments to section 1903(w)(4) are applicable to all States and the District of Columbia, but not to the territories.

E. Concerns Regarding Permissible Tax Classes of Health Care Services and Providers

Over the past several years, CMS has become aware of States imposing taxes on health insurers, typically as a tax on health insurance premium revenue. Because health insurers are not currently identified as a permissible class, many existing taxes on health insurers would be impermissible to the extent they are health care-related taxes. Although CMS attempted to address the issue in the 2019 proposed rule "Medicaid Fiscal Accountability Regulation" (MFAR) (84 FR 63722), that rule was withdrawn and never finalized. Due to WFTC changes, CMS is revisiting the proposal. Besides the absence of a currently recognized permissible class for such taxes, taxes on health insurers are not presently subject to the same class-specific review process, making it more difficult for CMS to evaluate their structure and impact on Medicaid.

CMS first defined the permissible classes in the 1992 IFC based on the permissible classes listed in section 1903(w)(7)(A). In 1993, in accordance with section 1903(w)(7)(A)(ix), which authorizes the Secretary to establish "such other classification … as the Secretary may establish by regulation," CMS added other classes and described the criteria used for considering further additions:

(1) The revenue of the class is not predominantly from Medicaid and Medicare (not more than 50 percent from Medicaid and not more than 80 percent from Medicaid, Medicare, and other Federal programs combined);
(2) The class is clearly identifiable—for example through State licensing programs, Federal statutory recognition, or inclusion as a provider in State plans; and
(3) The class is nationally recognized rather than unique to a single State.

The list of permissible classes (§433.56(a)) has remained largely unchanged since that time.

As discussed in greater detail below in section II.B (and similar to the 2019 proposed rule), this proposed rule would add services of health insurers—other than services of managed care organizations (MCOs) (including HMOs and PPOs) as defined in §433.56(a)(8)—as a permissible class of health care items or services under §433.56. The indirect hold harmless threshold requirements in this proposed rule would apply to this new class.

II. Provisions of the Proposed Regulations

As typical as of late, CMS makes a statement about severability—that if any provision of the proposed rule, if finalized, is held to be invalid or unenforceable, or is stayed pending further action, that provision shall be severable from the remainder of the final rule.

A. General Definitions (§433.52)

CMS proposes to add new definitions to §433.52:

- Expansion State means a State that, beginning on January 1, 2014, or on any date thereafter, elects to provide Medicaid to all individuals in section 1902(a)(10)(A)(i)(VIII) under the Medicaid State plan or under a waiver.
- Net Patient Revenue means revenues received by the taxpayer, which are revenues attributable to the assessed permissible class of health care items or services, regardless of payer source.
- Non-Expansion State means a State that is not an expansion State.

Regarding the definition of net patient revenue, CMS says it is a restatement of how the term currently appears in §433.68(f)(3)(i)(A). It also emphasizes that those revenues are limited to the permissible class being taxed; for example, the net patient revenue from a tax on a hospital's inpatient hospital services permissible class (§433.56(a)(1)) would not include patient revenue from the hospital's outpatient hospital services (§433.56(a)(2)). Further, net patient revenue does not include revenues from non-patient care (such as gift shop revenues, cafeteria revenues, or parking revenues) because such revenues cannot be subject to a health care-related tax under any permissible class in §433.56(a).

CMS notes that it considered but did not propose to define net patient revenue to include only revenue associated with the providers within the permissible class that are actually taxed. It did not propose this alternative definition for multiple reasons, including that it would conflict with the statute. **CMS invites comment** on this alternative definition of net patient revenue or other modifications to the definition.

CMS also considered but did not propose to define a term such as "total tax collection" for the numerator of the indirect hold harmless calculation, which is the total tax revenue collected for all health care-related taxes imposed on a permissible class. It did not propose such a definition because it does not believe there is confusion about this concept and has not used a single term consistently for this feature as it has with net patient revenue. **CMS invites comment** on inclusion of a term such as "total tax collection" or any other additional terms in the definitions in §433.52.

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

As previously mentioned, section 1903(w)(7)(A)(ix) authorizes permissible classes of health care items and services based on "such other classifications consistent with section 1903(w)(7)(A) of the Act as the Secretary may establish by regulation." The Secretary has used that authority to add to the list of classes in §433.56(a).

CMS is proposing to add a new class of health care items and services to the list in §433.56(a). CMS proposes paragraph (a)(19) would say:

> "*Services of health insurers (other than services of managed care organizations (including health maintenance organizations and preferred provider organizations) as specified in paragraph (a)(8) of this section).*"

This addition would permit States and units of local government to use revenue collected from taxes imposed on these services as the non-Federal share since, if finalized, such tax revenue would be derived from a permissible class for purposes of section 1903(w). Several States *already* use taxes imposed on health insurers as the source of non-Federal share, including taxes based on health insurance premiums revenue or other insurance-related measures, despite health insurers not currently being identified as a permissible class under §433.56(a). The new health insurer class would encompass health insurer services that are not MCO services, which are already accounted for in current regulations at §433.56(a)(8). The Deficit Reduction Act of 2005 modified the MCO provider class to "more broadly encompass services provide [sic] by all managed care organizations without regard to their status as Medicaid or commercial health plan or the form of such plan" (73 FR 9690). While there is potential overlap between these two provider classes, CMS says they are distinct and believes at least some of these taxes have been in place for a long time and appear to meet the definition of, and function as, health care-related taxes. CMS is opting to establish a new permissible class rather than determine which particular circumstances are inappropriate.[13]

CMS says some States may not have understood that, for example, certain taxes imposed through their insurance commissions, which possibly provided the non-Federal share for Medicaid expenditures, could constitute health care-related taxes under section 1903(w) of the Act, notwithstanding that health insurers are not currently included in §433.56(a). This situation has resulted in identification of numerous taxes on health insurers that may not have previously been evaluated under a clear regulatory framework addressing their treatment under section 1903(w), creating uncertainty among States that CMS is addressing through this rule.[14]

The WFTC legislation amended the indirect hold harmless requirements pointing to the regulatory list of permissible classes in effect on May 1, 2025.[15] CMS notes that the legislation did not amend section 1903(w)(7)(A)(ix) or address the establishment of new permissible classes not in Federal regulation as of May 1, 2025, "leaving CMS authority to establish additional permissible classes undisturbed."

Adding to the regulatory list would facilitate CMS review of such taxes under the existing framework for permissible classes, including whether they are structured to impermissibly target items or services financed primarily or exclusively through Medicaid, which would make it unlikely the tax could satisfy the "generally redistributive" requirement if the State sought a waiver of the broad-based and/or uniformity requirements.

Examples of metrics that could be used to assess a tax on services of health insurers include health insurance premium revenue or covered lives. The proposed class would also include health insurers offering plans to Medicaid beneficiaries under a section 1115 demonstration that

[13] The agency previously attempted to address the issue in the 2019 proposed MFAR rule, but that proposed rule was withdrawn.
[14] The agency notes that it is not aware of any other State-imposed taxes that appear to be health care-related taxes under section 1903(w) despite the absence of a corresponding permissible class under §433.56(a).
[15] Section 71115 of the WFTC legislation points to May 1, 2025, as the date to use for when the list of permissible classes at §433.56(a) was in effect. The other date-specific components of that section (for example, the date on which the "State has enacted a tax and imposes such tax") are on the date of enactment, which was July 4, 2025.

provides premium assistance to purchase qualified health plan coverage through the Health Insurance Exchange. **CMS is seeking comment** on the scope of this permissible class to ensure all appropriate services of health insurers are included.

