VIZIENT OFFICE OF PUBLIC POLICY AND GOVERNMENT RELATIONS

Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care Related Taxes

August 4, 2026

BACKGROUND & SUMMARY

On July 21, the Centers for Medicare & Medicaid Services (CMS) issued a Proposed Rule on the Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes (hereinafter, "Proposed Rule"). The Proposed Rule implements statutory changes from Section 71115 of the Working Families Tax Cut (WFTC) legislation,[1] enacted into law on July 4, 2025. Section 71115 of the WFTC legislation prohibits states from establishing new provider taxes or increasing provider taxes that were not already enacted and in effect as of July 4, 2025. In addition, for Medicaid expansion states, the provision would gradually phase down the allowable indirect hold harmless threshold for existing grandfathered provider taxes by 0.5 percentage points per year beginning in FY 2028, reducing the threshold from 6% to 3.5% by FY 2032.

The Proposed Rule also includes changes that are not explicitly included in the WFTC legislation, including proposals to create a new permissible provider tax class for oversight purposes and eliminate one of the tests used to evaluate certain indirect hold harmless arrangements. CMS estimates the Proposed Rule would reduce federal spending by $246 billion from 2026 through 2035.

A CMS fact sheet on the Proposed Rule is available here. Comments are due **on September 21, 2026**. Vizient looks forward to working with our provider clients to help inform our letter to CMS.

PERMISSIBLE HEALTH CARE-RELATED TAXES

INDIRECT HOLD HARMLESS THRESHOLD

States currently use provider taxes to help finance the non-federal share of Medicaid expenditures but are restricted from structuring these taxes in a manner that directly or indirectly holds providers harmless for the cost of the tax. This means that states generally cannot guarantee that providers will be repaid for the tax through increased Medicaid payments or other arrangements that effectively offset the cost of the tax. Currently, CMS applies a nationwide indirect hold harmless threshold of 6% of net patient revenue attributable to the assessed permissible class of healthcare items or services when evaluating whether a provider tax complies with federal Medicaid financing requirements. The WFTC legislation replaces the uniform nationwide threshold with state- and provider-class-specific indirect hold harmless thresholds based on provider taxes that were enacted and imposed as of July 4, 2025. In the Proposed Rule, effective October 1, 2026, CMS proposes regulations to implement the new state and provider-specific indirect hold harmless threshold from Section 71115 of the WFTC legislation.[2]

For Medicaid non-expansion states[3], the threshold for each provider class would be set at the provider tax rate in effect on July 4, 2025. That percentage would become the state's maximum allowable indirect hold harmless threshold for each provider class. For Medicaid expansion states, the provider tax threshold will be the lower of either the provider tax rate in effect on July 4, 2025, or the applicable statutory phase-down percentage outlined below, beginning in fiscal year (FY) 2028. For provider

[1] CMS refers to Public Law 119-21 as the "Working Families Tax Cut" (WFTC) legislation. This law is also known as the One Big Beautiful Bill Act (OBBBA).
[2] The WFTC legislation establishes two key dates that are relevant for determining the new provider tax thresholds. May 1, 2025, determines which permissible provider classes are subject to the new framework, while July 4, 2025, determines whether a state had a qualifying provider tax in place and the maximum allowable threshold for that provider class. If a state did not have a qualifying provider tax enacted and imposed for a particular provider class by July 4, 2025, the threshold for that class would be zero percent. As a result, allowable provider tax thresholds may vary across states and across provider classes within the same state. Once CMS calculates these percentages, they become the state's maximum allowable provider tax collection level for that provider class. CMS explains that different states can have different thresholds for the same provider class and different provider classes within the same state can have different thresholds. For example, state- A may have a threshold percentage of 3.5% for taxes on nursing facility services, while state-B may have a threshold percentage of 2% for those same services. In addition, each permissible class within a state would have its own threshold. For example, state-A may have a 3.5% threshold for taxes on nursing facility services and a 4% threshold for taxes on inpatient hospital services.
[3] CMS proposes to add a definition for "Non-Expansion State", to mean those states that did not adopt the Affordable Care Act Medicaid expansion to adults and would be subject to the phased reduction in provider tax thresholds.

classes that did not have a provider tax in effect as of July 4, 2025, the indirect hold harmless threshold would be 0%, preventing states from establishing new provider taxes in those classes for Medicaid financing purposes.

