National Rural Health Association

July 14, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-2448-P; Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole Proposed Rule

Comment submitted electronically via regulations.gov

Dear Administrator Oz,

The National Rural Health Association (NRHA) thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to provide comments on the proposed rule, *Preserving Medicaid Funding for Vulnerable Populations*. Medicaid is a critical source of coverage for rural residents and a major payer for rural providers.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Medicaid plays an outsized role in rural areas compared to urban areas. In 2023, almost one fifth of rural adults and almost half of rural children were insured by Medicaid or CHIP.[1] As a result, rural providers greatly rely upon Medicaid reimbursement as a source of financing. For example, the average rural hospital sees about 20% of its revenue come from Medicaid.[2] Overall, public payers comprise a larger share of hospital services in rural areas, making rural hospitals acutely vulnerable to cuts or changes in Medicaid or Medicare.[3]

Modifying the structure of provider taxes, as outlined in the recently passed *H.R.1 One Big Beautiful Bill Act* (OBBBA) and contemplated in this proposed rule, will harm rural providers and patients alike. Lowering Medicaid payments to providers ultimately threatens access to care, particularly in rural areas where Medicaid is a dominant payer.

[1] Joan Alker, Aubrianna Osorio, & Edwin Park, *Medicaid's Role in Small Towns and Rural Areas*, Georgetown Center for Children and Families, Jan. 15, 2025, https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.
[2] Zachary Levinson, et al., *Key Facts About Hospitals: Rural Hospitals*, KFF, Feb. 19, 2025, https://www.kff.org/key-facts-about-hospitals/?entry=rural-hospitals-rural-discharges-by-payer.

[3] Manatt Health, Estimated Impact on Medicaid Enrollment and Hospital Expenditures in Rural Communities, (June 20, 2025), chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ruralhealth.us/getmedia/f79547dc-19b6-4f39-ac95-4f24ba0e0a84/OBBB-Impacts-On-Rural-Communities_06-20-25-final_v3-(002).pdf (accessed June 14, 2025).

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According to the Government Accountability Office, 17% of overall state Medicaid funds come from provider taxes.[4] In this rule, CMS proposes to close loopholes around certain provider tax arrangements. Currently, provider taxes must be broad-based and uniform, but states are able to apply for waivers of these requirements so long as the provider taxes are "generally redistributive".[5] CMS proposes to tighten the definition of generally redistributive by prohibiting provider taxes that impose a lower tax rate on providers based on lower Medicaid volumes compared to those with higher Medicaid volumes or that tax Medicaid units, such as bed days or member months, at a higher rate than non-Medicaid units. Further, CMS clarifies that any provider tax that would have the same effect as those two prohibitions would not be permissible. CMS found that prohibiting these waivers would impact 7 states.

Medicaid funding is critical for sustaining rural healthcare systems, including hospitals, clinics, community health centers, long-term care facilities, and EMS agencies. Right now, almost half of all rural hospitals across the country are operating with negative margins,[6] meaning that any reductions to Medicaid reimbursement may force facilities to reduce or eliminate essential services, delay much-needed equipment upgrades, or close their doors entirely. Since 2010, nearly 190 rural hospitals have shuttered their doors or stopped inpatient care.[7]

Coupled with Medicaid provider tax changes in OBBBA, many states will be severely limited in their ability to adequately fund their Medicaid programs. State budgets are already strained, and restricting legitimate funding mechanisms may mean reductions to Medicaid services, cuts elsewhere in state budgets, and/or increases in state and local taxes. Cuts to benefits and services in Medicaid will not only directly impact enrollees, but the rural health care infrastructure who cares for those patients. Many rural providers already operate on thin margins and are forced to do more with less to keep access available in their areas. Significant limitations on Medicaid provider taxes may ultimately lead to service line reductions or closures, worsening rural access to care. Reduced access to care will impact all rural patients, not just Medicaid enrollees.

Given the significance of Medicaid in rural areas and provider taxes as a funding mechanism for Medicaid, **we urge the agency to protect rural providers and patients from losing access to care.**

We understand that a substantially similar provision was included and passed in the OBBBA, therefore CMS is obligated to finalize this policy in some form. Therefore, we ask that **CMS provide all states with an extended transition period to comply with the proposed changes,** regardless of when a state's provider tax arrangement was approved. We ask that CMS finalize a 3-year transition period for all impacted states. CMS proposes to allow certain states a one-fiscal year transition period to get a new compliant waiver approved but would not offer this transition period to states that have received approvals within the past two years. NRHA does not believe that a one-year transition period is sufficient to create or revise provider taxes, which typically need state legislature approval. Several predominately rural states have state legislatures that only meet every 2 years, further complicating this transition period.[8] States that are not eligible for a transition period are at a major disadvantage because their

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[4] Government Accountability Office, *CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight* (Dec. 2020), 17, https://www.gao.gov/assets/gao-21-98.pdf.
[5] 42 C.F.R. 433.68(e).
[6] Michael Topchik, et al., *2025 rural health state of the state*, Chartis Center for Rural Health (2025), 4, https://www.chartis.com/sites/default/files/documents/CCRH%20WP%20-%202025%20Rural%20health%20state%20of%20the%20state_021125.pdf.
[7] Rural Hospital Closures, N.C. Rural Health Research Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
[8] https://www.billtrack50.com/info/blog/how-legislative-sessions-work#:~:text=Every%20other%20year%20sessions,Special%20Sessions

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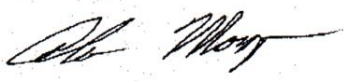
waivers that do not comply with this proposed regulation would be subject to deductions until they can make necessary changes.

Thank you for the opportunity to respond to this proposed rule. We look forward to working together to protect rural patients and providers across the country. If you have any questions or would like further information, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us).

Sincerely,



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