CMS goes on to describe in detail how taxes on the new permissible class qualify as "health care-related taxes" and how the new class satisfies all of the agency's 1993 criteria for adding another class. It also describes why it chose the broad term of "[s]ervices of health insurers," rather than something narrower like "services of a health insurance issuer," which is a defined term at 45 CFR 144.103. For example, CMS says the proposed class would include:

- Insurers that issue policies for the group market and/or the individual market, including high-deductible or "catastrophic" plans;
- Issuers of short-term limited-duration policies as defined in 45 CFR 144.103;
- Issuers of coverage for "excepted benefits," as defined in 45 CFR 146.145 for the group market and 45 CFR 148.220 for the individual market, such as dental-only and vision-only policies;
- Medicare Advantage plans pursuant to Medicare Part C;
- Prescription drug plans offered under Medicare Part D; and
- Coverage under which premiums are paid on behalf of individuals as part of a section 1115 demonstration in which Medicaid funding is used for premium assistance to help beneficiaries purchase coverage through commercial health insurance plans.

CMS is soliciting comments on the definition of this permissible class to ensure that the appropriate entities and services (or payment for services) are included.

While section 71115 of the WFTC legislation amends the statutory indirect hold harmless threshold to health care-related taxes imposed on permissible classes "as in effect on May 1, 2025," CMS notes that the statute is silent on whether, or how, the amended indirect hold harmless threshold provisions should apply to permissible classes added after May 1, 2025. In the absence of an express statutory directive and consistent with its general authority to implement section 1903(w), CMS proposes that if the permissible class for services of health insurers is finalized, health care-related taxes imposed on this class would be subject to the same indirect hold harmless threshold framework that applies under section 71115 of the WFTC legislation to taxes imposed on permissible classes as in effect on May 1, 2025. Although section 71115 of the WFTC legislation does not specify thresholds for permissible classes established after May 1, 2025, the agency believes the most appropriate implementation of section 1903(w) is to apply the same indirect hold harmless framework applicable to preexisting permissible classes. Thus, taxes on the newly established class (if finalized as proposed) that were not enacted and imposed as of July 4, 2025, would have an applicable percent of zero. CMS also proposes that the newly added permissible class of health insurers would be subject to the same phase-down requirements applicable to other permissible classes for expansion States.

C. Permissible Health Care-Related Taxes (§433.68)

The current indirect hold harmless threshold regulations—specifically, the two-prong test—are codified in regulations at §433.68(f)(3)(i)(A) and (B). The following sections describe CMS' proposals to implement the section 71115 of the WFTC legislation, which applies to the indirect

hold harmless thresholds "for fiscal years beginning on or after October 1, 2026," and to make other related changes.

1. Restructure of existing regulations, effective until October 1, 2026

For the two-prong test in current regulations, CMS proposes to restructure the language in §433.68(f)(3)(i) to add new introductory language specifying that test applies for periods prior to October 1, 2026, for determining if an indirect guarantee exists. Proposed paragraph 433.68(f)(3)(i)(A) would describe the first prong, the "6 percent test," as an examination of the tax as a percent of net patient revenue. Proposed paragraph (f)(3)(i)(B) would generally maintain the language for the second prong, the "75/75 test." The only change proposed is to divide the first sentence into two sentences and slightly revise them, to state more clearly when CMS will apply the second prong. As discussed later in section II.C.4, CMS is proposing not to maintain the second prong after October 1, 2026.

The new regulations in §433.68(f)(3)(ii) would apply for "Federal fiscal years beginning on or after October 1, 2026," stating that "an indirect guarantee will be determined to exist if a State exceeds a threshold calculated and applied as specified in this paragraph." Section 71115 of the WFTC legislation used the term "fiscal years," but CMS proposes to specify "Federal fiscal years," which is elaborated on below in section II.C.3.

CMS says it does not intend to change the meaning of any of the existing requirements and **invites comment** on any further ways to make the existing regulations clearer.

2. Calculation of Threshold

Current regulations in §433.68(f)(3)(i) specify the methodology used to calculate whether a tax exceeds the indirect hold harmless threshold. Those basic mechanics are not altered by this proposal. The applicable percent would continue to be calculated by dividing the total amount of tax revenue collected for the permissible class by the net patient revenue attributable to that class.

However, section 71115 of the WFTC legislation requires CMS to determine a new applicable percent for each permissible class based on whether a health care-related tax was enacted and imposed on that class as of July 4, 2025. The next section describes how CMS would apply the existing methodology in light of the new statutory requirements to ensure consistent implementation before and beginning October 1, 2026. This section describes the proposed methodology to calculate the threshold that would replace the 6 percent indirect hold harmless percentage for each permissible class for which a State or locality enacted and imposed a tax as of July 4, 2025.

In proposed §433.68(f)(3)(ii)(A), CMS would establish how it would perform the calculations of the new threshold that will apply for a permissible class in a particular State. Once determined, that percentage would not change and would be the maximum tax revenue percentage for that class. However, each State would have its own percentage for each permissible class, which could differ across States and permissible classes. For example, State A may have a threshold

percentage of 3.5 percent for taxes on nursing facility services, while State B has a threshold percentage of 2 percent for those same services. State A may have a 3.5 percent threshold for taxes on nursing facility services and a 4 percent threshold for taxes on inpatient hospital services.

CMS reminds States that the tax rate and the indirect hold harmless threshold are not the same. For example, a State could obtain a broad-based waiver to exclude psychiatric hospitals from its inpatient hospital services tax. Thus, the indirect hold harmless percentage would likely be lower (e.g., 3 percent) than the tax rate (e.g., 4 percent) because the net patient revenue used for the indirect hold harmless percentage calculation would include all hospitals in the permissible class for the State, including psychiatric hospitals with an inpatient hospital services tax rate of zero. As such, a tax may be permissible even when the tax rate is higher than the indirect hold harmless threshold, provided the total tax collected for the permissible class does not exceed that threshold. This kind of scenario can exist under current regulations and would continue under the proposed regulations.

CMS proposes to round to nine decimal places when calculating the new thresholds since that is the limit it uses for resource proxies in eligibility determinations. Currently, no rounding policy is specified for CMS' tax-related calculations. **CMS invites comment** on the appropriate number of decimal places to use in determining the indirect hold harmless threshold.

a. Enacted and Imposes

CMS recaps the effects of section 71115 of the WFTC legislation on the statutory indirect hold harmless threshold applicable for health care-related taxes, effective October 1, 2026:

- For non-expansion States, the threshold may not exceed the applicable percent of net patient revenue attributable to health care-related taxes enacted and imposed as of July 4, 2025; and
- For expansion States, the threshold is the lower of the July 4, 2025, applicable percent or the applicable phase-down amount beginning in FY 2028.

On November 14, 2025, CMS released sub-regulatory guidance entitled "Section 71115 and 71117 of Working Families Tax Cuts Legislation on Provider Taxes," referred to as the "Dear Colleague Letter" describing CMS' initial interpretation of the terms "enacted" and "imposes." CMS now proposes to revise its interpretation "in a manner we believe more accurately reflects the status of a tax relative to waiver approval when applicable … ." Proposed §433.68(f)(3)(ii)(A)(*1*) would codify CMS' updated interpretation of the terms "enacted" and "imposes."

Proposed §433.68(f)(3)(ii)(A)(*1*)(*i*) would specify that a tax is enacted if the applicable State or local government has completed the entire legislative process necessary to authorize the tax, either initially or to amend an existing tax that was in effect on or before July 4, 2025. The enacted tax structure as of July 4, 2025, would not include administrative or legislative adjustments to a tax structure, including actions by a State budget office or State legislature (including revenue increases) that are retroactively applicable to July 4, 2025, or earlier.

