

CMS ISSUES HEALTH CARE-RELATED TAX FINAL RULE

On February 2, 2026, the Centers for Medicare & Medicaid Services ("CMS") published a final rule, effective April 3, 2026, that targets a perceived "loophole" in the current regulatory statistical test applied to State proposals for health care-related tax waivers. The test is intended to make certain that non-uniform or non-broad-based health care-related taxes, authorized under a waiver granted by CMS, are "generally redistributive." CMS claims the loophole impermissibly allowed some health care-related taxes to be imposed at higher tax rates on Medicaid-related activities and higher-volume Medicaid providers than on non-Medicaid-related activities and lower-volume Medicaid providers. According to CMS, the final rule closes the loophole by adding additional safeguards to ensure that tax waivers that previously would have passed the "generally redistributive" statistical test, but are not generally redistributive, are not approvable. Section 71117 of the Working Families Tax Cuts (which was legislation included in the "One Big Beautiful Bill Act") serves as the statutory basis for the final rule.

I. TRANSITION PERIODS

Although the final rule is effective April 3, 2026, transition periods are provided for States to bring their current health care-related tax programs into compliance with the final rule:

- For States with health care-related tax waivers (other than waivers for health care-related taxes on managed care organizations ("MCOs")) that are not compliant with the final rule, regardless of the date of CMS's most recent approval of the waiver, the final day of the transition period is the final day of the state fiscal year that ends in calendar year 2028, but no later than September 30, 2028.[1]
- For States with health care-related tax waivers for health care-related taxes on MCOs that are not compliant with the final rule, where the date of CMS's most recent approval of the waiver occurred two years or less before April 3, 2026, the final day of the transition period is December 31, 2026.[2]
- For States with health care-related tax waivers for health care-related taxes on MCOs that are not compliant with the final rule, where the date of CMS's most recent approval of the waiver occurred more than two years before April 3, 2026, the final day of the transition period is the day before the first day of the first state fiscal year beginning at least one year from April 3, 2026.[3]

II. OVERVIEW OF THE THREE PROHIBITED TAX STRUCTURES

Regardless of whether a State's health care-related tax waiver meets the other criteria in federal regulations for a "generally redistributive" health care-related tax, the final rule specifies that the tax will not satisfy the generally redistributive standard—and therefore will not be a permissible health care-related tax—under any of the following three prohibited tax structures:

First Prohibited Tax Structure (42 CFR § 433.68(e)(3)(i)). Within a permissible class of providers, the tax rate imposed on any taxpayer, or "group of entities contained within . . . [the] class that is taxed at the same rate" (per 42 CFR § 433.52, "Tax Rate Group"), based *explicitly* upon the taxpayer's or Tax Rate Group's "Medicaid taxable units" (for example, Medicaid bed days, Medicaid revenue, costs associated with the Medicaid program, etc.) is *higher* than the tax rate imposed on any taxpayer or Tax Rate Group within the class based upon the taxpayer's or Group's "non-Medicaid taxable units" (for example, non-Medicaid bed days, non-Medicaid revenue, costs not associated with the Medicaid program, etc.), except as a result of excluding from taxation certain specified Medicare or Medicaid revenue or payments.

In the preamble to the final rule, CMS advises that its determination of whether this tax structure exists will be "straightforward" and will "fundamentally" rely on whether one tax rate is greater than another.[4] *Moreover, unlike the third prohibited tax structure noted below, CMS advises that the prohibition against this tax structure applies regardless of whatever public policy a State might rely on in support of one tax rate being greater than another.*[5]

As an example of this prohibited tax structure, the regulation, 42 CFR § 433.68(e)(3)(i), describes a health care-related tax where MCOs are taxed \$200 per Medicaid member month, but only \$20 per non-Medicaid member month.

Second Prohibited Tax Structure (42 CFR § 433.68(e)(3)(ii)). Within a permissible class of providers, the tax rate imposed on any taxpayer or Tax Rate Group (where such taxpayer or Group is *explicitly* defined by the taxpayer's or Group's relatively lower volume or percentage of

Medicaid taxable units) is lower than the tax rate imposed on any *other* taxpayer or Tax Rate Group within the class (where such taxpayer or Tax Rate Group is defined by the taxpayer's or Group's relatively higher volume or percentage of Medicaid taxable units).

