Submitted electronically via www.regulations.gov

July 9, 2025

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Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1833-P
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator Oz,

The Association of American Medical Colleges (AAMC or the association) welcomes this opportunity to comment on the proposed rule entitled "**Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule**," 90 FR 20578 (May 15, 2025), issued by the Centers for Medicare & Medicaid Services (CMS or the agency).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, biomedical research, and community collaborations. Its members are 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 12 accredited Canadian medical schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

After the proposed rule was issued by CMS, the "One Big Beautiful Bill Act" (OBBBA),[1] which included many significant changes to the Medicaid program, was passed by Congress and signed by the President on July 4, 2025**. In light of these changes, we urge CMS to withdraw and reevaluate the proposals included in this rule.**

[1] P.L.119-21

The following summary reflects the AAMC's comments on CMS' proposals in this rule to alter the waiver approval process for broad-based and uniform requirements for provider taxes utilized as a tool for state's Medicaid financing.

- ***Ensure Changes to Medicaid Financing Mechanisms Ensure Sufficient Funding to Support Beneficiary Access*:** Ensure mechanisms to finance Medicaid payment rates are available to states and sufficient to support beneficiaries' access to care.
- ***Limit Subjectivity in the Approval Process for Broad-Based and Uniform Waiver Applications:*** CMS should not introduce additional subjectivity in the approval process for the waiver of broad-based and uniform requirements and should continue to rely on statistical tests to determine whether requirements are met.
- ***Recognize that Provider Taxes Designed to Support Academic Medicine are a Legitimate Public Policy Goal***: Teaching health-systems and hospitals train and develop the future healthcare workforce as well as ensure access to specialty and sub-specialty care, some of which is not offered by other providers. Supporting these institutions is a legitimate public policy goal that improves access to care.
- ***Finalize a Longer, Three Year Transition Period for All Impacted States:*** Finalize a longer, three-year transition period for all impacted states to ensure compliance with any waiver application changes to minimize harm to state Medicaid programs.

PROVIDER TAXES AS A MEDICAID FINANCING MECHANISM

The Medicaid program is funded in partnership between the federal and state governments. States have access to a few financing mechanisms to shore up their required share of Medicaid financing, including the use of provider taxes, which allows states to impose taxes on certain classes of providers. Provider taxes are defined in statute as a health care related fee, assessment, or other mandatory payment for which at least 85 percent of the burden of the tax revenue falls on health care providers.[2] By statute, these taxes must be broad-based and uniform, meaning that a tax is applied to all providers in a provider class and at a uniform rate so that the tax is not disproportionately levied more heavily on providers serving Medicaid patients.[3] Currently, CMS allows states to request a waiver of the broad-based and/or uniformity requirements so long as the net impact of the tax is generally redistributive, and the amount of the tax is not directly correlated with Medicaid payments for items and services for which the tax is imposed. However, CMS has become concerned with state's use of waivers for provider taxes and is proposing modifications to how it currently approves waivers for broad-based and uniform requirements.

Specifically, to determine if a provider tax meets these requirements, CMS utilizes two different statistical tests. The first is the P1/P2 test which is used to waive the broad-based requirement and the second is the B1/B2 test which is used to waive the uniformity requirement. (P. 20581).

[2] Section 1903(w)(3) of the Social Security Act
[3] *Id.*

If a state's provider tax meets the statistical requirements under these calculations to be considered generally redistributive, then CMS will approve a state's request for a waiver. However, CMS is concerned that passing these statistical tests is not enough to warrant an automatic approval and to satisfy the assumption that these provider taxes are generally redistributive. In response to the agency's concerns, they are proposing to alter how they review waiver applications to prevent states from "gaming" these calculations. While this would not alter the statistical tests that CMS utilizes, it would amend both provisions so that CMS is not required to "automatically approve the waiver request" if it satisfies the applicable test. This change would introduce additional subjectivity into the waiver request process. (P. 20586).

Further, CMS is proposing that if a tax rate imposed is based upon a provider's Medicaid taxable units and is higher than the tax rate imposed on others in the tax rate group based upon its non-Medicaid taxable units, then the tax would not be generally redistributive. CMS proposes similar language around the use of varied tax rates for an explicitly defined lower volume or percentage of Medicaid taxable units to lower the tax rate imposed on others in the tax rate group. (P. 20586). CMS believes health care-related taxes designed in this way would be inconsistent with a tax that is generally redistributive and would run counter to congressional intent and statutory direction that taxes receiving a waiver of broad-based and uniform requirements be generally redistributive. CMS also proposes to apply this same thinking to provider taxes that do not explicitly reference Medicaid, but instead utilize a substitute definition or measure as a proxy for Medicaid that would in turn have the 'same effect' as explicitly referencing Medicaid. (P. 20587). CMS has stated that this proposed rule would impact seven states with currently approved health-care related taxes levied on Managed Care Organizations (MCOs) and one state with currently approved health-care related taxes levied on hospital inpatient services. (P. 20591).