In the Dear Colleague Letter, CMS had included a requirement for waiver approval in its interpretation of "enacted," on the basis that waiver approval was necessary for a tax to be both enacted and imposed. However, following initial feedback from States and interested parties, CMS has determined it is more appropriate to address waiver-related requirements under the interpretation of "imposes," not "enacted." CMS believes this better reflects the role of waiver approval in determining when a tax may be *imposed* for purposes of using the resulting revenues as Medicaid non-Federal share, consistent with the regulatory language currently in §433.72(b) concerning requirements for a waiver to permit the State "to receive tax revenue … without a reduction in FFP … ."

CMS also proposes an updated interpretation of "imposes" from that described in the Dear Colleague Letter—specifically, that a tax is "imposed" as of July 4, 2025, if it was in effect. In other words, the tax was imposed on taxpayers as a legally enforceable obligation to pay as of July 4, 2025.[16] Under the proposal, if the tax requires a broad-based and/or uniformity tax waiver, the tax waiver must have either been approved as of July 4, 2025 or, if approved after that date, must have an effective date of July 4, 2025, or earlier. CMS provides additional examples and discussion of the interpretation change from the Dear Colleague Letter.

In general, CMS expects that a State can demonstrate that the tax was imposed—that is, the taxpayers were subject to a legally enforceable obligation to pay the tax as of July 4, 2025—by pointing to the legislative language establishing the tax. Otherwise, States may provide documentation demonstrating that the tax obligation was in effect, such as billing information or collection activity. Under the reporting requirements discussed in section II.E.1, States must provide the documentation necessary to demonstrate a tax is imposed as of July 4, 2025.

Under proposed §433.68(f)(3)(ii)(A)(*2*), in cases where a tax has not been enacted and imposed as of July 4, 2025 (that is, there are no revenues attributable to the July 4, 2025, timeframe), the threshold would be calculated to be zero.

Under proposed §433.68(f)(3)(ii)(A)(*3*), in no case shall the threshold percentage exceed 6 percent—unless, as of July 4, 2025, a State has demonstrated to CMS that the State's tax met the requirements for the 75/75 test. This provision is intended to address two circumstances:

- If the State's new threshold exceeds 6 percent and the tax was not permissible under the 75/75 test as of July 4, 2025, the State's new threshold would be capped at 6 percent.
- If the tax was permissible under the 75/75 test, CMS would allow for the continuation of taxes that exceeded the 6 percent threshold as of July 4, 2025, to the extent the tax was permissible under the 75/75 test. However, CMS does not expect any State will meet these criteria.

[16] In the Dear Colleague Letter, CMS discussed circumstances where a State was *actively collecting* the tax as of July 4, 2025, and where the State was collecting on a delayed schedule according to routine practice. While the agency generally expects that active collection of the tax as of that date would be conclusive evidence that the State or local taxing authority "imposes" the tax as of that date, the framing caused some individuals to believe CMS was defining "imposed" as effectively synonymous with "collected." The revised interpretation is intended to address those concerns by explaining that the operative issue is whether or not the tax was in effect such that taxpayers were subject to a legally enforceable obligation to pay the tax as of July 4, 2025.

If a tax exceeds 6 percent and was not permissible under the 75/75 test as of July 4, 2025, the tax could place the State at risk of reductions in claimed expenditures by the amount of revenue raised from the tax if the State imposes a tax rate that exceeds the capped 6 percent threshold. While CMS says it does not believe any aspect of this proposed regulation contradicts prior CMS guidance on how to calculate this percentage in terms of the basic data and calculations performed, it recognizes the details and specific methodology proposed may differ from approaches States have used in the past to produce the data for such calculation and for which CMS confirmed compliance with the applicable threshold.

For example, during tax waiver submissions, CMS has historically accepted estimates, trended figures, and prior period data as substitutes for actual tax collections to establish compliance with the 6 percent threshold. Under this proposal, CMS would standardize the methodology by relying on actual tax revenue collected and actual net patient revenue for the relevant period, which may be different from the data States previously used. However, absent evidence of fraud or other exceptional circumstances, CMS states that if a State would have satisfied the 6 percent test during a financial review using estimates, prior-period figures, or base-year data under previously accepted CMS practices, the agency generally would not expect to seek reduction in claimed expenditures solely because the actual data required under this methodology show that the tax "slightly" exceeds the 6 percent threshold. CMS expects such situations to arise infrequently—for example, when net patient revenue has decreased unexpectedly—and for the amount that exceeds 6 percent to be minimal.

The agency emphasizes that this position does not preclude it from reviewing and considering reductions in claimed expenditures for more significant excesses in revenue or in circumstances where a State is unable to demonstrate the tax would have satisfied the 6 percent test using data sources that historically would have been accepted. CMS says that States in this position must take proactive steps if they determine that their tax revenue collections for the State fiscal year (SFY) that includes July 4, 2025, will exceed the 6 percent threshold. For example, before the final threshold is calculated, States may refund tax revenues collected in excess of the 6 percent threshold (in proportion to the amount of total tax revenue that the taxpayer paid[17]).

CMS invites comment on applying these definitions and policies to the proposed new permissible class.

b. Data Timelines and Reporting

To determine the new indirect hold harmless threshold applicable for a State and permissible class, CMS must first calculate the indirect hold harmless percentage based on the tax revenue attributable to the enacted and imposed tax structure as of July 4, 2025. Currently, the percentage is calculated using a fraction comparing tax collections to net patient revenue; CMS is proposing to change the basic methodology.

[17] States may make only uniform changes to rates specified in an approved tax waiver, without obtaining a new waiver approval. A uniform change is a change that is the same percentage change for all providers, such as a 2 percent reduction in the tax rate for all taxpayers.

The numerator would consist of the total dollar amount collected for all health care-related taxes that are imposed on a permissible class. Specifically, the State would add all revenue actually collected for each health care-related tax imposed on that permissible class, including amounts recovered through involuntary mechanisms such as Medicaid payment offsets. CMS lists several reasons why it is important not to include unpaid tax liabilities and to include only the money actually collected.

The denominator would consist of the net patient revenue attributable to all providers in the permissible class, including both providers that are subject to the tax and those that are not, and excluding patient revenue owed but not collected. CMS intends to work with States to ensure proper attribution of revenue amounts from combined data sources, such as inpatient and outpatient hospital revenue (which must be disaggregated into their individual permissible classes). In general, and depending on the circumstances, CMS does not intend to take enforcement actions against States for misattributions. Where misattributions occur, CMS will work collaboratively with States to correct them. However, the agency says that under no circumstance can revenues from a different class of items or services be included in the calculation.

The calculation of the percentage of net patient revenue attributable to a permissible class for which a health care-related tax was enacted and imposed as of July 4, 2025, requires both the *total tax revenue collected* under the enacted and imposed tax structure and the *total net patient revenue* attributable to the permissible class. However, due to differences in State collection cycles and the timing of reporting revenue, a single snapshot date (e.g., July 4, 2025) cannot accurately represent the relationship between tax collections and net patient revenues for all States and all providers in all permissible classes. CMS has historically relied on annualized data for these purposes and continues to view a full year of data as the most appropriate timeframe for measuring the relationship between tax revenue and net patient revenue. Thus, proposed §433.68(f)(3)(ii)(A)(*4*) would use the SFY in which July 4, 2025, falls as the measurement period for calculating thresholds for taxes that are enacted and imposed.[18]

The SFY that includes July 4, 2025, may not readily provide a year of data for certain taxes that are enacted and imposed as of that date, which CMS proposes to accommodate. In proposed subparagraph (*4*), "in circumstances where State or local legislative or administrative changes subsequent to July 4, 2025, affect the revenue collected for the State fiscal year that contains July 4, 2025, States must deduct any revenues attributable to increases that were enacted or imposed after July 4, 2025; where such changes decreased the revenue collected for such period, CMS will consider using tax data from an alternate time period to prevent the post-July 4, 2025, decrease from adversely affecting the threshold calculation." For example, States with increases to taxes effective after July 4, 2025, would have to deduct the increase in revenue attributable to that later change from the tax collection data.

