

IA ELECTRONIC SUBMISSION

September 21, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. 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]

Dear Administrator Oz:

Thank you for the opportunity to submit comments on this proposed rule implementing the provider tax provisions established by Public Law 119-21.

Our undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on Medicaid coverage. We have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In Public Law 119–21, under section 71115, Congress set new restrictions on the longstanding state use of provider taxes to finance their share of Medicaid costs. These new restrictions will lead to state funding losses of an estimated $191.1 billion over ten years (2025-2034) according to the Congressional Budget Office (CBO).[1] On July 23, 2026, the Centers for Medicare & Medicaid Services (CMS) published a Notice of Proposed Rulemaking on Amending the Indirect Hold-Harmless Threshold of Health Care-Related Taxes (the "NPRM").[2]

The NPRM goes far beyond the provider tax restrictions established by Public Law 119-21 without specific legal authorization; in some cases, it does so in direct conflict with the Medicaid statute, and in many cases, in direct conflict with longstanding CMS policy and state understanding. This will lead to far greater funding cost shifts to states, which will lead to additional reductions in eligibility and services for individuals with serious and chronic illnesses enrolled in Medicaid, and potentially reduced access for those enrolled in state-based Marketplace plans and benefiting from other state health programs.

Overall, CMS expects Public Law 119-21's provider tax provision in section 71115 and the proposed rule would cut federal Medicaid spending by $245.8 billion over ten years—billions more than Congress authorized. As explained below, these estimates likely understate the harmful impact of the NPRM.

Our organizations recommend that CMS *not* finalize numerous provisions of the NPRM that go beyond the requirements of Public Law 119-21, which will increase risks of harmful cuts to Medicaid and reduced access to care affecting individuals with serious and chronic illnesses. Instead, CMS should finalize only the provisions of the rule that are specifically required by section 71115 of Public Law 119-21, consistent with the statute, longstanding CMS policy and practice, and state understanding, and in consideration of the vital coverage and access needs of individuals with serious and chronic health conditions.

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[1] 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," July 21, 2025, https://www.cbo.gov/publication/61570

[2] Center for Medicare & Medicaid Services, "Medicaid Program: Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes," July 23, 2026, 91 Fed. Reg. 46652, https://www.federalregister.gov/documents/2026/07/23/2026-14897/medicaid-program-amending-the-indirect-hold-harmless-threshold-of-health-care-related-taxes.

Revenues raised by provider taxes are a critical part of state budgets. All states but Alaska rely on provider taxes to finance a portion of their share of Medicaid costs, with 41 states having three or more provider taxes. States have used new or increased provider taxes to finance their overall Medicaid program as well as to specifically support eligibility expansions, including Medicaid expansion and provider reimbursement rate increases. Provider taxes have also been used to close state budget shortfalls that have arisen during past economic recessions.[3] The provisions of Public Law 119-21 will be incredibly harmful for states--at least 31 expansion states will have to shrink the size of existing provider taxes and thus will have considerably less revenues available to finance Medicaid over time.[4] Moreover, some existing taxes on hospitals that are subject to these reductions, such as in Arizona, were used to specifically finance the Medicaid expansion. These expansion states will therefore be at particular risk of being unable to continue to finance the Medicaid expansion moving forward. In fact, as part of a draft waiver renewal application, one expansion state has already cited the Public Law 119-21 provider tax restrictions as why it may be unable to financially sustain its Medicaid expansion in the future.[5] CMS's proposed regulation exacerbates this harm by going beyond the requirements of Public Law 119-21 in many provisions, as detailed below. We also identify some elements of the proposed rule that faithfully implement Public Law 119-21 and should be preserved.

Definition of Net Patient Revenue (§433.52)
The NPRM defines "net patient revenue" consistent with Public Law 119-21 and current CMS regulations and policy. As a result, states will continue to count all patient revenues, irrespective of payer source and irrespective of some providers within the class being exempted from the tax, as part of net patient revenue. **We support this definition.**

Addition of Health Insurers as Class Subject to Provider Tax Requirements (§433.56)
The NPRM would newly and expressly define taxes on health insurers as constituting a provider class subject to all general Medicaid provider tax rules and the new Public Law 119-21 restrictions in section 71115, irrespective of whether such taxes are used to finance Medicaid or not. States impose such health insurer taxes for a wide range of reasons, many unrelated to Medicaid. Taxes on health insurers finance the operations of state health insurance departments, commissions that oversee and regulate insurers, and state-based marketplaces. They support guaranty funds that protect enrollees if their insurer becomes insolvent, fund coverage assistance programs for low- and middle-income marketplace enrollees, and make possible individual market reinsurance programs — the last usage was previously championed by this Administration because it reduces marketplace premiums and makes coverage more

[3] Alice Burns et al., "5 Questions and Answers About Medicaid and Provider Taxes," KFF, August 20, 2026, https://www.kff.org/medicaid/5-questions-and-answers-about-medicaid-and-provider-taxes/.

[4] Burns et al., *op cit*.