In the preamble to the final rule, CMS advises that, akin to the first prohibited tax structure described above, its determination of whether this tax structure exists will be "straightforward" and will "fundamentally" rely on whether one tax rate is greater than another.^[6] Also, as with the first prohibited tax structure described above, *the prohibition against this tax structure applies regardless of whatever public policy a State might rely on in support of one tax rate being greater than another.*^[7]

The regulation, 42 CFR § 433.68(e)(3)(ii), includes two examples of this prohibited tax structure:

- A tax on nursing facilities with more than 40 Medicaid-paid bed days of \$200 per bed day, and on nursing facilities with 40 or fewer Medicaid-paid bed days of \$20 per bed day.
- A tax on hospitals with less than 5% Medicaid utilization at 2% of net patient service revenue for inpatient hospital services, and on all other hospitals at 4% of net patient service revenue for inpatient hospital services.

Third Prohibited Tax Structure (42 CFR § 433.68(e)(3)(iii)). The tax excludes or imposes a lower tax rate on a taxpayer or Tax Rate Group within the class of providers, and the taxpayer or Tax Rate Group is defined by or based on any description that results in the same effect as described in the first or second prohibited tax structures above.

The regulation at 42 CFR § 433.68(e)(3)(iii)(A) provides that this tax structure may be indicated by the use of terminology to establish a Tax Rate Group within a class of providers based on Medicaid without explicitly mentioning Medicaid to accomplish the same effect as described in the above-referenced first or second prohibited tax structures.

- As an example of this tax structure, the regulation describes a tax on inpatient hospital service discharges that imposes a \$10 rate per discharge associated with beneficiaries covered by a "joint Federal and State health care program" and a \$5 rate per discharge associated with individuals not covered by a "joint Federal and State health care program." Per the regulation, this example is a prohibited tax structure because "joint Federal and State health care program" describes Medicaid, and a higher tax rate is imposed on Medicaid discharges than on discharges for individuals not covered by the "joint Federal and State health care program."

In addition, the regulation at 42 CFR § 433.68(e)(3)(iii)(B) provides that this tax structure may be indicated by the use of terminology that creates a Tax Rate Group within a class of providers that closely approximates Medicaid to the same effect as described in the first or second prohibited tax structures referenced above.

- As an example of this tax structure, the regulation describes a tax on hospitals located in counties with an average income less than 230% of the federal poverty level of \$10 per inpatient hospital discharge, while hospitals in all other counties are taxed at \$5 per inpatient hospital discharge. Per the regulation, this example is a prohibited tax structure because the distinction being drawn between the Tax Rate Group is associated with a Medicaid eligibility criterion, with a higher tax rate imposed on the Tax Rate Group that is likely to involve more Medicaid taxable units.

Significantly, unlike the first and second prohibited tax structures above, a tax that falls within this third prohibited tax structure may be approved if CMS determines that Tax Rate Groups were not constructed to target taxation to Tax Rate Groups with higher Medicaid utilization, or away from lower Medicaid utilization Tax Rate Groups, but instead for a "legitimate public policy purpose not directed at manipulating relative tax burden."^[8] The preamble to the final rule includes a number of important points relative to the application of this "legitimate public policy purpose" concept, including the following:

- The term "legitimate public policy purpose" does not appear in the regulatory text. Instead, CMS explains and applies the concept in the preamble to the final rule.
- A legitimate public policy purpose determination will be made by CMS through its regular health care-related tax waiver review process. If the waiver submission raises questions about differing tax rates on any taxpayer or groups of taxpayers within the provider class, CMS will send targeted follow-up questions and may hold technical-assistance discussions, allowing the State to explain and support its rationale. CMS will then consider that explanation together with the overall design and practical effect of the tax. ^[9]
- CMS emphasizes that providing a comprehensive list of legitimate public policy purposes "would not be a feasible task,"^[10] and explicit

standards outside of illustrative examples for the application of the concept “would be impossible to create”^[11] so it will evaluate legitimacy case-by-case.

