THE PARTNERSHIP FOR MEDICAID

September 21, 2026

The Honorable Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes (CMS-2452-P)

On behalf of the Partnership for Medicaid—a nonpartisan, nationwide coalition made up of organizations representing clinicians, health care providers, safety net plans, and counties— the undersigned organizations appreciate the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS') "Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes" notice of proposed rulemaking.

Provider taxes are health care-related fees, assessments, or other mandatory payments states place on health care providers to help finance the state's share of Medicaid expenditures. All states except Alaska have at least one health care related tax to raise the non-federal share of their Medicaid spending. Restricting states' uses of provider taxes will cause major strain on state budgets and will put access to care at risk for millions of people who rely on Medicaid, including children, seniors, and people with disabilities.

CMS should continue prospective calculation of hold harmless threshold compliance

Since CMS first established the hold harmless threshold in 1992, states have worked with CMS to prospectively project revenues and obtain CMS approval. This has enabled states to determine compliant tax rates in advance of enacting, imposing, and collecting the taxes, as well as using tax proceeds as the non-federal share of Medicaid payments for a particular tax year.

In this rule, CMS proposes to switch to a retrospective system. Under this system, states will continue to project tax collections and net patient revenue when setting tax amounts but will need to redetermine compliance after the tax year is complete based on actual revenues collected and net patient revenues for the applicable services. Retrospective determination of the hold harmless threshold will result in states and localities needing to refund tax collections and recoup payments anytime net revenues decline, without providing any increase in program integrity.

Unforeseen circumstances, such as a public health emergency like COVID-19, can dramatically impact provider revenues, and even more routine changes in net patient revenues could result in providers needing to return millions in dollars of payments for services they provided. In the event net patient revenues decline, even slightly, states will have to undertake the arduous process of not only refunding tax revenues, but also recouping payments funded with any revenues that are determined to have exceeded actual net patient revenues.

Prospective compliance ensures that states and providers have certainty regarding the amount of tax revenues that may be collected and utilized as the non-federal share. Such certainty is critical to ensuring states can effectively finance and administer their state Medicaid programs and that providers do not risk recoupment of payments they have appropriately earned through the provision of services simply because net patient revenues across all providers of the service were lower than expected. CMS should maintain the current prospective process.

CMS should align provisions with state fiscal years

In enacting Section 71115, Congress provided CMS with discretion to interpret fiscal years to mean federal or state fiscal years. CMS notes that it is proposing to interpret fiscal year in this instance to mean federal fiscal year. However, as the agency acknowledges it has interpreted a general statutory reference to "fiscal year" to mean state fiscal year (SFY) in the past.

In this case, CMS should interpret fiscal year to mean SFY due to the significant operational and compliance challenges that will be required for states to align taxes that typically comport with the state fiscal year with the federal fiscal year. States have had long established SFYs that structure their budget planning, tax collection, and legislative sessions. States purposedly align state Medicaid plan years and state rating years with SFYs as well as state tax years. Because these systems are already built around the SFY, implementation of the indirect hold harmless provisions should also align with SFYs. If implementation of the hold harmless limit aligns with the FFY, states will be forced to prorate and attribute tax revenue across split portions of their portions of SFYs to match FFY reporting periods and then verify those tax revenues to not exceed the applicable threshold. The misaligned reporting periods create unnecessary complexity. It increases the risk of compliance errors, may require states to build and maintain parallel tracking systems, and adds administrative cost with no corresponding benefit.

CMS has gone beyond the statute and its authority

Two sections of HR 1 – Section 71115 and Section 71117 – make amendments to how provider taxes may be used. However, this proposed rule goes beyond both the statutory requirements and CMS's jurisdiction.

Section 71115 amends the hold harmless threshold for provider taxes. However, in implementing this section, CMS has gone beyond the statute in a number of ways, including:

- Elimination of the 75/75 test
- Addition of a new permissible class, expanding the limitations on provider taxes to commercial health plans

Neither of these changes are required by the statute. CMS is particularly reaching beyond its jurisdiction in limiting how states can tax commercial health plans. CMS asserts, without evidence, that states are using such funds to fund Medicaid. In reality, states use these taxes to support a variety of state programs, including Marketplace operations and other public health initiatives.

CMS has not sufficiently accounted for impacts on enrollment and benefits

We are concerned that CMS has not conducted sufficient analysis on the impact of this regulation. In the Regulatory Impact Analysis (RIA), CMS estimates that the proposed rule would have no impact on enrollment and that all reductions in spending would be made through cuts to provider payments and benefits. While CMS acknowledges the potential for benefit cuts in the beginning of the RIA, it shows no analysis of potential benefit cuts and the impact on enrollees.

To support its assertion that this rule would have "no effect on enrollment," CMS cites to a 2021 issue brief by the Medicaid and CHIP Payment and Access Commission (MACPAC). This report does indeed say that "states generally use provider taxes to either increase payment to providers or offset potential cuts to provider payment that otherwise would be made to fill budget gaps." [1] However, MACPAC also provides an example of a provider tax used to expand coverage. Specifically, in Colorado "a portion of the hospital provider fee was used to implement Health First Colorado eligibility for adults up to 133 percent FPL and Child Health Plan Plus eligibility for children and pregnant women up to 250 percent FPL," countering the agency's stance that this regulation will have "no effect on enrollment." In contrast, the Congressional Budget Office has estimated that Section 71115 of HR 1 would increase the number of uninsured by 1.1 million by 2034.[2]

[1] Medicaid and CHIP Payment and Access Commission, "The Effect of State Approaches to Medicaid Financing on Federal Medicaid Spending," https://www.macpac.gov/wp-content/uploads/2021/11/The-Effect-of-State-Approaches-to-Medicaid-Financing-on-Federal-Medicaid-Spending.pdf, pg. 6.
[2] Congressional Budget Office, "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline," https://www.cbo.gov/publication/61570.

CMS also does not fully account for the interaction with other aspects of HR 1. It takes into consideration the impacts of a previous regulation on provider taxes and changes to state directed payments, but it does not take into account the other sections of HR 1 which will cause coverage losses and negatively impact the health care workforce. Beneficiaries who lose coverage will continue to seek care, increasing uncompensated care costs for those providers. This combination of factors will place significant strain on hospitals and other safety-net providers, risking access to care for millions.

For these reasons, CMS should amend the rule to adhere to the statutory requirements, continue to allow for prospective analysis, align with state fiscal years, and appropriately analyze the impact on enrollment.

For more information contact Paulo Pontemayor, Chair of the Partnership for Medicaid, at ppontemayor@chausa.org.

Sincerely,

Advocates for Community Health
America's Essential Hospitals
American Academy of Pediatrics
American College of Obstetricians & Gynecologists
American Nurses Association
Association for Community Affiliated Plans
Association of Clinicians for the Underserved
Catholic Health Association of the United States
Children's Hospital Association
Easterseals, Inc.
LeadingAge
National Association of Pediatric Nurse Practitioners
National Association of Rural Health Clinics
National Health Care for the Homeless Council