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# CMS Issues Proposed Rule Implementing H.R 1 Provider Tax Limits, Revisits Definitions of Enacted and Imposed Taxes

The Centers for Medicare and Medicaid Services (CMS) issued a proposed rule on how the agency expects to implement changes to health-care related (provider taxes) contained in H.R.1.

- **What it is.** H.R. 1 established a new indirect hold harmless threshold effective October 1, 2026. For states that have not expanded Medicaid, the new hold harmless threshold requires that the state freeze all existing provider taxes at the rate the tax was enacted and imposed as of July 4, 2025, the date of the law's enactment. For states that have expanded Medicaid, they must gradually reduce existing provider taxes by 0.5% per year beginning in 2028 until the maximum hold harmless threshold reaches 3.5% in 2032. Previously, the agency had released preliminary guidance to help states prepare for these changes. The proposed rule revisits previously established interpretations of "enacted and imposed" to clarify that states do not have to have collected tax by July 4, 2025, to be considered enacted and imposed under the statutory language. CMS is also proposing to include a new class for taxes on health insurers that would also be subject to the new thresholds, which was not previously included in the law.

- **Next steps.** Comments on the proposed rule are due by September 21, 2026. New thresholds would apply beginning October 1, 2026, and the expansion-State phase-down begins October 1, 2027.

Highlights of the proposed rule follow:

- ***Background (p. 3)*** – CMS outlines the statutory and policy basis for the proposed rule by describing Medicaid's shared federal-state financing structure and the federal requirements governing health care-related provider taxes used to finance the non-federal share of Medicaid expenditures. The agency explains that these taxes generally must be imposed on a permissible provider class, satisfy broad-based and uniformity requirements (or qualify for a waiver), and avoid prohibited direct or indirect "hold harmless" arrangements that effectively reimburse providers for the cost of the tax.

  CMS also reviews the existing framework for evaluating indirect hold harmless arrangements, including the longstanding 6 percent safe harbor and 75/75 tests, and references a 2018 HHS Office of Inspector General report recommending that CMS reevaluate these policies because certain state tax programs substantially offset providers' tax burden while remaining compliant with existing regulations. The Background further explains that the proposed rule would implement amendments enacted in the Working Families Tax Cut (WFTC) legislation, which

replace the uniform 6 percent indirect hold harmless threshold with state- and provider class-specific thresholds beginning in FY 2027, including phased reductions for most permissible classes in Medicaid expansion states.

Finally, CMS proposes adding health insurers (excluding managed care organizations already recognized under existing regulations) as a new permissible provider tax class. According to CMS, this change would provide greater regulatory clarity and subject taxes on health insurers to the same statutory and regulatory requirements that apply to other permissible Medicaid provider taxes.

- ***Provisions of the Proposed Regulations***
  a. **General Definitions (p. 15)** – CMS proposes adding new definitions to implement the WFTC legislation and improve regulatory clarity. Specifically, CMS would define "Expansion State" and "Non-expansion State" consistent with the statutory language and formally define "Net Patient Revenue," codifying its longstanding interpretation that the term includes all patient care revenue attributable to the taxed provider class, regardless of payer source, while excluding non-patient care revenue. CMS also solicits comments on the proposed definitions and whether additional regulatory terms should be formally defined.
  b. **Classes of Health Care Services and Providers Defined (p. 17)** – CMS proposes adding health insurers (excluding managed care organizations already recognized under existing regulations) as a new permissible class of health care services subject to Medicaid provider tax requirements. CMS explains that many states already use taxes on health insurers to finance the non-federal share of Medicaid expenditures, even though health insurers are not currently recognized as a permissible provider tax class. Rather than treating these existing taxes as impermissible, CMS proposes formally recognizing health insurers as a permissible class to provide regulatory clarity, facilitate consistent federal oversight, and subject these taxes to the same statutory and regulatory requirements, including applicable provider tax and hold harmless provisions, that govern other permissible provider taxes.

- ***Permissible Health Care-Related Taxes (p. 25)***
  - **Restructure of existing regulations, effective until October 1, 2026** – CMS is proposing to restructure the existing regulatory language to more clearly distinguish between regulations and threshold before October 1, 2026 from those that apply afterwards and to more clearly introduce the concept of the two-prong test.
  - **Calculation of Threshold** – CMS clarifies that the proposed rule will not change the basic mechanism by which the agency determines if a provider tax exceeds the indirect hold harmless threshold, which is currently calculated by dividing the total amount of tax revenue collected for the permissible class by the net patient revenue attributed to that class. CMS is

proposing new language to implement the changes to provider taxes required by H.R.1, which decreased the safe harbor threshold, from its current rate of 6 percent to 3.5 percent, for Medicaid expansion states. The agency notes that CMS will determine new thresholds for each permissible class for each state, and these percentages will differ both across states and across permissible classes.

a. Enacted and Imposed: CMS is proposing to revise its previous interpretation of the terms "enacted" and "imposed" used in the statutory language (IHPP Summary). CMS reminds states that it will limit the threshold for each permissible class based on provider taxes that were enacted and imposed as of July 4, 2025, noting that there may potentially be lower limits for expansion states in future years. CMS is proposing to establish that a tax is considered enacted if the State or local government has completed the entire legislative process necessary to authorize the tax, either at the start or to an amend existing taxes. The agency clarifies that the enacted distinction would not apply to a tax structure where the State budget office or legislature took actions that were retroactively applicable to July 4, 2025 or earlier. CMS is proposing to update its interpretation of "imposed" to mean that the State or local government imposed on taxpayers a legal obligation to pay as of July 4, 2025. The agency is also proposing to apply these definitions and policies to the new class of health insurers if the rule is finalized, and CMS welcomes comments on this proposal.
b. Data Timelines and Reporting – CMS is proposing that states will be required to report actual collection and revenue data for a full fiscal year instead of using projections or extrapolations. The agency also clarifies that longstanding provider taxes will be considered continuous for purposes of applying the new threshold, even if there is a new waiver request or need for routine reauthorization. Finally, the agency is proposing to establish a one-time reporting requirement, and CMS will use this data to calculate and give states the new threshold percentage for each of their permissible classes.