[5] Indiana Family and Social Services Administration, "Healthy Indiana Plan (HIP) 3.0 Section 1115 Waiver Application," August 5, 2026, https://www.in.gov/fssa/hip/files/FSSA_1115-Waiver-Application-Draft.pdf?j=170095&sfmc_sub=225383661&l=1707_HTML&u=3741987&mid=546006736&jb=6009.

affordable for people not eligible for an ACA tax credit. Public Law 119-21's provider tax restrictions did not include any provisions limiting or otherwise addressing these kinds of health insurer taxes, and the NPRM policy targeting these taxes should be withdrawn for several reasons.

First, this is inconsistent with the statutory language in Public Law 119-21 which only applies the new provider tax restrictions to a "class of health care items or services described in section 433.56(a) of title 42, Code of Federal Regulations (as in effect on May 1, 2025)". Even if the NPRM's provision establishing a new health insurer class is finalized, such a class was not described in regulations in effect as of May 2025.

Second, it is our understanding that CMS has not required states to report on these kinds of health insurer taxes and that states have never understood that such taxes, which are unrelated to Medicaid, would constitute provider taxes under the Medicaid statute and regulations and have to comply with federal provider tax requirements. The NPRM itself acknowledges that states have not considered health insurer taxes as relevant to provider tax rules. As such, states also have not put in place uniformity waivers that would be needed for various types of targeted health insurer taxes—meaning that states would be heavily punished by the new policies on provider taxes *and* uniformity waivers.

Third, the NPRM would therefore have a major negative effect on states, non-Medicaid health programs, and their overall budgets. States would have to eliminate many existing health insurer taxes or otherwise face a major financial penalty in their Medicaid program: the loss of federal matching funds related to the amount of revenues raised by these non-Medicaid health insurer taxes and assessments. States would either have to identify alternative revenues or, as is more likely, cut state spending financed by these health insurer tax revenues. Among its many consequences, the rule could reduce oversight of health insurers and enforcement of state health insurance laws, jeopardize consumer education, outreach, and protection initiatives, and force the termination of state reinsurance programs now operating in states from Alaska to Maine.

CMS does not offer any justification or evidence of why these taxes, which have nothing to do with state Medicaid financing, are a serious problem that needs to be addressed in the NPRM or how they somehow violate the new Public Law 119-21 restrictions. **CMS should therefore entirely drop the provision adding services of health insurers as a new class subject to Medicaid provider tax rules (and the new Public Law 119-21 restrictions) and should clarify that it will continue to apply such rules consistent with past CMS policy and practice and state understanding.**

Furthermore, the preamble to the NPRM goes even further and states that any health-related taxes on a provider type that is not specifically enumerated as a class in § 433.56 are by definition impermissible. This could effectively bar many other taxes unrelated to Medicaid that states have enacted or are considering. **CMS should instead clarify that it will assume these taxes and assessments will continue to be viewed as outside the purview of the provider tax**

rules (and the new Public Law 119-21 restrictions) if they are unrelated to financing of states' share of Medicaid costs.

Definition of Enacted and Imposed (§433.68)
Under Public Law 119-21, an existing tax is not subject to the prohibition against new or increased taxes if it has already been enacted and imposed as of the date of enactment: July 4, 2025. In preliminary guidance issued in November 2025, CMS took an unduly restrictive approach to defining which taxes had been enacted and imposed by July 4, 2025.[6] This would have likely resulted in a number of provider taxes and provider tax increases that states instituted prior to Public Law 119-21's enactment being unexpectedly barred by Public Law 119-21, as states would not have had time to obtain any necessary waivers and/or fully implement these taxes.

The NPRM would significantly modify and improve the November guidance by including within the definition taxes with a legally enforceable obligation on providers to pay by the date of enactment and ones with a waiver that was effective as of July 4, 2025. The NPRM would therefore appropriately protect most or all of the provider taxes states instituted before enactment from the Public Law 119-21 prohibition against new or increased provider taxes. **As a result, we strongly support this element of the NPRM.** However, there may be some provider tax increases that may still potentially be prohibited because while enacted before July 4, 2025, their effective date may have been set after July 4, 2025. **The definition of imposed should clarify that a tax enacted before July 4, 2025 but with an effective date after July 4, 2025 still constitutes a legally enforceable obligation for taxpaying entities.**

Additionally, the NPRM would define an enacted tax as a tax where the entire necessary legislative process authorizing the tax has been completed by July 4, 2025, effectively foreclosing the ability of states to modified taxes with retroactive adjustments. This raises a particular problem because under another provision of Public Law 119-21, states may sometimes be required to obtain a new and unexpected "uniformity waiver" for an existing tax. This seemingly puts states in a regulatory trap, where states are prohibited from making a change that they are required to make, leaving them with no lawful means of complying with both Public Law 119-21 sections at the same time. While the preamble to the NPRM indicates that states would be allowed to establish new taxes or modify existing taxes under some circumstances, **such a clarification should be explicitly included in the regulatory language of any final rule.**

New Burdensome Reporting and Punitive Compliance Systems (§433.74)
The NPRM would establish a new and burdensome compliance and reporting process under which CMS would now retrospectively review all state provider taxes to ensure that the taxes do not exceed the safe harbor threshold in any given fiscal year. For purposes of determining

