The Great Provider Tax Squeeze: Wha the November CMS Guidance Means f Health Tech Investors

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Abstract

On November 14, 2025, CMS released guidance on two critical provisions from t Working Families Tax Cuts Legislation (WFTCL) that fundamentally reshape Medicaid provider tax policy. This essay examines:

- The mechanics of the new indirect hold harmless thresholds under Section 711 which effectively freeze most state provider taxes at July 4, 2025 levels

- The closure of the “statistical loophole” under Section 71117 that allowed state shift Medicaid costs disproportionately to federal taxpayers

- Specific implications for managed care organizations, hospitals, nursing facilit and other provider classes

- Second-order effects on Medicaid managed care rates, provider payment model state budget dynamics

- Investment opportunities and risks across digital health verticals including car delivery platforms, revenue cycle management, and healthcare infrastructure

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When most health tech investors think about Medicaid policy changes, they typi focus on eligibility expansions, benefit modifications, or new alternative paymen models. Provider taxes occupy this weird corner of healthcare finance that most people outside state budget offices and CMS actuaries never think about, which exactly why the November fourteenth CMS guidance on the Working Families T Cuts Legislation deserves way more attention than it's getting. This isn't some ar technical adjustment that only matters to state Medicaid directors. This is a fundamental restructuring of how roughly thirty to forty billion dollars annually through the Medicaid financing system, and it's going to create both massive headwinds and surprising tailwinds for different categories of health tech compa over the next three to five years.

Before we get into what changed, let me explain what provider taxes actually are why they matter so much. States contribute the non-federal share of Medicaid spending, which depending on the state's Federal Medical Assistance Percentage ranges from about twenty-two percent in wealthy states like Massachusetts to somewhere in the mid-twenties to low thirties in most states. The federal goverr picks up the rest through matching funds. States have always looked for creative to maximize federal matching dollars while minimizing their actual out-of-pock

contribution, and provider taxes became the most popular mechanism for this financial engineering.

Here's how the basic scheme works. A state imposes a tax on hospitals or nursing homes or managed care organizations within its borders. Let's say California taxes hospitals three percent of their net patient revenue, generating maybe two billion dollars. California then uses that two billion as its state share to draw down federal Medicaid matching funds at whatever the FMAP rate is, let's call it fifty percent for simplicity. So California puts in two billion, the feds put in two billion, and now there's four billion in the Medicaid budget. California then increases Medicaid rates to hospitals by enough that the hospitals get back more than they paid in taxes. The hospitals pay two billion in taxes but get back maybe two point three billion in higher Medicaid payments. The hospitals are net positive by three hundred million, California's general fund didn't actually contribute anything because the provider tax covered the state share, and the federal government just sent California an extra billion dollars.

This is an incredibly simplified version and there are lots of nuances about how money flows and who benefits, but that's the core dynamic. The federal government recognized this was happening and tried to put guardrails around it through the hold harmless provisions in Section 1903(w) of the Social Security Act. The basic idea is that if states are taxing providers at a really high rate, that's probably a signal that the tax is just a pass-through mechanism and the state is guaranteeing providers get their money back through higher Medicaid payments. The regulations established a six percent of net patient revenue threshold as the indirect hold harmless limit. If a state's provider tax exceeded six percent of net patient revenue for a particular provider class, that triggered a presumption that the state was running a hold harmless arrangement and the entire tax revenue would be disallowed as the state share.

In practice, this six percent threshold became the target. States would tax each provider class right up to six percent because that maximized the amount of federal matching dollars they could draw down. Some states got really sophisticated about this. They created multiple provider classes and sub-classes to maximize their tax

authority. They also figured out ways to structure non-uniform taxes that concentrated the tax burden on providers with high Medicaid volume while givi favorable treatment to providers with low Medicaid volume, then used statistica in the waiver process to argue these taxes were still “generally redistributive” ev though they very clearly were not.

