July 9, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Caprice Knapp, PhD
Interim Acting Director of Medicaid & Children's Health Insurance Program Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via regulations.gov

RE: **Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole (CMS-2448-P)**

Dear Dr. Oz,

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 family physicians and medical students across the country, we appreciate the opportunity to comment on the proposed rule published in the Federal Register on May 15, 2025, regarding State proposals for Medicaid tax waivers.

CMS is proposing to close a perceived loophole in the methodology states use to pass the regulatory statistical test that verifies whether health care-related taxes are "generally redistributive", while concentrating the tax burden among certain Medicaid providers, including MCOs. CMS believes these arrangements do not align with statutory intention. If finalized, the rule would require state health care-related taxes meet new criteria beyond the existing statistical test to be considered generally redistributive.

The AAFP appreciates CMS's commitment to preserving and strengthening the Medicaid program as a vital safety net for the nation's most vulnerable populations. We share the goal of ensuring robust and sustainable Medicaid funding for those most in need. However, we are concerned that certain provisions in the proposed rule may have unintended consequences that could adversely affect both patients and providers, potentially undermining Medicaid's core mission. As CMS considers changes to state Medicaid financing, it is essential that these efforts prioritize protecting and strengthening coverage for the most vulnerable populations across the country.

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org

To maintain strong Medicaid access nationwide, the AAFP recommends that CMS:

- **Protect taxpayer dollars and preserve lawful state Medicaid financing tools by conducting a one-year revenue allocation analysis to guide targeted reform prior to finalizing this rule.** Targeting regulations to areas of greatest misallocation will strengthen oversight, optimize federal resources, and give states time to proactively align Medicaid financing structures with legislative changes —minimizing disruptions in patient access.
- **Pair health care-related tax reform with Medicaid access guarantees to safeguard the most vulnerable Americans from gaps in access to necessary care.**
- **Provide a three-year transition period to all states with active health care-related tax waivers to prevent coverage gaps, maintain payment stability, and align with the timeline established under H.R.1, given the overlap in provisions.**

The Essential Role of State Financing in Sustaining Medicaid

Medicaid is a vital payer for family physicians, particularly in underserved and rural areas where they provide more care than any other specialty and often serve as the initial point of access for patients facing significant barriers to affordable care.[i]

Family physicians are the backbone of primary care for Medicaid enrollees. In 2021, 76% family physicians were accepting new Medicaid patients, significantly more than many other specialties.[ii] And by 2023, just one-third of primary care physicians delivered 90% of all Medicaid office visits, underscoring the outsized role family medicine plays in sustaining access to care.[iii] Thus, any policy that threatens Medicaid's stability directly jeopardizes the care family physicians provide to millions of patients nationwide.

Initially, states relied on general revenues to fund their share of Medicaid program costs under the Federal Medical Assistance Percentage (FMAP) formula, but rising health care costs and growing coverage needs drove many states to adopt health care-related taxes to sustain Medicaid and draw down federal matching funds. Now, health care-related taxes, particularly Provider and Managed Care Organization (MCO) taxes, are foundational state financing mechanisms, used by 49 states to support their Medicaid program.[iv] Authorized under Section 1903(w) of the Social Security Act, these taxes have become central to Medicaid financing, helping states preserve and expand access to care for millions of low-income individuals and families.

States may impose health care-related taxes to help fund Medicaid programs, but CMS requires these taxes to be broad-based, uniform, and not include hold-harmless provisions. States may also request waivers from the broad-based and uniform requirements if they can demonstrate, through statistical modeling, that the tax is generally redistributive. A tax is considered generally redistributive if it derives revenues from non-Medicaid services and uses these revenues as the State's share of Medicaid payments.

Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule

CMS is concerned that seven states, including California and New York, are using a methodological "loophole" to structure health care-related taxes that appear generally redistributive while concentrating the burden to certain Medicaid providers, such as MCOs. CMS believes these arrangements contradict statutory intent and, if finalized, would impose additional criteria for all future state health care-related taxes to qualify as generally redistributive.

General Definitions (§433.52)

CMS proposes adding new definitions to clarify terms used in evaluating health care-related tax waivers submitted by States. CMS states that these new definitions aim to improve clarity and consistency in regulatory analysis, particularly in assessing whether a tax is generally redistributive under proposed updates.

These definitions include:

1. "Medicaid taxable unit", referring to units tied to Medicaid payments (e.g., Medicaid bed days or revenue).
2. "Non-Medicaid taxable unit", referring to units unrelated to Medicaid (e.g., commercial revenue).
3. "Tax rate group", meaning a group of entities within a tax class that are taxed at the same rate.