Ensure Changes to Medicaid Financing Mechanisms Ensure Sufficient Funding to Support Beneficiary Access

While the AAMC supports ensuring fiscal integrity of the Medicaid program, we oppose limitations to waivers for the broad-based and uniform requirements or other changes that may limit state's ability to leverage health-care related taxes to finance the non-federal share of Medicaid, as outlined in this proposed rule. The provider taxes and waivers CMS aims to limit have been permissible by CMS since the early 1990's.[4] This includes CMS' current policy to allow for the approval of state' waiver requests so long as their healthcare-related tax passes the B1/B2 and P1/P2 statistical tests. Over the years states have become more reliant on healthcare-related taxes with all states, except Alaska, utilizing at least one healthcare-related tax.[5] While this proposed rule suggests having a limited direct impact on seven states, the introduction of greater scrutiny and limits on provider taxes impacts all states by limiting all states' flexibility to fund the non-federal share of Medicaid expenditures. An inability to design programs for

[4] 58 FR 43156
[5] KFF, 5 Key Facts About Medicaid and Provider Taxes (March 2025)

financing the non-federal share of Medicaid is likely to prevent states from adequately reimbursing health care providers for their services and jeopardize access to care.

Further, sudden changes to the status quo that limit Medicaid financing options, without an adequate transition period or support, would create sudden gaps in Medicaid funding, jeopardizing access to care for the Medicaid population and the operation of their providers. This proposed change comes at a time when states and providers are already grappling with uncertain funding changes and ever-increasing costs.[6] These mechanisms allow states to levy taxes on health care providers to help finance their Medicaid programs without placing additional tax burden on individual residents or the vulnerable populations which Medicaid serves. Provider taxes allow states to balance fiscal constraints with the need to ensure adequate access to necessary care, an essential role in the Medicaid program. These changes could force states to increase taxes on individual taxpayers, cut other non-health care budget items, such as education, or reduce Medicaid expenditures, resulting in lower payments to providers, more limited benefit offerings, and reduced enrollment.

Patients would still require and use medical care, resulting in higher uncompensated care costs. It is estimated that each additional uninsured individual raises uncompensated care costs by $1,455 per full-year, and when adjusted for by inflation is estimated to reach $2,263 per full-year uninsured individual by 2034.[7] Reductions in Medicaid coverage and reimbursement ultimately drive up health care costs for everyone in order to fill the gaps or result in service line or hospital closures, impeding patient access to care.[8]

Impact of Proposed Changes to Academic Health Systems and Providers in Impacted States

Academic medical centers are particularly vulnerable to changes in Medicaid financing and reimbursement, as they furnish a significant volume of services to Medicaid beneficiaries. AAMC member teaching health-systems and hospitals account for 27 percent of Medicaid hospitalizations, while only accounting for 5 percent of all U.S. hospitals.[9] Adequate funding for Medicaid is essential to ensure access for the patients served by AAMC members. The healthcare-related taxes referenced in CMS' proposed rule are often utilized to fund increases in Medicaid reimbursement to providers, including additional supplemental payments such as state directed payments (SDPs) and Medicaid GME. Teaching health-systems and hospitals rely on these revenue streams to provide patient care and train the future physician workforce. Underpayment for Medicaid services or loss of supplemental payments further strains the

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[6] KFF, Health Care Costs and Affordability (May 2024)

7 Center for American Progress, New CBO Estimates Confirm Massive Rise in Uncompensated Care Costs Under One Big Beautiful Bill Act (June 2025)

[8] A. Gaffney, MD, MPH, et al, Projected Effects of Proposed Cuts in Federal Medicaid Expenditures on Medicaid Enrollment, Uninsurance, Health Care, and Health, Annals of Interna Medicine (June 2025)

[9] AAMC analysis of FY2023 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2024, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2024. Note: Data reflect short-term, general, nonfederal hospitals.

financial stability of many hospitals that care for a disproportionate number of Medicaid beneficiaries. Enabling states to maintain adequate funding for their Medicaid programs helps to ensure Medicaid beneficiaries' access to care, including specialty and sub-specialty care some of which is only provided at specific institutions, such as academic medical centers.

