July 14, 2025

Dr. Mehmet Oz
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is writing in response to the Centers for Medicare and Medicaid Services' (CMS) proposed rule, Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule [CMS–2448–P].

In this rule, CMS proposes to amend their current test for determining if a health care-related tax is generally redistributive to address situations in which health care-related taxes have passed existing statistical tests but are not, in effect, generally redistributive. Specifically, CMS proposes to codify certain "described attributes" that would indicate that a tax is not generally redistributive, even if the tax passes the B1/B2 test.

NAMD supports CMS's aim of increasing fiscal transparency and accountability in Medicaid. **However, Medicaid agencies report that the proposed "described attributes" would create uncertainty and subjectivity in CMS's review process, leading to operational and fiscal challenges for states. Additionally, Medicaid agencies report significant concern over the proposed lack of a transition period for states with more recently approved non-compliant waivers and a one-year transition period for states with longer-standing non-compliant waivers. CMS should provide a transition period of at least three years for all states to mitigate impacts on providers and Medicaid members.**

NAMD is a professional community of state and territory leaders who provide health insurance to almost 80 million individuals and families through Medicaid and the Children's Health Insurance Program in each of the 50 states, the District of Columbia and the U.S. territories. NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives.

The Proposed Rule Would Create Uncertainty and Subjectivity in the Health Care-Related Taxes Approval Process

In the rule, CMS proposes to create a set of "described attributes" that would indicate that a tax is not generally redistributive, even if it passes the B1/B2 test. CMS proposes

a different set of described attributes for taxes that refer to Medicaid explicitly and for taxes that do not refer to Medicaid explicitly. **Medicaid agencies report significant concerns over both sets of proposed described attributes.**

First, Medicaid agencies report that the proposed described attributes for taxes that refer to Medicaid explicitly (§ 433.68(e)(3)(i) and (ii)) are overly restrictive and would hinder the ability of states to design tax structures that meet local needs. CMS proposes that a tax would not be generally redistributive if, within a permissible class: 1) the tax rate imposed on any taxpayer or tax group based on its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax group based on its non-Medicaid taxable units; or 2) the tax rate imposed on any taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer or tax rate group defined by its relatively higher volume or percentage of Medicaid taxable units.

Medicaid agencies report that this proposal would significantly hinder their ability to apply two or more tax rates within a permissible class, even if the net impact of the tax and associated expenditures is generally redistributive. Because the proposed described attributes just consider the tax rate and not expenditures, there may be situations in which taxes that are, in effect, generally redistributive are not approvable (for example, in cases where Medicaid providers in a permissible class receive a higher tiered reimbursement rate that is funded by a health care-related tax). Similarly, this provision may restrict the ability of states to design tax structures that address local needs. For example, a state may use Medicaid-paid bed days as a proxy for total bed days for operational reasons such as data completeness or timeliness. Under this rule, the state could not apply a higher tax rate to nursing facilities with higher numbers of Medicaid-paid bed days, even if the state had a legitimate public policy aim for wanting to apply a higher tax rate to larger providers.

Second, Medicaid agencies report that the proposed described attributes for taxes that do not refer to Medicaid explicitly are overly broad and would create uncertainty and subjectivity in the review process. CMS proposes that a tax would not be generally redistributive if it excludes or imposes a lower tax rate on a taxpayer or tax group defined by or based on any characteristic that results in the same effect as § 433.68(e)(3)(i) and (ii)**.** Through this provision, CMS seeks to prevent Medicaid agencies from using substitute definitions, measures, attributes, or proxies to apply a higher tax rate based on Medicaid taxable units. CMS clarifies that this provision is not intended to prevent states from designing tax groups to achieve “legitimate public policy goals.”

Medicaid agencies report that this provision would create substantial uncertainty for their programs. Determining if a tax “results in the same effect,” if a measure is a proxy for Medicaid taxable units, or if a public policy goal is legitimate are all highly subjective and may be applied inconsistently across CMS staff and over time. Because of this

subjectivity, it would be substantially more difficult for Medicaid agencies to understand if health care-related taxes are approvable under this rule, undermining the ability of states to make accurate fiscal projections. For example, a state may have a legitimate, non-Medicaid-related reason for applying different tax rates among subgroups of providers in the same class that coincidentally aligns with high and low Medicaid utilization. In this case, CMS would have discretion to either accept the state's policy rationale as a legitimate policy goal and approve the tax, or to instead interpret the subgrouping as a proxy measure and disapprove the tax. This uncertainty creates fiscal challenges for states by making revenue less predictable.

NAMD recommends that CMS work with Medicaid agencies to develop a new statistical test or other objective measure of whether a tax is generally redistributive. If CMS does move forward with the proposed approach, NAMD strongly recommends codifying the exception for tax groups designed to achieve legitimate public policy goals into regulation.

CMS Should Provide a Transition Period of at Least Three Years

CMS proposes to provide a transition period for some states with approved health care-related taxes that do not comply with the rule, dependent on when the tax was most recently approved. If the tax was most recently approved more than two years before the effective date of the final rule, the state would receive a transition period of at least one year. If the tax was most recently approved less than two years before the effective date of the final rule, the state would not receive a transition period.

Medicaid agencies report serious concerns with CMS's proposed lack of a transition period for states with more recently approved taxes. In the rule, CMS notes that states with more recently approved taxes received companion letters indicating that CMS intended to pursue rulemaking in the future. These companion letters, however, did not outline CMS's new policy framework for health care-related taxes or inform states of steps they must take to address CMS's concerns, making it impossible for states to pre-emptively modify their provider tax structures. In effect, the rule would penalize states for not complying with a federal requirement that had not even been proposed at the time of waiver approval.

Medicaid agencies report that the proposed one-year transition period for states with longer-standing taxes would not be adequate. If finalized, states would need to take several steps to come into compliance with this rule, including: 1) seeking federal guidance and technical assistance on the new requirements; 2) designing new, compliant taxes; 3) obtaining state legislative authority for the tax, with some states operating on biennial cycles; and 4) seeking and obtaining federal approval.

An inadequate transition period (or the lack of a transition period entirely) would have material impacts on Medicaid members and providers. Medicaid agencies use provider taxes to fund critical components of their programs, including eligibility groups,

payments to providers, and long-term care services. An inadequate transition period would have significant negative impacts on state budgets and would likely necessitate reductions in coverage, services, and reimbursement rates.

NAMD strongly recommends that CMS finalize a transition period of at least three years for all states. A three-year transition period would allow states to work through the implementation steps discussed above. It would also give states time to replace revenue that was previously generated by the health care-related tax, mitigating impacts on providers and Medicaid members.

Thank you for the opportunity to provide comments on this proposed rule. NAMD looks forward to continuing to work with CMS to improve fiscal accountability and transparency in the Medicaid program.

Sincerely,

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Medicaid Director
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Director
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