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Insights

One Big Beautiful Bill, Part II

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This article is the 2nd in our series on H.R. 1 (known as the One Big Beautiful Bill or "OBBB"), in which we select specific areas of Medicaid impacted by the OBBB and drill down into the full weight and effect of not only the OBBB, but also recent Federal rules, guidance, and policies on these topics. The second topic in the series is Medicaid financing, specifically health care-related taxes (referred to herein as "Provider Taxes"), which States are statutorily permitted to use to supplement state funding of Medicaid expenditures. While Provider Taxes may be used to fund a variety of Medicaid expenditures, their use to fund additional Medicaid payments to providers, such as "supplemental payments" in the Medicaid fee-for-service program or "state directed payments" in the Medicaid managed care program ("SDPPs," which were the topic of our first article in this series), has garnered enhanced scrutiny by the Federal government.

Background on Provider Taxes

Medicaid programs are administered by the States but jointly financed by the Federal and State governments. The State government can fund their share of Medicaid expenditures (referred to as the non-Federal share) through a variety of statutorily permitted means so long as not less than 40% of the non-Federal share is funded by the State itself. The remaining 60% of the non-Federal share can be funded by other units of non-State government, which are generally in the form of intergovernmental transfers, certified public expenditures, bona fide provider-related donations, or permissible health care-related taxes (i.e. Provider Taxes, the topic of this article).

To be used for the non-Federal share, Provider Taxes must meet several statutory requirements, including but not limited to: (1) unless waived by the Secretary of Health and Human Services ("HHS"), Provider Taxes must be (a) broad-based and (b) uniform; and (2) Provider Taxes must not have any hold harmless provisions. In order for the Secretary of HHS to approve a waiver of the broad-based and/or uniformity requirement, the net impact of the tax and associated Medicaid expenditures must be "generally redistributive," i.e. the amount of the tax is not directly correlated to the Medicaid payments received. The purpose of these Provider Tax requirements is to ensure that the burden of financing the Medicaid program is not improperly shifted to the Federal government as the only net payer and due to concerns that a lack of actual "cost" to the State and providers will result in States maximizing use of Provider Taxes and maximizing Medicaid payments without regard to the quality of the Medicaid services being funded.

Recent Publications on Provider Taxes

On May 15, 2025, the Centers for Medicare and Medicaid Services ("CMS") published a proposed rule seeking to amend the provider tax regulations at 42 CFR Part 433 ("Proposed Rule"). Specifically, the Proposed Rule is intended to address what the current CMS Administration believes is a loophole in a regulatory statistical test

applied to State proposals for Medicaid tax waivers (of the aforementioned broad-based and/or uniformity requirements) to ensure that Provider Taxes are indeed generally redistributive. The Proposed Rule adds some definitions and additional requirements for states to demonstrate a tax is generally redistributive and therefore eligible for a waiver of the broad-based and/or uniform requirements. Essentially, the Proposed Rule provides that a Provider Tax will not be considered to be "generally redistributive" if the tax excludes taxpayers based on Medicaid volume, the tax rate imposed varies based on Medicaid volume, or another description that has the same effect of either.

The public comment period for this Proposed Rule closed on July 15, 2025 and at least 1,265 comments were received regarding the Proposed Rule, which CMS will review as part of its finalization of the rule.

Provider taxes were also addressed, along with SDPPs, in President Trump's June 6, 2025 Memorandum for the Secretary of HHS the Administrators of the CMS regarding the subject "Eliminating Waste, Fraud, and Abuse in Medicaid" ("Presidential Memo"). The Presidential Memo discussed the Biden Administration's permitting of States and providers to "game the system" – using provider taxes to fund Medicaid payments with States avoiding contributing money toward the Medicaid services. The Presidential Memo ultimately directed the Secretary of HHS to take action to cap Medicaid payments rates at Medicare levels without specifically directing action with regard to specific funding mechanisms – Provider Taxes.

OBBB Changes to Provider Taxes

The OBBB amended the Provider Tax statute in two substantial ways. First, OBBB Sec. 71117 amended Soc. Sec. Act 1903(w)(3)(E) to address the "generally redistributive" requirement for a waiver of the broad-based or uniform requirements. Such amendments to the statute are nearly identical to the Proposed Rule and therefore indicate that the Proposed Rule will likely be finalized without significant revision.

Second, OBBB Sec. 71115 amended Soc. Sec. Act 1903(w)(4) to:

1) Prohibit new Provider Taxes;

2) Cap the ceiling (based on percent of net patient revenue) for satisfying the hold harmless requirement for:

a) existing Provider Taxes in Non-Expansion States (in other words, States that have not expanded Medicaid under the Affordable Care Act—more on this later); and

b) existing Provider Taxes for nursing facility services and ICF/IDD services in Expansion States; and

3) Cap or reduce the ceiling for existing Provider Taxes in Expansion States.

These limitations are to apply for fiscal years beginning on or after October 1, 2026, but also look back to the status of the State's Provider Tax on the date of enactment (July 4, 2025) for purposes of assessing whether a Tax is considered new or existing. Similar to our first article, we note that the OBBB language raises a lot of questions for States to consider as they are assessing the future of their Provider Tax programs, including the definition of Expansion State and whether it applies to a State that partially expands or later expands, and what ceiling applies (i.e. what exactly is the "applicable percent of net patient revenue attributable to such class that has been so determined").

For questions regarding OBBB and its impact on state Medicaid programs, please contact Meghan Linvill McNab, Grant Achenbach, or Brandon Shirley.