As referenced by CMS, seven states will be directly impacted by the proposed changes to the broad-based and uniform waivers. (P. 20591). The AAMC represents members in all seven of these states. As stated, many of these provider taxes are implemented to fund the state's supplemental payments, which are often tied to specific policy goals such as supporting workforce programs or improving quality. For example, in Massachusetts, the state's tax on hospital services and MCOs play a significant role in helping finance the state's Health Safety Net Trust Fund, estimating the tax on MCOs alone provides $625 million in funding.[10] This trust fund helps to support payment to acute care hospitals and community health centers providing care to qualified safety-net patients.[11] Currently, the fund is experiencing a large shortfall, even with existing provider taxes. Removing the ability for Massachusetts to continue its current provider tax program would result in an even greater deficit, putting these investments paid to acute care hospitals and community health centers providing care to qualified safety-net patients in jeopardy. In Ohio, limits on the state's ability to finance Medicaid through funding mechanisms such as provider taxes endanger billions of dollars for health care funding. For FY 2025, Ohio estimates that the revenue from their provider tax on MCOs will provide $415 million in funding.[12] Removing this funding source subsequently endangers patient access to care and other healthcare investments, such as state directed payments (SDPs), in the state.[13] West Virginia would also be forced to contend with similar cuts to their state's Medicaid program if funding mechanisms are limited by proposals such as restricting the broad-based and uniform waiver requests.[14]

Similarly, New York supports a Safety Net Transformation Fund, which is an initiative to pair safety net hospitals with stronger health system partners to improve their financial sustainability, ensuring continued access for patients. New York's recently approved MCO tax is slated to ensure $1.6 billion in funding for a number of Medicaid investments funded solely by the state. Without this funding stream, Medicaid funding to New York hospitals would be cut by $665 million, while funding to the Safety Net Transformation Fund stands to lose $300 million in operating support. In total, losing the MCO tax would cut funding to New York hospitals by nearly $1 billion.[15] This hospital funding supports several initiatives in Medicaid, including improving the reimbursement rate for outpatient hospital services under Medicaid to ensure

[10] Blue Cross Massachusetts Foundation, What is the Role of Provider Taxes in the MassHealth Program? (May 2025)
[11] Massachusetts Health Safety Net (HSN)
[12] Ohio Department of Medicaid, Redbook. (February 2025)
[13] *Id*.
[14] West Virginia Center on Budget & Policy, The Budget Bill Is Bad for West Virginia (June 2026)
[15] Raske, Kenneth E, Greater New York Hospital Association "Closing Hospitals Doesn't Fit the Waste, Fraud, and Abuse Narrative" (June 2025)

financial viability and protect patient access to care as well as quality initiatives to improve patient care. Michigan's Medicaid program also stands to lose up to $450 million, if its MCO tax is removed.[16]

The AAMC is fully supportive of CMS' goal of ensuring fiscal integrity. However, this proposed rule will cause significant reductions in the program, effectively eliminating Medicaid coverage for millions of vulnerable patients**. To this end, the AAMC urges CMS to preserve state's ability to obtain waivers related to provider taxes and work with states to maintain current financing mechanisms utilized fund their share of Medicaid expenditures.** At a minimum, the agency must work with states to ensure these changes do not result in sudden, dramatic cuts jeopardizing access for all patients in their state.

Limit Subjectivity in the Approval Process for Broad-Based and Uniform Waiver Applications

As stated earlier, CMS is also proposing to limit its approval of waivers for the broad-based and uniform requirements for provider taxes that do not explicitly reference Medicaid, but instead utilize a substitute definition or measure as a proxy for Medicaid that would in turn have the 'same effect' as explicitly referencing Medicaid. (P.20587). The AAMC is concerned CMS' current proposal provides the agency with broad and unclear discretion around the approval of provider tax designs. As written, there are no clear standards regarding how CMS will interpret the 'same effect' or what the agency will consider constitutes a proxy for Medicaid. Such an open-ended policy creates confusion for states looking to modify existing taxes or design new provider taxes and would allow the agency to maintain a moving target for what it would consider to be a proxy for Medicaid that would cause the 'same effect.' Moreover, such a policy leaves the requirements for obtaining a waiver of the broad-based and uniform requirements unclear while providing the agency with the ability to alter requirements without engaging in proper rulemaking channels.