CMS invites comment on the use of the SFY that includes July 4, 2025, as the annual measurement period and whether an alternative annual period would be more appropriate.

[18] Most States already report tax revenue and net patient revenue data on a SFY basis.

CMS clarifies situations in which a State had a health care-related tax that was in effect as of July 4, 2025, but for which continued collection of the tax revenue requires approval of a new broad-based or uniformity waiver. While a State may regard a waiver approval as new based on State tax authorization cycles, CMS generally would treat the tax as continuous for purposes of the applicable threshold. This approach is intended to avoid excluding longstanding taxes solely due to routine reauthorizations or waiver request timing.

CMS invites comment on alternative measurement methodologies for measuring the applicable percent in circumstances where a full year of data may not be available or may not accurately reflect the tax as it existed as of July 4, 2025, including the use of partial year data, which CMS would then annualize to calculate the threshold.

Finally, CMS proposes to include a cross reference in §433.68(f)(3)(ii)(A)(*4*) to the proposed one-time reporting requirements to ensure States are aware that the permissibility of the tax would depend on whether the State has submitted data necessary for CMS to calculate the threshold. States would be required to provide to CMS by June 30, 2028, in the form and manner specified by CMS, the data described in §433.74(b)(1) (section II.E). Because CMS cannot finalize thresholds until these data are submitted and reviewed, States would operate under "interim" indirect hold harmless limits from October 1, 2026, through September 30, 2028 (section II.C.3.c); States would be subject to the indirect hold harmless framework described in §433.68(f)(3)(ii), informed by *interim* threshold amounts based on available reported data, pending submission and review of final data necessary to calculate the applicable thresholds. CMS intends to announce *final* thresholds to States, including the phase-down schedule for expansion States, on Medicaid.gov or another suitable website maintained by HHS, no later than September 30, 2028.

3. Application of Threshold

Based on the preceding description of proposed requirements for calculating the new indirect hold harmless threshold, this section describes how CMS proposes to apply these new thresholds.

a. Timing

The requirements of section 71115 of the WFTC legislation are effective "for fiscal years beginning on or after October 1, 2026." Although CMS proposes to calculate the thresholds based on a SFY of data, it also proposes to apply the threshold for the purposes of monitoring and possible enforcement on a FFY basis (proposed §433.68(f)(3)(ii)(B)). CMS has generally interpreted statutory references to "fiscal year," where Congress has not included distinguishing language, to mean the FFY, except in limited circumstances when the timing makes FFY application impossible or unreasonable, as it mentions in certain examples. In this instance, CMS believes the FFY is the most appropriate basis for application of the indirect hold harmless threshold for several reasons.

Thus, beginning with FFY 2027, States would be required to comply with the indirect hold harmless thresholds established for their health care-related taxes enacted and imposed as of July

4, 2025, on a permissible class basis. Because CMS proposes that States would report the necessary information through the quarterly CMS-64, CMS would be able to determine compliance with the threshold on a FFY basis using the four quarters in that FFY.

b. Phase-down for Expansion States

As previously mentioned, section 71115 of the WFTC legislation specifies that expansion States will be subject to a phase-down of the indirect hold harmless threshold, with respect to taxes on permissible classes as in effect on May 1, 2025, as well as, under this proposal, the new permissible class for health insurers, if finalized.

Under proposed §433.68(f)(3)(ii)(B)(*1*), in the case of a non-expansion State and a class of health care items or services, the threshold would be the amount calculated under paragraph (f)(3)(ii)(A). In other words, because non-expansion States have no phase-down, the provision would codify that the threshold calculated based on the tax structure enacted and imposed as of July 4, 2025, would remain the final threshold for non-expansion States.

Under the WFTC legislation, the phase-down for expansion States is not applicable to health care-related taxes levied on the nursing facility or ICF/IID permissible classes. Thus, CMS proposes to codify that for an expansion State and these two permissible classes (specified in §433.56(a)(3) or (4)), the threshold will be the amount calculated under paragraph (f)(3)(ii)(A), without a phase-down.

In proposed §433.68(f)(3)(ii)(B)(*3*), the indirect hold harmless threshold for expansion States for permissible classes other than those specified in §433.56(a)(3) or (4) would be the lower of:

- The indirect hold harmless threshold of the tax as enacted and imposed as of July 4, 2025; or
- 5.5 percent for FFY 2028, 5 percent for FFY 2029, 4.5 percent for FFY 2030, 4 percent for FFY 2031, or 3.5 percent for FFY 2032 and after.

Since most expansion States have SFYs that do not align with the FFY, CMS says it may need to make accommodations to account for the threshold decreases that may occur mid-SFY. In a lengthy discussion, CMS describes two potential methods to address the issue:

(1) The State could phase down its tax at the same dates to the same rate as required in the phase-down—that is, taxing based on the specific FFY dates and rates.
(2) The State could pro-rate the aggregated net inpatient revenues for all providers for the entire SFY to reflect its partial SFY periods and their applicable net patient revenues and phase-down rates.

CMS acknowledges that net patient revenue may not be earned evenly throughout the year and **solicits comments** on how States may operationalize implementation of the requirements established by section 71115 of the WFTC legislation, including whether the two approaches are appropriate and whether there might be other appropriate approaches.

CMS believes States should already be able to operationalize the differences between the SFY and the FFY, including the mid-SFY changes in the applicable indirect hold harmless percentage

during the phase down because States are already expected to be monitoring compliance with indirect hold harmless thresholds for changes to net patient revenues from year to year.

Finally, CMS proposes that if a current non-expansion State chooses to expand Medicaid and become an expansion State, the phase-down thresholds would apply for the FFY in which the expansion becomes effective.

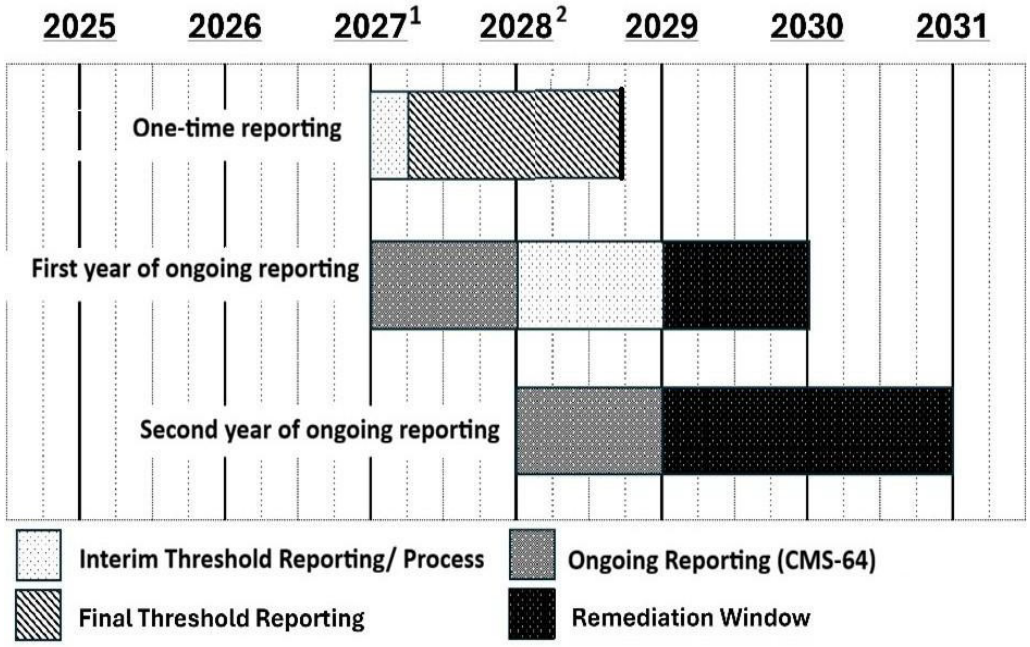
c. Interim Indirect Hold Harmless Threshold Process

Section 1903(w)(4) of the Act, as amended by section 71115 of the WFTC legislation, requires CMS to collect additional tax data to verify that all States are in compliance with the applicable indirect hold harmless threshold. Because those data are not available as quickly as the amendments made by section 71115 of the WFTC legislation take effect, CMS proposes an interim indirect hold harmless threshold process to provide States with an early indication of the thresholds that ultimately may apply. Under this interim process, CMS and States would have time to address data lags and routine revenue collection delays, provide States the opportunity to correct errors in initial reporting, provide reference points for monitoring potential compliance issues, and facilitate review of waiver proposals submitted after October 1, 2026, but before final thresholds are established.

