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State Directed Payments and Health Care-Related Taxes

Summary of Proposed Rules

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Overview

- Background
- State directed payment (SDP) proposed rule
  - SDP payment limits
  - Targeted Medicaid payment limit in fee for service (FFS)
- Health care-related taxes (provider taxes) proposed rule
  - Indirect hold harmless threshold (safe harbor)
  - Permissible classes
  - Elimination of 75/75 test

2025 Budget Reconciliation Act

- Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act) introduced new limits on SDPs and provider taxes
- Reduces the payment limit for SDPs that require written prior approval to Medicare payment rates
  - 100 percent of Medicare in expansion states and 110 percent of Medicare in non-expansion states
  - Current SDP arrangements grandfathered in at existing dollar amount and phased down
- Amends the safe harbor threshold for provider taxes
  - Freezes existing tax arrangements at current tax rate and essentially prohibits new provider tax arrangements
  - Phase down of safe harbor threshold in expansion states starting in fiscal year (FY) 2028

Payment Limits for SDPs

Supplemental Payment and SDPs

- Under FFS, states may pay supplemental payments in addition to base payments
  - Total payment (base + supplemental) subject to upper payment limits (UPL)
  - For institutional providers, UPL is defined as reasonable estimate of what would have been paid under Medicare payment principles in the aggregate
  - For physician services, there is not a regulatory UPL but the Centers for Medicare & Medicaid Services (CMS) has used a standard of average commercial rate (ACR)
- Under managed care, states pay managed care plans through a capitation payment and the plans negotiate payment rates with providers
  - States can only direct managed care plans to pay specific rates to providers or to use specific payment method under SDPs that meet regulatory requirements
  - 2024 managed care rule formalized ACR as the limit on SDPs for hospital services, nursing facility services, and qualified practitioner services at academic medical centers

Payment Limits on SDPs

- For rating periods beginning on or after July 4, 2025, implements Medicare-based payment limits for specified SDP arrangements in the 50 states and the District of Columbia
  - SDPs receiving prior written approval for inpatient and outpatient hospital services, nursing facility services, or qualified practitioner services at AMCs
  - **Expansion state:** 100 percent of the specified total published Medicare rate
  - **Non-expansion state:** 110 percent of the specified total published Medicare rate
- Total published Medicare rate defined as the amounts calculated as payment for the specific services under Medicare Parts A and B
  - Applies at the service and provider-level (i.e., individual claim level)
  - If there is not a specified total published Medicare payment rate for that service, the limit is the Medicaid state plan payment rate
- For rating periods beginning on or after January 1, 2029, the Medicare-based limit extended to all SDP arrangements beyond those specified in legislation
  - All services and not just the four specified in the 2025 Budget Reconciliation Act
  - SDPs that don't require prior written approval
  - Includes territories

Grandfathering of SDPs

- Certain SDPs that apply to rating periods within 180 days of July 4, 2025 are grandfathered in at current dollar amount (e.g., ACR)
  - Required prior written approval and for the four services specified in legislation
  - Rating period includes any business day between October 11, 2024–July 3, 2025 or July 5, 2025–March 27, 2026
  - State submitted a completed SDP preprint prior to July 4, 2025
- Ceiling set at the estimated total dollar amount listed in the preprint of the grandfathered SDP
  - Total payment rate cannot exceed ACR
- Subject to a gradual phasedown of 10 percentage points of grandfathered total dollar amount each year beginning with rating periods starting on or after January 1, 2028, until the Medicare-based limit is reached
- Will allow the use of separate payment terms for grandfathered SDPs

Permissible SDPs

- For rating periods beginning on or after January 1, 2028, CMS proposes to only allow SDPs that are:
  - Value-based payment models;
  - Delivery system reform or performance improvement initiatives; or
  - Minimum or maximum fee schedules that are no greater than the applicable payment limit
- Eliminates the option to use uniform dollar or percentage increases for new SDPs or renewal of non-grandfathered SDPs
  - Uniform rate increases are allowed for grandfathered SDPs until they reach the payment limit
- CMS indicates that it would consider situations in which the state directs actuaries to develop capitation rates assuming higher provider payment rates as implicit SDPs and would be subject to regulatory requirements

