concluded that the petitioners did not establish the likely duration, intensity, frequency, and number of exposures resulting from catastrophic releases of HF used in or distributed for domestic refining. Therefore, notwithstanding the data and analyses provided in the petition, the petitioners' underlying rationale to support that that is necessary to initiate the proceeding requested is deficient.

2. Summary of Applicable Federal Authorities and Recommended Practices

The petitioners argue that a TSCA section 6(a) rule is necessary because ''[e]xisting government and industry initiatives have fallen far short of eliminating the unreasonable risks that refinery use of HF present to public health and the environment'' (Ref. 1, p. 53). The petition briefly describes the Risk Management Program (RMP) established via section 112(r) of the Clean Air Act (CAA) (42 U.S.C. 7412(r)) and the Process Safety Management of Highly Hazardous Chemicals regulations (29 CFR 1910.119) implemented by the Occupational Safety and Health Administration. In a discussion of how other federal statutes and regulations designate HF as a hazardous (or extremely hazardous) substance, the petition also cites relevant portions of the Emergency Planning and Community Right-to-Know Act (EPCRA), the Clean Water Act, and the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA). The petition also describes the American Petroleum Institute's Recommended Practice 751 on ''Safe Operation of HF Alkylation Units'' (API RP–751), which the petitioners describe as ''the most detailed national standards available'' while also pointing to ''limitations of relying on voluntary industry guidance to protect the public and environment'' (Ref. 1, p. 54–55). As explained in Unit III.B.1., the petition fails to establish unreasonable risk because it is predicated on circumstances EPA does not generally consider as part of risk evaluation under TSCA section 6. Thus, the petitioners' claims as to the efficacy of existing authorities and recommended practices to eliminate such risks is moot.

C. What were EPA's conclusions?

The petitioners' request to initiate a proceeding for the issuance of a rule under TSCA section 6(a) is deficient for the reasons explained in this notice. While the petitioners can point to historical incidents of HF releases at refineries, the petition did not establish the likely duration, intensity, frequency, and number of exposures of HF involving such releases. In their own words, the petitioners describe the releases as catastrophic, accidental, and worst-case scenarios, as well as circumstances involving extreme weather and natural disaster events. The Agency has been consistent in its position that it is not appropriate for a risk evaluation in accordance with TSCA section 6(b) to consider catastrophic or accidental releases, extreme weather events, and natural disasters that do not lead to regular and predictable exposures. As a result, the facts presented in the petition did not establish unreasonable risk under the conditions of use of using and distributing in commerce HF for domestic refining. By extension, the petitioners' claim that governmental authorities and industry programs cannot eliminate such unreasonable risk is moot. Accordingly, EPA denied the request to initiate a proceeding for the issuance of a rule under TSCA section 6(a).

IV. References

The following is a listing of the documents that are specifically referenced in this document. The docket includes these documents and other information considered by EPA, including documents that are referenced within the documents that are included in the docket, even if the referenced document is not physically located in the docket. For assistance in locating these other documents, please consult the technical person listed under **FOR FURTHER INFORMATION CONTACT**.

1. Clean Air Council, Communities for a Better Environment, and the Natural Resources Defense Council. 2025. Petition to Prohibit the Use of Hydrogen Fluoride in Domestic Oil Refining under Sections 21 and 6(a) of the Toxic Substances Control Act.
2. Clean Air Council, Communities for a Better Environment, and the Natural Resources Defense Council. 2025. Petition to Prohibit the Use of Hydrogen Fluoride in Domestic Oil Refining under Sections 21 and 6(a) of the Toxic Substances Control Act—Appendix A.
3. Clean Air Council, Communities for a Better Environment, and the Natural Resources Defense Council. 2025. Petition to Prohibit the Use of Hydrogen Fluoride in Domestic Oil Refining under Sections 21 and 6(a) of the Toxic Substances Control Act—Appendix B.
4. Clean Air Council, Communities for a Better Environment, and the Natural Resources Defense Council. 2025. Petition to Prohibit the Use of Hydrogen Fluoride in Domestic Oil Refining under Sections 21 and 6(a) of the Toxic Substances Control Act—Appendix C.
5. EPA. April 2024. Procedures for Chemical Risk Evaluation Under the Toxic Substances Control Act (TSCA) [EPA–HQ–OPPT–2023–0496]; EPA Response to Public Comments.
6. EPA. January 2025. Draft Scope of the Risk Evaluation for Vinyl Chloride (Ethene, chloro-) [CASRN 75–01–4].

Authority: 15 U.S.C. 2601 *et seq.*

Dated: May 12, 2025.

Nancy B. Beck,

Principal Deputy Assistant Administrator, Office of Chemical Safety and Pollution Prevention.

[FR Doc. 2025–08658 Filed 5–14–25; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 433

[CMS–2448–P]

RIN 0938–AV58

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule is intended to address a loophole in a regulatory statistical test applied to State proposals for Medicaid tax waivers. The test is designed to ensure, as required by statute, that non-uniform or non-broad -based health care-related taxes, authorized under a waiver, are generally redistributive. The inadvertent loophole currently allows some health care-related taxes, especially taxes on managed care organizations, to be imposed at higher tax rates on Medicaid taxable units than non-Medicaid taxable units, contrary to statutory and regulatory intent for health care-related taxes to be generally redistributive. The proposed provisions would better implement the statutory requirements by adding additional safeguards to ensure that tax waivers that exploit the loophole because they pass the current statistical test, but are not generally redistributive, are not approvable.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by July 14, 2025.

ADDRESSES: In commenting, please refer to file code CMS–2448–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2448–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2448–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Jonathan Endelman, (410) 786–4738, and Stuart Goldstein, (410) 786–0694, for Health Care-Related Taxes.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at *https://www.regulations.gov/.*

I. Background

A. Overview

Title XIX of the Social Security Act (the Act) authorizes Federal grants to the States for Medicaid programs to provide medical assistance to persons with limited income and resources. While Medicaid programs are administered by the States, the program is jointly financed by the Federal and State governments. The Federal government pays its share of Medicaid expenditures to the State on a quarterly basis according to a formula described in sections 1903 and 1905(b) of the Act. The amount of the Federal share of Medicaid expenditures is called Federal financial participation (FFP). The State pays its share of Medicaid expenditures in accordance with section 1902(a)(2) of the Act. As described in more detail in the next section, the State may raise its non-Federal share obligation in various ways, subject to certain requirements, including through health care-related taxes (generally, taxing health care items or services, or providers of such items and services).

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102–234, enacted December 12, 1991) amended section 1903 of the Act to specify limitations on the amount of FFP available for medical assistance expenditures in a fiscal year when States receive certain funds donated from providers or certain related entities, and revenues generated by certain health care-related taxes. The Centers for Medicare & Medicaid Services (CMS) issued regulations to implement the statutory provisions concerning provider-related donations and health care-related taxes in an interim final rule (with comment period) published in November 1992 (57 FR 55118 (Nov. 24, 1992). CMS issued the final rule in August 1993 (58 FR 43156 (Aug. 13, 1993)). The Federal statute and implementing regulations were intended to prevent States from shifting a disproportionate amount of the tax burden to entities with a high percentage of Medicaid business, thus shifting the State responsibility for financing of the program to the Federal government. In these financing-shifting scenarios, Medicaid payments to providers would be made up of the Federal share plus non-Federal share raised from the providers themselves, rather than obtained from general revenue or other permissible source or non-Federal share. In part, the statute addresses this concern by requiring that health care-related taxes be broad-based (generally, applicable to an entire permissible class of health care items and services, or to providers of the same) and uniform (generally, applied at the same rate to all health care items and services, or providers, in a permissible class). The statute does permit waivers of the broad-based and uniform requirements under certain circumstances, including that the Secretary of Health and Human Services (Secretary) must determine that the net impact of the tax and associated Medicaid expenditures as proposed by the State would be generally redistributive in nature, which is at issue in these provisions and which we discuss more fully later. However, since that time, we have discovered that, due to an unintended loophole in the statistical test used to determine if a health care-related tax is generally redistributive, as specified in the August 1993 final rule, some States are still able to shift the financial burden of the non-Federal share of Medicaid program expenditures to entities with a high percentage of Medicaid business, and thus ultimately to the Federal government, contrary to the statutory framework.

B. Medicaid Program Financing

Shared responsibility for financing lies at the foundation of the Medicaid program. Sections 1902(a), 1903(a), and 1905(b) of the Act require States to share in the cost of medical assistance and in the cost of administering the State plan. Under this statutory framework, Medicaid expenditures are jointly funded by the Federal and State governments. Section 1903(a)(1) of the Act provides for payments to States of a percentage of medical assistance expenditures authorized under their approved State plan. Generally, FFP is available when a covered Medicaid service is provided to a Medicaid beneficiary, which results in a Federally matchable expenditure that is funded in part through non-Federal funds from the State or a non-State governmental entity.[1] The share of Federal funding for medical assistance expenditures is determined by the Federal medical assistance percentage (FMAP), which is calculated for each State using a formula set forth in section 1905(b) of the Act, or other applicable FFP match rates specified by the statute.

Section 1902(a)(2) of the Act and its implementing regulation in 42 CFR part 433, subpart B requires States to share in the cost of Medicaid expenditures, with financial participation by the State

[1] See the Medicaid and CHIP Payment and Access Commission's (MACPAC) list of ''Federal Match Rate Exceptions'' for a comprehensive list of higher FMAPs at *https://www.macpac.gov/federal-match-rate-exceptions/.*

of not less than 40 percent of the non-Federal share of expenditures. These requirements also permit other units of non-State government to contribute to the financing of the non-Federal share of medical assistance expenditures up to the remaining 60 percent of the non-Federal share. As a result, States must participate in operating an efficient and fiscally responsible system for providing health care services to eligible beneficiaries. Because States must invest some of their own dollars to pay for the program, they have an incentive to monitor and operate their programs competently to ensure the best value for the dollars that they spend.

There are several manners in which States can finance the non-Federal share of Medicaid expenditures, including: (1) State general funds, typically derived from tax revenue appropriated directly to the Medicaid agency; (2) revenue derived from health care-related taxes when consistent with Federal statutory requirements at section 1903(w) of the Act and implementing regulations at 42 CFR part 433, subpart B; (3) provider-related donations to the State which must be ''bona fide'' in accordance with section 1903(w) of the Act and implementing regulations at 42 CFR part 433, subpart B; (4) intergovernmental transfers (IGTs) from units of State or local government that contribute funding for the non-Federal share of Medicaid expenditures by transferring their own funds to and for the unrestricted use of the Medicaid agency; and (5) certified public expenditures whereby units of government, including health care providers that are units of government, incur FFP-eligible expenditures under the State's approved State plan, consistent with section 1903(w)(6) of the Act and § 433.51(b).

C. Health Care-Related Taxes

Section 1903(w) of the Act specifies certain requirements to which permissible health care-related taxes must adhere. Specifically, section 1903(w)(1)(A) of the Act states that the Secretary will reduce a State's medical assistance expenditures, prior to calculating FFP, by the sum of any revenues from health care-related taxes that do not meet the requirements under section 1903(w) of the Act. This reduction in a State's claimed expenditures is codified in regulation at § 433.70(b). Because of the way that the statute is constructed, the baseline assumption is that all health care-related taxes are impermissible with limited exceptions for health care-related taxes that satisfy the parameters specified by the statute.

Health care-related taxes may only be imposed permissibly on certain groups of health care items or services known as permissible classes that are outlined in section 1903(w)(7) of the Act and expanded upon in § 433.56 of the implementing regulations. In general, and as discussed in the introduction to this section, such health care-related taxes must be broad-based, or apply to all non-governmental providers within such a class as specified by section 1903(w)(3)(B) of the Act and § 433.68(c). They generally must also be uniform, such that all providers within a class generally must be taxed at the same rate or dollar amount as specified by section 1903(w)(3)(C) of the Act and § 433.68(d). Additionally, the tax must not have in effect any hold harmless provisions as specified in section 1903(w)(4) of the Act and implementing regulations in § 433.68(f).

There is no possibility under the statute of waiving the permissible class or the hold harmless requirements. However, a State can request a waiver of the broad-based and/or uniformity requirements. As discussed earlier, section 1903(w)(3)(E) of the Act states that the Secretary shall approve a health care-related tax waiver for the broad-based and/or uniformity requirements if the net impact of the tax and associated expenditures is ''generally redistributive'' in nature and the amount of the tax is not directly correlated to Medicaid payments for items and services with respect to which the tax is imposed. As previously stated, in the preamble of the August 1993 final rule, CMS interpreted ''generally redistributive'' to mean ''the tendency of a State's tax and payment program to derive revenues from taxes imposed on non-Medicaid services in a class and to use these revenues as the State's share of Medicaid payments (58 FR 43164). The preamble stated that assuming a State imposes a non-Medicaid tax and uses the funds solely for Medicaid payments, we believe a complete redistribution would exist.

States are not required to use health care-related taxes to finance the non-Federal share of Medicaid payments; in practice, it is frequently done. When this occurs, taxes that are generally redistributive have some entities that benefit financially as a result of the tax and the associated payment(s) funded by the tax, and some entities that lose money because the amount of tax they pay is greater than the amount of tax-funded payments they receive. Under a health care-related tax that is generally redistributive, entities that have more Medicaid business would expect to receive greater Medicaid payments than entities with less Medicaid business. Although the entities with a higher percentage of Medicaid business may also pay the tax, they often receive more total Medicaid payments than they pay in tax, and therefore benefit from these arrangements. By contrast, entities that serve a relatively low percentage of Medicaid beneficiaries or no Medicaid beneficiaries often do not receive Medicaid payments in an amount equal to or higher than their cost of paying the tax. These entities do not benefit financially because they do not receive Medicaid payments sufficient to cover their tax payments. These results are inherent in a system of Medicaid payments supported by a health care-related tax that is generally redistributive, as discussed in the preamble to the August 1993 final rule.

Entities that do not benefit from a tax and tax-supported payments are unlikely to support a State or locality establishing or continuing a health care-related tax because the tax would have a negative financial impact on them. Hold harmless arrangements often eliminate this negative financial impact or turn it into a positive financial impact for most or all taxpaying entities, likely leading to broader support among the taxpayers for legislation establishing or continuing the tax. Hold harmless arrangements often result in the Federal government as the only net contributor to Medicaid payments that are supported by the tax program, since the non-Federal share is both sourced from and paid back to the taxpaying providers. This circumstance allows States and/or local governments to garner widespread support among taxpayers to successfully enact or continue tax programs that support increased payments to providers.

As stated earlier, tax programs can result in taxpayers that receive relatively lower Medicaid payments (typically because they furnish a lower volume of Medicaid services) than they pay in taxes, experiencing a negative financial impact. States and providers have sought out ways to avoid this result and to ensure greater support among taxpayers for the tax program. For example, groups of providers may collaborate to ensure that no provider is financially harmed for the cost of the tax. We described an example of this type of this arrangement, known as redistribution arrangements, in a February 17, 2023, Center for Medicaid and CHIP Services Informational Bulletin (CIB) entitled, ''Health Care-Related Taxes and Hold Harmless Arrangements Involving the

Redistribution of Medicaid Payments.'' [2] In these redistribution arrangements, entities that benefit financially because their Medicaid payments supported by the tax are greater than their tax amount will redirect a portion of their Medicaid payments to those that are harmed financially, to achieve the effect of holding providers harmless for the cost of the tax.