Although the interim threshold would not be binding, CMS intends for it to facilitate review of State waiver proposals while minimizing the later collection adjustments a State may need to make. Section II.E describes the final threshold reporting process as well as a remediation process that would apply after final thresholds have been established and under which States would have up to 2 years to submit all required data for the relevant FFY. At the end of that period, CMS would assess the data for the applicable FFY against the final threshold to determine whether taxes for a permissible class exceed the threshold and, if so, would proceed to reduce the State's expenditures before calculating FFP, in accordance with §433.70(b).

Although the data remediation process and reporting requirement proposals are discussed later, they are duplicated below in CMS' Figure 1 and Table 1 to illustrate how these processes work with the interim period. Figure 1 reflects the time periods for the interim period and remediation processes. Although the ongoing reporting and remediation process will be continuous, CMS represents them as annual processes to reflect the related time periods for the interim period and remediation processes. Table 1 summarizes the various timeframes in this proposal, which may shift based on the timing of the final rule.

FIGURE 1: Interim and Final Threshold Reporting and Process, by FFY



[1] October 1, 2026: Section 71115 becomes effective (FFY 2027).
[2] October 1, 2027: Expansion State phase-down begins (FFY 2028).

TABLE 1: Dates and Timeframes Associated with Proposals

Event	Data Used	Anticipated Timing
Reporting and Calculation of Interim Threshold	Data applicable to the SFY that contains July 4, 2025 – Best estimates	With the CMS-64 for quarter ending December 31, 2026
Reporting and Calculation of Final Threshold	Data applicable to the SFY that contains July 4, 2025 – Actual data	Reporting by June 30, 2028
Ongoing Reporting	Data applicable to the respective quarters of the relevant FFY – Actual data	Quarterly, with enhanced reporting beginning October 1, 2026
Interim Period – Monitoring and waiver submissions	Interim Threshold	October 1, 2027 – September 30, 2028
Announcement of Final Thresholds	Actual data as submitted by June 30, 2028, for SFY that contains July 4, 2025	September 30, 2028
Remediation	Final Threshold	Ongoing, for the time between the end of a reporting period (or in the first year, the interim period when States would adjust based on the interim threshold before a final is available), and possible enforcement
Enforcement	Applicable FFY of ongoing reporting data and data about any remediation undertaken for the FFY	2 years following the end of the applicable reporting period

Based on the data reported under the one-time process proposed in §433.74(b)(2), discussed below in section II.E.1, States would use the interim threshold to make initial adjustments until the final threshold is available, at which point States must reconcile payments and reporting and complete any necessary remediation steps before the remediation period concludes. CMS generally does not intend to make determinations regarding whether a penalty should apply to a tax exceeding the interim threshold until after a final threshold is available and States have had an opportunity to take corrective actions. CMS will make a determination regarding whether a penalty should apply in circumstances where it has reason to believe that a State may have engaged in excessive or intentional overcollections (for example, collections that exceed the current 6 percent threshold or excessive tax collections that are used as a source of non-Federal share to claim Federal matching funds before those excess collections are returned to taxpayers).

CMS says States must report accurate and complete tax collection information and should not attempt to inflate reported tax collection information to artificially increase their interim or final indirect hold harmless threshold. Following review of reported data, if reported amounts appear inconsistent with available information regarding a State's health care-related taxes and tax collection practices, CMS may request additional information under its authority in §433.74.

CMS says it generally does not intend to use this interim threshold to apply penalties but retains discretion to apply penalties and take enforcement action for any period of time, including for the period going back to October 1, 2026, based on the applicable indirect hold harmless threshold.

Under the proposal, the interim period would last 1 year following the first reporting cycle of FFY 2027—that is, FFY 2028—and would allow States to use the interim threshold for oversight and potential waiver submission purposes until CMS issues the final threshold calculations, anticipated no later than September 30, 2028. However, in case of unforeseen administrative challenges, CMS proposes that, where necessary, the interim period may extend through the period between the one-time reporting used to calculate the interim threshold and the announcement of final thresholds.

CMS also proposes to rely on the interim threshold for purposes of evaluating waiver submissions on or after October 1, 2026, and prior to CMS' announcement of final thresholds. However, even if a waiver meets the *interim* threshold and is otherwise approvable, States must address any revenue that exceeds the *final* threshold, once announced, even for time periods covered in the approved tax waiver. In other words, the existence of an approved tax waiver does not mean the tax would not be subject to penalty if it ultimately exceeds the final threshold.

d. Data Remediation

Again, because CMS proposes that the final threshold would be based on *actual* tax revenue collected under the tax structure enacted and imposed as of July 4, 2025, each permissible class with an existing tax as of that date generally will, by definition, already be at its indirect hold harmless threshold. Previously, many State tax rates were set at or below the 6 percent threshold. Thus, many States would already be operating at or near their applicable thresholds, although

they may need to adopt new procedures to ensure they do not exceed the threshold once it becomes effective.

Once the final indirect hold harmless threshold is established, this threshold would be fixed moving forward and therefore the need for an interim threshold would cease. However, the availability of the actual tax revenue collection and net patient revenue data needed to assess compliance for each FFY will continue to lag, which affects the timing of oversight and enforcement for a particular FFY. Therefore, CMS proposes to allow up to 2 years for States to submit all required data for the relevant FFY, including reporting net patient revenue derived from cost reports that are finalized after the close of the FFY and to make any necessary corrections. CMS believes 2 years is an appropriate length of time for States to obtain, report, and correct the actual tax data applicable to a given time period and generally would not assess such time period for possible enforcement actions until after 2 years have passed.

As its first example here, CMS uses data for FFY 2027, labeled in Figure 1 as "First year of ongoing reporting" after section 71115 becomes effective. As described in the prior section, the "interim period" would take place during FFY 2028 (or until a final threshold is announced). If that announcement occurs by September 30, 2028, as intended, States would have an additional year (the second year, shown in Figure 1 as the "Remediation Window") to complete any necessary remedial steps before CMS evaluates compliance for FFY 2027.

FFY 2028 (with associated data reporting labeled in Figure 1 as "Second year of ongoing reporting") would end September 30, 2028, coinciding with CMS' intended announcement of final thresholds. CMS would similarly allow 2 years for States to continue to report, correct, and remediate data for that time period (FFY 2028) before CMS review and possible enforcement action (beginning October 1, 2030).

In the remediation time period, States would have the opportunity to collaborate with CMS to correct reporting or adjust their tax collections (or both) to ensure the tax has not exceeded the final threshold for a particular FFY. Most importantly, CMS says it would expect States to use this time to return collections that exceed the threshold to all taxpayers in the permissible class on a consistent basis.