AAFP comments on General Definitions (§433.52)

AAFP welcomes efforts to clarify definitions and offer transparency into CMS's process in assessing waiver applications. We encourage CMS to ensure these definitions are clearly communicated to existing and new health care-related tax waivers from States, and do not unintentionally disqualify longstanding provider or MCO taxes that have historically supported Medicaid access and meet statutory criteria.

Permissible Health Care-Related Taxes (§433.68(e), §433.68(e)(3))

CMS proposes that current and all future state health care-related tax waivers must be "generally redistributive". The proposed changes include establishing additional criteria to prevent tax structures that disproportionately burden Medicaid providers, particularly those serving a high share of Medicaid beneficiaries, despite passing the existing statistical modeling tests that verify redistribution, known as the B1/B2 test. The B1/B2 tests assess the relationship between provider taxes and Medicaid revenues (B1) and the overall redistributive effect of the tax (B2).

If finalized, states must pass existing statistical modeling tests to verify redistribution *and* ensure the taxes do not disproportionately burden providers with high Medicaid utilization,

based on CMS' proposed criteria, grouped into two categories: (1) Taxes that refer to Medicaid explicitly, and (2) Waivers that do not refer to Medicaid explicitly.

1. *Taxes that refer to Medicaid explicitly*

CMS proposes new criteria to clarify that health care-related taxes are not considered "generally redistributive" if they impose higher tax rates on providers based on their Medicaid volume. Specifically, taxes that explicitly apply higher rates to Medicaid units or to providers with higher Medicaid utilization, compared to non-Medicaid units or providers with lower Medicaid volume, would violate the redistributive requirement.

CMS provides examples, such as disproportionate taxes on 'Medicaid managed care member months' or nursing facilities with high 'Medicaid bed days', to illustrate noncompliant structures. This provision aims to prevent states from designing taxes that shift the financial burden away from non-Medicaid providers and onto the federal government, which CMS views as inconsistent with statutory intent and a risk to Medicaid's fiscal integrity.

2. *Waivers that do not refer to Medicaid explicitly*

CMS also proposes to prohibit states from structuring health care-related taxes that indirectly target Medicaid by using proxies, such as income levels, geographic areas, payer mix, or general terms like "joint federal-state programs" without explicit mention of Medicaid, that result in higher tax rates on Medicaid-related units. CMS claims that this provision ensures that taxes with similar effects to those already deemed noncompliant from utilizing the statistical generally redistributive "loophole", are also considered noncompliant.

CMS clarifies that states may structure tax rate groups to support lawful public policy goals, such as aiding rural hospitals or continuing care retirement communities, even if these groups have lower Medicaid utilization. If finalized, CMS will assess the legitimacy of tax rate groups and deem them acceptable if they do not shift tax burdens away from non-Medicaid providers or serve as a disguised means of targeting Medicaid. Acceptable tax groupings must be based on pre-existing classifications and not "contrived features" that could signal an attempt to exploit the system.
CMS provides examples of acceptable and unacceptable groups:

a. Acceptable tax rate groups: Rural location, hospital type, or other healthcare metrics
b. Unacceptable tax rate groups: Number of ER entrances

AAFP Comments on Permissible Health Care-Related Taxes (§433.68(e), §433.68(e)(3))

Let Revenue Allocation Data Drive Reform and Protect Lawful Medicaid Financing

We support CMS's focus on greater transparency in state financing structures and commend CMS for developing clear definitions (§433.52) and examples of permissible tax groupings (§433.68(e), §433.68(e)(3)) in this proposed rule. However, it is critical that Medicaid tax reforms be grounded in robust evidence to avoid destabilizing access to essential care. **Therefore, before finalizing the rubric for evaluating permissible tax rate groupings, we recommend CMS leverage their proposed definitions to conduct a one-year, data-driven analysis of current health care-related tax revenue allocation. This study will identify tax rate groups *most* susceptible to misallocation, enabling CMS to implement precise and cost-effective regulation in these high-risk areas.** This approach of evidence-based, targeted regulation will minimize costly case-by-case waiver reviews, streamline the use of limited resources, and strengthen stewardship of taxpayer funds. Further, this approach would benefit states by providing greater clarity on waiver approval criteria, reducing compliance complexity, and giving them time to proactively adjust their Medicaid financing systems with overlapping provisions in H.R.1. Most importantly, this approach would safeguard patient access by preventing unnecessary disruptions to permissible tax arrangements that support coverage.