States are aware that arrangements explicitly guaranteeing to hold taxpayers harmless, whether directly or indirectly, such as through the aforementioned redistribution arrangements, are unallowable . If CMS identifies such an arrangement, it would then reduce the State's total medical assistance expenditures by the amount of revenue collected from the impermissible tax before the calculation of FFP as mandated by section 1903 (w)(1)(a)(iii) of the Act.[3] These types of arrangements are problematic as they improperly shift the burden of financing the Medicaid program to the Federal government, and have been identified as such by oversight entities including the Governmental Accountability Office (GAO) and the HHS Office of Inspector General (OIG).[4] [5] In an effort to achieve a similar effect as a hold harmless arrangement, some States have attempted to impose taxes using variable rates or provider exclusions (described in further detail later in this proposed rule) to increase the tax burden on the Medicaid program, thus mitigating or eliminating the tax burden on entities with relatively lower Medicaid business that may not be able to receive the amount of the tax they paid through increased Medicaid payments funded by the tax. Essentially, health care-related taxes designed to tax Medicaid business more than its fair share, makes it easier for States to guarantee taxpayers are reimbursed their tax payments through increased Medicaid payments. Due to the current regulations governing health care-related tax waiver determinations, this can occur in certain circumstances despite the regulatory statistical test designed to ensure that non-uniform or non-broad-based health care-related taxes meet the statutory requirement to be generally redistributive.

As previously discussed, a tax seeking a broad-based and/or uniformity waiver must be ''generally redistributive,'' which we have established in this context means the tax program generally generates tax revenues from entities that serve relatively lower percentages of Medicaid beneficiaries and uses the tax revenue as the State's share of Medicaid payments. Therefore, a tax that does the opposite, by establishing lower tax rates on entities that serve relatively lower percentages of Medicaid beneficiaries or on non-Medicaid items or services (compared to entities that serve relatively higher percentages of Medicaid beneficiaries) to prevent the redistribution of tax revenue is clearly not generally redistributive or consistent with the statutory requirement that a tax program be generally redistributive to qualify for a waiver.[6]

To enforce the requirement that taxes have a net impact that is ''generally redistributive'' in accordance with section 1903(w)(3)(E)(ii)(I) of the Act, CMS established certain tests when a State is seeking a broad-based and/or uniformity waiver. If a State is seeking a waiver of the broad-based requirement for its health care-related tax, the tax must comply with § 433.68(e)(1) to be considered generally redistributive, which establishes the test known as the P1/P2 test. If the State seeks a waiver of the uniformity requirement, whether or not the tax is broad-based, the tax must comply with § 433.68(e)(2) to be generally redistributive, which establishes the test known as the B1/B2 test. These tests, where applicable, are intended to demonstrate that the State's tax program does not impose a higher tax burden on the Medicaid program compared to a broad-based and uniform tax.[7]

The P1/P2 test applies on a per class basis to a tax that is imposed on all items or services at a uniform rate, but is not broad based because it excludes certain providers. The State must divide the proportion of the tax revenue applicable to Medicaid if the tax were broad-based and applied to all providers or activities within the class (called P1), by the proportion of the tax revenue applicable to Medicaid under the tax program for which the State seeks a waiver (called P2). The resulting quotient is the P1/P2 figure. Generally, to be granted a waiver of the broad-based requirement, this figure must be at least 1, with some exceptions noted in §§ 433.68(e)(1)(iii) and (iv). For taxes enacted and in effect prior to August 13, 1993, States may pass the P1/P2 test if they have a value of at least 0.90 and only exclude one or more of the following provider types: providers that furnish no services within the class in the State, providers that do not charge for services within the class, rural hospitals as defined at § 412.62(f)(1)(ii), sole community hospitals as defined at § 412.92(a), physicians practicing in medically underserved areas as defined in section 1302(7) of the Public Health Service Act, financially distressed hospitals under certain circumstances, psychiatric hospitals, and hospitals owned and operated by Health Management Organizations (HMOs). For taxes in effect after that date, the same exceptions would apply, and the passing value is 0.95 rather than 0.90.

The B1/B2 test also applies on a per class basis to a non-uniform tax (whether or not it is broad based) that applies different rates to different tax rate groups of providers within the permissible class. Under the B1/B2 test, the State calculates and compares the slope (designated as B) of two linear regressions. Univariate linear regression attempts to find the line that best fits a series of points, plotted on a graph using two variables, an independent variable X and a dependent variable Y.[8] In the B1/B2 test, the independent variable or X-axis, for both regressions, represents the ''the number of the provider's taxable units funded by the Medicaid program during a 12-month period'' or the ''Medicaid Statistic.'' [9] The regression measures how much impact for the average provider a one-unit increase in the Medicaid Statistic has on how much that provider is taxed. For example, if the tax were based on provider inpatient days, the number of providers' inpatient Medicaid days during a 12-month period would be its

[2] *https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf.*

[3] As we stated in the 2008 tax rule described below, ''We chose to use the term reasonable expectation because we recognized that State laws were rarely overt in requiring that State payments be used to hold taxpayers harmless.'' *https://www.govinfo.gov/content/pkg/FR-2008-02-22/pdf/E8-3207.pdf.*

[4] See, for example, ''Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight,'' Governmental Accountability Office (GAO), November 1, 2007; ''Medicaid: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight,'' GAO, December 7, 2020.

[5] *https://oig.hhs.gov/oas/reports/region3/31300201.pdf.*

[6] See Congressional Record-House, November 26, 1991, 35855 *https://www.congress.gov/102/crecb/1991/11/26/GPO-CRECB-1991-pt24-1-2.pdf.*

[7] ''The Federal statute and implementing regulations were designed to protect Medicaid providers from being unduly burdened by health care related tax programs. Health care related tax programs that are compliant with the requirements set forth by the Congress create a significant tax burden for health care providers that do not participate in the Medicaid program or that provide limited services to Medicaid individuals.'' 73 FR 9685 (Feb. 22, 2008).

[8] Linear regression attempts to model the relationship between two variables by fitting a linear equation to observed data. One variable is considered to be an explanatory variable, and the other is considered to be a dependent variable. Linear Regression (*yale.edu*) *http://www.stat.yale edu/Courses/1997-98/101/linreg.htm.*

[9] *42 CFR 433.68(e)(2)(A).*

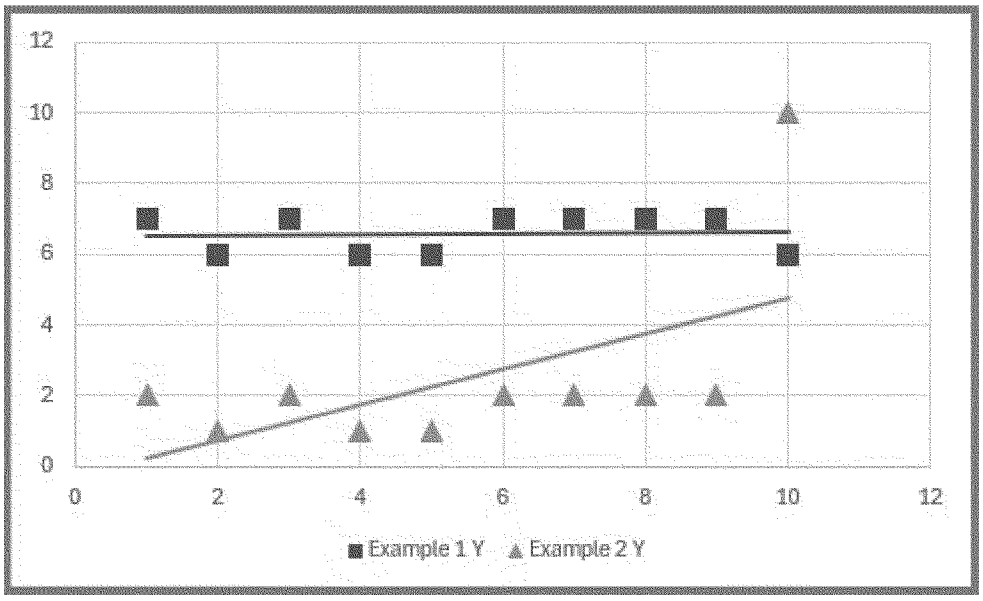
''Medicaid Statistic.'' Or, if the tax were based on member months, the number of Medicaid member months for a managed care organization (MCO) would be the Medicaid Statistic. The Y variable, or the dependent variable, is the percentage of the tax paid by each provider in the tax program compared to the total tax amount paid by all providers during a 12-month period. Through this test, CMS seeks to ensure that, as Medicaid units increase, the tax paid by the provider does not increase more under the State's waiver proposal (the B2 regression) than would occur in a broad-based and uniform tax (the B1 regression).

The first linear regression represents the slope of the line for the tax if it were broad-based and applied uniformly (B1). In other words, a State would submit data regarding all taxable payers in the permissible class for the tax and apply a uniform tax rate. The B1 is the slope of the line for that data. The second linear regression represents the slope of the line for the tax program for which the State is requesting a waiver (B2). To calculate the test value figure, B1 is divided by B2. If the quotient is at least 1 the tax passes the test, as specified in § 433.68(e)(2)(ii), with certain limited additional flexibility under § 433.68(e)(2)(iii) and (iv). This B1/B2 test was intended to indicate that when the B1/B2 figure is equal to or greater than one (1), the State's proposed tax is not more heavily imposed on the Medicaid program compared to a tax that is levied on all providers at the same rate.

D. Concerns About the B1/B2 Test

Since the early 1990s, the B1/B2 test has generally worked well to ensure health care-related taxes for which States seek waivers of the uniformity requirement (whether or not the tax is broad based) are generally redistributive. However, over the last decade, CMS became aware that some States are manipulating their health care-related taxes to impose tax structures that the State intends not to be generally redistributive, but that were still able to pass the B1/B2 test. In these cases, the State does not impose taxes on non-Medicaid services in a class to then use the tax revenue as the State's share of Medicaid payments. Instead, the States derive the vast majority of their tax revenue from Medicaid services, which they then use to fund the non-Federal share of Medicaid payments. In essence, this process results in a simple recycling of Federal funds to unlock additional Federal funds. Generally, health care-related tax programs can accomplish this by taking advantage of linear regression analyses' statistical sensitivity to outliers.[10] See Figure 1.

Figure 1: Effect of an Outlier on the Slope of a Line



In Figure 1, the two data sets, represented by squares (example 1) and triangles (example 2), have similar data with the exception of the last data point. In Example 2, this data point is an outlier. As a result, the line that fits the triangle data set is at a different angle, or slope, from the square data set. We note that this example uses basic data, not a B1/B2 analysis, to show the effect of an outlier on a linear regression.

Using these approaches, this loophole, counterintuitively, allows a tax program to place a much higher tax burden on Medicaid activities compared to commercial activities and to still pass the B1/B2 test. Health care-related taxes that exploit the loophole effectively permit a State to shift most of the tax burden, disproportionately, onto the Medicaid program, which is the exact result the B1/B2 test was intended to prevent. The State may then use the tax revenue to fund the non-Federal share of Medicaid payments to the same Medicaid entities subject to the health care-related tax. As a result, the Federal government pays an artificially inflated percentage of Medicaid expenditures on health care services, far beyond the Federal matching rates the Congress has specified in statute, because payments to providers consist of Federal funds and funds the providers have contributed themselves through taxes,

[10] In statistics, an outlier is ''an observation that lies an abnormal distance from other values in a random sample from a population.'' Information Technology Laboratory National Institute of Standards and Technology (NIST) Engineering and Statistics Handbook 7.1.6 ''What Are Outliers in Data?'' *https://www.itl.nist.gov/div898/handbook/toolaids/pff/prc.pdf.*

without the full contribution of non-Federal share the statute requires from the State.

At its core, the B1/B2 test is centered on averages. As noted previously, the regression measures how much impact a one-unit increase in the Medicaid Statistic has on how much a provider is taxed. The rate at which each entity's tax changes with every unit of change to the entity's Medicaid Statistic is based on the average rate of change for all of the entities in the regression analysis. In many cases, taking an average of all the points does not necessarily give a useful picture of the typical participant or the general nature of the population. Averages can be misleading when they include outliers or other irregularities. Similarly, outliers can distort the regression model, masking important deviations within the data. For instance, imagine one wanted to assess the relationship between education level and annual salary for a group of employees at a corporation. At this corporation, employees with a high school diploma make between $40,000 to $45,000. Employees with a bachelor's degree make between $65,000 to $70,000. Employees with a master's degree make between $80,000 to $90,000. Employees with a doctoral degree make between $100,000 to $115,000. The founder of the company's highest education level is a high school diploma, but they make $1.6 million per year. If one were to exclude the company founder from the linear regression, the line would have a positive upward slope indicating an increase in salary with each increasing level of education. However, if one were to include the founder, the regression line would be diverted sharply to accommodate the $1.6 million salary. The founder only represents one data point in the regression analysis, but since this point is drastically different than the rest, it potentially distorts the relationship that the regression analysis is trying to assess. In this example, the average value, while accurate, only represents a mathematical mean in the data that is not necessarily useful for the purpose of assessing the relationship between level of education and salary among the corporation's employees. Likewise, in the case of the B1/B2 linear regressions, outliers can skew our ability to use the data to assess effectively if a tax is generally redistributive.

We have found that States can manipulate B2 by excluding from the tax a few larger providers with much higher Medicaid taxable units than the average provider in the taxable universe. Doing so drastically affects the B-coefficient value for B2. Therefore, because the Medicaid taxable units are not evenly distributed among all providers, States can effectively charge higher rates on the remaining Medicaid taxable units that make up most of the tax without running afoul of the B1/B2 test. In other words, excluding a few large providers with high Medicaid utilization from the tax, but including them in the regression calculation alters the slope of the line of the regression in a way that allows the State to pass the statistical test, while simultaneously imposing outsized burden on the Medicaid program. In these cases, the proportional percentage of the tax imposed on the Medicaid program becomes greater than Medicaid's proportion of the total taxable units.