INTERPRETATION OF "ENACTED" AND "IMPOSED"

Section 71115 of the WFTC legislation requires CMS to base the new state- and provider-class-specific indirect hold harmless thresholds on provider taxes that were enacted and imposed as of July 4, 2025.[4] However, the WFTC legislation does not further define "enacted" or "imposed". In November 2025, CMS released a Dear Colleague Letter, where the agency considered a provider tax to be "enacted" if the state had completed the legislative process authorizing the tax and, where applicable, obtained any required CMS waiver approval by July 4, 2025.[5] CMS also interpreted "imposed" to mean that the state was actively collecting revenue associated with the tax, or collecting it on a delayed but routine schedule, as of July 4, 2025."

In the Proposed Rule, CMS proposes to revise the agency's interpretation of the terms "enacted" and "imposed". Specifically, CMS proposes that "enacted" means that a state must have legal authority to impose a provider tax by July 4, 2025, while "imposed" refers to whether the tax was legally in effect and, where applicable, had received any required CMS waiver approval.[6] CMS further clarifies that a tax may be considered imposed even if collections had not yet begun on July 4, 2025, if providers were subject to a legally enforceable obligation to pay the tax. This approach represents a notable change from the November 2025 guidance because the proposed new interpretation of these terms now focuses on whether a tax was legally in effect rather than whether collections had already occurred.

DATA TO CALCULATE EACH STATE'S INDIRECT HOLD HARMLESS THRESHOLD

CMS proposes to use the state fiscal year (SFY) that includes July 4, 2025, to calculate each state's applicable indirect hold harmless threshold. CMS proposes to require states to submit actual provider tax collection and net patient revenue data, rather than estimates or projections, to support the threshold calculation. Under the proposal, any provider tax increases implemented after July 4, 2025, would be excluded from the calculation. However, if a state reduced a provider tax after July 4, 2025, CMS would still calculate the indirect hold harmless threshold based on the tax structure that existed on July 4, 2025, preserving the state's ability to increase collections up to its established threshold in the future.

States must submit the data necessary for CMS to calculate final indirect hold harmless thresholds by June 30, 2028. CMS also proposes an interim indirect hold harmless threshold period beginning October 1, 2026, outlined further below, during which states would operate under CMS-calculated estimated indirect hold harmless thresholds while CMS collects and reviews state-submitted data and develops final thresholds. CMS intends to notify states of their final provider tax thresholds, including any applicable phase-down schedule for expansion states, no later than September 30, 2028.

Although indirect hold harmless thresholds would be calculated using SFY data, CMS proposes to apply and enforce the indirect hold harmless thresholds on a Federal Fiscal Year (FFY) basis, consistent with the WFTC legislation, which takes effect for FYs beginning on or after October 1, 2026.[7] To support ongoing monitoring, states would report provider tax collections through the quarterly CMS-64 report, which CMS would use to determine whether states remain within their allowable provider tax thresholds during each FFY. CMS notes that because many SFYs do not align with the FFY, states will need to ensure compliance with the applicable threshold during each FFY regardless of how states structure their own tax year. **CMS requests comment on these proposals.**

CMS recognizes that expansion states whose SFYs do not align with the FFY may need to adopt operational approaches to ensure compliance when the applicable indirect hold harmless threshold decreases in the middle of an SFY. CMS proposes

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[4] If no indirect hold harmless thresholds on provider taxes were enacted and imposed as of July 4, 2025 then the state's indirect hold harmless threshold would generally be 0%, significantly limiting the state's ability to use provider taxes to help finance Medicaid.
[5] https://www.medicaid.gov/medicaid/downloads/providertax_dcl_11142025.pdf
[6] CMS considered several alternative ways to interpret which provider taxes would qualify under Section 71115. The agency considered requiring CMS waiver approval as part of the definition of a tax being "enacted," but ultimately concluded that waiver approval is more appropriately tied to whether a tax is "imposed." CMS also considered allowing taxes without required waiver approval to qualify but rejected that approach because a tax that requires a waiver is not permissible until CMS approves it. In addition, CMS considered requiring a tax to be actively collecting revenue as of July 4, 2025, but decided this would unfairly exclude taxes that were legally in effect but collected on a delayed or infrequent schedule.
[7] CMS clarifies that because many state fiscal years do not align with the federal fiscal year, states will need to ensure that provider tax collections remain within the applicable threshold during each FFY, regardless of how the state structures its own tax year.

two potential approaches to address this issue, including applying different provider tax rates before and after the indirect hold harmless threshold change takes effect, or prorating provider revenues across the SFY and applying the applicable threshold to each portion of the year.