The managed care organization tax became particularly egregious. States would impose taxes on MCO premium revenue but structure the rates so that Medicaic MCOs paid vastly higher rates than commercial MCOs. In one example CMS cit the guidance, the tax rate on Medicaid business was one hundred seventeen time higher than the rate on commercial business. This is completely absurd and obv not redistributive in any meaningful sense, but states argued it passed the statis tests in the regulations so CMS had to approve it. CMS has been trying to close t loophole through rulemaking for years, most recently with a proposed rule in M 2025, but states kept finding ways to game the system.

Enter the Working Families Tax Cuts Legislation, signed July fourth 2025. Secti 71115 and 71117 fundamentally change the rules in ways that are going to force adjustments in state Medicaid financing and create ripple effects throughout the healthcare delivery system.

Section 71115: Freezing the Game Boa

Section 71115 does something remarkably blunt. It establishes new indirect hold harmless thresholds that are essentially frozen at whatever level each state’s pro taxes were at on July fourth 2025. For taxes that existed and were being collected that date, the new threshold is whatever percentage of net patient revenue those represented as of that snapshot. For taxes that didn’t exist on July fourth 2025, t threshold is zero. This means states generally cannot increase existing provider t and cannot implement new provider taxes without running afoul of the hold har rules.

The CMS guidance spends considerable time defining what “enacted and impose means as of July fourth. A tax is enacted if the state or local government complet

the entire legislative process to authorize that specific tax structure and if CMS approved any necessary waivers by that date. A tax is imposed if the state was ac collecting revenue under that tax structure as of July fourth. The guidance emph that retroactive increases or administrative adjustments after July fourth don't c even if they're made retroactive to before July fourth, which closes off one poten workaround states might have tried.

For non-expansion states, that's basically the end of the story. Their thresholds a frozen at July fourth 2025 levels permanently. For Medicaid expansion states, th an additional phase-down that starts in fiscal year 2028. The threshold becomes lower of the July fourth 2025 level or five point five percent in FY 2028, then ste down by half a percentage point each year until it reaches three point five percer FY 2032. There's a carveout for nursing facility and ICF-IID taxes which don't fa the phase-down, presumably because CMS views those provider classes as partic financially vulnerable.

The practical effect of this is that states lose their primary tool for generating additional state share for Medicaid expansions without actually appropriating ge fund dollars. Let's say a state wants to expand Medicaid dental benefits or increa provider rates or add new covered services. Under the old regime, they could jus increase their hospital tax or implement a new tax on a different provider class, u that as state share, draw down matching funds, and fund the expansion. Now the can't do that. They either need to appropriate real state general fund dollars, wh requires difficult budget decisions and potentially tax increases on the general population, or they need to find cuts elsewhere in the Medicaid program.

This is a really big deal for state budget flexibility. Provider taxes have become a massive part of Medicaid financing. The CMS guidance mentions that this affect thirty to forty billion dollars flows through the system annually, and I'd bet that' conservative. Some states are incredibly dependent on provider tax revenue. Los the ability to increase these taxes or implement new ones fundamentally constra states' ability to expand Medicaid without federal matching rate increases or ger fund appropriations.

Section 71117: Closing the MCO Tax Loophole

While Section 71115 is about freezing the overall level of provider taxes, Section 71117 is about fixing how taxes are structured within a provider class. Specifical codifies that a health care related tax is not considered generally redistributive i tax rate imposed on providers with lower Medicaid volume is lower than the rate providers with higher Medicaid volume, or if the tax rate on Medicaid business i higher than on non-Medicaid business, or if the tax achieves the same effect thro any description even without explicitly naming Medicaid.

This directly targets the statistical loophole that states were exploiting, particula with MCO taxes. States would argue that their non-uniform taxes passed the regulatory tests for being generally redistributive even when the structure obvio concentrated tax burden on Medicaid business. The statute now explicitly says t taxes are not redistributive regardless of what the statistical tests show.