Although CMS is proposing to allow this time for remediation, it reiterates its expectation that "every State would make every effort to stay under its indirect hold harmless percentage on an ongoing basis" and that it intends to conduct oversight activities to determine if any State appears to be collecting amounts above the applicable limit with the expectation that such amounts can later be refunded.

4. Revision of the Second Prong of the Indirect Hold Harmless Test (the 75/75 Test)

Under current regulations, a State that exceeds the 6 percent indirect hold harmless threshold may still be able to permissibly collect the tax revenue without penalty if it passes the second prong, the 75/75 test (§433.68(f)(3)(i)(B)). As discussed previously, under this test, CMS will consider an indirect hold harmless arrangement to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments

or other State payments. The 75/75 test was established in the 1993 final rule (58 FR 43156) and is not expressly set forth in statute. If a tax produces revenues above the threshold under the first prong and then fails the 75/75 test, CMS will find that an indirect hold harmless arrangement exists and reduce a State's medical assistance expenditures, prior to calculating FFP, by the amount of tax revenue raised by the impermissible tax.

The changes made by the WFTC legislation do not address the 75/75 test but generally limit States from adopting new or increased health care-related taxes above the threshold percentage. Thus, States may have greater incentives to rely on the 75/75 test as a mechanism that permits collections above the first prong's threshold. This incentive is magnified for expansion States, which will be subject to a phase-down. CMS anticipates States may try to manipulate a way to increase tax revenue collections in order to maintain existing levels of non-Federal share generated through health care-related taxes.

Although the 75/75 test was designed to allow some flexibility for States if the need arose for a health care-related tax to be imposed at a higher overall tax level than 6 percent, CMS says that since that time significant changes have been made to Medicaid financing and reimbursement policies, and the use of health care-related taxes has increased dramatically. CMS believes the continued application of the 75/75 test could create opportunities for States to maintain or increase tax collections above the thresholds established under section 71115 through arrangements that satisfy the regulatory second prong. Thus, CMS proposes to discontinue the 75/75 test.

In addition, CMS says this test has been utilized extremely rarely and is typically impractical to pass. Only one health care-related tax has ever utilized this second prong to collect tax revenue above the indirect hold harmless threshold permissibly. Thus, the agency believes removing this test will not be disruptive to existing taxes.

The proposal to discontinue application of the regulatory 75/75 test would apply to Federal fiscal years beginning on or after October 1, 2026.[19] The indirect hold harmless percentage would be the sole indirect hold harmless test.

CMS invites comment on the proposed revisions to the second prong of the indirect hold harmless test, including additional or different revisions. For example, an alternative that CMS considered but did not propose was to delete the 75/75 test from §433.68 entirely since it is not currently in use by any State.

D. Limitation on Level of FFP for Revenues from Health Care-Related Taxes (§433.70)

Section 1903(w)(1)(A)(iii) of the Act requires CMS to reduce the medical assistance expenditures of a State by any health care-related taxes that involve an impermissible hold harmless arrangement. Section 433.70(b) mirrors the statute, requiring CMS to reduce from a State's medical assistance expenditures, *before* calculating FFP, the amount of any health care-

[19] As discussed in section II.B.2.b, if a State has a threshold that exceeds 6 percent that CMS previously approved under the second prong as of July 4, 2025, the State may continue to collect at that higher level (specifically, the level in effect as of July 4, 2025). However, CMS does not expect any State will be in this situation.

related taxes that involve hold harmless arrangements (or are otherwise impermissible). Thus, the State must return to CMS any FFP that was paid and associated with revenue collected from the impermissible tax. This can occur through a voluntary return of funds by the State. Otherwise, CMS may initiate a deferral action under §430.40 or a disallowance action under section 1903(d)(2)/§430.42.[20] The WFTC statutory changes did not modify the recoupment process for impermissible taxes and thus would continue to operate as it always has—through voluntary returns and, if necessary, deferrals and disallowances.

CMS proposes to add language to existing §433.70(b) making clear that the deduction for exceeding the indirect hold harmless threshold is applied on a permissible class basis. The proposed language would specify that CMS would deduct revenues from health care-related taxes *within a permissible class* that has exceeded the threshold specified in §433.68. Therefore, if a State has more than one tax in a permissible class, including taxes imposed by localities, and the aggregate tax amount collected for that class exceeds the applicable threshold, *all* taxes within that class would be subject to deduction under §433.70(b). CMS notes this is not a deviation from current practice but is particularly important for States to understand now that most taxes would initially be at or near the threshold and therefore at risk of exceeding it.

Section 1903(w)(1)(A)(iii) of the Act does not state that only the portion above the threshold is impermissible. The aggregate amount of tax revenue raised from *all* taxes on the permissible class is impermissible when the threshold is exceeded for the permissible class, and CMS would deduct all revenues from all taxes on the permissible class from the State's claimed medical assistance expenditures. For example, if the applicable percent for a given permissible class is 5 percent of net patient revenue and the State imposes a tax that is 5.5 percent of net patient revenue, CMS would deduct from the State's medical assistance expenditures *all* revenues of the 5.5 percent tax, in accordance with the longstanding statutory language, not just the 0.5 percent excess.

However, as discussed previously, CMS is proposing an interim threshold process and a remediation process that would provide States with time to modify their tax collection practices before taxes are deemed impermissible and subject to deduction.

Once a final threshold is calculated, for FFYs starting on or after October 1, 2026, if a State does not comply with the indirect hold harmless threshold for a permissible class, the State would have an impermissible hold harmless arrangement for the tax or taxes in that class. In such cases, CMS intends to notify the State that its tax(es) exceeded the indirect hold harmless threshold and to request that the State return the applicable Federal funds. If the State refuses to do so, CMS would initiate a disallowance. As is currently the case, the State would have the opportunity to challenge any disallowances through the administrative reconsideration process (§430.42(b) through (e)) or appeal to the HHS Departmental Appeals Board (DAB) (§430.42(f)).

[20] Deferrals are initiated when CMS requires additional information to determine if a given expenditure is allowable. Disallowances are initiated after CMS has determined that the expenditure is unallowable and requires the State to adjust its expenditure report and repay the disallowed FFP.

E. Reporting Requirements (§433.74)

Current regulations in §433.74 specify reporting requirements for States pertaining to provider-related donations and health care-related taxes. States must report on a quarterly basis to CMS a "complete, accurate, and full disclosure of all of their donation and tax programs and expenditures," which is currently collected through Form CMS 64.11 and Form CMS 64.11A. CMS proposes to retain this general requirement prior to October 1, 2026.

A new paragraph (b) would set forth the proposed reporting requirements beginning October 1, 2026, requiring that States' reports present a complete, accurate, and full disclosure of all tax programs and expenditures. Proposed paragraph (b)(1) would separate out the reporting requirements related to provider-related donations, since donations are not subject to the new indirect hold harmless threshold under the WFTC legislation.

1. <u>One-Time Reporting Requirements</u>

Interim Data. Proposed §433.74(b)(2) describes the one-time data reporting requirements necessary to support implementation of section 71115 of the WFTC legislation and to allow CMS to calculate an *interim* threshold for State planning purposes. Under the proposal, this information must be provided by December 31, 2026, in a form and manner specified by CMS and include tax collection and net patient revenue data, by tax and permissible class, applicable to the SFY that contains July 4, 2025. For this interim reporting, States may use estimated, projected, or otherwise extrapolated data in order to provide the amounts requested. CMS is not proposing a particular approach for developing these interim estimates.