Monitoring and Compliance of SDP Limits

- For grandfathered SDPs:
  - ACR demonstration until the first rating period beginning on or after January 1, 2029
  - Total payment rate comparison for rating periods beginning on or after January 1, 2027 expressing the grandfathered total dollar amount as a percentage of the most recent total published Medicare payment rate must be submitted until the first rating period the payment limit is met
- For all SDPs:
  - A list of providers eligible for the SDP and their national provider identifiers (NPI)
  - The total published Medicare payment rate (or state plan approved rate) that serves as basis for payment limit
  - A description of how the state will ensure payment to each provider, for each service, will not exceed the payment limit
  - For VBPs and reform/improvement initiatives, a detailed validation methodology to ensure payments do not exceed the payment limit on a per-service basis

CMS Guidance

- Proposed rule requires CMS to issue guidance on an as needed basis regarding:
  - Federal requirements and standards for the SDP;
  - Documentation required to determine that the SDP has been developed in accordance with requirements;
  - Any considerations for applicability of the payment limit;
  - The documentation required to demonstrate compliance with the payment limit;
  - Any updates or developments in the SDP review process to facilitate prompt CMS review; and
  - Any considerations for state monitoring, oversight, and evaluation of the SDP

FFS Targeted Practitioner Payments

Limit on FFS Targeted Practitioner Payments

- Impose Medicare-based payments limits to FFS when all or a portion of a base or supplemental payment is targeted to a subset of participating providers within the state or a specific geographic area
  - **Expansion states:**100 percent of the specified total published Medicare rate
  - **Non-expansion states:** 110 percent of the specified total published Medicare rate
- Medicare-based limit would apply at the service and provider-level
  - Medicare FFS payment rate that would be paid under the applicable Medicare payment rates established under Parts A and B
- Effective for first state fiscal year beginning on or after January 1, 2029
- Provision was not included in the 2025 Budget Reconciliation Act

Exceptions

- Medicare-based limit does not apply if payment rates are:
  - Uniform for all Medicaid providers furnishing the applicable services within state or region
  - Subject to other statutory or regulatory limits (e.g., hospital UPL)
- The limit may not be less than the required payment rate under statutory requirements (e.g., federally qualified health centers)
- Services that do not have a reasonably comparable Medicare equivalent service
- Payments that are reconciled to a practitioner's actual costs incurred

Commission Comment Letter

- Commission submitted comments on July 21, 2026
- Concern about the application of the Medicare-based limits on SDPs and targeted FFS practitioner payments at the service level
  - Limits state flexibility to use payment as a tool to achieve policy goals and implement innovative payment models
  - Medicare payment rates have been developed to promote Medicare-specific goals, which do not include certain populations and services important to Medicaid, such as children and pregnant women
  - Administration of Medicare-based payment rate limits at the provider and service level will be administratively complex and burdensome
- Need for additional guidance on when actuaries can include certain payment rate assumptions to meet actuarial soundness requirements without being considered implicit SDP arrangements
- Need to clarify what SDP payment limit would apply to providers who have not been paid by Medicare, such as some children's hospitals, but could be paid under a Medicare-based methodology

Provider Tax Proposed Rule

Permissible Provider Taxes

- A tax for which at least 85 percent of the tax burden falls on health care providers or services
  - Assessed against a permissible class of services or providers
  - Broad-based: applied to all providers within the class, with the exception of governmental providers
  - Uniform: applied to all providers in the same manner
- States cannot hold providers harmless for the cost of the tax, including through direct or indirect guarantees
- Two prong test to determine if an indirect guarantee exists:
  - **Indirect hold harmless threshold:** a tax less than or equal to 6 percent of the net patient revenue from the providers are deemed permissible
  - **75/75 test:** indirect guarantee exists if 75 percent or more of the providers that are taxed receive 75 percent or more of their tax costs back

New Safe Harbor Threshold

- Beginning October 1, 2026, for each permissible class that was in effect as of May 1, 2025, the safe harbor threshold will be equal to the applicable percent of net patient revenue attributable to taxes imposed as of July 4, 2025
  - Enacted: State or local government has completed the entire legislative process necessary to authorize a new or amended tax structure in effect on July 4, 2025
  - Imposes: State or locality imposed on taxpayers a legally enforceable obligation to pay the tax as of July 4, 2025
- After October 1, 2026, the hold harmless threshold is 0 percent for any provider tax that was not in effect as of July 4, 2025
  - Effectively prohibits any new provider taxes
- For expansion states, the threshold will be subject to a potential phasedown of 0.5 percentage points beginning in FY 2028
  - Lower of tax in effect as of July 4, 2025 or 5.5 percent in FY 2028, 5.0 percent in FY 2029, 4.5 percent in FY 2030, 4.0 percent in FY 2031, and 3.5 percent in FY 2032
  - Phasedown does not apply to taxes on nursing facilities or intermediate care facilities for individuals with intellectual disabilities