The transition periods are interesting and reveal CMS's priorities. For MCO taxe exploit the loophole, states get until the end of their fiscal year ending in calend year 2026, which for most states means they have roughly six to eighteen months now to fix these taxes. For all other provider classes, states get until the end of th fiscal year ending in calendar year 2028, which could be as long as three years. C very clear about why MCO taxes get less time. The guidance points out that one tax approved under the loophole taxed Medicaid business at one hundred sevent times the commercial rate, while a hospital tax using the same loophole was only point five times higher on Medicaid. The MCO taxes are more egregious in term cost shifting to the federal government, so CMS wants them fixed faster.

What's particularly notable is that CMS says they've been warning states about t loophole taxes for a while, in many cases before states even implemented them, a that states were on notice CMS considered them problematic. The guidance has tone of "we're being generous even giving you a transition period because you kn this was coming." But CMS acknowledges state budgetary and legislative realitie require some transition time.

The Transition Timeline and State Response Dynamics

Let's think through the timeline here because it matters for how this plays out a when investors will start seeing effects. The legislation was signed July fourth 2(we're already four and a half months in. The new indirect hold harmless thresho from Section 71115 don't take effect until October first 2026, which is about ten half months from now. This gives states some time to plan but not a huge amour given how legislative calendars work.

States with MCO taxes that exploit the Section 71117 loophole need to fix those by the end of their fiscal year ending in calendar year 2026. Most states operate (July first fiscal years, so those states need to fix their MCO taxes by June thirtiet 2026, which is only about seven and a half months away. A handful of states have different fiscal years. Texas runs September first to August thirty-first, so they'd until August thirty-first 2026. New York runs April first to March thirty-first, s they'd have until March thirty-first 2026, which is only about four and a half mo away. These are really compressed timeframes for states to redesign their MCO structures, get the changes through their legislatures, and implement new collec systems.

States with non-MCO taxes that use the loophole have until the end of their fisc ending in 2028, so that's generally June thirtieth 2028 for most states, which give them about two and a half years. That's more breathing room but still requires a

The question is what states actually do in response. They have a few options. Fir they could eliminate their non-compliant taxes entirely and replace the revenue general fund appropriations. This is politically difficult and probably not realist most states. Second, they could restructure their taxes to be uniform across Med and non-Medicaid business, which would comply with Section 71117 but would tax burden from high-Medicaid providers to low-Medicaid providers. Third, the could reduce their overall tax rates to stay within the frozen thresholds under Se 71115 while also making them compliant with Section 71117. Fourth, they could

find other creative financing mechanisms, though the legislation and guidance s designed to limit the available workarounds.

My guess is most states will do some combination of restructuring their existing to be compliant while also making cuts elsewhere in their Medicaid programs to lost revenue. The states that have been most aggressive with MCO taxes are prob going to face the most pain because they have the least time and the biggest stru changes needed.

What This Means for Health Tech Investors

Okay, so we've covered the mechanics of what changed. Why should health tech investors care? There are several channels through which this affects investment opportunities and risks.

First, Medicaid managed care rates are probably going to come under pressure i of states. MCO taxes have been a significant revenue source for states, and those have been using the revenue to fund higher capitation rates to MCOs or to expa benefits without increasing general fund spending. If states lose the ability to co MCO taxes at current levels or have to restructure them in ways that generate le revenue, that money has to come from somewhere. States could cut capitation ra which would pressure MCO margins. They could reduce covered benefits, which would reduce utilization and revenue. They could shift more risk to MCOs throu contract structure changes. Any of these responses makes life harder for Medica MCOs.

This is relevant for health tech companies selling into Medicaid MCOs or buildi tech-enabled care delivery models that depend on Medicaid MCO contracts. If M margins are getting squeezed, they're going to be more price sensitive on vendor contracts and more conservative about taking on new risk-based arrangements. Companies building virtual care platforms or specialty medical groups that cont with Medicaid MCOs on capitation or shared savings arrangements should expe

tougher negotiations and potentially less favorable economics than they would h
gotten a year ago.