The interim reporting would also include:

- The authorizing legislation (date and citation) for all State and local health care related taxes,
- The date and citation for any related State regulation or administrative issuance required to implement the tax,
- The type and date of waiver(s) approved under §433.68(e)(1) or (2) (if applicable),
- Documentation that demonstrates when the tax was imposed, and
- Information regarding what the taxes are used to fund, including the specific Medicaid payments supported by the applicable tax.

Final Data. Under proposed §433.74(b)(3), by June 30, 2028, each State must provide, in a form and manner determined by the Secretary, the actual net patient revenue and tax collection data for all health care-related taxes enacted and imposed as of July 4, 2025, along with any documentation and data necessary for CMS to calculate the *final* indirect hold harmless percentage for each permissible class. Specifically, CMS proposes the following data and documentation, by tax:

- The permissible class,
- Tax collection amount, and
- The net patient revenue for all providers in the permissible class.

CMS would verify the State's data and perform the calculations necessary to establish the final indirect hold harmless percentage for each permissible class. After completing this review, CMS would notify the State of the final indirect hold harmless percentage for each permissible class, including any applicable phase-down.

CMS says it is imperative that States submit data in a complete and accurate manner using the best available information, including accounting for all taxes. If a State subsequently reports a health care-related tax that was not included in the State's final threshold calculation and inclusion of that tax causes the permissible class to exceed the applicable indirect hold harmless threshold, the State may be in violation of the indirect hold harmless requirement and its tax collections for that permissible class may be impermissible. As a result, after a remediation period, CMS may pursue recovery of FFP associated with those taxes through the voluntary return or disallowance process. During the data submission window for the final threshold, CMS intends to work with States to resolve any questions or issues regarding documentation requirements or form of submission. If necessary, CMS would issue subregulatory guidance; **CMS invites comment** on what additional information would be helpful for States to understand the proposed reporting requirements.

In addition to State-imposed taxes, units of local government (such as, cities, counties, or parishes) may also impose taxes on providers and transfer the tax revenue to the State Medicaid Agency through an intergovernmental transfer (IGT). As a result, a provider may be subject to multiple taxes within the same permissible class. For calculating the final indirect hold harmless threshold, there can be only a single percentage for each permissible class within a State. Thus, if one or more units of local government within a State impose a health care-related tax, those tax revenue amounts must be added to any Statewide assessments on the same permissible class and then divided by the net patient revenue for the whole State to calculate the final indirect hold harmless percentage. CMS provides various examples.

2. Ongoing Reporting Requirements

On an ongoing basis, proposed §433.74(b)(4)(i) through (v) would require each State to submit to CMS quarterly the following data for all State and local health care-related taxes:

- Total tax revenue collections, by tax and permissible class, in its entirety;
- Net patient revenue by permissible class,
- What the tax is used to fund (that is, how the tax collections are utilized within the State or locality and any specific Medicaid payments associated with the tax);
- Whether the State has exempted any providers that are units of government; and
- Any additional information requested by the Secretary related to any health care-related taxes imposed on health care providers.

The total tax collections and total net patient revenues for a permissible class includes all taxes *imposed* on that specific permissible class, including both State and locality taxes. The State would be required to report the net patient revenue and the tax amount collected for the reporting period in question, even if the actual collection occurs *after* the end of the reporting period. For example, if a State imposes a tax for FFY 2028 but does not collect the tax revenue from a provider until FFY 2029, the State would report that tax revenue as part of its FFY 2028

reporting, not its FFY 2029 reporting. In other words, tax collections would be reported for the period to which the tax obligation relates, rather than the period in which payment is actually received.

CMS further proposes in §433.74(b)(5) that any data reported must reflect actual data and not rely on estimates, projections, or other statistical methods, except as permitted for interim reporting.

If this proposal is finalized, CMS would make technical assistance available, consistent with current practice, to ensure that any such allocation methodologies used for reporting net patient revenue are based on accurate, complete, and verifiable information. Net patient revenue may be determined differently for permissible classes other than hospitals. For example, MCOs generally do not directly provide patient services, and net patient revenue for an MCO tax would consist of premium revenue or per-member per-month payments made by the State under its Medicaid contract (and possibly including premium amounts paid by beneficiaries to the MCO). Other permissible classes, such as nursing homes, rely on cost reports tailored to the provider type.

To support ongoing compliance with the reporting requirements, CMS says States should use the most accurate, complete, and recent data that they have available and should rely on standardized provider forms where possible. States must be prepared to identify the source of any reported data upon request by CMS. For ongoing reporting, States may amend previously reported tax data for a period of up to 2 years following the quarter to which the data relate. (Previously, summary tax data reflected only what was collected in a particular quarter or year, but under this proposal, if a State needs to correct tax data or add additional amounts attributable to an earlier time period, it would have the opportunity to do so within that 2-year period.)

In §433.74(b)(4)(iv), CMS proposes that, to the extent a State or unit of local government updates a tax to remove one or more providers that are also units of government and the State is not submitting a waiver associated with this change, the State must *notify* CMS of this change when submitting the CMS-64 applicable to the quarter in which the change is effective. States are able to exempt public providers without submitting a waiver because, under section 1903(w)(3)(B)(i), a broad-based tax is on all non-Federal, non-public providers; thus, the inclusion or exclusion of public providers does not affect the broad-based determination. CMS is proposing this notification requirement to address concerns that the limitations on expanding provider taxes created by section 71115 of the WFTC legislation could motivate States to seek out potentially impermissible means to maximize Federal match. Therefore, CMS says it intends to look closely at certain changes States make to taxes once the new thresholds are in effect, to determine whether such changes facilitate a hold harmless arrangement—for example, when a State exempts a large State hospital system from a tax but then establishes an IGT for that hospital system.

CMS further notes that it intends to enhance its scrutiny of health care-related taxes as States adjust to the new requirements, describing a scenario where providers are removed from a tax (including providers that are units of local government) followed by an increase in the tax imposed on the remaining providers to maximize the available room under the indirect hold

harmless threshold. CMS would "scrutinize" such situations to determine whether the resulting arrangement complies with the statutory and regulatory hold harmless requirements. It also intends to review Medicaid utilization data for providers subject to and exempted from a tax during the course of tax waiver reviews and financial reviews of taxes to ensure there is not a correlation that indicates a direct hold harmless.

III. Collection of Information Requirements

This section of the rule contains proposed collection of information requirements (ICRs) that are or may be subject to Office of Management and Budget (OMB) review and approval under the authority of the Paperwork Reduction Act. Based on the proposed requirements and burden on States, including the District of Columbia, CMS prepared the proposed burden estimates shown in Table 3 below for required State reporting based on the proposal. **CMS invites comments** on these potential information collection requirements.

TABLE 3: Proposed Burden Estimates

Regulation	Respondents	Responses (per State)	Total Responses	Time per Response (hr)	Total Time (hr)	Labor Cost ($/hr)	Total Cost ($)	Fed Gov't Share ($)
One-time Interim Threshold Reporting (§433.74)	51 States	1	51	18.25	931	varies	44,548	22,274
One-time Final Threshold Reporting (§433.74)	51 States	1	51	6	306	varies	16,872	8,436
On-going (Quarterly) Enhanced Reporting of Tax Data (§433.74)	51 States	4	204	0.25	51	43.26	2,206	1,103
TOTAL	51 States	varies	306	varies	1,288	varies	61,420*	30,710*

* Sum of the one-time costs (first two rows of numbers), not the ongoing/quarterly costs.

IV. Regulatory Impact Analysis

Various Federal laws and executive orders require agencies to assess a rule's impact. A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory actions or with significant effects of $100 million or more in any 1 year. Based on CMS' estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant. Thus, CMS has prepared an RIA that presents the costs, benefits, and transfers of the rulemaking.