The open-endedness of this proposal raises additional concerns that CMS is relying more heavily on policy-based arguments for determining if a provider tax meets the requirements of a broad-based and/or uniform requirement waiver. Such a change introduces additional subjectivity and moves away from a reliance on the statistical tests as a reasonable test of the broad-based and uniform requirements. This is directly in contrast to the agency's original implementation of the B1/B2 and P1/P2 tests. In the original 1993 implementation of the broad-based and uniform waivers, the agency argued against the inclusion of policy-based arguments in determining if a waiver met the requirements for the broad-based and uniform waiver. The agency cited that policy based arguments would give the agency "no specific standards by which a waiver of these requirements could be measured."[17] The agency also goes on to say that "subjective analysis would be administratively burdensome and virtually impossible to apply fairly throughout the

[16] Michigan Department of Health and Human Services, Executive Directive (March 2025)
[17] 58 FR 43164

nation."[18] **The AAMC shares CMS' sentiment that subjective analysis does not provide clear standards, is administratively burdensome, and is challenging to apply uniformly across the U.S. and urges the agency not to finalize changes that introduce additional subjectivity into the waiver application process.**

Recognize that Provider Taxes Designed to Support Academic Medicine are a Legitimate Public Policy Goal

Beyond the agency's departure from their historical interpretation of how to manage waiver applications for broad-based and uniform requirements, we are concerned with the agencies' interpretation of what constitutes a legitimate public policy goal. CMS reaffirms that the proposed changes to permissible health-care related taxes are not intended to prevent States from designing tax rate groups to achieve legitimate public policy goals. However, the agency specifically calls out teaching hospitals as a tax rate group that would be scrutinized under the changes as a tax rate group that is defined based on criteria that mirrors Medicaid eligibility or other defining characteristics. (P. 20588). This language seems to suggest that referencing teaching-health systems and hospitals would be considered a proxy for Medicaid. The language also suggests that states seeking to support teaching-health systems and hospitals and aiming to advance the missions of academic medicine, including medical education and access to patient care, would not be pursuing legitimate public policy goals under this policy. At the same time, CMS currently allows for a lower threshold to pass the B1/B2 test for taxes that provide more favorable tax treatment for specified types of entities, such as sole community hospitals (SCHs) or rural hospitals. CMS' reasoning for this is due to the vital role these facilities play in ensuring access to care, including ensuring a sufficient number of qualified providers to serve the needs of Medicaid beneficiaries. (P. 20589). Based on this reasoning, we believe that CMS is unjust in excluding teaching health-systems and hospitals from this exception. These providers play a vital role in ensuring a sufficient number of qualified providers by training the next generation of physicians, and offering specialty and sub-specialty care some of which is not offered by other providers.

The AAMC strongly disagrees with the agency's interpretation of 'proxy' for Medicaid in this context. While teaching health-systems and hospitals provide a disproportionate amount of care Medicaid patients receive, they also provide care to many other patients that are covered by a wide and diverse payer mix. **Further, the AAMC believes a state aiming to advance the missions of academic medicine, including medical education and improved access to patient care, would be a legitimate and worthy public policy goal.** By 2036, the United States faces a projected shortage of up to 86,000 physicians due to the nation's growing and aging population and a significant portion of the physician workforce approaching retirement age.[19] Without filling this gap, the shortage of physicians would place significant strain on the entire healthcare system, which is only compounded by greater care needs as the nation's population continues to

[18] *Id.*
[19] AAMC, The Complexities of Physician Supply and Demand: Projections From 2021 to 2036 (March 2024)

grow and age. AAMC member teaching health systems and hospitals represent only 5 percent of all inpatient U.S. hospitals, but train 70 percent of residents nationwide.[20] Our member teaching health systems and hospitals support the mission of advancing and improving patient care by operating 100 percent of comprehensive cancer centers, 75 percent of burn unit beds, 59 percent of level-one trauma centers, and 64 percent of pediatric intensive care unit (ICU) beds.[21] Our members also provide 33 percent of hospital charity care nationwide, ensuring access to care for those most in need.[22] This dedication to the missions of patient care, education, and community collaboration showcase a commitment to improving access to quality care and ensuring a robust healthcare workforce for generations to come.

While teaching health systems and hospitals continue to invest in their physician training and patient care missions, reimbursement from payers may not always fully support these goals and states may choose to craft public policy goals and financing mechanisms to support these missions. Current Medicaid rules allow states substantial flexibility to determine Medicaid benefits and to fund their Medicaid programs to meet states' needs and the needs of Medicaid beneficiaries. If a state were to undertake policies within their Medicaid program to support teaching health-systems and hospitals, that would be considered legitimate public policy goals that aim to support and improve the health of communities across their state.