There are several other mechanisms that States have used to undermine the efficacy of the B1/B2 test. Some States create tax programs with extraordinary differences in tax rates within a provider class based on taxpayer mix of Medicaid taxable units versus non-Medicaid taxable units. Tax rates imposed on Medicaid-taxable units are often much higher, sometimes more than one hundred times higher, when compared with comparable commercial taxable units (for example, Medicaid member months are taxed $200 per member month compared to $2 for comparable non-Medicaid member months). The ''tiering'' structure on some of these tax waivers enable States with these disparate tax rates to pass the B1/B2 test. Consider an MCO tax with tax rates that vary by an MCO's member months. Medicaid- member months from zero to 1,000,000 are excluded from the tax. Medicaid- member months from 1,000,001 to 2,000,000 are taxed $300 per member month. Medicaid-member months in excess of 2,000,000 are excluded from the tax. Commercial member months from zero to 1,000,000 are excluded from the tax. Commercial-member months from 1,000,001 to 2,000,000 are taxed $3 per member month. Commercial member months in excess of 2,000,000 are excluded from the tax. The ''middle tier'' of member months, the only one that is taxed at all, has a tax rate of 100 times on Medicaid-member months compared to their commercial counterparts. The State passes the B1/B2 test because certain Medicaid-paid member months in excess of 2,000,000 artificially ''pull'' the slope of B2 down making it appear as though the State is giving a larger break to Medicaid-member months than it actually is.

Historically, these taxes that targeted Medicaid first began with MCO taxes, one of the permissible classes for health care related taxes. We note that in all of these arrangements, Federal rules prohibit States from taxing Medicare Advantage Plans,[11] or certain plans that contract with the Office of Personnel Management to provide health care for Federal employees through the Federal Employee Health Benefits (FEHB) program [12] or plans that contract with the Department of Defense to provide care to military personnel, retirees and their families under the TRICARE system.[13] According to § 422.404, States are prohibited from imposing premium taxes, fees, or other charges on payments made by CMS to Medicare Advantage (MA) organizations, payments made by MA enrollees to MA plans, or payments made by a third party to an MA plan on a beneficiary's behalf.

Over several years, the Congress and CMS have actively attempted through Federal statutes and regulations, to prevent States from designing MCO taxes to target Medicaid MCOs or Medicaid activities. Before the Deficit Reduction Act of 2005 (DRA), the statute included a permissible class, under which States could only tax services of Medicaid MCOs, but not other MCOs. In the DRA, the Congress broadened the permissible class to include all MCO services (no longer limited to Medicaid MCO services). Realizing that States would need time to address financial impacts within their State budgets and enact potentially necessary legislative modifications to health care-related tax programs, the DRA provided a grace period to allow States to come into compliance by October 1, 2009. CMS issued a final rule entitled ''Medicaid Program; Health Care Related Taxes'' (73 FR 9685) that implemented the changes in the DRA. After the DRA and the 2008 final rule, States were no longer permitted to assess health care-related taxes only on Medicaid MCOs. Instead, States must assess health care-related taxes on the services of all MCOs, not just Medicaid MCOs, to qualify as broad-based within the amended permissible class, except for those excluded by Federal rules from taxation.

In response to these changes, several States attempted to ''mask'' health care-related taxes on Medicaid MCOs within

[11] Under Medicare regulations at § 422.404(a), States are prohibited from taxing Medicare MCOs. Therefore, a State's taxation of MCO services is limited to commercial payers and Medicaid. As a result, taxes that exclude or sharply curtail the tax amount paid by commercial payers fall exclusively on Medicaid and to a lesser extent BHP if applicable.

[12] 5 U.S. Code § 8909—Employees Health Benefits Fund.

[13] 5 U.S.C. 8909(f). 32 CFR 199.17 (a)(7).

broader taxes that included non-health care items and activities. See, for example, the Office of Inspector General (OIG) Report, ''Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears To Be an Impermissible Health-Care-Related Tax,'' issued on May 28, 2014.[14] Some States did this to continue taxing only Medicaid MCOs and thereby maximizing the burden on Medicaid without needing to bring in additional MCO lines of business. Section 1903(w)(3)(A) of the Act and in § 433.55(b) establish that a tax is considered to be a health care-related tax if at least 85 percent or more of the burden of the tax revenue falls on health care providers. Section 1903(w)(3)(A)(ii) of the Act and regulations in § 433.55(c) further specify that taxes will still be considered health care-related even if they do not reach the 85 percent threshold if the treatment of individuals or entities providing or paying for health care items or services is different than the tax treatment provided to other taxpayers. Some States with these taxes in place argued that, since the percentage of the tax imposed on health care items and services fell below the 85 percent threshold and the State did not treat health care items or services differently than other items being taxed, the portion of the tax imposed on Medicaid MCOs was not considered health care-related and was not governed by section 1903(w) of the Act. In a 2014 State Health Official Letter (SHO),[15] CMS explained that taxing a subset of health care services or providers at the same rate as a Statewide sales tax, for example, does not result in equal treatment if the tax is applied specifically to a subset of health care services or providers (such as only Medicaid MCOs), since the providers or users of those health care services are being treated differently than others who are not within the specified universe. These taxes were attempting to continue to tax a subset of services within a permissible class when paid for by Medicaid, but not when the same services were not paid for by Medicaid.

Oversight agencies, including the Health and Human Services OIG, have noted health care-related taxes as a program integrity concern in Medicaid financing several times. On January 23, 1996, the Director of Health Systems at the GAO wrote a letter to the Ranking Member of the United States House Commerce Committee that outlined some of the ways that States use ''creative financing mechanisms,'' including health care-related taxes, to finance the non-Federal share of Medicaid expenditures.[16] In 2014 and 2017, the OIG issued reports highlighting concerns about State taxes that target Medicaid MCOs or Medicaid MCO business.[17] Although the 2017 report discussed a different approach that States used to target taxes on Medicaid MCOs, it reflects the same State motivations and implicates the same concerns for Federal fiscal integrity.

As the agency responsible for Federal oversight over the Medicaid program, CMS attempted to address the concerns raised by the OIG, which mirror our own concerns based on recent experience with particular health care-related taxes that target Medicaid with a disproportionately high tax burden. In 2019, we issued a proposed rule with many financial provisions, one of which proposed to address the B1/B2 statistical loophole issue (2019 proposed rule (84 FR 63722). The 2019 proposed rule was much broader in scope in terms of the number of financial topics than this proposed rule. In addition, the terminology in this proposed rule is more precise and technical than that used in the corresponding provisions in the November 2019 proposed rule. While the entirety of the November 2019 proposed rule was subsequently withdrawn in January 2021, we indicated at the time that the withdrawal action did not limit CMS' prerogative to make new regulatory proposals in the areas addressed by the withdrawn proposed rule, including new proposals that may be substantially identical or similar to those described therein (86 FR 5105).

Since then, as CMS has reviewed State proposals involving these problematic tax structures, we have advised States, and in some instances notified States in writing, regarding our concerns. In some cases, because a State's health care-related tax waiver proposal satisfied current regulatory requirements to be considered generally redistributive, we approved the proposal as required under the current regulations that include the loophole but gave the State written notice of our concerns. Specifically, CMS sent States with problematic taxes ''companion letters'' to their most recent tax waiver approvals outlining why CMS believed that their taxes did not meet the spirit of the law in terms of being ''generally redistributive'' because of the much higher tax burden they imposed on Medicaid taxable units compared to comparable non-Medicaid taxable units. In addition, we put these States on notice through these letters that CMS was contemplating rulemaking in this area and that those States should prepare for this possibility in their budget planning.

Recently, we noticed an increase in both the number of health care-related taxes that exploit the statistical loophole as well as an increase in the revenue raised by those taxes. Before Federal fiscal year (FFY) 2024, CMS was aware of five States with six taxes that exploited the statistical loophole. The estimated total dollar revenue collected by States related to these taxes at that time was approximately $20.5 billion annually. In FFY 2025, CMS approved two additional States' MCO tax waiver proposals that exploit the statistical loophole that total $3.5 billion in estimated tax revenue for the States. Notably, the State with the largest MCO tax that exploits the statistical loophole submitted an update to its previously approved MCO tax waiver, which increased the tax revenue from approximately $8.3 billion per year to about $12.7 billion per year. CMS estimates the total tax collection by States for all taxes that exploit the loophole currently is approximately $23.6 billion per year.

Recent examples illustrate what occurs when the B1/B2 test alone does not ensure that the tax is generally redistributive. In one MCO tax that exploits the loophole (and that was approved by CMS because it passed the B1/B2 test and met other applicable regulatory requirements), Medicaid member months comprise 50 percent of all member months subject to taxation, but bear more than 99 percent of the tax burden due to the difference in tax rates for Medicaid and non-Medicaid member

[14] Department of Health and Human Services Office of the Inspector General, ''Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears to be an Impermissible Health-Care Related Tax'' Issued May 2014 (A–03–13–00201). *https://oig.hhs.gov/documents/audit/6720/A-03-13-00201-Complete%20Report.pdf.*

[15] SHO #14–001, ''Health Care-Related Taxes,'' issued on July 25, 2014, available at *https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-001.pdf.*

[16] Letter from Dr. William J. Scanlon to Representative John Dingell written on January 23, 1996. GAO/HEHS–96–76R State Medicaid Financing Practices. *https://www.gao.gov/products/hehs-96-76r.*

[17] See Department of Health and Human Services Office of the Inspector General ''Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears to be an Impermissible Health Care-Related Tax'' Issued May 2014 (A–03–13–00201) *https://oig.hhs.gov/documents/audit/6720/A-03-13-00201-Complete%20Report.pdf* and ''Ohio's and Michigan's Sales and Use Taxes on Medicaid Managed Care Organization Services Did Not Meet the Broad-Based Requirement But Are Now In Compliance'' issued on April 2017 (A–03–16–00200) *https://oig.hhs.gov/documents/audit/6782/A-03-16-00200-Complete%20bReport.pdf.*

months. In a different State, Medicaid member months comprise 53 percent of the total member months taxed, but bear over 94 percent of the tax burden. Instead of raising revenue by equally taxing non-Medicaid and Medicaid services in a class, these tax programs raise only a de minimis amount of revenue from non-Medicaid member months while imposing a much greater tax burden on Medicaid member months. They are examples of States maximizing taxation of Medicaid items and services by design to minimize the impact for entities that serve relatively lower percentages of Medicaid beneficiaries. This has an effect similar to taxing only Medicaid MCOs (as opposed to all MCOs), which is the practice the DRA amendments sought to eradicate, as discussed previously. Allowing States to achieve something at odds with the DRA amendments by exploiting a statistical loophole in the current regulations undermines the cooperative Federalism central to the structure of the Medicaid statute, as GAO has noted.[18] For this reason, CMS believes that it is necessary to address the statistical loophole to ensure fiscal integrity of the Medicaid program.

When taxes in the Medicaid program are not generally redistributive, it can result in the Federal government as the only net payer for payments funded by those taxes (generally, the non-Federal share is generated by a tax on entities that receive at least their total tax cost back in the form of increased Medicaid payments, with no net contribution of any funds that are not Federal funds). Without any net cost to the entities paying the tax, States and entities in the tax class have an incentive to maximize health care-related tax collections and maximize Medicaid payments possibly without regard to the Medicaid services delivered or programmatic goals or outcomes, such as quality or patient outcomes. This creates a substantial risk to the fiscal integrity and effective operation of the Medicaid program, as reflected in the impacts calculated in section V of this proposed rule.

Given recent State proposals and technical assistance requests, national proliferation of taxes that utilize the B1/B2 statistical test loophole presents a substantial and urgent risk to the fiscal integrity of the Medicaid program. Absent the regulatory changes described in this proposed rule, we are concerned that there will be significant increases in Medicaid expenditures and shifting of State Medicaid costs onto the Federal government, all without commensurate benefit whatsoever to the Medicaid program or its beneficiaries. As previously noted, CMS has witnessed the proliferation of MCO taxes that exploit the statistical loophole and, in some instances, drastically increase the revenues raised by existing MCO taxes. As a result, CMS is greatly concerned that such increases will continue and similar tax structures will be developed, further exacerbating the impact on the Federal government. Moreover, CMS has learned as part of our review of tax waiver proposals and communication with States that certain States are using the revenue to fill shortfalls that exist in their State budgets as opposed to reinvesting this money in the Medicaid program. Furthermore, this influx of Federal share to State general funds could be used as State-only financing for services not eligible for FFP, such as the provision of non-emergency medical care for non-citizens without satisfactory immigration status. Although States are permitted to use health care-related tax revenue for other general revenue purposes, it nevertheless highlights the importance of ensuring Federal matching dollars are limited to the appropriate Federal share of financing the Medicaid program, or else the Federal Medicaid contribution is effectively financing these other endeavors.

While CMS has found taxes on MCOs to be the predominant class of health care items and services utilizing this loophole, CMS is also aware of other permissible classes vulnerable to this approach. CMS is concerned that absent regulatory action, additional similar tax programs that exploit the loophole may be developed. We believe that this proposed rule will substantially address concerns of CMS and outside oversight agencies by curtailing non-Federal share financing arrangements that are counter to the statute and do not serve the best interests of Medicaid beneficiaries, the Federal treasury, Federal taxpayers, nor the long-term health and fiscal stability of the Medicaid program as a whole. Health care-related taxes that use the regulatory B1/B2 loophole create a substantial financial risk to the Medicaid program (see section V of this proposed rule). This proposed rule would mitigate this risk, safeguard the fiscal health of Medicaid, and ensure appropriate use of Federal Medicaid dollars.

II. Provisions of the Proposed Regulations

CMS is clarifying and emphasizing our intent that if any provision of this proposed rule, if finalized, is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further action, it shall be severable from the remainder of the final rule, and from rules and regulations currently in effect, and not affect the remainder thereof or the application of the provision to other persons not similarly situated or to other, dissimilar circumstances. If any provision is held to be invalid or unenforceable, the remaining provisions which could function independently should take effect and be given the maximum effect permitted by law. In this rule, we propose several provisions that are intended to and will operate independently of each other, even if each serves the same general purpose or policy goal. Where a provision is necessarily dependent on another, the context generally makes that clear.

A. General Definitions (§ 433.52)

We are proposing to add new definitions to 42 CFR 433 subpart B at § 433.52. We propose to add and define ''Medicaid taxable unit'' to mean ''a unit that is being taxed within a health care-related tax that is applicable to the Medicaid program. This could include units that are used as the basis for Medicaid payment, such as Medicaid bed days, Medicaid revenue, costs associated with the Medicaid program such as Medicaid charges, or other units associated with the Medicaid program.'' Although we had previously established the use of taxable unit in preamble of prior rulemaking,[19] we believe formalizing a definition in regulation will allow us to better specify the inclusion of factors in our consideration of whether a tax is generally redistributive, which we will discuss in section II.B.

We propose to add and define ''non-Medicaid taxable unit'' to mean ''a unit that is being taxed within a health care-related tax that is not applicable to the Medicaid program. This could include units that are the basis for payment by non-Medicaid payers, such as non-Medicaid bed days, non-Medicaid revenue, costs that are not associated with the Medicaid program, or other units not associated with the Medicaid program.'' We believe it is important to define non-Medicaid taxable units, despite the definition we are adding for Medicaid taxable unit, to further State and other interested parties' understanding of what is not

[18] GAO–08–650T ''Medicaid Financing Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight'' April 3, 2008.

[19] See 57 FR at 55128 (''By the term ''Medicaid Statistic,['']'' we mean the number of the provider's taxable units applicable to the Medicaid program.'')

encompassed in the definition of Medicaid taxable unit.