INTERIM INDIRECT HOLD HARMLESS THRESHOLD PROCESS

Section 71115 requires CMS to collect additional tax data to verify that all states are complying with the applicable indirect hold harmless threshold. However, the actual data CMS needs to set the indirect hold harmless threshold are not available until after changes from Section 71115 take effect. As a result, CMS proposes an interim indirect hold harmless threshold process to provide states with an early indication of the indirect hold harmless thresholds that ultimately may apply and to support a transition to the new reporting requirements. CMS expects states to use this interim threshold to help manage provider tax collections, monitor compliance, and support provider tax waiver requests until CMS calculates final thresholds, which are expected by September 30, 2028. CMS clarifies that the interim threshold is intended as a planning and oversight tool and generally would not be used to determine penalties; CMS expects states to use the interim indirect hold harmless threshold to avoid overcollections and minimize the need for later corrections.[8]

Once the final thresholds are established, CMS recognizes that the data needed to determine compliance might not be immediately available. As a result, CMS proposes a two-year remediation period after the end of each FFY where states can submit final data, correct reporting errors, and make any necessary adjustments before CMS reviews compliance and considers enforcement action.[9]

REVISION OF THE SECOND PRONG OF THE INDIRECT HOLD HARMLESS TEST (THE 75/75 TEST)

Under current regulations, CMS uses a two-part framework to determine whether a provider tax creates an impermissible indirect hold harmless arrangement. First, CMS evaluates whether provider tax collections exceed the applicable indirect hold harmless threshold as a percentage of net patient revenue. If a tax exceeds that threshold, CMS then applies the 75/75 test, which examines whether at least 75% of taxpayers, including providers, paying the tax receive at least 75% of their tax costs through enhanced Medicaid payments or other state payments. If both conditions are met, CMS determines that providers are effectively being reimbursed for the tax they paid and that an impermissible hold harmless arrangement exists.

In the Proposed Rule, CMS proposes to eliminate the second part of the framework, the 75/75 test, for FFYs beginning on or after October 1, 2026, so that only compliance with the applicable indirect hold harmless threshold is relevant when determining whether a provider tax creates an impermissible indirect hold harmless arrangement. Although Section 71115 of the WFTC legislation does not explicitly address the 75/75 test, CMS contends that retaining the 75/75 test could create a pathway for states to bypass the new statutory limits, particularly as states look for ways to preserve existing levels of non-federal Medicaid financing. CMS further notes that the 75/75 test is a regulatory policy rather than a statutory requirement and has rarely been used successfully.[10] To preserve existing financing arrangements, if a state had a provider tax that was already approved above 6% under the 75/75 test as of July 4, 2025, CMS clarifies that the agency would not require that state to immediately reduce the tax to 6% because the test is being eliminated. However, CMS states that it does not expect any state to qualify for this exception. **CMS requests comment on these proposals.**

PHASE DOWN FOR MEDICAID EXPANSION STATES

Section 71115 of the WFTC legislation established a phased reduction, beginning October 1, 2027, of the allowable indirect hold harmless thresholds for most provider taxes in Medicaid expansion states. CMS proposes regulations to implement the phased reduction. Under this proposed phase-down the applicable indirect hold harmless threshold for an affected provider class would be the lower of: (1) the threshold calculated from the provider tax structure in effect on July 4, 2025, or (2) the applicable statutory percentage, which phases down from a cap of 5.5% in FFY 2028 to 3.5% in FFY 2032 and subsequent

[8] While an approved provider tax waiver may be evaluated using the interim threshold, states will ultimately be judged against the final threshold and may still need to make adjustments if collections exceed the final allowable limit once that threshold is determined.
[9] For example, FFY 2029 ends on September 30, 2029. If a state discovers during the remediation period, such as in August 2030, that its provider tax collections exceeded its allowable threshold, the state would have until September 30, 2031 to correct the problem.
[10] According to CMS, only one provider tax arrangement has relied on the 75/75 test to collect revenues above the indirect hold harmless threshold.

