Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

July 14, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS–2448–P - Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations, Closing a Health Care-Related Tax Loophole Proposed Rule (90 Fed. Reg. 20579, May 15, 2025)

Dear Dr. Oz:

I am writing on behalf of the Catholic Health Association of the United States (CHA), the national leadership organization representing more than 2,200 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations. Our ministry is present in all 50 states and the District of Columbia, with one in every seven patients in the United States cared for in a Catholic hospital each year. CHA appreciates the opportunity to comment on the referenced proposed regulation on health-care related provider taxes. We are deeply concerned about the potential negative impact the new requirements could have on access to care for Medicaid beneficiaries and the heath care facilities that serve them.

States finance the non-federal share of their Medicaid programs through various sources, including general fund revenue and taxes on health care providers. Almost every state uses at least one provider tax to help finance Medicaid. In state fiscal year 2018, 68% of state funds came from state general revenues, 17% from health care-related taxes, 12% from local governments, and 4% from other sources. Provider taxes are often used to fund supplemental payments to providers and are critical tools for offsetting low provider reimbursement levels and ensuring access to care. States also use provider tax revenues for a range of investments, such as improving behavioral health access.

The proposed rule would alter requirements for health care-related taxes, which states use to fund the non-federal share of their Medicaid programs. Health care-related taxes are generally required to apply equally to all providers in a given class (e.g., inpatient hospitals), otherwise known as being "broad based" and "uniform." CMS allows states to waive the broad-based

and/or uniformity requirements if the state meets a statistical test to demonstrate that the tax is "generally redistributive," meaning that it does not shift the tax burden onto Medicaid providers. Some states have designed taxes that meet the statistical test but have been criticized as not following the spirit of being "generally redistributive." CMS states that the proposed rule targets this "health care-related tax loophole" where states impose higher taxes primarily on Medicaid managed care organizations (MCOs).

The recently enacted reconciliation bill, H.R. 1, the One Big Beautiful Bill Act (the OBBBA), largely codified the provisions of the proposed rule. Both the proposed rule and the law prohibit any tax - MCO tax or otherwise - that either (1) imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes, or (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service. They also prohibit taxes that have the "same effect" as in (1) or (2) above. The OBBBA provides the Secretary of Health and Human Services (the Secretary) with significant discretion to assess which taxes are impermissible due to their "same effect" as the prohibited taxes. The law also allows states to impose a new tax or increase an existing tax in order to comply with the newly modified requirements, though this flexibility lasts only until "the effective date of this paragraph." The effective date is the date of enactment, July 4, 2025, unless the Secretary chooses to allow for a transition period of up to three years.

These new requirements will result in substantially less state funding available to finance Medicaid in the affected states, leaving them no choice but to raise other taxes, cut other parts of their budget like education, or more likely, sharply cut their Medicaid programs. To mitigate the negative effect on beneficiary access and minimize additional disruption to states and providers, we urge you to utilize the discretion provided in H. R. 1 in the following ways:

- **"Same Effect" Test**

The OBBBA gives the Secretary significant discretion to determine whether a given tax is impermissible as having the "same effect" as Prohibited taxes. **CHA urges CMS to be explicit and transparent about how it will assess whether health care-related taxes have the "same effect" as prohibited taxes.** As proposed, the "same effect" language creates significant uncertainty for states and providers. Without clearly defined criteria, CMS risks creating inconsistencies in how the policy is applied across states and their tax structures.

In the proposed rule's preamble, CMS notes that states could impose varying tax rates or exclude certain providers from a health care-related tax if done "in support of a public policy purpose" (e.g., excluding rural hospitals or setting lower rates for continuing care retirement communities). However, greater specificity is needed to guide state decision-making.

In its final rule, we urge CMS to outline specific criteria for assessing the "same effect" threshold and provide clear guidance on how a state can determine -and demonstrate - that a health care-related tax that appears to shift the relative tax burden toward the Medicaid program is, in fact, justified by legitimate public policy goals.

- **Transition Period**

Both the OBBBA and the proposed rule provide for transition periods. The OBBBA authorizes the Secretary to grant transition periods of up to three years. Under the proposed rule, however, a transition period would only be available for states whose waiver approvals were granted more than two years prior to the effective date of the final rule. States eligible for a transition period would have approximately one year (depending on their state fiscal year) to submit a new waiver proposal that meets the new requirements.

CMS proposes to deny any transition period to states with waivers granted within the past two years and not to count any tax collections made under those waivers after the effective date of the final regulations toward the federal match. It believes this is appropriate because these states had received notice that CMS was planning rulemaking in this area. However, as CMS notes, this notice was communicated through a letter which accompanied CMS' approval of the very waiver at issue. It was reasonable for states to anticipate any future changes would be accompanied by an opportunity to comply with new requirements. States should not be punished retroactively when they relied in good faith on CMS' approval of their waivers.

CHA urges CMS to include in the final rule the full three-year transition period for all states as allowed under the OBBBA. All states that may be out of compliance with the new uniformity requirement should have three years to transition existing health care-related taxes and come into compliance. States and providers have come to rely upon them, and taking advantage of the full transition period could help to mitigate disruptions in care.

It will take time for states to examine existing health care-related taxes to determine those that are in violation of the new requirements and to take steps to modify them. Under the OBBBA states also cannot implement new or increased taxes; therefore, it is crucial that states have time to plan changes to any prohibited tax without significant disruption to states' Medicaid funding. A three-year transition period will enable states to plan, prioritize, and engage with health care providers as they implement changes to comply both with these new requirements but also the numerous other Medicaid provisions of the OBBBA, in a way that minimizes as much as possible disruption in care and lack of access for Medicaid beneficiaries.

This maximum transition period will also give CMS the best opportunity to provide states with the technical assistance they will need and sufficient time for its own review of modified waiver proposals to ensure the policy is implemented with consistency and transparency.

Thank you for the opportunity to comment on the proposed regulation. We look forward to a continued partnership to strengthen and improve Medicaid for the people it serves. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

Lisa A. Smith
Vice President
Advocacy and Public Policy