We propose to add and define ''tax rate group'' to mean ''a group of entities contained within a permissible class of a health care-related tax that are taxed at the same rate.'' Our work on the subsequent provisions of § 433.68 (e)(3)(i), (ii), and (iii) led to the development of this term to illustrate this concept succinctly, and we therefore decided it would be beneficial to define it formally in regulations as well. These provisions referred to groups of providers or health care items and services taxed at the same rate. For the sake of clarity and simplicity, we felt it easiest to use a single term to refer to these types of groupings.

We invite comments on the inclusion of these terms, the definitions we have proposed, and if there are any other terms used in this proposed rule that should be included in the regulatory definitions as well.

B. Permissible Health Care-Related Taxes—Generally Redistributive (§ 433.68(e))

Section 1903(w)(3)(E)(ii)(I) of the Act provides that the Secretary shall approve a State's application for a waiver of the broad based and/or uniformity requirements for a health care-related tax, if the State demonstrates to the Secretary's satisfaction that the tax meets specified criteria, including that the net impact of the health care-related tax and associated Medicaid expenditures as proposed by the State is generally redistributive in nature.

In section II.C. of this proposed rule, we discuss additions we are proposing to the regulatory language in § 433.68(e)(3) to better implement the statutory mandate that a tax be generally redistributive. Those changes would necessitate conforming changes to the preceding regulatory language to reflect the new requirement, if finalized. Accordingly, we are proposing to amend § 433.68(e) to provide that a proposed tax must satisfy proposed new paragraph (e)(3), in addition to, as applicable, paragraph (e)(1) or (2) of that section. The addition of paragraph (e)(3) is discussed in section II.C. of this proposed rule.

We further propose to amend paragraphs (e)(1)(ii), (iii), (iv), (e)(2)(ii) and (iii) to add that the waiver must [satisfy] the requirements of paragraph (e)(3) and (f), in addition to existing requirements, for the waiver request to be approvable. Paragraph (f) refers to the current regulatory implementation of limitations on hold harmless arrangements in connection with health care-related taxes, which we are not proposing to modify in this proposed rule. The proposed addition of this reference to paragraph (f) in various places in paragraph (e) is intended to enhance clarity, but not to make any substantive change concerning hold harmless limitations. We note that paragraph (e)(1)(iii) references taxes enacted prior to August 13, 1993. Although a new waiver submission for a tax in effect prior to August 13, 1993, would be unlikely, it is still possible, (for example, if a State makes a non-uniform change to its longstanding tax and needs a waiver), and this proposal accounts for that possibility.

We seek comment on our proposed amendments to § 433.68(e), (e)(1)(ii) through (iv), (e)(2)(ii), (iii), and (iv) and on any additional conforming regulatory edits that may be needed to reflect that (e)(3), if finalized, would be a requirement to be approved for a waiver of the broad-based and/or the uniformity requirement.

C. Permissible Health Care-Related Taxes—Additional Requirement To Demonstrate a Tax Is Generally Redistributive (§ 433.68(e)(3))

CMS is seeking to address health care-related taxes that do not have the effect of being generally redistributive despite being able to pass the P1/P2 or B1/B2 test, as applicable, as previously discussed. We believe that, in large part, the B1/B2 test has served its function as a straightforward mathematical implementation of the statutory requirement under section 1903(w)(3)(ii)(I) of the Act that to be granted a waiver a tax must be generally redistributive. Although the linear regression used in the B1/B2 analysis is vulnerable to certain kinds of manipulation by States, as discussed in section I.D., CMS's experience has shown that the B1/B2 test usually works as intended. In this proposed rule, we aim to eliminate the possibility these vulnerabilities will be exploited. As a result, we propose to retain the B1/B2 test based on the long-term reliance of many States on it, and its overall utility in accomplishing its purpose of ensuring that taxes for which waivers are requested are generally redistributive in conjunction with the proposed regulatory provisions that would close the loophole. However, as demonstrated by the problematic taxes discussed earlier that are designed to target Medicaid with increased tax rates compared to other taxpayers, it is necessary to take our analysis a step beyond the mathematical result of the B1/B2 test to ensure we uphold the statutory mandate that a tax for which a waiver is approved be generally redistributive, which we propose to do through the addition of the requirements in proposed paragraph (e)(3). In addition, as specified in existing statute and by cross reference in regulation at section 1903(w)(1)(A)(iii) of the Act and § 433.70(b), respectively, even if a tax passes the applicable statistical test, it is still considered impermissible if it contains a hold harmless arrangement prohibited by section 1903(w)(4) of the Act and § 433.68(f). Therefore, we propose to add cross-references to § 433.68(f) in regulatory language we are proposing to update in § 433.68(e)(1)(ii), (1)(iv), (2)(ii), and (2)(iii) regarding the approvability of a tax waiver proposal.

As previously discussed, § 433.68(e) specifies the applicable statistical test for evaluating whether a proposed tax is generally redistributive: if the State is seeking only a waiver of the broad-based requirement, paragraph (e)(1) specifies that a State must meet the test referred to as ''P1/P2'' described in section I.C. of this proposed rule, while a State seeking a waiver of the uniformity requirement or both the broad-based and uniformity requirements must meet the test specified in paragraph (e)(2), referred to as ''B1/B2,'' also described in section I.C.

We propose to add new paragraph § 433.68(e)(3), to ensure that a health care-related tax is generally redistributive by preventing taxes that impose higher tax rates on providers that primarily serve Medicaid beneficiaries than on other providers that serve a relatively smaller number of such beneficiaries. Specifically, at paragraph (e)(3), we propose that the new requirements would apply on a per class basis. We also propose that regardless of whether a tax meets the standards in paragraph (e)(1) and (e)(2) the tax would not be ''generally redistributive'' if it has certain described attributes that are contrary to the tax program being generally redistributive in nature.

The proposed regulations would specify the attributes of a tax that would violate the generally redistributive requirement in paragraphs § 433.68(e)(3)(i), (ii) and (iii). The applicability of these provisions, and the associated analysis of whether a tax violates the generally redistributive requirement, would differ based on whether the tax or waiver indicates Medicaid explicitly. We discuss each of these in turn. We note that, if this policy is finalized, it would not interfere with a State's ability to implement otherwise permissible State and locality taxes (that

is, taxes imposed by units of local government such as counties).

1. Taxes That Refer to Medicaid Explicitly

In § 433.68 (e)(3)(i), we propose that if, within the permissible class, the tax rate imposed on any taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable units (except as a result of excluding from taxation Medicare or Medicaid revenue or payments as described in paragraph (d) of this section) the tax would not be generally redistributive. The proposed regulations would also specify an example of a tax that would violate this provision, though the example is not the only example of how a tax might be structured to violate this requirement. The example we propose in regulations text specifies that an MCO tax where Medicaid member months are taxed $200 per member month whereas the non-Medicaid member months are taxed $20 per member month would violate this requirement. Medicaid would, in this context, also include descriptions where a State uses its proper name of its State-specific Medicaid program.

In § 433.68(e)(3)(ii), we propose that if within a permissible class, the tax rate imposed on any taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer or tax rate group defined by its relatively higher volume or percentage of Medicaid taxable units, it would not be generally redistributive. This proposed regulation also would specify two examples of taxes that would violate this provision, though the examples are not intended to be the only examples of how a tax might be structured to violate this requirement. The first example specifies that a tax on nursing facilities with more than 40 Medicaid-paid bed days of $200 per bed day while nursing facilities with 40 or fewer Medicaid-paid bed days are taxed $20 per bed day would violate this requirement. The second example we include in our proposed regulation describes a tax on hospitals with less than 5 percent Medicaid utilization at 2 percent of net patient service revenue for inpatient hospital services, while all other hospitals are taxed at 4 percent of net patient service revenue for inpatient hospital services; this tax structure also would violate this requirement.

Health care-related taxes with the attributes described in the examples in proposed § 433.68(e)(3)(i) and (ii) are designed to generate less tax revenue from non-Medicaid sources and more tax revenue from Medicaid sources for the same amount of taxable services or revenue, which is inconsistent with a generally redistributive tax. This is counter to the Congressional intent and statutory direction that non-broad based and non-uniform taxes that are granted a waiver be generally redistributive. Based on our analysis, existing State taxes that use the B1/B2 loophole described previously would all fail the requirement in proposed § 433.68(e)(3)(i). One existing State tax that uses the loophole would also fail the requirement in proposed § 433.68(e)(3)(ii).

In these scenarios, targeting Medicaid taxable units with higher tax rates than non-Medicaid taxable units helps ensure that taxed entities, particularly those that serve no or relatively low percentages of Medicaid beneficiaries that would be less able to be made whole by additional Medicaid payments are generally not burdened by any, or more than a de minimis, tax liability. As a result, the State, its localities, and taxpayers do not appear to shoulder a net non-Federal share, or appear to shoulder a significantly reduced net non-Federal share, and the Federal government is the only net payer or a substantially higher net payer than contemplated by statute. In addition to this being counter to the statutory framework, this presents a significant fiscal integrity risk to the Medicaid program as States have significant flexibility with regard to payment methods, which increases the financial obligation of the Federal treasury without any inherent benefit to the Federal taxpayer. Without any non-Federal entity incurring a net non-Federal share cost (or incurring a reduced non-Federal share cost), there is reduced incentive for States to propose payment methods that are efficient, economic, and consistent with Federal requirements.

2. Waivers That Do Not Refer to Medicaid Explicitly

In § 433.68(e)(3)(iii), we propose to prohibit a State from imposing a tax that excludes or imposes a lower tax rate on a taxpayer or tax rate group defined by or based on any characteristic that results in the same effect as described in paragraph (e)(3)(i) or (ii). In other words, there does not need to be an explicit reference to Medicaid in the State's tax program if the State is using a substitute definition, measure, attribute, or the like as a proxy for Medicaid to accomplish the same effect. By ''the same effect,'' we mean imposing a higher tax rate on Medicaid taxable units than on non-Medicaid taxable units, even if this is accomplished with less mathematical precision under an approach that does not explicitly reference Medicaid than would be possible under an approach that violates proposed paragraph (e)(3)(i) or (e)(3)(ii).

The proposed regulation would specify two examples of taxes that would violate this provision, but does not provide an exhaustive list of ways a tax might be structured to violate it. The first example involves the use of terminology to establish a tax rate group based on Medicaid without explicitly mentioning ''Medicaid'' (or the State-specific name of the Medicaid program) to accomplish the same effect as described in paragraph (e)(3)(i) or (ii). This example specifies that a tax on inpatient hospital service discharges that imposes a $10 rate per discharge associated with beneficiaries covered by a joint Federal and State health care program and a $5 rate per discharge associated with individuals not covered by a joint Federal and State health care program would violate this requirement, because joint Federal and State health care program describes Medicaid, and a higher tax rate is imposed on Medicaid taxable units. The second example concerns the use of terminology that creates a tax rate group that closely approximates Medicaid, to the same effect as described in paragraph (3)(i) or (ii). This example specifies that a tax on hospitals located in counties with an average income less than 230 percent of the Federal poverty level of $10 per inpatient hospital discharge, while hospitals in all other counties are taxed at $5 per inpatient hospital discharge, would violate this requirement, because the distinction being drawn between tax rate groups is associated with a Medicaid eligibility criterion (income) with a higher tax rate imposed on the tax rate group that is likely to involve more Medicaid taxable units.

The intent of the proposed regulatory provision in paragraph (e)(3)(iii) is to address potential efforts by States or local units of government to mask a health care-related tax that falls more heavily on Medicaid taxable units using some other terminology or defining factor to circumvent the requirements in (e)(3)(i) and (ii) by avoiding explicitly targeting Medicaid taxable units with higher tax rates. For the same reasons described previously regarding taxes that would violate (e)(3)(i) or (ii), such taxes would not meet the statutory generally redistributive requirement and would have a substantially negative impact on the fiscal integrity of the Medicaid program. Absent this provision, CMS is concerned that if we

only finalized the requirements in § 433.68(e)(3)(i) and (ii), States might choose to pursue taxes that would otherwise be prohibited under § 433.68(e)(3)(i) and (ii) through the use of a proxy for Medicaid.

We are proposing to codify this regulatory language with this level of detail directly in response to feedback we received to a similar proposal in the November 2019 proposed rule. Although we remain committed to addressing the statistical loophole, as we were in the November 2019 proposed rule, we acknowledge that the level of detail in the November 2019 proposed rule might not have provided enough context to give commenters an accurate picture of our intent. Under the analogous provision of the 2019 proposed rule, we would have determined a tax program not to be generally redistributive if it imposed an ''undue burden'' on the Medicaid program because the tax ''excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the tax rate group having no Medicaid activity or relatively lower Medicaid activity than any other tax rate group.'' (84 FR 63778). The 2019 proposed rule may not have presented a clear idea of how we would apply the requirement to avoid imposing an undue burden on the Medicaid program. In this proposed rule, we added language to § 433.68(e)(3) to provide reassurance to interested parties that these current proposals are intended only to shut down the loophole to better effectuate the statutory directive that health care-related taxes for which the broad-based and/or uniform requirement is waived must be generally redistributive, and not impact permissible State health care-related tax programs unrelated to this goal. For example, in section II.A., we propose to define ''Medicaid taxable unit'' to narrow the scope from ''Medicaid activity'' as used in the November 2019 proposed rule. We also chose, in all paragraphs of paragraph (e)(3), to propose specific illustrative examples that demonstrate our commitment to a clear, specific, and predictable application of our regulations. We believe that the illustrative examples will provide the public with a better understanding of what this proposed provision would do and how we would apply it in practice when evaluating State tax waiver proposals, compared to the November 2019 proposed rule. We invite comment on other examples we could provide, whether in final rule preamble or in regulation text, that could make even clearer how we will implement the proposed policies, if finalized.

Because the scenarios described in § 433.68(e)(3)(iii) would not name Medicaid explicitly, CMS would need to assess whether Medicaid is nevertheless implicated, and whether the tax results in the same effect as described in paragraph (3)(i) or (ii). Under this assessment, we would examine the tax and waiver submission, including the characteristics of each tax rate group description, the entities in the tax rate group, and the Medicaid taxable units and non-Medicaid taxable units associated with each tax rate group and entities in each tax rate group. While no single factor we examine when Medicaid is not named explicitly would result in an automatic determination by CMS that the tax rate groups have been designed to target Medicaid, the mere fact that a State has chosen to use language that does not specify Medicaid explicitly, but appears to invoke it implicitly, will in and of itself call for closer scrutiny. For example, if CMS analyzes a Medicaid utilization table in a tax waiver submission (which lists providers, their tax rates, and their Medicaid utilization) and observes that a certain group of excluded providers described as ''Provider Group A'' has little to no Medicaid utilization, we will further scrutinize ''Provider Group A'' to ascertain whether it is a proxy for lack of Medicaid utilization, as discussed further below.

