GOVERNOR GREG ABBOTT

August 7, 2026

The Honorable Robert F. Kennedy Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Kennedy:

I am writing regarding healthcare-related taxes in Texas (specifically those related to hospital services) and the use of local provider tax revenues as the non-federal share of Medicaid expenditures. This matter not only stands to impact more than $12 billion annually in Texas but also threatens to undercut our efforts to ensure that more than 29 million Texans—many of whom reside in rural communities—continue receiving access to lifesaving emergency services. Texas' approach to financing a non-expansion Medicaid program works, and it is a product of deliberate and considered decision-making by the Texas Legislature. To that end, please extend my thanks to U.S. Centers for Medicare and Medicaid Service (CMS) staff for the time and effort they have already spent working to resolve this issue.

During a call on August 4, 2026, however, CMS staff indicated their belief that it is impermissible for a local jurisdiction to assess payments on the total net patient revenue of a hospital, even if the taxes paid by the hospital can be mathematically allocated to separate classes of hospital services. CMS staff also confirmed that they expect Texas local governments to change the structure of their tax assessments to apply exclusively and separately to discrete classes of services. Essentially, CMS staff asked that local governmental entities in Texas disregard the structure of healthcare-related taxes established by state law—some as long ago as 2013. CMS further asked the State to separately conduct a demonstration calculating the indirect hold harmless percentage by each separate class of hospital service.

Texas disagrees that an overhaul of Texas' Medicaid finance system is required or authorized by the Social Security Act. Further, the One Big Beautiful Bill Act was clear: For purposes of the Social Security Act's provisions authorizing reduction of Medicaid funds based on revenues received via "hold harmless" tax arrangements, a "non-expansion State" (like Texas) may continue to utilize a tax that the "State has enacted . . . and impose[d]" before "July 4, 2025," and that was previously found to be "within the hold harmless threshold as of that date." *See* H.R. 1, Pub. L. No. 119-21, § 71115, 139 Stat. 72, 301 (July 4, 2025), *codified at* 42 U.S.C. § 1396b(w)(4)(D)(i)(I)(aa). In other words, this grandfather provision assured States that, even if

they could not enact and impose *new* broad-based healthcare-related taxes, they could continue to use such tax arrangements adopted before July 4, 2025.

The tax structure previously enacted by the Texas Legislature, and being implemented daily by local governments, fully complies with federal law. What CMS is requesting does not. In fact, CMS' request directly undermines the protections recently passed by Congress and signed by the President in the One Big Beautiful Bill Act.

Nevertheless, Texas is willing to request that local governments make updates in accordance with CMS' newly announced preferences if CMS can provide certain written assurances in the Memorandum of Understanding currently being drafted between CMS and Texas Health and Human Services (HHSC). As Texas continues to evaluate potential changes to the basis upon which local provider taxes are assessed, there remain three fundamental issues on which Texas requires certainty before it can agree to any transition.

First, Texas requests written confirmation that CMS will not treat a transition to a class-of-services tax methodology as forfeiting the grandfather provision's protection for existing provider taxes. HHSC has consistently explained to CMS that local provider taxes in Texas have historically been assessed on overall net patient revenue. And CMS has already paid out claims pursuant to that assessment methodology, even *after* the effective date of the statutory amendments described above. Before Texas can commit to changing the basis of those taxes, the State needs written assurance that provider tax revenues assessed under the current structure will continue to be recognized as "enacted" and "imposed" as of July 4, 2025—even if subsequent administrative or statutory changes are made to transition the taxes to be assessed based on discrete classes of services in accordance with CMS' preference. A Notice of Proposed Rulemaking that CMS may ultimately choose not to adopt is plainly insufficient.

Second, Texas requests written confirmation that CMS intends to focus on prospective enforcement efforts related to the permissible class of services to which a tax is assessed. Considering that the grandfather provision approves the State's prior taxing structure, Texas obviously believes that its prior taxing arrangement—in place from 2013 to the present—was administered in good faith and in full compliance with federal law. If CMS would like to adopt a different view that treats existing taxes as no longer eligible for federal matching funds, despite the tension with the One Big Beautiful Bill Act, then CMS must assure the State that it will not pursue retrospective disallowances, deferrals, or other penalties against the State based on the structure of provider taxes in Texas. Any voluntary change that the State makes should be understood as the product of a desire to work collaboratively with CMS and not as any kind of admission about a legal defect in Texas' broad-based healthcare-related taxes.

Third, Texas requests a written explanation of CMS' position on multijurisdictional provider taxes. CMS has expressed concerns about multijurisdictional local provider participation funding structures and asked the State to commit to sunsetting such taxes by October 1, 2026. CMS suggests that multicounty districts may not qualify as units of local government and has expressed vague concerns about the fiscal integrity of these arrangements. HHSC, however, has explained that federal law defines "unit of local government" as including a "special purpose district."

42 U.S.C. § 1396b(w)(7)(G). And multicounty districts are special purpose districts. Neither HHSC nor CMS has the authority to repeal existing statutes or rewrite ordinances imposed by units of local government. While HHSC may refuse to accept intergovernmental transfer (IGT) funds if they are derived from an impermissible source, multicounty districts are permissible sources of IGT funds. Without a clearer understanding of CMS' position, Texas cannot evaluate the operational, fiscal, or legal options related to these arrangements, nor can it provide useful guidance to the local governments that administer them or the Legislature that might see fit to modify them.

Just two months ago, the U.S. Supreme Court reiterated that Spending Clause schemes like Medicaid rest on the States' knowing and voluntary agreement to undertake certain obligations in exchange for federal dollars. *Landor v. La. Dep't of Corr. & Pub. Safety*, 146 S. Ct. 1931, 1938, 1940 (2026). So, while the federal government may withhold funding for States violating funding conditions, those conditions must be "unambiguously expressed" beforehand, rather than announced after the fact as a $12 billion "economic 'gun to the head.'" *Id.* at 1941, 1943. As our offices continue discussions, it may be worth recalling these legal principles. Texas remains committed to working collaboratively with CMS, including by resolving remaining issues concerning the calculation of the indirect hold harmless percentage, as well as discussing the timelines and processes by which the State will be able to utilize tax revenues that have already been assessed and collected in accordance with state law.

I appreciate your consideration and look forward to a written response from your office.

Sincerely,

Greg Abbott
Governor

cc: The Honorable Mehmet Oz
U.S. Centers for Medicare and Medicaid Services