Calculation of Safe Harbor Threshold

- Safe harbor percentage calculated based on data from the state fiscal year (SFY) in which July 4, 2025 falls
  - All tax revenue collected for each provider tax imposed on that permissible class, including amounts recovered through Medicaid payment offsets and delinquent tax payments and penalties collected
  - All net patient revenue attributable to all providers in the permissible class, including both providers that are subject to the tax and those that are not
- States must report actual tax and net patient revenues by June 30, 2028
- States operate under interim safe harbor limits from October 1, 2026–September 30, 2028

Calculation of Interim Threshold

- To calculate the interim threshold, states must submit the following information to CMS by December 31, 2026:
  - The best available tax collection amounts, by tax and permissible class, and net patient revenue data, by permissible class
  - The authorizing legislation, as well as date and citation for any related state regulation or administrative issuance required to implement the tax
  - The type and date of any broad-based or uniformity waiver(s) approved
  - Documentation that demonstrates when the tax was imposed in accordance with regulatory requirements
  - What the tax is used to fund, including, as applicable, the specific Medicaid payments supported by the tax

Calculation of Final Threshold

- To calculate the final threshold, states will need to submit the following information to CMS by June 30, 2028
  - Actual tax collection amounts, by tax and permissible class
  - Actual net patient revenue for all providers in permissible class
- CMS intends to announce final thresholds to states, including the phase-down schedule for expansion states no later than September 30, 2028

New Permissible Class of Services

- Adds a new permissible class for services of health insurers other than services of managed care organizations (including health maintenance organizations and preferred provider organizations) that are already specified in regulations
- Preamble provides examples:
  - High deductible/catastrophic plans
  - Short-term limited-duration policies
  - Insurers providing coverage for limited benefits (e.g., dental or vision)
- Could include premiums from:
  - Private FFS plans under Medicare Advantage Part C or premiums for Part D plans
  - Plans that provide premium assistance to purchase coverage through the exchange as part of a Medicaid 1115 demonstration
- Would apply the new safe harbor threshold even though this class was not described in regulations as in effect on May 1, 2025
- Provision was not included in the 2025 Budget Reconciliation Act

Elimination of the 75/75 Test

- Proposes to eliminate the 75/75 test as of October 1, 2026
  - Effectively, only provider taxes under safe harbor threshold would be considered permissible
- CMS noted that the 75/75 test is typically impractical to pass and only one tax has ever utilized this test
- Provision was not included in the 2025 Budget Reconciliation Act

Ongoing Reporting Requirements

- States must submit to CMS, via the CMS-64 quarterly report, data for all provider taxes that includes:
  - Actual tax collections, by tax and permissible class
  - Actual net patient revenue for each permissible class for each reporting period, even if the actual collection occurs after the end of the reporting period
  - What each tax on each permissible class is used to fund
  - The removal of one or more providers that are units of government from a tax assessment when a waiver of the broad-based and uniformity requirements was not sought
  - Any additional information requested by CMS
- Tax collection and net patient revenue amounts must reflect actual data without using estimates, projections, or other approximations
- States must furnish a complete, accurate, and full disclosure of all of their tax programs and expenditures

Commission Comment Letter

- Commission submitted comments on September 21, 2026
- Support for the ongoing reporting of provider tax information that align with MACPAC recommendations
  - CMS should consider collecting and reporting these data at the provider level such that the financing data could enable analysis of net payments for specific providers
  - Net payment analysis needed to understand how the new provider tax limits affect payment rates to specific providers and subsequent outcomes (e.g., access)
- Need additional clarification prior to the effective date to clarify health insurers versus the existing class of managed care organizations
- Concern that the elimination of the 75/75 test removes a pathway for states to raise revenues more broadly when the tax revenues have a minimal tie to Medicaid expenditures
- Potential operational challenges with taxes aligned on a state fiscal year basis and safe harbor threshold applied on federal fiscal year

Discussion

- Commission has submitted comment letters on both proposed rules
- Staff welcome questions about the proposed rules and any areas for future consideration

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SEPTEMBER MEETING

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