Accordingly, we propose that CMS may examine whether the tax or waiver uses terminology that describes Medicaid implicitly without using the term itself, such as the ''joint Federal and State health care program,'' used in our earlier example. This example is described in proposed regulations text in § 433.68(e)(3)(iii)(A). We would also examine if the tax rate group is defined based on criteria that mirror Medicaid eligibility or other defining characteristics, such as a data point that is associated with Medicaid or a Medicaid eligibility criterion like income (such as percentages of low-income individuals in a geographic area), or a particular provider type that is associated with high Medicaid utilization (such as State or other public facilities and university/teaching hospitals). This income-associated example is described in proposed regulation text in § 433.68(e)(3)(iii)(B).

This initial analysis, and the subsequent analysis for whether the tax is generally redistributive, would fit into our regular review work and interactions with States. When CMS reviews a tax waiver submission, we assess the waiver for compliance with all applicable statutes and regulations. This assessment is not necessarily limited to the waiver submission itself, or to the materials as first submitted by the State. Upon review, we generally tailor a set of questions for the State to obtain any additional information necessary to adjudicate the waiver request or request revisions necessary for the submission to meet Federal requirements. For example, we might ask for clarification based on something we did not understand, that we want to confirm, or that may be in error. We regularly have additional discussions with the State, which may include technical assistance phone calls, and State submission of updated or additional materials. The process is both collaborative and iterative, to allow States to vary their taxes in ways appropriate for their individual circumstances, and to allow CMS to arrive at an appropriate approvability decision based on Federal requirements. An assessment of whether or not a State is utilizing a proxy in violation of proposed paragraph (e)(3)(iii) would be conducted under this same process. If we analyze a Medicaid utilization table and observe a disparate set of rates for higher and lower Medicaid utilization tax rate groups despite the tax passing B1/B2, and we cannot readily determine how the tax rate groups have been constructed, we would ask the State for additional information as is part of our standard practice. Consistent with our existing practice, this allows the State to identify for CMS any necessary clarifications or explanations that informed the development of the tax rate groups. The additional information we obtain from the State could allow us to determine that the tax rate groups were not constructed to target taxation to higher Medicaid utilization tax rate groups or away from lower Medicaid utilization tax rate groups, but instead for a legitimate public policy purpose not directed at manipulating relative tax burden.

The proposed provision in § 433.68(e)(3)(iii) is not intended to prevent States from designing tax rate groups to achieve legitimate public policy goals, when these do not prevent the tax from being generally redistributive. In this context, by ''legitimate,'' we mean any public policy goal that the State may lawfully pursue, which is the State's actual purpose and not a spurious or fictive or purpose offered to conceal or negate a true purpose of directing higher relative tax

burden to the Medicaid program. This type of assessment is already historically reflected in the consideration CMS gives to certain non-uniform taxes under § 433.68(e)(2)(iii)(B), where CMS permits a lower threshold to pass the B1/B2 test for taxes that provide more favorable tax treatment only for specified types of entities, including sole community hospitals as defined in 42 CFR 412.92. A ''sole community hospital'' (SCH) generally is a hospital that is the only hospital in its geographic area and therefore serves as the sole source of inpatient hospital services for the vulnerable population in the area. Because these hospitals play vital roles in providing access to care to beneficiaries, they were included in the statutory and regulatory flexibilities built into the statistical test in recognition of their importance to recipient access to services (57 FR 55118 through 55129).

For example, a State establishing a nursing facility tax program, within which a tax rate group for a provider type such as continuing care retirement communities (CCRCs) is subject to a lower tax rate for public policy reasons, would not, in and of itself, violate (e)(3)(iii), even if the CCRC tax rate group happens to have lower Medicaid utilization than other tax rate groups in the tax program. In this case, we would consider that the designation of CCRCs exists outside of the health care-related tax domain, and, for taxation purposes within the CCRC designation, the tax rate is not differentiated between Medicaid and non-Medicaid taxable units. CCRCs are licensed by the States in which they are located; this is not a classification or designation that the State created for the purposes of establishing health care-related tax provider groups or otherwise to minimize the impact on non-Medicaid providers or taxable units.

As another example, a State might seek to exclude providers located in rural areas from taxation. States often afford special consideration for rural providers as a means of helping preserve beneficiary access to services in rural areas that otherwise might not have a sufficient number of qualified providers to serve the needs of Medicaid beneficiaries. Like sole community hospitals, the existing regulations in § 433.68(e)(2)(iii)(B) currently provide additional flexibility for States in designing non-uniform tax waivers that favor rural hospitals. A tax structure that excluded rural providers without any explicit reference to Medicaid would likely not fall within the proxy provision. Generally, because the provider group would be defined by a pre-existing classification that exists for various public policy purposes apart from taxation (rural location) and because the tax treatment within the classification of rural providers would not vary between Medicaid and non-Medicaid taxable units, there would not appear to be an indication that the State is using the taxpayer rate group to direct tax burden to the Medicaid program or away from providers with relatively lower Medicaid utilization. When, by chance, a State effort to design a tax program in support of a public policy purpose like promoting health care access results in a tax rate group that happens to have lower Medicaid utilization ending up with a tax break, some States may balance this with a corresponding break for higher Medicaid utilization providers. Nothing in the proxy provision would prevent States from being able to balance tax rate groups in this way as they have in the past. Other possible examples of tax rate groups that States may wish to give a tax break to for policy reasons not related to directing higher relative tax burden to the Medicaid program include psychiatric hospitals and rural hospitals, among others. These instances would be permissible under proposed paragraph (e)(3)(iii)(B) because the State has a legitimate public policy reason not related to directing relative tax burden toward the Medicaid program for giving preferential tax treatment to the tax rate group for the type of provider in question.

As noted, the groupings discussed in the previous paragraphs exist for policy reasons outside of the context of taxation, indicating they were not created solely for the purpose of the tax and waiver under review. Conversely, a possible signal that a State is trying to exploit the loophole for a reason that is not tied to legitimate public policy would be the State's use of groupings that do not appear to have a connection to a reasonable policy purpose. This would indicate to CMS that we need to investigate further to determine if the State's proposal would lack a legitimate policy purpose and would impose disproportionate burden on Medicaid. Examples of groupings that could have a legitimate policy purpose include grouping providers within a permissible class by number of bed days for an inpatient hospital services tax and member months for managed care plan services tax. In these instances, the grouping uses health care-associated quantification measures. We note that this would not be the sole factor to determine whether a State has a legitimate public policy interest when establishing tax groupings; groupings like this would simply not raise the same red flags as groupings unrelated to health or tax policy.

An example of a grouping that does not appear to have a connection to a legitimate policy purpose (and that would prompt further inquiry) could include a feature of the physical plant of facility in question. For example, if a State was targeting a specific hospital with very high Medicaid utilization, and that hospital was unique in having two separate exterior entrances to the emergency department, the State might construct inpatient hospital tax rate groups based on the number of exterior entrances to the emergency department. CMS might see this on review of a waiver submission, and it would prompt additional questions to the State as part of our typical practice of assessing waiver submissions to understand the rationale for assigning tax rates in this manner, because it is not evident how incentivizing hospital emergency departments through taxation to have (or not to have) a particular number of separate exterior entrances to the emergency department would advance a legitimate State public policy goal.

CMS does not intend for § 433.68(e)(3) to target any taxes other than those that utilize the loophole in the B1/B2 test. CMS would apply this proposed provision narrowly, to reach only those situations where, based on considerations not related to a legitimate public policy goal as discussed previously, CMS determines that a State is attempting to mask that it is seeking to apply a higher tax rate based on a taxpayer's or tax rate group's Medicaid taxable units in a manner that, if done explicitly, would violate § 433.68(e)(3)(i) or (ii) of the proposed rule.

D. Permissible Health Care-Related Taxes—Transition Period (§ 433.68(e)(4))

We have made every effort to ensure the impact of this proposed rule would be limited to those health care-related taxes that exploit the statistical loophole. Moreover, we understand that the updated requirements proposed in previous sections of this rule would require those States with such taxes to modify or end them, or experience a reduction in medical assistance expenditures eligible for FFP. Our aim is to close the loophole as soon as possible, while acknowledging State circumstances. Therefore, we are proposing to provide a transition period only for those currently identified States

that would be out of compliance with proposed § 433.68 (e)(3), if finalized, that have not received the most recent approval within the past 2 years.

If this rule is finalized, States that received the most recent waiver approval for their tax that does not comply with § 433.68 (e)(3) 2 years or less from the effective date of the final rule would not be eligible for a transition period. Consistent with the other policies proposed in this rule, this will not affect any non-loophole taxes. The transition period, when applicable, would apply to those tax waivers that have been most recently approved by CMS more than 2 years prior to the effective date of a final rule. The transition period length would be the length of time between the effective date of the final rule and when the State's health care-related tax waiver that no longer conforms to regulatory requirements would have to be modified or discontinued to avoid a reduction in medical assistance expenditures. This timing would allow those affected States at least one full State fiscal year to adjust the tax in order to come into compliance. It is our understanding that this timing would give the States that fall into this category one full budget cycle to come into compliance.

We propose to look at the most recent approval date of the waiver in which the State utilizes the loophole. For example, if a State has a health care-related tax for which it most recently obtained approval for a waiver on July 1, 2016, and the effective date of the final rule is January 1, 2026, the 1-year transition period would apply because the initial tax waiver was most recently approved more than two calendar years before the effective date of the final rule. We invite comment on the length of time since a waiver was most recently approved and the time of the transition period applicable to those lengths of time, including whether the transition periods should be shorter or longer, and specifically whether the lengths of the transition periods should be adjusted to account for States that have a 2-year legislative cycle (see related discussion later in this section).

Specifically, we propose first that States with health care-related tax waivers that do not meet the requirements of paragraph (e)(3), where the date of the most recent approval of the waiver that violates paragraph (e)(3) occurred 2 years or less before [EFFECTIVE DATE OF A FINAL RULE], are not eligible for a transition period. Any collections made under that waiver following [EFFECTIVE DATE OF A FINAL RULE] may be subject to deduction from medical assistance expenditures as described in § 433.70(b). For example, if a State most recently received approval for a tax loophole waiver on December 10, 2024, and the final rule effective date is January 14, 2026, the State's waiver will no longer be valid on January 14, 2026. To avoid a reduction in medical assistance expenditures before calculation of FFP, the State must cease collecting revenue from the health care-related tax that does not meet the requirements of § 433.68 immediately as of the effective date of the final rule, because there is no transition period applicable to this waiver.

Second, we propose that ''States with health care-related tax waivers that do not meet the requirements of paragraph (e)(3), where the date of the most recent approval of the waiver that violates paragraph (e)(3) occurred more than two years before [EFFECTIVE DATE OF A FINAL RULE],'' must either ''submit a health care-related tax waiver proposal that complies with paragraph (e)(3) with an effective date no later than the start of the first State fiscal year beginning at least one year from [EFFECTIVE DATE OF A FINAL RULE],'' or ''otherwise modify the health care-related tax to comply with this rule and all other applicable Federal requirements with an effective date not later than the start of the first State fiscal year beginning at least one year from [EFFECTIVE DATE OF A FINAL RULE].'' For example, if we finalize this policy and the final rule has an effective date of January 14, 2026, and a State's fiscal year begins April 1, 2026, that State would need to submit a compliant health care-related tax waiver, or otherwise address the tax waiver's noncompliance, with an effective date no later than April 1, 2027. If a State's fiscal year begins January 1, 2026, and again the rule's effective date is January 14, 2026, that State would need to take corrective action with an effective date no later than January 1, 2028.

As reflected in the proposed regulatory language, we are proposing that States with a transition period would have until the start of the first State fiscal year beginning at least 1 year from the effective date of the final rule to be in compliance. We believe providing one full State fiscal year for States with a most recent approval more than 2 years before the effective date of the final rule is an appropriate timeframe for several reasons. First, we considered that past rulemaking that involved transition periods often had longer transition times in consideration of States that might have biennial legislative sessions. To our knowledge, all the potentially affected States (that is, States that have currently approved tax waivers that take advantage of the statistical loophole and would not comply with paragraph (e)(3), if finalized) have annual legislative sessions, which should give them sufficient time for their respective legislatures to enact any necessary changes. Second, we note that § 433.72(c)(2) specifies that a waiver will be effective for tax programs commencing on or after August 13, 1993, on the first day of the calendar quarter in which the waiver is received by CMS. For instance, in the event of an October 15, 2025, effective date for the final rule, a State with a 1-year transition period and a State fiscal year that begins July 1 would have until September 30, 2027, to submit a waiver package with a July 1, 2027, effective date. In this case, States would have nearly three extra months to submit a compliant waiver. Depending on when a State's fiscal year begins relative to the final rule's effective date, if finalized, a State eligible for the transition period may have approximately 2 years to remedy a noncompliant tax waiver under our proposal.

We are not proposing a transition period for waivers with the most recent approval date 2 years or less before the effective date of the final rule for several reasons. States that would fall into this category, if finalized, obtained their most recent approval knowing that CMS intended to undertake rulemaking in this area, as was communicated in a companion letter with the approval. We believe it has been incumbent upon States to assess the risk of having a waiver deemed prospectively impermissible in the future if related policy changes are finalized (including within a short timeframe) when determining whether to submit a waiver request that exploits the loophole. Although this circumstance could be administratively burdensome for States to address, an affected State would have risked that burden by requesting the exploitative waiver, and by not taking corrective action sooner, and with no guarantee of any type of transition period. Finally, we note that States with new tax loophole waiver proposals pending before CMS as of the effective date of a final rule, if finalized, would likewise not be eligible for a transition period.

In addition, we previously signaled in the November 2019 proposed rule that this is a policy area we want to address. As part of our standard health care-related tax waiver approval letters of the broad-based and/or uniformity requirements, CMS informs States that ''any changes to the Federal

requirements concerning health care-related taxes may require the State to come into compliance by modifying its tax structure.'' Based on both these signals, and on this current rulemaking activity, we believe that States in general should be sufficiently aware of our intent to make changes in this area and their responsibility to adjust accordingly.

Furthermore, of the seven States with existing loophole waivers that we have identified as of the date of this proposed rule, four have been issued companion letters with their most recently approved tax waiver letters, and all four waivers with approval dates within 2 years of a potential final rule effective date are included in those that received this notice. These companion letters were intended to notify these States that we viewed their tax structures as problematic and intended to address the issue through notice and comment rulemaking soon.

There are three States that have not been issued companion letters that we expect to be affected by this proposed rule, if finalized. Although we believe that they should still be sufficiently informed through previous actions that signaled our intent to address the loophole issue, we have communicated with these States directly, as part of our standard practice of offering technical assistance to States. They also would all be eligible for a transition period under this proposed rule, if finalized. Likewise, we are offering technical assistance to all States that we anticipate might be impacted by this proposed rule to ensure all are aware of the proposed requirements and timeframes and will be well positioned to meet them in the event these requirements are finalized as proposed.

