CMS Final Rule: Narrowing "Uniformity Waivers" for Medicaid Provider Taxes

H.R. 1 Implementation Explainer: February 2026

The 2025 budget reconciliation law (H.R. 1) imposes major new restrictions on states' ability to generate Medicaid provider tax revenue, including by narrowing states' ability to obtain so-called "uniformity waivers." On February 2, 2026, the Centers for Medicare and Medicaid Services (CMS) issued a final rule dictating how the agency will implement these new restrictions. Below is a detailed explanation of Medicaid provider taxes, uniformity waivers and the implications of CMS' new rule on states.

Medicaid provider taxes, uniformity waivers and new H.R. 1 restrictions

All states but Alaska levy taxes on health care providers to help finance the state's share of Medicaid spending. Federal rules require provider taxes to be broad-based and uniform: If a state is taxing hospitals, for example, then it must equally tax all hospitals across the state.[1] Many states have sought CMS' permission to waive these federal rules, allowing states to structure taxes in a nonuniform way, often to achieve important policy goals, for example to limit tax burden on vulnerable safety net hospitals or hospitals in rural areas.[2] However, states have also sought uniformity waivers to allow them to impose a higher tax on Medicaid providers: Hospitals with higher Medicaid patient volume, for example, have a higher tax rate than hospitals with lower volume. Starting July 4, 2025, H.R. 1 largely prohibits states from assessing higher or lower tax rates based on Medicaid revenue or patient volume.

CMS' final rule: at least nine taxes impacted across seven states

CMS' final rule modifies the statistical formula used by the agency to determine whether a provider tax inappropriately places a higher tax on Medicaid providers in violation of H.R. 1.[3] CMS has used this new formula to identify at least nine current provider tax waivers no longer considered compliant. The final rule grants a short transition period for states to modify any noncompliant taxes; the length of transition is specific to tax type and/or waiver approval date.

Provider Taxes Impacted by CMS' Final Rule		
Tax Type	**Impacted States**	**Transition**
Managed care organization (MCO) *CMS waiver approval* ***after*** *April 3, 2024*	The final rule confirms that ***four states*** have noncompliant MCO tax waivers subject to a shorter transition period (see section below for details). CMS previously identified four states with non-compliant MCO taxes:[4] **California**,[5] **Massachusetts**,[6] **Michigan**[7] and **New York**,[8] all of which received CMS approval after April 3, 2024.	Prior to January 1, 2027
MCO *CMS waiver approval* ***before*** *April 3, 2024*	According to CMS, ***three additional states*** have noncompliant MCO taxes subject to a longer transition, but the agency has not named these states publicly. Researchers have identified **Illinois**,[9] **Ohio**,[10] and **West Virginia**[11] as having problematic MCO tax waivers.[12] All of these states received CMS approval before 2024.	Prior to State Fiscal Year 2028[13]
Other health care providers *Approved by CMS at any time*	CMS indicates that ***one hospital*** tax and ***one nursing facility*** tax from the same above seven states are noncompliant. CMS has not named these states publicly, but **Illinois** has indicated its nursing facility tax is not in compliance,[14] and sources have identified **California** as having the problematic hospital tax.[15]	Prior to State Fiscal Year 2029

Impact on Medicaid MCO provider taxes

While the final rule affects taxes on all provider types, it largely impacts taxes on MCOs. Several states turned to taxing MCOs in response to COVID-era budget pressures, but some of these states, in compromise after push-back from insurers, had to seek uniformity waivers to permit MCOs with a lower percentage of Medicaid beneficiaries to pay a significantly reduced tax rate.[16] In recent years, CMS made clear to states its discomfort with this waiver practice, putting certain states on notice that it intended to tighten its criteria for uniformity waiver approval (for example, see CMS' letter to California from 2024[17]). While H.R. 1 allows for transition periods up to three years, CMS has set a shorter transition through its final rule for those states that received written notice of impending changes.

Additional provider taxes at risk

Importantly, the final rule indicates that there may be one additional noncompliant nursing facility tax (beyond the one identified above) and leaves open the possibility that CMS could identify additional taxes that violate the narrower uniformity waiver criteria in the future. However, CMS anticipates this final rule will impact only a small number of provider tax waivers overall.