Finalize a Longer, Three Year Transition Period for All Impacted States

Lastly, CMS is proposing and requesting feedback on how to best implement a transition policy for states with provider taxes in place that would no longer be permissible under the proposed changes. The agency is proposing a transition period only for states whose most recent approval was not within the past 2 years of the final rule's effective date. This transition would in effect give states one year from the rule's implementation date to come into compliance with the changes to provider taxes. States that received their most recent waiver approval for their provider tax within two years or less from the effective date of the final rule would not be eligible for a transition period. (P. 20590). Instead, these states would need to immediately end their provider tax as the waiver would no longer apply or be subject to penalties until the provider tax is ended or revised to come into compliance. CMS states that these states received a warning letter in companion with their state's approval for their waiver warning them of potential future changes to the waiver application process for the broad-based and uniform requirements. (P.20590). CMS also raises questions around whether this is the appropriate

[20] AAMC analysis of FY2023 American Hospital Association data. AAMC membership data, December 2024
Note: Data reflect short-term, general, non-federal hospitals. Data for AAMC-member teaching hospitals reflect integrated and independent AAMC members.
[21] AAMC analysis of FY2023 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2024, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2024.
Note: Data reflect short-term, general, nonfederal hospitals.
[22] *Id.*

timeframe for states or whether a longer transition period would be wanted, suggesting as much as two to three years for states to transition. (P.20591).

The AAMC does not believe that the initial proposal offered by CMS for states to transition would be sufficient. It is our understanding that, if necessary, states are willing to work with the agency to meet any new requirements but are unable to immediately implement changes as the current proposal suggests. States often work with a wide range of policymakers and stakeholders within their state to gain support and approval of these funding mechanisms. This may include utilizing state legislation or voter referendums to implement and require the use of provider taxes. The use of these avenues to implement provider taxes poses an additional challenge to states needing to comply with federal changes, while the language of state laws or a voter initiative may legally bind the states to implementing the provider taxes. Such language may require state law makers to pass additional legislation amending current state law in order to alter the design of a states' provider tax and come into compliance with these changes to the broad-based and uniform waiver requirements. All states, not just those for which CMS would allow a transition period, would need additional time to work with state policymakers and stakeholders to implement these changes. As CMS outlines, states' legislative sessions vary, meaning that a state may not begin or conclude their legislative session within one calendar year. This lends itself to the need for longer transition periods so that states may effectuate the changes needed to bring their provider taxes into compliance with as limited harm as possible to their state's Medicaid programs and the beneficiaries they serve.

At the same time, the "One Big Beautiful Bill Act" (OBBBA) enacted on July 4, 2025,[23] contains several provisions impacting Medicaid financing, representing some of the largest funding cuts in the program's history.[24] Included in OBBBA are broad changes to Medicaid financing and policies similar to those proposed by CMS in this rule. These changes further handicap states in their ability to fund their Medicaid programs and pose a risk of creating large shortfalls in financing these programs. CMS will need to align the proposed changes in this rule with the provisions included in OBBBA. To that end, we request CMS delay the finalization of this proposed rule until the agency has time to fully digest the changes to Medicaid financing enacted by Congress.[25]

We expect such changes to existing financing structures would result in revenue losses, causing states to need to restrict eligibility and enrollment or reduce payment to providers to make up for program shortfalls as a result. Changes to Medicaid financing do not occur in a vacuum and inevitably harm Medicaid enrollees through a loss of coverage, benefits, and access to providers. **If CMS moves forward with the proposed changes in this rule**, **the AAMC urges CMS to finalize a three-year transition period and apply this timeframe to all impacted states.** This

[23] P.L. 119-21
[24] Congressional Budget Office, Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act (June 2025)
[25] P.L. 119-21

will allow time to modify existing provider taxes and mitigate disruption to their Medicaid program and harm to the beneficiaries that utilize these programs.

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. The AAMC is fully supportive of CMS' goal of ensuring fiscal integrity; **however, we urge the agency to withdraw and reevaluate the proposals included in this rule given the passage of the OBBBA.** We remain concerned these changes would restrict states' ability to finance the non-federal share through health-care related taxes, jeopardizing patient access to care. Should the agency move forward with these proposed changes, the agency must provide sufficient time by allowing a transition period for states currently utilizing this funding mechanism to come into compliance to minimize harm to providers and Medicaid beneficiaries. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic medicine community. If you have questions regarding our comments, please feel free to contact my colleague Katie Gaynor (kgaynor@aamc.org).

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer
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Cc: David J. Skorton, M.D., AAMC President and Chief Executive Officer