Regardless of whether a State would receive a transition period for its waiver, we would consider a tax waiver proposal to be in compliance with the requirements proposed in this rule if (and when) the tax in question is generally redistributive as described in section 1903(w)(3)(E)(ii)(I) of the Act and § 433.68(e). We note that the proposal would also need to meet all other requirements for tax waiver proposals and health care-related taxes in general, which still includes the P1/P2 test and B1/B2 test, where applicable, in addition to the new requirements in paragraph (e)(3), if finalized. It does not mean CMS will automatically approve a waiver renewal or amendment request. CMS will still closely examine any renewals or amendments associated with taxes that exploit the loophole for any other violations of statutory and regulatory requirements, including hold harmless. CMS routinely provides technical assistance to States prior to the formal submission of a tax waiver proposal and would provide similar assistance to affected States upon request.

Alternatively, States are permitted to adjust the taxes in question in such a way as to be compliant with Federal requirements and not need to submit a new tax waiver proposal. Specifically, States are permitted to make uniform changes to the structure of a tax without submission of a new tax waiver. For example, a uniform change might be a change to a tax that reflects the same percentage tax rate change for every tax rate group of providers. In this example, assume that a State has a tax on inpatient hospital services, and it has two tax rate groups: ''Hospital Type A'' and ''Hospital Type B.'' The State has an approved tax waiver where it charges Hospital Type A $100 per discharge and Hospital Type B $10 per discharge. The State wishes to make a 10 percent reduction in the tax amount for both tax rate groups: Hospital Type A would be taxed $90 per discharge and Hospital Type B would be taxed $9 per discharge. Because the tax rates have changed by the same percentage for all providers, this constitutes a uniform change, and a State would not need to submit a new tax waiver to CMS. In addition, a State might adjust a tax in a manner that no longer requires a waiver, and therefore does not need to submit a new waiver to CMS. For example, a State may wish to adjust its tax to be imposed on all non-Federal, non-public entities, items, and services within a permissible class and to be applied consistently in amount/rate across all taxable units. The tax would also need to comply with the hold harmless provisions specified at § 433.68(f), but we would consider such a tax to be broad-based and uniform, and it would not require a waiver at all. CMS intends to monitor the individual circumstances of States that would be affected by this proposed rule, if it is finalized, to ensure that affected taxes have been amended if we do not receive a new tax waiver request for review and approval.

As stated, it is not our intention to be disruptive to States' health care-related tax programs. We acknowledge that this rule, if finalized, would require some States to make changes, with different applicable timeframes. However, we believe the proposed rule would likely have a minimal impact on the total amount of tax revenue States could collect because a State's ability to collect taxes will remain unchanged. In other words, affected States would have ample opportunity to modify their existing taxes to come into compliance with all requirements and maintain the same or similar level of revenue collection, if that is the State's policy choice. Further, CMS anticipates that loophole taxes modified to comply with the proposed rule would necessarily result in increased financial benefit to taxpayers that serve relatively high percentages of Medicaid beneficiaries, in the sense that they would no longer bear a disproportionate tax burden in relation to taxpayers that serve relatively lower percentages of Medicaid beneficiaries. We are also considering and soliciting comment on whether the final rule should instead include transition period lengths for each category of State waivers by permissible class, such as different lengths of time for inpatient hospital taxes versus MCO taxes. We invite comment on whether different permissible classes would be more or less burdensome to rectify a tax waiver that would be impermissible under this proposed rule, if finalized. Finally, we propose that, once the transition period for a tax waiver that qualifies under paragraph (e)(4) has expired, if applicable, CMS may deduct from a State's medical assistance expenditures revenues from health care-related taxes that do not meet the requirements of paragraph (e)(3) as specified by section 1903(w)(1)(A)(iii) of the Act and § 433.70(b). For States without a transition period, this would begin immediately following the effective date of a final rule. Under § 433.70(b), CMS can deduct from a State's medical assistance expenditures, before calculating FFP, revenues from health care-related taxes that do not meet the requirements of § 433.68. However, we assure States with a transition period that payments made with revenue collected during the transition period in accordance with an approved, existing loophole waiver would not be subject to disallowance on the basis of these new proposed regulatory requirements, if finalized. In the event that additional States submit waivers that exploit the loophole, and these waivers are approved prior to the effective date of any final rule, they would also be issued a companion letter with their tax waiver approval letter and would not receive a transition period under an eventual final rule.

We are proposing multiple alternatives to the transition period policies proposed in this section. First, we propose, alternatively, that waivers that do not comply with proposed § 433.68(e)(3) approved within the past 3 years before the effective date of a final rule would not receive a transition

period. As compared to the proposed policy, this 3-year period would include an additional, currently approved tax waiver that exploits the loophole, for a total of five loophole tax waivers that would not receive a transition period, instead of four waivers. We did send a companion letter with the most recent approval for this additional loophole tax waiver, so under this alternative transition period, all States with loophole tax waivers that would not receive a transition period still would have received a companion letter expressly notifying the State of our concerns about its tax structure with the most recent waiver approval. We further propose, alternatively, to extend this either 2 or 3-year timeframe as may be needed in a final rule to capture the four most recently approved loophole tax waivers (if we finalize a 2-year transition period) or five most recently approved such waivers (if we finalize a 3-year transition period), to ensure that these specific waivers (with which most recent approval we sent the State a companion letter) do not receive a transition period. Finally, we are considering an alternative to our proposal of no transition period for more recently approved loophole tax waivers and a 1-year transition period for loophole tax waivers with longer-standing most recent approvals. First, alternatively, we propose to offer no transition period for any loophole waiver, regardless of the time since the most recent approval of the waiver. Second alternatively, we propose that loophole waivers approved in the 2 years (or 3 years) before the effective date of a final rule would receive a 1-year transition period instead of no transition period, and the longer-standing most recent waiver approvals (more than 2 or 3 years before the effective date of a final rule) would receive a 2-year transition period. We invite comment on the transition periods, including whether any of the proposed cutoff timeframes and/or transition period lengths should be shorter or longer. We also invite comment on whether any of the policies in this proposed rule would be disruptive to existing State tax waivers that do not exploit the statistical loophole.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a ''collection of information,'' as defined under 5 CFR 1320.3(c) of the PRA's implementing regulations, is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements. Comments, if received, will be responded to within the subsequent final rule (CMS–2448–F, RIN 0938–AV58).

A. Wage Estimates

To derive average costs, we used data from the US Bureau of Labor Statistics' May 2024 National Occupational Employment and Wage Statistics for all salary estimates (*https://www.bls.gov/oes/tables.htm*). In this regard, Table 1 presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 1—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and other indirect costs ($/hr)	Adjusted hourly wage ($/hr)
Health care Support Worker	31–9099	23.44	23.44	46.88

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. Proposed Information Collection Requirements

The following sections of this rule contain proposed collection of information requirements (or ''ICRs'') that are or may be subject to OMB review and approval under the authority of the PRA. Our analysis of the proposed requirements and burden follow. For this rule's full burden implications, please see the Regulatory Impact Analysis under section V. of this preamble.

1. ICRs Regarding General Definitions (§ 433.52)

We do not anticipate that any of the proposed definition changes (adding and defining ''Medicaid taxable unit,'' ''non-Medicaid taxable unit,'' and ''tax rate group'') will result in the need for States to amend existing or create new State Plan or policy documents. Consequently, such changes are not subject to the requirements of the PRA.

2. ICRs Regarding Tax Waiver Submissions (§ 433.68)

The following proposed changes will be submitted to OMB for review under control number 0938–0618 (CMS–R–148).

Under the current regulations, States may submit a waiver to CMS for the broad-based requirements (all providers within a defined class must be taxed) and/or the uniformity requirements (all providers within a defined class must be taxed at the same rate) for any health care related tax program which does not conform to the broad based or uniformity requirements under § 433.68. For a waiver to be approved and a determination that the hold harmless provision (for example, guaranteeing to

repay taxpayers the cost of the tax) is not violated, States must submit written documentation to CMS which satisfies the quarterly reporting and recordkeeping requirements under § 433.74(a) through (d). Without this information, the amount of FFP payable to a State cannot be correctly determined.

Uniformity Requirements Waiver:[20] A State must demonstrate that its tax plan is generally redistributive by calculating the ratio of the slopes of two linear regressions, generally resulting in a value of 1.0 or higher. Under the changes in this proposed rule, States would still need to demonstrate this calculation, and the waiver proposal must reflect a tax that is generally redistributive under the requirements in proposed new paragraph § 433.68(e)(3) (entitled, ''Additional requirement to demonstrate a tax is generally redistributive''). However, this rule proposes to address an inadvertent regulatory loophole related to the current statistical test to ensure that taxes passing the test are generally redistributive. The loophole essentially allows States to shift the cost of financing the Medicaid program to the Federal government. As indicated in section II of this preamble, we are proposing to close the loophole in the statistical test by:

- Prohibiting States from explicitly taxing Medicaid units at higher tax rates than units of other payors.
- Prohibiting State gaming through ''proxy'' terminology.
- Including a transition period for States with existing loophole taxes.

We anticipate that the provisions of this proposed rule may require seven States to submit a total of eight new waiver proposals within 2 years of the effective date of the subsequent final rule that demonstrate compliance with the updated requirements. This number is based on the number of States that currently have tax waivers that exploit the loophole, and reflects that one State has two waivers. Although the submission of a new waiver is not the only way to address the requirements of this proposed rule, for purposes of scoring the impact of this rule we will assume all seven States will go this route, as we believe it is the most likely and we have no reliable way of knowing how each State may choose to proceed. However, some States may choose to restructure their taxes in a manner that does not require them to submit a new waiver request. Existing tax waivers that do not exploit the statistical loophole are not affected and, therefore, have no added requirements and burden.

Consistent with our active (or currently approved) estimates under the aforementioned OMB control number, we continue to estimate that it would take 80 hours at $46.88/hr. for a health care support worker to prepare and submit the waiver request. In aggregate, we estimate one-time burden of 640 hours (8 waivers × 80 hrs./waiver) at a cost of $30,003.20 (640 hr. × $46.88/hr.). When taking into account the Federal administrative match of 50 percent, we estimate a one-time State cost of $15,001.60 ($30,003.20 * 0.5).

Consistent with our active collection of information request, this proposed rule does not provide States with a waiver form or template. Instead, instruction for preparing and submitting the waiver is provided the aforementioned rules and what is codified in §§ 433.68 and 433.72.

Outside of the revised waiver, we do not anticipate that the proposed changes will result in the need for States to amend existing or create new State Plan or policy documents. Consequently, we are not setting out such burden.

C. Summary of Burden Estimates for Proposed Requirements

TABLE 2—PROPOSED ONE-TIME BURDEN ESTIMATE

Regulation Section(s) under Title 42 of the CFR	OMB Control No. (CMS ID No.)	Respondents	Responses (per State)	Total responses	Time per response (hr)	Total time (hr)	Labor costs ($/hr.)	Total cost ($)	State cost ($)
Waiver Documentation (§ 433.68).	OMB 0938–0618 (CMS–R–148).	7 States	1 or 2	8	80	640	46.88	30,003	15,001

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed previously, please visit the CMS website at *https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing,* or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **DATES** and **ADDRESSES** sections of this proposed rule and identify the rule (CMS–2448–P, RIN 0938–AV58), the ICR's CFR citation, and the OMB control number.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Statement of Need

This proposed rule would eliminate an inadvertent loophole in existing health care-related tax waiver regulations and strengthen CMS's ability to enforce section 1903(w)(3)(E) of the Act. These changes are necessary to address taxes that align with existing regulations but do not meet the requirement of the statute due to a statistical loophole that exists in the regulations. These provisions of the proposed rule are narrowly tailored to address this problem and enable CMS ability to enforce its new requirements, if finalized, with care to ensure that existing tax waivers that do not exploit the statistical loophole are not affected. All other changes are conforming or technical changes and related to this primary objective of closing the loophole. As reflected further in this section, the financial impact on the Federal government of the existing problem is large, and the potential for this problem to proliferate further demands swift action.

[20] We note that these policies, if finalized, will also apply to broad-based waivers; however, because we are focusing our estimates on existing waivers that exploit the loophole, we are only discussing the uniformity waiver in this section.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, ''Regulatory Planning and Review,'' Executive Order 13132, ''Federalism,'' Executive Order 13563, ''Improving Regulation and Regulatory Review,'' Executive Order 14192, ''Unleashing Prosperity Through Deregulation,'' the Regulatory Flexibility Act (RFA) (Pub. L. 96354), section 1102(b) of the Social Security Act, and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; and distributive impacts;). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with significant effects as per section 3(f)(1) ($100 million or more in any 1 year). Based on our estimates using a ''no action'' baseline, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1)). Accordingly, we have prepared an RIA that to the best of our ability presents the costs, benefits, and transfers of the rulemaking. Therefore, OMB has reviewed these proposed regulations, and the Departments have provided the following assessment of their impact.

Executive Order 14192, titled ''Unleashing Prosperity Through Deregulation,'' was issued on January 31, 2025. For E.O. 14192 accounting purposes, savings to the Federal government that are classified as transfers in regulatory impact analyses do not count as cost savings.

C. Detailed Economic Analysis

To enforce the requirement that taxes have a net impact that is ''generally redistributive'' in accordance with section 1903(w)(3)(E)(ii)(I) of the Act when a State is seeking a broad-based and/or uniformity waiver, CMS established certain tests such as the P1/P2 and the B1/B2 tests. These tests are described in detail in section I.C. of this proposed rule.

To determine the economic impact of this rule, we started with information collected by CMS on provider taxes that we anticipate would be affected by these changes, if finalized. We identified eight taxes in seven States that would be affected by this proposed rule, if finalized. This data is collected via the Form CMS–64 [21] and through State submissions for waivers, and to a lesser extent, as part of State plan amendments and State-directed payment preprints. The information collected included: the type of provider or health care-related entity taxed (for example, MCOs or hospitals); the expected amount of tax revenue to be collected; the percentage of total tax revenue paid based on association with Medicaid (the Medicaid taxable units); and the percentage that Medicaid constitutes of the total tax base for the relevant permissible class for the tax. In these eight cases, the amount of tax revenue paid based on Medicaid taxable units would be used to fund higher provider payments to account for the taxes paid by the providers to the States.

While we acknowledge that there is uncertainty about how States would respond, our approach does not assume any change in the total tax revenue; we assume that the burden of the tax would shift from disproportionately taxing Medicaid taxable units to a more proportional distribution on all taxable units. We calculated the amount of tax paid under the expected percentage of the tax paid based on Medicaid taxable units and compared it to the amount that would be paid if the burden for Medicaid taxable units was the same as the Medicaid-associated percentage of the total tax base. For example, for MCO taxes, we calculated the current tax burden that is assessed on Medicaid tax units (premiums or member months for Medicaid enrollees) and the overall amount of tax revenue. Then we calculated the tax burden that is assessed against Medicaid taxable units assuming that the tax was assessed evenly across all units (premiums or member months). For hospital taxes, we did the same analysis using the taxable units for hospitals (which could be revenue, hospital stays, or days hospitalized). This data is shown in Table 3.