State responses

Impacted states — particularly those with noncompliant MCO taxes — will need to adjust their tax structures within tight timeframes to maintain federal approval or risk losing billions of dollars in federal matching funds. According to CMS, the nine noncompliant taxes account for an estimated **$24 billion in revenue that supports Medicaid programs in impacted states.**

Estimated Annual Revenue From Impacted Provider Tax[18]

State	Tax Amount
CA	**MCO**: $7.5-$9 billion[19] **Hospital**: $5.9 billion[20]
IL	**MCO**: $1.5 billion21 **Nursing**: $348 million[22]
MA	**MCO**: $625 million[23]

State	Tax Amount
MI	**MCO**: $630-$650 million[24]
NY	**MCO**: $3.7 billion[25]
OH	**MCO**: $880 million[26]
WV	**MCO**: $59.8 million[27]

Coming into compliance will mean states have to decrease tax rates for Medicaid providers, increase rates on other providers, or implement some combination of these to bring uniformity to their tax rates. While some states have already found a pathway forward — in October 2025, **Michigan** passed legislation to preserve the state's Medicaid MCO tax by increasing taxes on commercial plans[28] — other states are facing challenges. Current **California** law, for example, limits the state's ability to increase taxes on commercial insurers,[29] and **Ohio** has faced challenges in previous attempts to broaden its MCO tax to more health insurers.[30] Despite political and legal hurdles, states are actively working to maintain their provider tax base, and lawmakers in **West Virginia** and **Illinois** have introduced legislation on this issue.[31]

Impact on state Medicaid budgets

CMS assumes that the only pathway forward for at least some of the impacted states will be to lower tax rates on Medicaid providers, meaning states will have less overall funding to support their Medicaid program. As a result, CMS estimates a **$9.6 billion reduction in state and federal Medicaid expenditures in 2027, growing to $15.1 billion by 2032.** Importantly, this does not mean state Medicaid programs have to shrink by this amount. If a state can determine ways to finance Medicaid by other permissible sources (generating other tax revenue or shifting budget resources toward Medicaid), it can recoup some or all of the lost Medicaid funding.

Interaction with other H.R. 1 provider tax provisions

In addition to narrowing uniformity waiver criteria, H.R. 1 prohibits states both from establishing any new provider taxes and increasing the rates of existing ones. CMS clarifies that any tax adjustment made during the uniformity waiver transition period will not violate H.R. 1's general provider tax moratorium. This allows **Michigan**, for example, to increase taxes on commercial plans. However, because all states in question here have expanded Medicaid under the Affordable Care Act's Medicaid expansion, H.R. 1 requires these states to reduce hospital, MCO and certain other provider taxes down to 3.5% by 2032. **California** and **Illinois** both have an MCO tax rate over 3.5%,[32] meaning these states will face additional reductions to their MCO provider tax base going forward.[33]

Next steps for advocates:

- **Provider tax transitions:** States needing to adjust their provider taxes must submit new waivers to CMS for approval.[34] **Michigan** is reportedly already in the waiver submission process.[35] Advocates in impacted states can help build political will and stakeholder support for necessary tax policy changes.
- **Provider tax rulemaking:** CMS will soon issue a proposed rule on H.R. 1's other provider tax provisions. Advocates should remain engaged here and be ready to comment on how H.R. 1's provider tax changes impact their state.
- **State budgets:** Advocates should work with state policymakers to model the fiscal impact of reduced provider taxes (both from the uniformity waiver change and the general provider tax moratorium) and remain engaged as states navigate budget shortfalls and make difficult decisions about Medicaid benefits and access.

Endnotes

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[18] Note: These annual tax estimates do not exactly match the projections CMS uses in its final rule. For the seven noncompliant MCO taxes, CMS estimates these bring in a total revenue of $18.5 billion annually. Based on state-level information, the total shown in the table is $15.4 billion. CMS estimates $5.1 billion in annual revenue from the one noncompliant hospital tax, but the California estimates cited in the table are $5.9 billion. CMS estimates $0.34 billion for the noncompliant nursing facility tax, and Illinois estimates cited in the table are approximately the same.

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[33] Six of the seven states discussed in this brief (all but West Virginia) have hospital provider taxes above 3.5%, meaning these taxes will start coming down starting in fiscal year 2028. California, Massachusetts, and West Virgina all have ambulance provider taxes above 3.5%. Nursing home taxes are not subject to the 3.5% cap, so Illinois's nursing home tax will not face any reductions under the law. Burns et al., "5 Key Facts About Medicaid and Provider Taxes."

[34] States can also transition taxes fully to comply with federal broad-based and uniformity requirements so that they do not need a waiver in the first place.

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