years.[11] For example, if a provider class had a calculated threshold of 4.75% on July 4, 2025, the applicable indirect hold harmless threshold would remain 4.75% in FFY 2028 and FFY 2029 because it is lower than the statutory caps of 5.5% and 5.0%. Beginning in FFY 2030, the threshold would decrease to 4.5% because the statutory cap would then be lower than the state's calculated threshold. Further, if a provider class had a calculated July 4, 2025 threshold of 5.8%, this state's original threshold is higher than the new statutory cap and the applicable indirect hold harmless threshold would be limited to 5.5% in FFY 2028 and would continue to decrease under the proposed phase-down schedule. CMS also proposes that if a current non-expansion state adopts Medicaid expansion in the future, the phase-down schedule for expansion states would apply beginning in the FFY in which the expansion becomes effective.

PROPOSED NEW DEFINITIONS

CMS proposes to define "Net Patient Revenue" as revenue received by a taxpayer subject to the provider tax that is attributable to the taxed provider class, regardless of payer source.[12] The calculation would include revenue from Medicaid, Medicare, commercial insurance, and patient payments, but would exclude non-patient care revenue such as gift shop sales, cafeteria revenue, or parking income. Net patient revenue is main element of the new indirect hold harmless threshold framework because CMS uses it to calculate and enforce the state- and provider-class-specific thresholds established under Section 71115. Since the allowable provider tax threshold is expressed as a percentage of net patient revenue, the amount of revenue included in the calculation can directly affect the amount of provider tax revenue a state is permitted to collect and whether a state remains in compliance with the applicable threshold. CMS clarifies that only revenue associated with the taxed provider class may be included in the definition. CMS notes that this proposal does not represent a change to the agency's longstanding interpretation of Net Patient Revenue but is intended to codify the definition for purposes of implementing Section 71115 of the WFTC legislation. **CMS is seeking public comment on the proposed definitions and whether additional terms should also be formally defined.**

PROPOSED EXPANSION OF PERMISSABLE TAX CLASS LIST

CMS proposes creating a new permissible provider tax class for services of health insurers that are not already included in the existing managed care organization (MCO) provider tax class.[13] The proposed class would include commercial health insurers and insurers offering high-deductible, catastrophic, short-term limited-duration, dental-only, and vision-only coverage. CMS notes that while some entities may function as both health insurers and MCOs, the proposed health insurer class would be distinct from the existing MCO class. The agency is proposing this change based on their opinion that several states currently impose taxes on health insurers to help finance Medicaid, even though health insurers are not currently recognized as a permissible provider tax class under federal regulations. CMS also proposes that the health insurer taxes would be subject to the same provider tax requirements that apply to other permissible classes, including the broad-based, uniformity, and hold harmless rules.

CMS also proposes to apply the new indirect hold harmless framework established by Section 71115 of the WFTC legislation to the health insurer class. As a result, health insurer taxes that were enacted and imposed as of July 4, 2025, could continue subject to the applicable threshold, while taxes not in place by that date would be subject to a 0% threshold. CMS acknowledges that the WFTC legislation revised the provider tax rules for permissible classes that existed as of May 1, 2025, but did not address how those provisions should apply to new permissible classes created after that date. **CMS is seeking**

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[11] Congress set 5.5% as the first statutory cap in the phase-down schedule for Medicaid expansion states and CMS is implementing the phase-down which includes:

- 5.5% in FFY 2028
- 5.0% in FFY 2029
- 4.5% in FFY 2030
- 4.0% in FFY 2031
- 3.5% in FFY 2032 and after

[12] For example, if a tax applies to inpatient hospital services, only inpatient hospital revenue could be counted, while outpatient hospital revenue would be excluded. This definition is intended to support consistent calculation and application of the new provider tax thresholds established under Section 71115

[13] MCOs, health maintenance organizations (HMOs), and preferred provider organizations (PPOs) are already recognized in the existing permissible MCO class under current Medicaid provider tax regulations.

comment on the scope of the proposed health insurer provider tax class, including which entities should be included, and how the Section 71115 indirect hold harmless thresholds should apply to the new proposed provider tax class.