TABLE 3—SUMMARY OF CURRENT MEDICAID TAX WAIVER DATA

[In billions of 2024 dollars]

Tax category	Number of state waivers	2024 estimated annual revenue (billions)	Medicaid tax burden as percentage	Medicaid share of taxable units as percentage	Medicaid tax burden (billions)	Medicaid tax burden under proposed rule (billion)
Managed care organization	7	$18.5	96	53	$17.9	$9.8
Hospital	1	5.1	44	32	2.2	1.6
Total	8	23.6	85	48	20.1	11.4

For 2024, we estimate that these taxes accounted for $23.6 billion in revenue for 7 States. (For States with waivers that started in 2025, we included the first year's revenues in 2024 for this analysis.) Of this amount, we estimate that $20.1 billion was assessed against Medicaid taxable units (85 percent), and thus was ultimately paid by the Medicaid program. We also estimated that if the taxes were assessed proportionately on all taxable units, that

[21] The Form CMS–64 is a collection under OMB 0938–1265 (CMS 10529).

only $11.4 billion (48 percent) would have been assessed against Medicaid taxable units.

The following example illustrates how we calculated the impact of the proposed policy change. Assume a State has a provider tax that exploits the loophole and is expected to collect $1 billion in revenue. Ninety-five percent of the taxes are assessed against Medicaid taxable units, but only 50 percent of the total taxable units are Medicaid taxable units. As a result, the Medicaid program (that is, the State and the Federal government) bears 95 percent of the tax burden, even though Medicaid only accounts for 50 percent of the basis for taxation (such as Medicaid member months or hospital stays) for this service in the State. Under existing regulations with the loophole, the Medicaid program would be expected to pay for $950 million of the tax revenue (via higher payments to providers) [95 percent * $1 billion = $950 million]. Under the proposal, the Medicaid program would be expected to pay for approximately $500 million for the tax revenue [50 percent * $1 billion = $500 million], because $500 million is 50 percent of the $1 billion collected in tax revenue, which reflects the share of the tax base attributable to Medicaid usage (or total taxable units). In that case, total expenditures made by the Medicaid program would be anticipated to decrease by $450 million [$950 million − $500 million].

We estimated that the impact on Federal Medicaid expenditures would be the difference in the taxes paid by Medicaid under current law multiplied by the average FFP matching rate. The average Federal share includes higher Federal matching rates for certain services or populations, most notably the 90 percent matching rate for expansion adults in States that expanded Medicaid eligibility under the Affordable Care Act. For example, if the average Federal share in the State for expenditures in the relevant permissible class in the previous example is 70 percent, then the Federal savings would be $315 million [$450 million * 70 percent].

To calculate the impact in future years, we made the following assumptions. We assumed no new additional waivers would be approved beyond the 8 currently in place. We also assumed that the 8 current waivers would be transitioned to new tax waivers over 2 years, with some States receiving transition periods and some not. We projected that the amount of tax revenues would increase at the same rate as Medicaid spending growth in the budget (based on the projections in the Mid-Session Review of the FY 2025 President's Budget). The Federal share of these impacts was estimated using the average Federal share for each State and service category by tax; this would include adjustments to the base Federal matching rates (notably, the 90 percent matching rate for costs for expansion adults).

We estimate that the proposed rule would reduce Federal Medicaid spending by $33.2 billion from 2026 through 2030 (in 2026 dollars). This estimate accounts for the transition period applicable to four of the eight known tax loophole waivers (as described in Section II.D.), A waiver with its most recent approval date within 2 years before the effective date of a final rule would not be eligible for a transition period. A waiver with its most recent approval date 2 or more years before the effective date of a final rule will have through the end of the first State fiscal year beginning after the effective date of the final rule to come into compliance with the rule's requirements. The annual impacts are shown in Table 4. In addition to the Federal savings, we also project a reduction in State Medicaid expenditures of $18.8 billion over 2026 through 2030. The annual impacts are shown in Table 4.

TABLE 4—PROJECTED IMPACT OF PROPOSED RULE ON MEDICAID EXPENDITURES

[In millions of 2026 dollars]

Year	2026	2027	2028	2029	2030	Total
Federal	−5,600	−6,500	−6,800	−7,000	−7,300	−33,200
State	−3,200	−3,700	−3,800	−4,000	−4,100	−18,800

Because it is possible, and we believe likely, that additional States may implement new taxes that exploit the waiver statistical loophole if current policy is unchanged, and that States may increase the revenues raised by existing taxes, we also developed estimates for an illustrative scenario where additional States submit similar taxes over the next several years. In this scenario, we assumed that 2 States would submit new MCO tax waivers for 2026, and 4 additional States would submit MCO tax waivers each year from 2027 through 2030 (reaching 25 States by 2030). We also assumed that 2 additional States would submit hospital tax waivers each year from 2027 through 2030 (reaching 9 by 2030). We produced estimates for both MCO taxes and hospital taxes based on those for which we have already seen loophole taxes. However, we note that we believe this loophole could be exploited on any permissible class. Tax revenue and burden on the Medicaid program is projected to increase at the same rate as the underlying service spending in Medicaid based on the mid-session review (MSR) 2025 projections. We assume that the impacts on other States are proportional to the largest MCO and hospital taxes currently approved, in the scenarios described herein. For MCO taxes, we assumed that the Medicaid program would account for 99.8 percent of the tax revenue using the loophole, and would account for only 50 percent of the revenue under the proposed policy; we also assumed that the tax revenue attributable to the Medicaid program would be equal to about 23 percent of State Medicaid managed care spending. For hospital taxes, we assumed that the Medicaid program would account for 44 percent of the tax revenue using the loophole and for only 32 percent under the proposed policy; and we assumed that that the tax revenue attributable to the Medicaid program would be equal to about 19 percent of State Medicaid hospital spending. We note again that this scenario does not reflect only the current taxes, but the impact if these taxes are allowed to proliferate. Under the illustrative estimate, the Federal government would avoid $74.6 billion in Medicaid spending over 2026 through 2030 (in real 2026 dollars) and State Medicaid expenditures would be $40.2 billion lower, as shown in Table 5.

TABLE 5—PROJECTED IMPACT OF PROPOSED RULE ON MEDICAID EXPENDITURES UNDER ILLUSTRATIVE SCENARIO

[In millions of 2026 dollars]

Year	2026	2027	2028	2029	2030	Total
Federal	−5,600	−9,600	−14,600	−19,700	−25,100	−74,600
State	−3,600	−5,100	−7,600	−10,400	−13,500	−40,200

1. Transfers (Additional Discussion)

We note that the amounts described in the previous section do not necessarily represent the total Federal burden that may arise from loophole taxes, and therefore the total savings that would result from closing the loophole. As discussed in the preamble section I.C. to this proposed rule, States can and sometimes do use the tax revenue generated by shifting the burden to Medicaid (and therefore onto the Federal government) through the loophole to fund additional payments to providers. Those subsequent payments can again be claimed as expenditures and receive Federal match, thus further increasing Federal spending; to the extent States reduce the revenue collected by provider taxes and in turn reduce Medicaid spending, the impacts on Federal and State Medicaid expenditures may be even higher than what we have estimated here.

However, it should be noted that effects on the Federal budget (as well as the costs to States and taxpaying entities) are highly dependent on how States would respond to these proposed changes. Broadly, we believe States generally have several ways to address these changes, and they are not mutually exclusive, with varying consequences for magnitude of regulatory effects and for who pays and receives transfers. As we estimated previously, States may decide to maintain the current level of revenue in these tax programs, with less revenue based on Medicaid taxable units and the burden distributed across other payers (which could include Medicare for non-MCO taxes—thus generating some tendency toward overestimation in the Federal budget savings estimates appearing elsewhere in this regulatory analysis—and private health insurers). States may choose to reduce or eliminate these taxes and may make up the revenue elsewhere (for example, through other taxes, health care-related or not). States may also opt to reduce spending—in Medicaid or in other parts of the State budget—to account for the decrease in tax revenue. We expect that these decisions will depend on several factors beyond our ability to predict, including: the relative impact these policies have on the State Medicaid program and overall State budgets; the response from other health care payers and providers of potentially higher tax burdens; and impacts on other entities, including on providers and beneficiaries in the State. We seek comments on how affected States would respond to these proposed changes.

2. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume the following entities will review: State Medicaid Agencies, State governments, MCOs, and health care providers. We assume at least three people at every State Medicaid Agency (56) will review and two people in every State and territory government (56), for a total of 280 reviewers. We then estimate an additional 20 reviewers in every State Medicaid Agency affected by these policies, as well as 1,124 members across seven State Legislatures, for a total of 1,544 reviewers. It is more difficult to predict how many individuals in how many MCOs and providers will review, so we are therefore doubling the number from the previous estimate, for 3,088 total reviewers. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule. We also recognize that this is a relatively short proposed rule with a single policy focus, and therefore for the purposes of our estimate we assume that each reviewer reads 100 percent of the rule. We seek comments on this assumption.

Using the wage information from the BLS (*https://www.bls.gov/oes/tables.htm*) for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $132.44 per hour, including overhead and fringe benefits. Assuming an average reading speed, we estimate that it would take approximately 2 hours for each person to review this proposed rule. For each person that reviews the rule, the estimated cost is $264.88 (2 hours × $132.44). Therefore, we estimate that the total cost of reviewing this regulation is $0.8 million ($264.88 × 3,088).

D. Alternatives Considered

We considered replacing the B1/B2 with another statistical test (discussed in more detail below) for all waivers of the uniformity requirements. Updating the statistical test to one that directly reflected Medicaid burden would have several advantages. First, it would have been administratively simple for CMS to implement, where one test would merely be replaced by another during a waiver review. Second, it would have had the clear effect of eliminating the statistical loophole. Third, it would have been a purely statistical test that would not require a separate decision-making process on the part of CMS.

This test would have measured Medicaid's proportion of the total business (numerator) compared to Medicaid's share of the expected total tax revenue (denominator). For example, suppose a tax on nursing facilities existed where there were 390,000 total bed days of which 330,000 bed days were Medicaid-paid bed days. Divide the second number 330,000 by the first number, 390,000 to receive a percentage of approximately 84.6 percent Medicaid bed days. Assume further that the total tax revenue collected was $11,000,000. Assume that the total tax amount collected based on Medicaid taxable units was $9,000,000. Divide the second number $9,000,000 by the first number $11,000,000, to receive a percentage of approximately 81.81 percent of tax revenue derived from Medicaid taxable units. Divide the first percentage, 84.6 percent, by the second percentage, 81.81 percent, to arrive at the final percentage, 103.41 percent.

We also considered various figures that would have represented a ''passing'' (that is, approvable) figure under this test, including 90 percent, or 95 percent, which may have allowed more existing taxes that do not exploit the loophole to pass. However, we ultimately decided against proposing this overall new statistical test option

for several reasons. First, we felt that this test would have been unnecessarily disruptive to our existing approved health care-related taxes with broad-based or uniformity waivers, many of them longstanding. Several of these waivers that did not exploit the statistical loophole would have failed this test, such as some nursing facility taxes, possibly due to excluding Medicare or other permissible differences in tax structure. We realize that States and have become accustomed to the B1/B2 test over a long period of time and wanted to solve the tax loophole issue while being minimally disruptive to their legislative and regulatory activities related to the Medicaid program, including their programs of health care-related taxes that do not exploit the statistical loophole. Finally, we realized that if we set the passing figure too low, several taxes that are exploiting the loophole would be able to continue with their tax programs that are not generally redistributive. We did not want to undertake a change that would not close the loophole completely or that risked opening a new one. In addition, through our experience of testing this new statistical test, we assessed the disruption to existing taxes and State processes that would result from replacing the B1/B2 test, regardless of the specific details of that test. As a result, we did not contemplate alternate statistical methodologies or tests.

In addition to the wholesale replacement of the B1/B2 by this new statistical test for all waivers of the uniformity requirement, we also considered various limiting conditions to the universe of tax waivers to which it would apply. For example, we considered having this new test apply only to taxes on services of MCOs, since most of the loophole exploiting taxes fall in this permissible class. However, there is at least one tax that we know of on hospitals that has different, higher, tax rates for Medicaid-payable days than non-Medicaid payable days. We wanted a fix that would cover this tax as well, because we believe that the higher rate imposed on Medicaid taxable units is not consistent with the statutory requirement that health care-related taxes for which waivers are approved must be generally redistributive. Additionally, applying this test only to MCOs would have left the Federal government open to future State tax waiver proposals that used the B1/B2 loophole in other permissible classes, including but not limited to inpatient hospital services and outpatient hospital services. In this proposed rule, we aim to be as comprehensive as possible to reduce the necessity of pursuing further rulemaking in this area in the short-term.

We also considered proposing this new statistical test discussed in the prior paragraphs, but proposing to apply it only to taxes that had separate tax rates for Medicaid taxable units compared to non-Medicaid taxable units, or separate tax rates for providers with Medicaid taxable units compared to providers with taxable non-Medicaid units. For example, a tax that had a rate of $20 per Medicaid-paid bed day compared to $2 per non-Medicaid paid bed day would fall under this category. To take another example, providers with more than 100 Medicaid bed days are taxed $20 per bed day compared to providers with less than 100 Medicaid bed days are taxed $2 per bed day. This would have been similar in scope to our current proposal. First, we would have still needed to adopt some kind of ''Medicaid substitute'' provision similar to § 433.68(e)(3)(iii) to address situations where the State did not use the word ''Medicaid'' in their descriptions but achieved the same effect. Second, we believe that this approach would have been somewhat confusing for States to implement. It would have required a longer learning process while we instructed States how to conduct the test. We wanted to adopt the simplest, most straightforward option. As a result, we decided against adopting this test into regulation to measure whether a tax waiver is ''generally redistributive'' in any format at the present time.

In addition, we considered not proposing that Medicaid proxies be addressed at all in this regulation. Up until this point, we have not received any proposals that we would consider to be ''Medicaid substitutes'' in the context of the B1/B2 loophole. However, up until this point, States have had no incentive for taxes that use the B1/B2 loophole not to describe groups using the word ''Medicaid.'' Under the provisions in this proposed rule, if finalized, they would have that incentive since, absent the ''substitute'' provision, the new regulation would apply only to States that explicitly target Medicaid. While closing one loophole, we did not wish to open another one with the exact or very similar effect as the first loophole. We believe that leaving the door open to this kind of manipulation would undermine the entire purpose of this rulemaking. We attempted to be as comprehensive as possible to foreclose the necessity of future rulemaking in the near-term if we were able to identify and preemptively prevent any serious deficiencies. This helps to create a stable, level, regulatory framework, reducing the needs for updates and changes. This is beneficial for both CMS and the States. States have a clear expectation of the regulatory framework within which they operate and can plan their budgets and legislative sessions accordingly. And CMS does not need to undertake new rulemaking soon after concluding prior rulemaking on the same subject. As a result, we felt that proposing the ''Medicaid substitute'' provision was necessary to make sure we were capturing the full universe of problematic practices that result in tax waivers that are not generally redistributive and effectively close the regulatory loophole.