On the flip side, there might be opportunities to help MCOs navigate this new
environment. MCOs are going to need better tools for managing medical expens
improving margins through operational efficiency rather than through favorable
contracting. Companies offering utilization management platforms, prior
authorization automation, fraud waste and abuse detection, or care management
that demonstrably reduce medical costs might find more receptive buyers. The p
changes from "this is a nice to have that improves quality" to "this directly prote
your margins in a constrained environment."

Second, hospital payment rates in Medicaid could also face pressure depending
how states respond. Hospitals have been major beneficiaries of provider tax sche
because they pay the taxes but generally get back more in enhanced Medicaid ra
than they paid. If states have to reduce hospital taxes or restructure them, states
might also reduce hospital payment rates or at least slow their growth. This affe
companies selling into hospitals or building hospital-at-home or post-acute mod
that depend on favorable hospital referrals and discharge patterns.

The hospital dynamics are complicated though because hospitals have way more
political power than MCOs. If a state tries to significantly cut hospital taxes witl
maintaining payments, the hospital association is going to raise hell and probabl
block it. My guess is states will try to maintain hospital payment rates as much a
possible while shifting the financing burden elsewhere, but there's definitely ris
payment pressure.

Third, there's going to be increased interest in delivery models that reduce Medi
costs without requiring upfront state investment. States are going to be looking
ways to bend the Medicaid cost curve because they can't just keep raising provid
taxes to fund expansions. This creates opportunities for companies offering risk-
or value-based care models that are budget neutral or cost saving from the state'
perspective.

For example, companies building serious mental health infrastructure or substa use disorder treatment capacity that can demonstrate cost offsets through reduc emergency department utilization or incarceration costs might find more state interest. Same for companies building robust home-based primary care for elder disabled Medicaid populations that can reduce nursing home utilization. The ke being able to show concrete cost savings that materialize relatively quickly, idea within a state fiscal year or two.

Fourth, there might be knock-on effects on commercial insurance markets in sta that have high Medicaid provider taxes. If states reduce hospital taxes, hospitals be under pressure to make up that revenue somewhere, which likely means more aggressive commercial rate negotiations. This could drive up commercial premiu which creates more demand for tools that help employers or health plans manag costs. It could also accelerate the shift to alternative payment models and value-b care in commercial markets as payers look for ways to constrain spending growt

Fifth, the reduction in state Medicaid financing flexibility might actually slow th pace of Medicaid expansion or benefit enhancements in non-expansion states. A that was considering expanding Medicaid or adding new benefits like dental or v coverage might decide the fiscal math doesn't work anymore without the ability provider taxes as the primary state funding mechanism. This reduces the addres market for companies building specifically for Medicaid populations in those sta

On the other hand, states that have already expanded Medicaid aren't going to r back those expansions, and the expansion states with phase-downs under Sectio 71115 are going to be scrambling to find ways to maintain their programs within new constraints. This could drive more interest in managed care innovations and delivery models that can serve expansion populations more efficiently.

Opportunities in the Wreckage

Whenever there's a major policy disruption like this, there are companies that ge hurt and companies that benefit. The companies that get hurt are usually the on whose business models depend on the continuation of the specific policy enviro

that just changed. The companies that benefit are usually the ones that solve prc created by the new policy environment or that were already positioned for where policy is headed.

In this case, I think there are a few categories of companies that could benefit. F revenue cycle management and financial infrastructure companies that help stat providers navigate the new tax and payment landscape. States are going to need financial planning and forecasting tools to manage Medicaid budgets within tigh constraints. Providers are going to need better visibility into their tax burden an Medicaid payment economics. Companies offering data infrastructure, analytics decision support in this domain could see increased demand.

Second, care delivery companies that can credibly demonstrate cost savings with requiring upfront capital investment from states. This is a high bar because mos delivery innovations actually increase short-term costs even if they reduce long-t costs, and states care way more about short-term budget impact. But companies have really nailed the execution of value-based care models with strong risk management and clear cost offsets could find states more willing to partner or sc existing programs.

