UNIVERSITY OF CALIFORNIA HEALTH

University of California Health
1111 Franklin Street
Oakland, CA 94607

universityofcalifornia.health

July 14, 2025

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

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

Dear Administrator Dr. Oz:

The University of California Health (UC Health) appreciates this opportunity to submit the following comments regarding the preservation of Medicaid funding for vulnerable populations. UC Health and its six academic health centers and 21 health professional schools are part of California's public health care system that form the core of the state's health care safety net. UC Health is deeply committed to providing health care to the Medicaid population as the state's second largest provider of Medicaid inpatient services, despite having only 7 percent of the hospital beds in California.

UC academic health centers are an essential part of California's health care safety net system. As designated public hospitals, UC's academic health centers provide high-quality care to those in need regardless of their insurance status or ability to pay. We provide care for patients' everyday health needs, as well as those with the most complex cases, including cancer, burn, transplant, and trauma care. These patients need and deserve these services, along with the ability to access them through their health coverage.

Ensuring the stability of the Medi-Cal program and its funding sources, including health care-related taxes and supplemental payments that fund patient care for Medicaid enrollees, is critical to our most vulnerable citizens. Given UC Health's leading role in California's health care safety net as one of the state's significant providers of Medicare and Medi-Cal inpatient and hospital outpatient services, we offer the following comments.

Medi-Cal is a Critical Safety Net for California's Most Vulnerable Citizens
The California Medicaid program, known as Medi-Cal, is foundational to the state's health and economic well-being; it serves as a critical health care safety

net for nearly 15 million low-income Californians, including children, seniors, individuals with disabilities, and working families. Medi-Cal accounts for a substantial portion of hospital funding — approximately 30% of California hospitals' net patient revenue, making it indispensable for the financial stability and operational capacity of health care providers across the state.[1] For its most vulnerable beneficiaries, Medi-Cal is a lifeline, ensuring access to comprehensive care that prevents financial devastation from medical crises, improving health outcomes, and enabling individuals to maintain employment and contribute to their communities, thereby fostering a more resilient and healthier California. Further, Medi-Cal's per capita spend for a full or partial scope beneficiary is below the national median, suggesting that California operates an efficient, low-cost Medicaid program compared to other states — despite operating in a high cost of living environment. [2]

Importance of Medicaid Funding

UC Health shares the Centers for Medicare & Medicaid Services' (CMS') commitment to preserving Medicaid funding for vulnerable populations. However, UC Health, is concerned that the CMS proposed rule on health care-related taxes would, in fact, put such funding — and the patients who rely on it — at serious risk.

Forty-nine states, including California, have long relied on provider tax programs, under strict federal oversight, to generate essential resources for Medicaid. Abruptly redefining the rules for these programs, as CMS proposes, could destabilize the Medicaid program and would have far-reaching impacts on Medicaid recipients and the vital hospital services on which they rely.

UC Health urges CMS to withdraw or substantially revise the proposed rule. While CMS may be required to promulgate future rulemaking to implement recently finalized federal legislation on this topic, the agency should not proceed with regulatory action proposed under a prior statutory construct that Congress has since dramatically altered. Indeed, due to recent Congressional action, this proposed rule is a redundant and potentially conflicting regulatory action that, if implemented in its current form, would undermine Congress's longstanding approach to Medicaid funding flexibility and threaten access to care for low-income individuals in California and across the nation. **If CMS chooses to proceed with this proposal despite these concerns, the agency must extend the public comment period, delay implementation, and ensure a sufficient and equitable transition period for all states that use health care-related taxes**. **UC Health's key concerns with the proposed rule are as follows:**

- **Threat to access and services:** The proposed tax uniformity requirements would upend critical financing mechanisms that California relies on to fund Medicaid, extracting billions of dollars from California's health care system that cannot possibly be replaced or backfilled from other sources[3]. If these funds are reduced, it will likely result in reduced Medicaid coverage, lower provider payments, and cuts to essential health services — all of which threaten vulnerable patients' access to care.[4] Provider taxes are an important source of Medicaid funding for UC Health, providing nearly $100 million annually.