In sum, over the next 10 years (2026-2035), CMS projects that the proposed rule would reduce Federal Medicaid spending by $245.8 billion[21] and State Medicaid spending by $138.2 billion, for a total reduction of $384.0 billion, as shown in Table 11 below. These reductions are projected across different provider classes, but CMS expects that the largest decreases would be

[21] This is the number touted in CMS' Fact Sheet: "The CMS Office of the Actuary estimates that this rule will reduce Federal government expenditures by $246 billion over the 10-year period from 2026 to 2035."

in payments to hospitals, given that hospital taxes account for the majority of provider tax revenues.[22]

TABLE 11: Projected Changes in Medicaid Expenditures Related to Changes in Provider Taxes (in billions of real 2026 dollars)

	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-2035
Federal share	-$3.4	-$4.1	-$8.2	-$13.7	-$20.7	-$29.2	-$39.0	-$40.7	-$42.5	-$44.4	-$245.8
State share	-$1.9	-$2.3	-$4.6	-$7.6	-$11.6	-$16.4	-$21.9	-$22.9	-$23.9	-$25.0	-$138.2
Total	-$5.3	-$6.3	-$12.8	-$21.3	-$32.3	-$45.6	-$61.0	-$63.6	-$66.4	-$69.3	-$384.0

Lower State tax revenues would result from two policies: the prohibition on new provider taxes (-$51.0 billion over 10 years in real 2026 dollars, Table 6) and lowering the indirect hold harmless threshold in expansion states (-$147.7 billion over 10 years in real 2026 dollars, Table 7). The combined effects would reduce State provider tax revenue by about $198.7 billion over the next 10 years (Table 8). By 2035, this would be a 27 percent reduction in State provider tax revenue. For impacted providers, CMS believes these changes are effectively increases in net revenues, because they would be paying less in State taxes.[23]

Lower Medicaid benefit spending would also result, according to CMS. Because States often use provider taxes to finance Medicaid spending, CMS expects that reductions in provider tax revenues would lead to lower Medicaid benefit expenditures via reductions in payments to providers, services covered, and enrollment. In making its projections, CMS estimates this proposed rule would have no effect on enrollment; all reductions in spending were assumed to be made through reductions in provider payments and benefits provided.[24] This is because CMS expects that the provider tax revenues impacted by this rule mostly have been associated with increased payments to providers, not expansions of enrollment. In addition, the agency believes States would be more likely to prioritize covering enrollees above maintaining provider payment rates and benefits offered in response to this proposed rule. In addition, as described later, many of the payment reductions may be through lower State-directed payments (SDPs), which would also avoid changes to enrollment.

CMS walks through its assumptions for projecting how Medicaid spending would change due to reductions in tax revenue, broken out for taxes on MCOs versus "other providers." In sum, CMS assumes that Medicaid effectively pays 50 percent of MCO taxes,[25] 3.5 percent of nursing facility and intermediate care facility taxes, and about 2 percent for hospital taxes and taxes on

[22] According to Table 4 in the rule, hospitals account for $61.8 billion in estimated 2026 provider tax revenue, out of a total of $98.6 billion. Thus, hospitals account for 62.7 percent of total Medicaid provider tax revenue.
[23] CMS also expects there would also be a reduction in payment rates to managed care organizations from private payers (non-Medicaid, non-Medicare), as the provider taxes are likely passed through to payers as an increase in premiums.
[24] CMS did not break out these projections separately but projected the total amount of reduced spending as a result of the change in provider tax revenues.
[25] This is because the full cost of an MCO tax is likely passed onto the payers, and CMS assumes that Medicaid accounts for half of all managed care premiums subject to these taxes.

other provider categories. The agency also assumes that 90 percent of the provider tax revenue is used to fund the State share of Medicaid payments.

With all these factors, CMS estimates that, absent the WFTC legislation, projected Medicaid spending associated with provider taxes would total $2.883 billion between 2026 and 2035 ($1.843 Federal, $1.041 State, Table 10). Following reductions in provider tax revenues, it expects decreases in Medicaid spending, particularly through reductions in higher payments that had been supported through provider taxes. However, CMS also assumes that States would use other revenues (mainly general fund revenues) to offset some payment reductions, assuming that States would offset 30 percent of these cuts with other revenue sources.

The net effect of both the changes in provider tax revenues and the resulting effects on Medicaid expenditures is shown by payer/entity in Table 12 below. Reductions in payments are shown as positive to payers and negative to providers, and reductions in tax revenue are shown as negative to recipients (the States) and positive to providers.

TABLE 12: Projected Net Changes Related to Changes in Provider Tax Revenues and Expenditures (in billions of real 2026 dollars)

	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-2035
Federal government	$3.4	$4.1	$8.2	$13.7	$20.7	$29.2	$39.0	$40.7	$42.5	$44.4	$245.8
States	-$0.7	-$0.9	-$1.9	-$3.2	-$5.0	-$7.2	-$9.7	-$10.2	-$10.6	-$11.1	-$60.5
Providers	-$3.4	-$4.0	-$7.8	-$12.7	-$18.7	-$26.0	-$34.6	-$36.1	-$37.7	-$39.3	-$220.3
Private payers	$0.7	$0.8	$1.4	$2.2	$3.0	$4.1	$5.3	$5.6	$5.8	$6.0	$35.0

CMS acknowledges that Table 12 does not take into account interactions with section 71116 of the WFTC legislation, which sets new limits on State Directed Payments (SDPs) by lowering the effective payment rate allowable for SDPs.[26] SDPs are often used to fund payment increases to providers and are often funded by provider taxes. Section 71116 was projected to reduce 10-year Federal Medicaid expenditures by $510.1 billion (Table 13). If CMS first takes into account the projected reduction in SDPs under the proposed SDP rule, the amount of additional/net reductions in provider payments under this proposed rule decreases significantly:

- Excluding the impacts of the SDP rule, CMS projects that the Federal government and States would pay providers $384.0 billion less from 2026 through 2035 under this rule (Table 11[27]).

[26] SDPs are contract arrangements in which the State directs a Medicaid managed care plan's expenditures, generally to pay a provider a particular rate or amount or under a particular model or methodology. SDPs are currently authorized under §438.6(c).

[27] CMS erroneously pointed to Table 12 here.

- When accounting for the effects of the SDP rule, CMS projects payments to providers would "only be reduced an additional $142.1 billion beyond the reductions projected under the SDP rule." [28,29]

CMS walks through alternative "high" and "low" scenarios for its projected costs. It also describes alternative policies considered, such as using the alternative definitions of "enacted" and "imposes" and not retiring the 75/75 prong.

If a rule has a significant impact on a substantial number of small entities, the Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small entities. CMS states that many health care providers subject to provider taxes are small entities, including the great majority of hospitals.[30] The agency states that this proposed rule, if finalized, will not have a significant impact (measured as a change in revenue of 3 to 5 percent) on a substantial number of small businesses or other small entities. **CMS seeks comment** on this assessment.

[28] The difference ($241.9 billion) represents the amount of provider payment reductions already attributed to the SDP reductions.

[29] Table 14 in the proposed rule attempts to show the net effects of the policies in this rule after accounting for the SDP rule. The results are somewhat confusing, showing a net benefit to providers from this rule of $21.7 billion over 10 years. According to CMS, "For providers, when considering the effects of SDP provisions, we project that they would experience a net gain in this scenario ($21.7 billion over 10 years). Providers would experience decreases in Medicaid payments, but the reduction in taxes paid to States would be greater; however, this also accounts for the significant decrease in provider payments through SDPs ($774.8 billion over 10 years), so that the net effect of both proposed rules would still be a significant reduction to provider payments through Medicaid over time."

[30] Either by being nonprofit organizations or by "having revenues of less than $9.0 million to $47.0 million" (depending on the provider category) in any 1 year.