Proposed Provider Tax Rule: Implications for Mental Health and Substance Use Organizations

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What Happened

On July 21, 2026, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule (CMS-2452-P) (CMS Fact Sheet) implementing Section 71115 of H.R.1, the section of the law restricting the use of Medicaid provider taxes. Provider taxes are a financing tool nearly every state uses to fund its share of Medicaid. States tax hospitals, nursing facilities, managed care organizations (MCOs), and other provider types to use the revenue to draw down federal matching funds. Beginning Oct. 1, 2026, H.R.1 freezes each state's provider tax capacity at the level in place on July 4, 2025. **Comments are due Sept. 21, 2026.**

Why this Matters to Mental Health and Substance Use Organizations

While most community behavioral health organizations are not directly taxed, provider tax revenue is a major source of the state dollars that fund Medicaid rates and directed payments, including a significant portion of the financing behind behavioral health programs. CMS estimates the rule would cut combined federal and state Medicaid spending by roughly $384 billion over ten years. Shrinking this revenue source will likely lead to states backfilling with general funds or cutting spending. As a result, states may reduce optional behavioral health benefits.

What the Rule Would Do

Freeze provider taxes at July 4, 2025 levels. Under H.R.1, the current nationwide 6% “safe harbor” provider tax is replaced with a separate cap for each provider class in each state, set at the percentage of net patient revenue the state's tax actually generated as of July 4, 2025. Where a state had no qualifying tax for a class, the cap is 0%, effectively banning new provider taxes.

Phase down taxes in expansion states. In Medicaid expansion states, most provider tax caps will be phased down annually. This will range from 5.5% in FY 2028 to 3.5% in FY 2032, depending on the state. Nursing facility and intermediate care facility for individuals with intellectual disabilities (ICF/IID) taxes are exempt. Hospitals and MCOs (the classes whose taxes most often finance behavioral health payments) will likely face the greatest pressure. Non-expansion states will maintain their frozen capped rates as of July 4, 2025, without a phase-down.

Prevent alternative methods of alleviating pressure from other H.R.1 changes. Tax increases enacted after July 4, 2025 cannot raise a state's cap. As a result, states cannot offset H.R. 1's other Medicaid cuts by raising provider taxes. CMS also proposes to eliminate the regulatory “75/75 test,” starting October 1, 2026, even though the statutory text of H.R.1 does not require this. Under current law, taxes exceeding the applicable threshold can remain in place if they pass a second test assessing whether 75% of taxpayers receive at least 75% of tax costs through Medicaid or other state payments. **This is arguably the most consequential policy choice in the rule.** This test is essentially an alternative pathway that lets some taxes exceed the threshold. The effect of eliminating the 75/75 test is to essentially close one of the last significant methods for preserving financing above a state's frozen cap.

Create a new taxable class for health insurers. CMS would bring premium taxes and covered-life assessments (beyond MCOs) into the provider tax framework. These arrangements would have a 0% cap for any insurer tax not in place as of July 4, 2025. This was not required by statute and would place financing arrangements that historically operated outside these rules under direct CMS oversight.

Impose new compliance measures. The rule proposes interim caps starting Oct.1, 2026, while CMS collects data to set final caps (which are anticipated by Sept. 30, 2028), plus interim state reporting by Dec. 31, 2026, baseline data submissions by June 30, 2028, and ongoing quarterly reporting of tax collections and class-level net patient revenue. Noncompliance can trigger reductions or withholding of federal matching funds. States will likely need substantially more provider-level financial data to successfully meet these requirements.

Apply the thresholds on a federal fiscal year basis. Many state tax programs run on state fiscal years, so states may need to redesign tax schedules and payment methodologies. CMS's detailed methodology choices will determine how much financing capacity each state retains.

Implications for Behavioral Health

- Reduced tax capacity, coupled with H.R.1's other Medicaid changes, will apply pressure to state budgets. This may impact optional benefits, rate increases, and non-mandatory behavioral health services.
- Hospital and MCO tax revenue often finance directed payment programs that support behavioral health rates. Frozen or phased-down caps constrain those arrangements and may be amplified by the separate directed payment limits also implemented by H.R.1. States planning to raise provider taxes to alleviate H.R.1's other Medicaid reductions would gain little or no new capacity under the frozen-cap structure.
- States will need class-level revenue and collections data on a quarterly basis and may pass detailed financial reporting requirements down to providers.

What Members Can Do Now

1. Submit comments by September 21, 2026, at **regulations.gov** (docket CMS-2452-P). Comments are most effective when they document concrete impacts: how provider tax-financed payments support your services, rates, and workforce.
2. Work with the National Council and your state association to identify which provider taxes finance behavioral health payments in your state, whether your state is an expansion state subject to the phase-down, and what the frozen cap may mean for programs you utilize.
3. Engage your state Medicaid agency on how it plans to comply with interim caps and reporting deadlines.
4. Understand what is needed for data requests and ensure your finance team can produce net patient revenue and payer-level data if your state seeks provider-level information for threshold calculations.
5. Share impacts with the National Council so we can reflect member experiences in our comments on the rule and ongoing H.R.1 advocacy. Reach out to us at policy@thenationalcouncil.org to share stories or other impacts, or for any questions you may have about this proposal or any other changed under H.R.1.