Third, companies helping MCOs and providers prepare for more constrained Medicaid environments. This includes utilization management, care coordinatio social determinants of health interventions that reduce acute care utilization, an other tools that directly impact medical loss ratio. The challenge is these categor are already crowded and many of the solutions have marginal or unproven ROI, winners will be companies with really strong evidence of impact and proven abil integrate into clinical and operational workflows.

Fourth, there might be opportunities in helping states find alternative financing mechanisms that comply with the new rules. I'm not entirely sure what these wo look like because the legislation seems pretty comprehensive in closing loophole there's always demand for creative solutions to state budget problems. Maybe di payment arrangements under managed care contracts that don't trigger hold har issues, or supplemental payment programs structured in specific ways, or

intergovernmental transfers that meet the new requirements. Any consultants or technology companies that can help states navigate this complexity could do wel

The flip side is there are categories of companies that should probably be more cautious. Anything that depends on significant Medicaid rate increases or benef expansions over the next few years is risky. Companies building for Medicaid M markets should assume tougher sales cycles and more price pressure. Companie were counting on states expanding Medicaid in non-expansion states should red those assumptions in their models.

More broadly, this is another data point in the ongoing trend of federal oversigh state Medicaid programs getting more stringent and states having less flexibility engineer favorable financing arrangements. We saw this with the Medicaid fisca accountability rule, with increased scrutiny of section 1115 waivers, with the unwinding of continuous enrollment, and now with provider tax restrictions. Th federal government is clearly trying to reduce Medicaid spending growth and lir states' ability to shift costs to federal taxpayers.

For investors, this means building companies that depend on expansive Medicai policy is increasingly risky. Companies that can succeed within a more constrain Medicaid environment, or better yet companies that help states and plans operat more efficiently within constraints, are likely to be more successful. This is a shi from the 2010 to 2020 period when Medicaid expansion and enhanced federal fu created a lot of tailwinds for Medicaid-focused health tech companies.

One other consideration is that this policy change disproportionately affects cer states. States that have been most aggressive with provider taxes, particularly M taxes, are going to be scrambling. States that have been more conservative with provider taxes or that have diversified their Medicaid financing might have more flexibility. This creates geographic variation in how attractive different state Me markets are for health tech companies.

For example, a state like New York which has very high Medicaid spending and historically used provider taxes extensively is probably going to face more fiscal

pressure than a state like Utah which has lower Medicaid spending and less relia on provider taxes. Companies building for Medicaid markets should think about which states are most affected and potentially deprioritize those markets or at le adjust their assumptions about market growth and willingness to spend on new technologies.

The last thing I'll say is that policy changes like this create opportunities for rea deep subject matter expertise to become a competitive advantage. Most health te founders and investors don't understand Medicaid financing at this level of deta Most don't know what an indirect hold harmless threshold is or why MCO tax loopholes matter. If you're building a company in this space and you actually understand these dynamics, you can make much better strategic decisions about which markets to enter, which buyer personas to target, how to position your val proposition, and how to structure your pricing and contracting.

Similarly, investors who develop expertise in Medicaid policy and financing can identify opportunities and risks that other investors miss. If you understand tha particular state is about to face a budget crisis because they relied heavily on MC taxes and now have to restructure, you might avoid investing in companies heavi concentrated in that state's Medicaid market, or you might specifically target companies that help solve that state's problems. This kind of domain expertise is to develop but extremely valuable when major policy shifts happen.

The November fourteenth CMS guidance is one of those documents that ninety-percent of health tech investors will never read but that materially affects the opportunity set in Medicaid-adjacent markets. The companies that understand t implications and adjust their strategies accordingly are going to be better positi than the companies that ignore it. The investors who dig into the details are goi make better investment decisions than the investors who rely on surface-level understanding of Medicaid policy. These are the kinds of structural tailwinds ar headwinds that compound over time and determine which companies succeed ar which ones struggle.

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