As a result, we believe that the option we chose to propose mandating that Medicaid taxable units not be taxed at a higher rate than the rate imposed on any taxpayer or tax rate group based on non-Medicaid taxable units had several advantages. First, it removes the full universe of current taxes that exploit the statistical loophole. Second, it is narrowly tailored only to those taxes that exploit the statistical loophole. Third, it is not unnecessarily disruptive on States with currently approved tax waivers of the uniformity requirement that do not exploit the statistical loophole. All those factors, combined, make it the option that we have proposed.

Finally, we considered alternatives to our approach in the transition period section. Within that section, we have proposed some alternatives on which we invite comment, including no transition period for any waivers. We are confident that all States engaged in this practice are aware they are exploiting a loophole, and no transition period aligned with our intent to close the loophole as quickly as possible. However, we ultimately decided to initially propose a short transition period for waivers we had not approved most recently and therefore had not communicated with the State about this specific issue as recently. We also considered longer timeframes for transition periods for all waivers, but we did not want to extend the time that these loopholes are burdening the Medicaid program any longer than necessary. Finally, we considered associating the length of transition periods to how long the tax has been in place.

E. Accounting Statement and Table

Consistent with OMB Circular A–4 (available at *https://www.reginfo.gov/public/jsp/Utilities/a-4.pdf*), we have

prepared an accounting statement in Table 6 showing the classification of the impact associated with the provisions of this proposed rule or final rule.

TABLE 6—ACCOUNTING TABLE

Category	Estimate	Year dollar	Discount rate	Period covered	
Collection of Information Requirements:					
Total	$30,003	2025	N/A	One-time.	
State	$15,001	2025	N/A	One-time.	
Regulatory Review Costs:	$0.8 million	2025	N/A	One-time.	
Transfers:					
Annualized Monetized (Federal, $/year)	$6,587 million	2026	7 percent	2026–2030.	
	$6,617 million	2026	3 percent	2026–2030.	
Annualized Monetized (non-Federal, $/year)	$3,731 million		2026	7 percent	2026–2030
	$3,748 million		2026	3 percent	2026–2030

Quantitative:

• Estimated reduction in transfers from Federal government to States, ranging from $5,600 million to $7,300 million per year over 2026 through 2030, reflecting reduced Medicaid payments associated with certain health care-related taxes.

• Estimated reduction in transfers from State governments to other payers (for example, private insurance sponsors), ranging from $3,200 million to $4,100 million per year from 2026 through 2030, reflecting reduced Medicaid payments associated with certain health care-related taxes.

F. Regulatory Flexibility Act (RFA) and Section 1102(b) of the Social Security Act

Effects on Health Care Providers

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that many of the health care providers subject to health care -related taxes are small entities as that term is used in the RFA (include small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $9.0 million to $47.0 million in any 1 year).

Individuals and States are not included in the definition of a small entity. This proposed rule, if finalized, will not have a significant impact measured change in revenue of 3 to 5 percent on a substantial number of small businesses or other small entities. We do not anticipate that States will seek to rebalance the revenues to that extent through small entities, as the permissible classes affected by this rule are not small entities. Nearly all of the taxes that this policy will end are taxes on MCOs. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the requirements in this proposed rule. Therefore, the Secretary has certified that this proposed rule will not have a significant economic impact on a substantial number of small entities. We seek comments on this assessment.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We do not believe this rule will have a significant impact on small rural hospitals. Although as stated previously we cannot predict the ways a State may respond to the cessation of a Federal funding stream, we do not anticipate based on the requirements in this rule those revenues will be sought from small, rural hospitals, as States often seek to insulate these providers from increased costs. Therefore, the Secretary has certified that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $187 million. The UMRA's analysis requirement is met by the analysis included in section V. of this proposed rule, conducted per E.O. 12866. This proposed rule does not mandate any requirements for local, or tribal governments, or for the private sector. Costs may shift from the Federal government to States.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Allowing States to continue to exploit a loophole in current regulations undermines the statutory framework, and, as GAO has noted, undermines the cooperative Federalism that lies at the heart of the Medicaid program.[22] For this reason, CMS believes that it is necessary to address the statistical loophole to ensure fiscal integrity of the Medicaid program.

Hence, this rule does not impose substantial direct costs on State or local governments, preempt State law, or otherwise have Federalism implications.

I. Conclusion

The policies in this proposed rule, if finalized, will enable us to ensure FFP is distributed equitably and as intended and contemplated by statute.

[22] GAO–08–650T ''Medicaid Financing Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight'' April 3, 2008.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Mehmet Oz, MD, Administrator of the Centers for Medicare & Medicaid Services, approved this document on May 9, 2025.

List of Subjects in 42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs—health, Medicaid, Reporting, and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR Chapter IV as set forth below:

PART 433—STATE FISCAL ADMINISTRATION

■ 1. The authority citation for part 433 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 2. Amend § 433.52 by adding the definitions of ''*Medicaid taxable unit*'', ''*Non-Medicaid taxable unit*'' and ''*Tax rate group*'' in alphabetical order to read as follows:

§ 433.52 General definitions.

* * * * *

Medicaid taxable unit means a unit that is being taxed within a health-care related tax that is applicable to the Medicaid program. This could include units that are used as the basis for Medicaid payment, such as Medicaid bed days, Medicaid revenue, costs associated with the Medicaid program such as Medicaid charges, or other units associated with the Medicaid program.

Non-Medicaid taxable unit means a unit that is being taxed within a health-care related tax that is not applicable to the Medicaid program. This could include units that are used as the basis for payment by non-Medicaid payers, such as non-Medicaid bed days, non-Medicaid revenue, costs that are not associated with the Medicaid program, or other units not associated with the Medicaid program.

* * * * *

Tax rate group means a group of entities contained within a permissible class of a health care-related tax that are taxed at the same rate.

■ 3. Amend § 433.68 by—

■ a. Revising paragraphs (e) introductory text, (e)(1)(ii), (e)(1)(iii) introductory text, (e)(1)(iv) introductory text, (e)(2)(ii) and (e)(2)(iii) introductory text; and

■ b. Adding paragraphs (e)(3) and (e)(4).

The revision and additions read as follows:

§ 433.68 Permissible health care-related taxes.

* * * * *

(e) *Generally redistributive.* A tax will be considered to be generally redistributive if it meets the requirements of this paragraph (e). If the State requests waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraphs (e)(1) and (3) of this section. If the State requests waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraphs (e)(2) and (3) of this section.

(1) * * *

(ii) If the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 1, and satisfies the requirements of paragraphs (e)(3) and (f), the tax waiver is approvable.

(iii) If a tax is enacted and in effect prior to August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.90, CMS will review the waiver request. Such a waiver will be approved only if, in addition to satisfying the requirement at paragraphs (e)(3) and (f), the following two criteria are met:

* * * * *

(iv) If a tax is enacted and in effect after August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.95, CMS will review the waiver request. Such a waiver request will be approved only if, in addition to satisfying the requirement at paragraphs (e)(3) and (f), the following two criteria are met:

(2) * * *

(ii) If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 1, and satisfies the requirements of paragraphs (e)(3) and (f), the tax waiver is approvable.

(iii) If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 0.95, CMS will review the waiver request. Such a waiver will be approved only if, in addition to satisfying the requirement at paragraphs (e)(3) and (f), the following two criteria are met:

* * * * *

(3) *Additional requirement to demonstrate a tax is generally redistributive.* This paragraph (e)(3) applies on a per class basis. Regardless of whether a tax meets the standards in paragraphs (e)(1) and (2), the tax is not generally redistributive if:

(i) Within a permissible class, the tax rate imposed on any taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable units (except as a result of excluding from taxation Medicare revenue or payments as described in paragraph (d) of this section). For example, a tax on MCOs where Medicaid member months are taxed $200 per member month whereas the non-Medicaid member months are taxed $20 per member month would violate the requirements of paragraph (e)(3)(i).

(ii) Within a permissible class, the tax rate imposed on any taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer or tax rate group defined by its relatively higher volume or percentage of Medicaid taxable units. For example, a tax on nursing facilities with more than 40 Medicaid-paid bed days of $200 per bed day and on nursing facilities with 40 or fewer Medicaid-paid bed days of $20 per bed day would violate the requirements of paragraph (e)(3)(ii). As an additional example, a tax on hospitals with less than 5 percent Medicaid utilization at 2 percent of net patient service revenue for inpatient hospital services, and on all other hospitals at 4 percent of net patient service revenue for inpatient hospital services would also violate the requirements of paragraph (e)(3)(ii).

(iii) The tax excludes or imposes a lower tax rate on a taxpayer or tax rate group defined by or based on any characteristic that results in the same effect as described in paragraph (e)(3)(i) or (ii). Characteristics that may indicate this type of violation exists include:

(A) Use of terminology to establish a tax rate group based on Medicaid without explicitly mentioning Medicaid to accomplish the same effect as described in paragraphs (3)(i) or (ii) for a tax rate group. For example, a tax on inpatient hospital service discharges that imposes a $10 rate per discharge associated with beneficiaries covered by a joint Federal and State health care program and a $5 rate per discharge associated with individuals not covered by a joint Federal and State health care program would violate this requirement, because joint Federal and State health care program describes Medicaid and a higher tax rate is imposed on Medicaid discharges than on discharges for individuals not covered by a joint Federal and State health care program.

(B) Use of terminology that creates a tax rate group that closely approximates Medicaid, to the same effect as described in paragraphs (3)(i) or (ii). For example, a tax on hospitals located in counties with an average income less

than 230 percent of the Federal poverty level of $10 per inpatient hospital discharge, while hospitals in all other counties are taxed at $5 per inpatient hospital discharge, would violate this requirement, because the distinction being drawn between tax rate groups is associated with a Medicaid eligibility criterion with a higher tax rate imposed on the tax rate group that is likely to involve more Medicaid taxable units.

(4) *Transition Period.* (i) States with health care-related tax waivers that do not meet the requirements of paragraph (e)(3), where the date of the most recent approval of the waiver that violates paragraph (e)(3) occurred 2 years or less before [EFFECTIVE DATE OF A FINAL RULE], are not eligible for a transition period. Any collections made under that waiver following [EFFECTIVE DATE OF A FINAL RULE] may be subject to deduction from medical assistance expenditures as described in § 433.70(b).

(ii) States with health care-related tax waivers that do not meet the requirements of paragraph (e)(3), where the date of the most recent approval of the waiver that violates paragraph (e)(3) occurred more than two years before prior to [EFFECTIVE DATE OF A FINAL RULE], must either:

(A) Submit a health care-related tax waiver proposal that complies with paragraph (e)(3) with an effective date no later than the start of the first State fiscal year beginning at least one year from [EFFECTIVE DATE OF A FINAL RULE]; or

(B) Otherwise modify the health care-related tax to comply with this rule and all other applicable Federal requirements with an effective date not later than the start of the first State fiscal year beginning at least one year from [EFFECTIVE DATE OF A FINAL RULE].

(iii) Once the transition period for a tax waiver that qualifies under paragraph (e)(4)(ii) has expired, CMS may deduct from a State's medical assistance expenditures revenues from health care-related taxes that do not meet the requirements of paragraph (e)(3) as specified by section 1903(w)(1)(A)(iii) of the Act and § 433.70(b).

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2025–08566 Filed 5–12–25; 4:15 pm]

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DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Parts 32 and 71

[Docket No. FWS–HQ–NWRS–2025–0031; FXRS12610900000–256–FF09R20000]

RIN 1018–BI01

National Wildlife Refuge System; 2025–2026 Station-Specific Hunting and Sport Fishing Regulations

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), propose to open or expand hunting or sport fishing opportunities on 16 National Wildlife Refuge System (NWRS) stations and 1 National Fish Hatchery System (NFHS) station. This includes inaugural hunting opportunities at Southern Maryland Woodlands National Wildlife Refuge (NWR), the newest addition to the NWRS, and the formal opening of hunting opportunities at Grasslands Wildlife Management Area (WMA), as well as inaugural sport fishing at North Attleboro National Fish Hatchery (NFH). These actions will open or expand 42 opportunities for hunting and fishing across more than 87,000 acres of Service lands and waters. In addition, at the request of the State of Minnesota and the White Earth Nation, Tamarac NWR proposes to end an experimental 5-day early teal hunt where the refuge overlaps with Tribal land to ensure safety for wild rice harvesting and to align with State regulations. We also propose to make administrative changes to existing station-specific regulations to improve the clarity and accuracy of regulations, reduce the regulatory burden on the public, and comply with a Presidential mandate for plain-language standards.

DATES: We will accept comments received or postmarked on or before June 30, 2025.

Information collection requirements: If you wish to comment on the information collection requirements in this proposal, alongside proposed revisions and additions to the Code of Federal Regulations (CFR), please note that the Office of Management and Budget (OMB) is required to make a decision concerning the collection of information contained in this proposal between 30 and 60 days after the date of publication in the **Federal Register**. Therefore, comments should be submitted to the Service Information Collection Clearance Officer, U.S. Fish and Wildlife Service, (see ''*Information collection requirements*'' below under **ADDRESSES**) by July 15, 2025.

ADDRESSES:

Written comments: You may submit comments by one of the following methods:

- *Electronically:* Go to the Federal eRulemaking Portal: *https://www.regulations.gov.* In the Search box, type in FWS–HQ–NWRS–2025–0031, which is the docket number for these proposed revisions and additions to the CFR. Then, click on the Search button. On the resulting screen, find the correct document and submit a comment by clicking on ''Comment.''
- *By hard copy:* Submit by U.S. mail or hand delivery: Public Comments Processing, Attn: FWS–HQ–NWRS–2025–0031, U.S. Fish and Wildlife Service, 5275 Leesburg Pike, MS: PRB (JAO/3W), Falls Church, VA 22041–3803.

We will not accept email or faxes. We will post all comments on *https://www.regulations.gov.* This generally means that we will post any personal information you provide us (see Request for Comments, below, for more information).

Supporting documents: For information on a specific refuge's or hatchery's public use program and the conditions that apply to it, contact the respective regional office at the address or phone number given in Available Information for Specific Stations under **SUPPLEMENTARY INFORMATION**.

Information collection requirements: Send your comments on the information collection request by mail to the Service Information Collection Clearance Officer, U.S. Fish and Wildlife Service, by email to *Info_Coll@fws.gov;* or by mail to 5275 Leesburg Pike, MS: PRB (JAO/3W), Falls Church, VA 22041–3803. Please reference OMB Control Number 1018–0140 in the subject line of your comments.

FOR FURTHER INFORMATION CONTACT: Christian Myers, (571) 422–3595. Please see Docket No. FWS–HQ–NWRS–2025–0031 on *https://www.regulations.gov* for a document that summarizes these proposed revisions and additions to the CFR.

SUPPLEMENTARY INFORMATION:

Background

The National Wildlife Refuge System Administration Act of 1966 (16 U.S.C. 668dd–668ee), as amended (Administration Act), closes NWRs in all States except Alaska to all uses until opened. The Secretary of the Interior (Secretary) may open refuge areas to any use, including hunting and/or sport