LIMITATION ON LEVEL OF FEDERAL FINANCIAL PARTICIPATION (FFP) FOR REVENUES FROM HEALTH CARE-RELATED TAXES

Currently, if CMS determines that a health care-related tax does not comply with federal requirements, including the indirect hold harmless provisions, the agency may reduce federal financial participation (FFP) associated with the noncompliant tax. States may voluntarily return the applicable federal funds, or CMS may recover those amounts through established deferral or disallowance processes. In the Proposed Rule, CMS proposes to retain the current penalty process for provider taxes that exceed the allowable indirect hold harmless threshold. If CMS determines that federal funds were improperly claimed as a result of a noncompliant provider tax, the agency may recover the associated federal funds through established Medicaid overpayment, deferral, or disallowance processes.

CMS clarifies that compliance will be assessed at the provider class level, meaning all provider taxes within the same class, including state and local taxes, will be combined when determining whether the threshold has been exceeded. If total collections for a provider class exceed the allowable threshold, CMS may reduce federal funding for that class. CMS also clarifies that once a provider class exceeds the applicable threshold, all provider tax revenues collected within that class are considered impermissible, not just the amount collected above the threshold. CMS states that this reflects its longstanding interpretation rather than a new policy.

REGULATORY IMPACT ANALYSIS

IMPACT ON PROVIDER TAX REVENUES

Provider taxes are a significant Medicaid financing tool, with 49 states and the District of Columbia currently using them to help fund the state share of Medicaid expenditures. CMS estimates that the prohibition on new provider taxes and provider tax increases beginning October 1, 2026, will reduce provider tax revenue by approximately $51.0 billion from 2026 through 2035.[14] CMS notes that this reduction reflects lower future growth in provider tax revenues rather than the immediate elimination of existing provider taxes. In addition, based on CMS's analysis, proposals that would gradually reduce the maximum allowable provider tax threshold in Medicaid expansion states would reduce provider tax revenue by $147.7 billion from 2026 through 2035.[15] CMS estimates these changes will reduce state provider tax revenue by approximately $198.7 billion over ten years, resulting in states collecting roughly 27% less provider tax revenue by 2035 than they would have collected absent the WFTC legislation.

IMPACT ON FEDERAL MEDICAID SPENDING AND ENROLLMENT

CMS expects that reductions in provider tax revenue will result in lower Medicaid spending because states frequently rely on provider taxes to finance the state share of Medicaid expenditures. While CMS does not predict how individual states will respond, the agency assumes states will generally preserve Medicaid eligibility and enrollment and instead absorb the financial impact through lower provider payments or, potentially, reductions in covered benefits. CMS estimates that the provider tax provisions would reduce federal Medicaid spending by approximately $245.8 billion and state Medicaid spending by $138.2 billion between 2026 and 2035, for a combined reduction of $384.0 billion. CMS expects hospitals to experience the largest effects because hospital provider taxes generate a substantial share of provider tax revenue and support many Medicaid supplemental payment programs.

CMS acknowledges substantial overlap between the provider tax and state directed payment (SDP) provisions because many Medicaid payment reductions projected under the provider tax changes would also occur through reduced SDPs. After accounting for this overlap, CMS estimates that provider payments would decline by an additional $142.1 billion between

[14] Table 6 in the Proposed Rule (pg. 46589) shows the projected annual impacts on provider tax revenues from 2026-2035.
[15] Table 7 in the Proposed Rule (pg. 46590) shows the annual projected decrease in provider tax revenue due to the phase down of the thresholds in expansion States.

2026 and 2035, rather than the full $384.0 billion initially attributed to the provider tax provisions alone.[16] **CMS notes that these estimates are uncertain and requests comment on the agency's financial impact assumptions and projections.**

WHAT'S NEXT?

Comments on the Proposed Rule are due on September 21, 2026. Vizient's Office of Public Policy and Government Relations looks forward to hearing continued client feedback on this Proposed Rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or comments regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. Please direct your feedback to Randi Gold, Director, Hospital Payment Policy and Regulatory Affairs in Vizient's Washington, D.C. office.

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[16] Table 12 in the Proposed Rule (pg. 46592) shows the combined projected effects of the revenue changes and expenditure changes to show the net impact by each payer and entity under the projected rule. In this table, reductions in payments are shown as positive to payers and negative to providers, and reductions in tax revenue are shown as negative to recipients (the states) and positive to providers.

TO LEARN MORE, CONTACT:
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