Health care-related taxes, like provider taxes and MCO taxes, have been critical in expanding coverage and maintaining payment stability. Provider taxes are a critical funding source for Medicaid, accounting for 32% of state Medicaid funding in 2024 and generating $37 billion annually for states' non-federal share.[v,vi] In some states, provider taxes contribute up to 17-30% of Medicaid financing.[vii] Provider taxes have also played a key role in Medicaid expansion states, with many states funding their share by introducing or increasing these taxes. [viii] Beyond program financing, provider taxes help sustain payment adequacy for physicians. Without them, states may reduce payment rates, leading to lower physician participation, longer wait times, and diminished access to preventive and chronic disease care. Given that Medicaid payments to family physicians already average just 72% of Medicare rates, and are even lower in some states, further reductions would threaten access to care.[ix] And according to the Congressional Budget Office (CBO), restricting provider tax flexibility could shrink state revenue by 28% or $241B in a decade.[x]

As more states have shifted to managed care, provider taxes levied on MCOs, have also emerged as a linchpin of Medicaid managed care funding in at least 20 states, many approved by CMS waivers or guidance when they maintain access and program integrity.[xi] For states with large Medicaid populations, these taxes are essential for stabilizing managed care funding without directly taxing providers. Restricting or eliminating MCO taxes would jeopardize this balance, creating fiscal gaps that could drive down capitation rates, destabilize provider participation, and ultimately limit patients' access to timely, high-quality care. If network adequacy erodes, patients may face longer wait times, reduced provider choice, or loss of access altogether. While MCOs have room for reform, well-designed MCO taxes remain essential to sustaining coverage, maintaining provider networks, and keeping care affordable for patients who rely on Medicaid the most.

Health care-related taxes also play a crucial role in supporting the family physician workforce, which is more essential than ever as the population ages and chronic disease rates rise. Medicaid GME funding, clinic preceptor payments, and community-based training stipends are often funded through general state Medicaid revenues, including those strengthened by provider taxes. Understanding how health care tax-related revenues support workforce development is crucial for informed policymaking. Without this insight from the one-year data collection study on health care tax-related revenue allocation, any reduction in state financing risks exacerbating the primary care shortage, particularly in rural areas, where access is already strained.

Thus, limiting states' financing flexibility may yield short-term savings but will likely increase downstream costs, particularly in uncompensated emergency and specialty care visits. Reduced Medicaid funding will strain health care systems in rural and low-income communities, where resources are already stretched thin. Further, to offset lost funding, states may be forced to narrow eligibility, reduce provider reimbursements, limit enrollment, and cut benefits, starting with services that, while not federally mandated, are essential to patient care and well-being.

Weakening Medicaid Financing Risks Frontline Access to Care for the Most Vulnerable.

AAFP has long warned that such cuts could destabilize care delivery, especially for vulnerable populations. By limiting states' financing flexibility, the rule would disproportionately affect low-income families, mothers, children, communities of color, and rural patients. These groups rely heavily on Medicaid and would be most harmed by reduced access and coverage.

1. *Children's health care:* Currently, 40% U.S. children rely on Medicaid or CHIP for their coverage.[xii] If states lose provider and MCO tax revenue, they may be driven to restrict eligibility or reduce covered services, limiting access to preventive care, chronic disease management, and essential immunizations for children. This presents a clear misalignment with this administration's pledge to protect American children and address rising rates of chronic disease. Without sustainable funding, states may struggle to provide the care necessary to prevent and manage chronic conditions, leaving children at greater risk.
2. *Maternal health care:* Medicaid covers 43% U.S. births and is the primary payer for maternal health care in rural and low-income communities across the nation.[xiii] If health care-related tax restrictions result in physician payment cuts, many family physicians who provide a significant share of Medicaid prenatal care, especially in rural areas, may be forced to leave the program. This loss of funding and providers could compel maternal health clinics to scale back essential services, such as lactation support and maternal mental health screenings, further deepening gaps in access.
3. *Rural health care:* Medicaid covers nearly 1 in 3 rural Americans. Rural clinics and Critical Access Hospitals already operate with slim margins, with more than 45% operating with negative margins.[xiv] Further, southern states have been hit hardest by

Medicaid non-expansion, leading to higher uncompensated care costs, particularly in their rural communities. If states lose provider or MCO tax revenue, these challenges may intensify, and rural health systems may be compelled to reduce services, lay off staff, or close entirely.

We recommend CMS protect Medicaid coverage and ensure robust access protections are provided to states impacted by this ruling by taking the following actions:

1. Guarantee that primary care payment rates will not fall below current levels due to these proposed changes to provider tax policy.
2. Establish state-level monitoring mechanisms to track and prevent access degradation, particularly in rural and high-need areas.
3. Preserve provider and MCO tax authority, which supports preventive care services that offer long-term cost savings and improved health outcomes.