- Access to care (so long as it is provable) may serve as a legitimate public policy purpose that can justify lower tax rates for groups of providers within a class, provided that the design is “not something contrived or spurious that has been concocted or fabricated for the purpose of evading the requirements to be generally redistributive.”^[12]
 - As illustrative examples, CMS points to provider types that can be central to maintaining access to care, such as rural hospitals^[13] and other rural providers^[14], sole community hospitals^[15] and psychiatric hospitals.^[16]
- States may have other legitimate public policy purposes besides access, including quality of care and efficiency of care—what matters is that the purpose is real and “not contrived to evade the generally redistributive requirement.”^[17]
- Other factors influencing a State’s legitimate public policy purposes include “public health priorities, state fiscal administration, or the health insurance marketplaces.”^[18]
- States are not prohibited from adopting lower tax rates for Tax Rate Groups “that happen to have lower Medicaid utilization—provided there is a legitimate public policy reason unrelated to directing tax burden to Medicaid.”^[19]
- The final rule does not create a blanket prohibition on States establishing separate tax rates for “a particular provider type that is associated with high Medicaid utilization (such as State or other public facilities and university/teaching hospitals),” nor does it “suggest that these facilities will be subject to any special scrutiny in and of themselves.”^[20]

Parenthetically, it should be noted that the introductory sentence of the regulatory text for this third prohibited tax structure (see 42 CFR § 433.68(e)(3)(iii)) refers to lower tax rates imposed on a Tax Rate Group *or* a “taxpayer.” However, in the preamble to the final rule, CMS only mentions Tax Rate Groups when discussing the application of the legitimate public policy purpose concept. It is not clear whether CMS intends for the concept to apply only to Tax Rate Groups and not individual taxpayers.

A final point: nothing about the final rule changes the longstanding tenet that public providers may be exempted from a health care-related tax without violating the requirements for a broad-based tax.^[21]

III. CONCLUSION

According to CMS, the final rule will close an “inadvertent”^[22] loophole in existing health care-related tax waiver regulations. One can reasonably debate whether the final rule closes an actual “loophole,” and whether the supposed loophole was actually “inadvertent,” but without question, the final rule terminates health care-related tax methodologies that have been allowed for several years. Providers that are currently exempt from their State’s health care-related tax, or taxed at a discounted rate, should be alert to whether their State’s reaction to the final rule will alter their exemption or discount. Fortunately, the final rule grants States a generous transition period—at least for noncompliant tax waivers for health care-related taxes other than MCO taxes.

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[references]

[1] See 42 CFR § 433.68(e)(4)(i)(C).

[2] See 42 CFR § 433.68(e)(4)(i)(A).

[3] See 42 CFR § 433.68(e)(4)(i)(B).

[4] 91 Fed. Reg. 4794, 4809 (February 2, 2026).

[5] See 91 Fed. Reg. at 4810.

[6] 91 Fed. Reg. at 4809.

[7] See 91 Fed. Reg. at 4810.

[8] 91 Fed. Reg. at 4813.

[9] *Id.*

[10] 91 Fed. Reg. at 4814.

[11] *Id.* at 4815.

[12] *Id.* at 4817.

[13] *Id.* at 4814.

[14] *Id.*

[15] *Id.* at 4818.

[16] *Id.*

[17] *Id.*

[18] *Id.* at 4817.

[19] *Id.* at 4816.

[20] *Id.*

[21] Per 42 CFR § 433.68(b), a health care-related tax must be broad-based and uniform. A broad based health care-related tax is defined in 42 CFR § 433.68(c)(1) as a tax “on at least all health care items or services in the class or providers of such items or services furnished by all non-Federal, *non-public providers* in the State” (emphasis added) Stated differently, a broad based health care-related tax need not include public providers.

[22] 91 Fed. Reg. at 4804 - 4805, 4827 - 4828.

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