- ***Application of Threshold –***

c. Timing – Beginning October 1, 2026, the agency CMS is proposing to use federal fiscal year to apply the threshold as the basis for monitoring and possible enforcement. Under the proposal, 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.
d. Phase down for Expansion States - CMS reminds states that for states that have expanded Medicaid, they must gradually reduce existing provider taxes by 0.5% per year beginning in 2028 until the maximum hold harmless threshold reaches 3.5% in 2032. Provider taxes on nursing and immediate care facilities are exempt and not subject to reduction. CMS is also proposing to apply the gradual reduction for

expansion states to include the new class of health insurers. CMS details the two paths that a state can take when the hold harmless threshold decreases mid-state fiscal year beginning on p. 50.

e. Interim Indirect Hold Harmless Threshold Process – Until CMS has had time to review and calculate the new thresholds using actual tax collection data and net patient revenue data, the agency is proposing an interim hold harmless threshold process to support states in transitioning to the new reporting requirements.

f. Data remediation – CMS is proposing to allow up to 2 years for states to submit all required data for the relevant fiscal year. The agency clarifies that during this time period the state can collaborate with CMS to make corrections and adjust their collections to ensure that they have not exceeded the threshold.

- **Revision of the Second Prong of the Indirect Hold Harmless Test (the 75/75 Test)** – CMS reminds states that due to a 1993 final rule, the agency allows provider taxes that exceed the 6 percent hold harmless threshold so long as it passes the 75/75 test, meaning that 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. CMS is proposing to eliminate the 75/75 test, explaining that the agency is concerned that states, especially expansion states, would have an incentive to use this mechanism to circumvent the limits in H.R.1. The agency clarifies that any states with an existing provider tax that was approved under the 75/75 test will be allowed to continue. CMS welcomes comments on this proposal.

- ***Limitation on level of FFP for revenues from health care-related taxes (p. 65)*** - The rule outlines CMS' approach if states utilized impermissible hold harmless arrangements. States will be required to repay CMS any FFP that was paid that is associated with revenue collected from the impermissible tax. States can voluntarily return the funds or CMS can initiate a deferral action or disallowance action. Deferrals are initiated when CMS requires additional information to determine if an expenditure is allowable; disallowances are initiated when CMS has determined an expenditure is not allowable and requires the states to repay it.

H.R. 1 did not alter the recoupment process for penalties for impermissible taxes. Hence, the existing process will continue to operate as it historically has, through voluntary returns with the use of deferrals and disallowances to prevent he payment of or recoup overpaid FFP. CMS is, however, proposes to add clarifying language for greater clarity about how penalties function.

The relevant longstanding statutory language does not state that only the portion of the tax above the threshold is impermissible. Rather, the aggregate amount of tax revenue raised from all taxes

on the permissible tax is impermissible when the threshold is exceeded, and CMS would deduct the full amount of the revenue from all taxes on the permissible class.

- ***Reporting Requirements (p. 68)*** - This section details new state reporting requirements to demonstrate compliance with the threshold changes. States are generally required to report quarterly. Reporting remains the same through the end of FFY 2026 (i.e. through October 2026). CMS then separates out reporting requirements for provider-related donations since they are not subject to the new thresholds under H.R. 1. CMS outlines one-time reporting requirements to implement H.R. 1 section 71115 by allowing CMS to calculate the interim threshold for state planning purposes, and to determine whether taxes are enacted and imposed.

  First, by December 31, 2026, states are required to report on their tax collections and net patient revenue, by tax and provider class, for the SFY that includes July 4, 2025. For this, states can use estimated, projected, or otherwise extrapolated data in order to provide the amounts requested. Essentially, states will be required to submit data that shows the tax revenue levels that were enacted and imposed as of July 4, 2025. CMS is not proposing a singular approach for doing this but rather giving states flexibility. CMS will work with states to ensure the adequacy of documentation.

  By June 20, 2028, states must submit the actual, verified data for the same baseline that was previously estimated and CMS will use it to lock in each state's final threshold percentage per provider tax.

  CMS may release additional sub-regulatory guidance if additional clarity is needed.
  In terms of ongoing requirements, CMS proposes requiring states to submit quarterly reports including tax revenue and net patient revenue by class, what each tax funds, and any provider exemptions. CMS outlines additional details regarding reporting requirements. Of note, states will have a two year window to correct past filings if needed.
  Also of note, states are required to tell CMS if the state exempts a public provider, such as a public hospital, from a tax. CMS notes that the agency is specifically watching for states that exempt a public provider from a tax, then quietly funnel money back to it through an intergovernmental transfer, which would function as a disguised hold-harmless scheme.
  If states do not comply with these requirements, penalties could include reduced federal grants, disallowances, and the newly added penalty of CMS being allowed to freeze approval of a state's payment proposal if missing tax data results in the agency being unable to verify the funding is legitimate.