Transition Period (§433.68(e)(4))

This provision establishes a transition period for states with previously approved health care-related tax waivers that may not meet the updated redistributive requirements outlined in the proposed rule. CMS states that the seven states identified (including CA, MI, MA, and NY) with waivers approved within the last two years will not be granted a transition period, while those with waivers older than two years will have one year from the final rule's effective date to comply. Affected states will have to either submit a new waiver request that complies with the revised standards or modify their existing tax arrangement to bring it into compliance. After the transition period ends, all new waivers submitted after the final rule is in effect would need to meet the revised standards immediately. CMS will be offering technical assistance to all states that may be impacted.

AAFP Comments on Transition Period (§433.68(e)(4))

The AAFP appreciates CMS's recognition that states need time to adjust their Medicaid financing structures. However, we urge CMS to extend the transition period to acknowledge overlapping Congressional actions in H.R.1 and provide clear guidance and safeguards to ensure a smooth adjustment, prevent coverage gaps, and maintain payment stability.

This proposed rule aligns with ongoing legislative efforts, including H.R.1, the budget reconciliation bill, which introduces significant changes to Medicaid financing. With overlapping provisions restricting health care-related taxes and additional reductions through work requirements, eligibility testing, and a moratorium on new health care-related taxes, states may face substantial fiscal challenges. Given this evolving landscape, it is crucial to ensure that Medicaid access remains stable. If finalized, this rule could further constrain states' ability to maintain funding and safeguard essential Medicaid programs, making thoughtful implementation and support all the more necessary.
Allowing states sufficient time to adapt is critical. A rushed transition would impose considerable administrative burdens, forcing states to make difficult decisions regarding

eligibility, services, and provider reimbursement, ultimately harming patients and vulnerable communities.

We recommend CMS take the following actions to ensure a smooth transition for affected states:

- Ensure a three-year transition period for states, as afforded to states in H.R.1, to adjust existing Medicaid financing arrangements, preventing abrupt disruptions in funding and care delivery.
- Establish clear, detailed guidance on CMS's evaluation process for state waiver submissions, including the specific acceptance criteria used, to promote transparency, consistency, and accountability.
- Define explicit standards beyond illustrative examples for CMS's new classification criteria, clearly distinguishing legitimate tax models from those deemed to be disguised, Medicaid-targeting tax groups.
- Establish clear, quantitative benchmarks and reproducible thresholds to guide states in demonstrating that health care-related taxes are "generally redistributive." This framework will ensure consistency in statistical modeling, allowing states to align with CMS's new guidelines and secure approval for future waivers.

We appreciate the opportunity to provide comments on this proposed rule. For additional questions, please contact Sahana Chakravartti, Regulatory Specialist, at schakravartti@aafp.org

Sincerely,

Steve Furr, M.D., FAAFP

Steven Furr, MD, FAAFP
American Academy of Physicians, Board Chair

[i] https://www.ruralhealth.us/about-us/about-rural-health-care#:~:text=The%20obstacles%20faced%20by%20health,to%20lead%20normal%2C%20healthy%20lives.
[ii] https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf
[iii] https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/medicaid-patients-office-practices-high-quality-primary-care
[iv] Health Care-Related Taxes in Medicaid - MACPAC
[v] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/
[vi] https://www.macpac.gov/wp-content/uploads/2020/01/Health-Care-Related-Taxes-in-Medicaid.pdf#:~:text=Data%20from%20SFYs%202008–2018%20(the%20most%20recent,percent%20in%20SFY%202008%20(GAO%202015%2C%202021).
[vii] https://www.macpac.gov/wp-content/uploads/2020/01/Health-Care-Related-Taxes-in-Medicaid.pdf#:~:text=Data%20from%20SFYs%202008–2018%20(the%20most%20recent,percent%20in%20SFY%202008%20(GAO%202015%2C%202021).
[viii] https://familiesusa.org/wp-content/uploads/2019/09/MCD_States-Share-10-Percent_Fact-Sheet.pdf
[ix] https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf
[x] https://www.cbo.gov/budget-options/60897
[xi] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/#:~:text=All%20states%20except%20for%20Alaska%20use%20provider,finance%20the%20state%20share%20of%20Medicaid%20spending.&text=Beyond%20institutional%20providers%2C%2020%20states%20have%20provider,and%20home%20care%20providers%20(Appendix%20Table%201).
[xii] https://ccf.georgetown.edu/topic/childrens-health-insurance-program/
[xiii] https://pmc.ncbi.nlm.nih.gov/articles/PMC10691745/#:~:text=In%20recent%20years%2C%20Medicaid%20paid,Mexico%20(KFF%2C%202020b).
[xiv] https://www.ruralhealth.us/blogs/2025/04/critical-condition-how-medicaid-cuts-would-reshape-rural-health-care-landscapes#:~:text=If%20Medicaid%20funding%20is%20reduced,Medicaid%20reimbursement%20are%20still%20lagging.