[1] https://www.chcf.org/resource/how-vital-are-medi-cal-payments-to-hospitals-in-ca-congressional-districts-22-40-41/
[2] https://www.kff.org/medicaid/issue-brief/a-look-at-variation-in-medicaid-spending-per-enrollee-by-group-and-across-states/
[3] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/
[4] https://www.aha.org/system/files/media/file/2025/02/Fact-Sheet-Medicaid-Provider-Taxes-20250204.pdf

- **Puts Graduate Medical Education (GME) funding in rural and underserved communities at risk:** Provider taxes in California fund Medicaid GME investments that support medical resident and fellowship positions across the state, as well as planning grants and direct technical assistance to hospitals undertaking physician training for the first time. UC oversees the distribution of a $75 million GME fund from provider taxes to hospitals expanding existing GME programs and seeking accreditation for new programs. Priority is given to accredited residency and fellowship programs that serve Medi-Cal patients and are in physician shortage areas, with the goal of increasing the number of GME positions in California. With the first two years of funding alone, this program will train an estimated 800 physicians, with a focus on medically underserved areas — including rural areas — across the state. Without this critical provider tax funding, this expansion of physician workforce to serve Medicaid patients is at risk.

- **Redundant and potentially conflicting**: The proposed rule is now redundant and unnecessary — and it potentially conflicts with Congress' provider tax reforms in Public Law (P.L.) 119-21. CMS should withdraw the rule and reissue separate, subsequent rulemaking narrowly focused on implementing the new law to both ensure consistency and avoid duplicative or burdensome requirements for states.

- **Contrary to statutory intent and in violation of the Administrative Procedure Act (APA):** The Medicaid statute explicitly permits states to seek waivers of broad-based and uniform tax requirements when a tax is "generally redistributive." This reflects Congress' intent to allow some non-uniform provider taxes, including those based on Medicaid-specific characteristics — and it remains unchanged by recent Congressional action. By functionally eliminating this flexibility and rendering the existing B1/B2 test obsolete for the most common forms of non-uniformity, the proposed rule exceeds CMS' authority and violates the APA (5 U.S.C. § 706(2)(A) & (C)). Moreover, it fosters disparate outcomes for similarly situated states, introduces open-ended and subjective standards that inject significant uncertainty into the evaluation of waiver requests, and threatens vital financing mechanisms without statutory justification. This level of regulatory discretion — particularly when coupled with the arbitrary denial of transition periods for some states — amounts to precisely the kind of agency overreach the APA was designed to prevent.

- **Arbitrary and insufficient transition period.** The proposed rule provides an inequitable (and in some cases, non-existent) transition period that favors a few states while denying any such path for other similarly situated states. States that recently renewed provider tax waivers, like California, are denied any transition period, whereas others receive a limited one-year phase-in. This arbitrary cutoff fails to account for the complexity of unwinding long-established funding arrangements and the constraints of state legislative cycles.

If CMS opts to continue advancing the proposed rule despite these strenuous objections, UC Health recommends:

- **A targeted, flexible approach:** CMS should consider a safe harbor for taxes with a modest degree of non-uniformity under the existing "generally redistributive" test. This would honor Congress' intent in permitting waivers of uniformity, which remains unchanged in recently passed federal legislation, and the longstanding practice of permitting health care-related taxes with reasonable degrees of

variation.

- **Equitable, multi-year transition:** All states need a meaningful multi-year transition of at least three years, consistent with new statutory directives under P.L. 119-21, to avoid destabilizing Medicaid programs and providers and compromising patient access to care. Any final rule should be applied only prospectively after a multi-year delay (e.g., aligning with state fiscal year cycles) to give states ample time to adjust or seek necessary statutory changes.

- **Extended comment period to assess impact:** If CMS does not withdraw the rule, the agency should, at a minimum, extend the comment period for an additional 60 days to allow states, providers, and other stakeholders sufficient time to fully evaluate the proposed rule's complex interactions with overlapping provisions of P.L. 119-21. The rule raises far-reaching policy, legal, and operational questions — particularly around financing structures that have been in place for decades. Stakeholders need additional time to conduct detailed impact analyses that are essential for informing meaningful comments and avoiding unintended disruptions to Medicaid programs nationwide.

In closing, UC Health is deeply committed to ensuring that Medicaid remains strong and continues to serve Californians who depend on Medi-Cal for their health and well-being. We believe CMS shares these goals. Yet the proposed rule, as written, would undermine the financial pillars of Medicaid and jeopardize the vulnerable populations it aims to protect. UC Health respectfully asks CMS to reconsider this approach. Instead of imposing broad new restrictions, let us collaborate on solutions that maintain accountability without sacrificing the coverage and care on which our communities rely. Medicaid provider taxes protect access to care for everyone.

Thank you again for the opportunity to submit these comments, if you have any questions, please contact Kent Springfield at (202) 993-8810 or kent.springfield@ucdc.edu.

Sincerely

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs
UC Health