[6] Centers for Medicare & Medicaid Services, "Section 71115 and 71117 of Working Families Tax Cuts Legislation on Provider Taxes," November 14, 2025, https://www.medicaid.gov/medicaid/downloads/providertax_dcl_11142025.pdf.

compliance, states would also be newly required to report on a quarterly basis *actual* data, rather than rely on *reasonable projections* as allowed under longstanding CMS policy and for which states are not punished if, years later, tax and patient revenues vary in unanticipated ways from what states originally estimated due to market conditions and other factors outside states' control. (The preamble states that if states exceed the threshold by "slight" or "minimal" amounts, that may not be considered to be out-of-compliance, yet CMS does not define any of these terms or actually provide for any de minimis exception in the regulatory language.) This will be particularly problematic in the coming years as Public Law 119-21's full range of Medicaid cuts result in losses and volatility for providers and states.[7]

Additionally, in the preamble, CMS clarifies that if a provider tax is determined to have exceeded the safe harbor threshold, *all* revenues raised by such a tax would then be deemed impermissible, not just the amount by which the safe harbor threshold is being exceeded. As a result, states would be on the hook for returning all federal matching funds associated with the entirety of that provider tax. None of these additional reporting, compliance, and penalty requirements are necessitated under Public Law 119-21. **The new reporting and compliance system should therefore be entirely eliminated from any final rule. Instead, CMS should seek input from states and other key stakeholders on how best to ensure that states are in compliance with the provider tax restrictions under section 71115 without imposing undue burdens on state Medicaid programs and creating substantial fiscal risks and uncertainty for state budgets. This includes continuing to review compliance on a prospective basis and relying on state estimates, projections, and other statistical methods consistent with longstanding CMS policy.**

Significant Concerns with the Regulatory Impact Analysis

Our organizations have several concerns with the regulatory impact analysis in the NPRM. First, according to CBO, section 71115 of Public Law 119-21 reduces federal Medicaid spending by $191.1 billion over ten years (fiscal years 2025-2034)[8] and increases the number of uninsured by 1.1 million by 2034.[9] In contrast, the Regulatory Impact Analysis for the NPRM does not include any estimates of the impact on Medicaid enrollment or on the uninsured, as CMS assumes that "this proposed rule would have no effect on enrollment and that all reductions in spending would be made through reductions in provider payments and benefits provided." CMS offers no evidence to support this assumption, only asserting that provider tax revenues have mostly been associated with increased payments to providers and not expansions of enrollment even though it later acknowledges "there is limited information on how States use the revenue from provider taxes today." It also ignores the fact that states have specifically

[7] Manatt Health, "CMS Releases Provider Tax Proposed Rule," State Health and Value Strategies, July 31, 2026, https://shvs.org/resources/cms-releases-provider-tax-proposed-rule/.

[8] 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," *op cit.*

[9] Congressional Budget Office, "CBO's Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, Public Law 119-21," *op cit.*

increased provider taxes to help fund adoption of the Medicaid expansion (most recently in states like North Carolina[10] but also in states like Arizona and Missouri) as well as other improvements such as greater access to home- and community-based services. This unsupported CMS assumption is also highly inconsistent with the fact that states do typically cut eligibility or make it harder for eligible people, particularly individuals with serious and chronic illnesses, to enroll or renew their Medicaid coverage in response to Medicaid-specific and overall budget deficits.[11] By not analyzing or including the projected impact on Medicaid enrollment, CMS has failed to engage in the level of reasoned decision-making necessary to adopt these proposed regulatory changes.

Second, the Regulatory Impact Analysis assumes that states would "use other revenues (mainly general fund revenues) to "offset 30 percent of" the provider tax revenue reductions. CMS, however, provides no basis for this assumption that states would be able to identify significant alternative revenues to offset a portion of the cost-shift to states under Public Law 119-21 and the proposed rule.

Third, as noted above, the Regulatory Impact Analysis estimates that section 71115 and the proposed rule would together cut federal Medicaid spending by $245.8 billion over ten years (2026-2035). Using the same budget timeframe as the CBO estimate of Public Law 119-21 (2025-2034), the Regulatory Impact Analysis's estimate of the ten-year federal Medicaid spending reduction is only 5.4 percent higher than CBO's estimate. While the CMS and CBO estimates are not directly comparable because of assumed methodological and data differences, the proposed rule, which goes far beyond the requirements of Public Law 119-21 as discussed in detail above, is virtually certain to institute greater cost-shifts to states and thus result in larger federal Medicaid spending reductions over time, compared to the provider tax restrictions included in section 71115 by themselves. Moreover, the Regulatory Impact Analysis does not include any estimates of state spending cuts outside of Medicaid (due to cuts to state health initiatives funded by health insurer premium taxes and other taxes and assessments unrelated to Medicaid). **As a result, the Regulatory Impact Analysis is substantially incomplete and flawed.** CMS should revise the Regulatory Impact Analysis to accurately capture the impact of the changes proposed.

Thank you for the opportunity to make the above comments to the NPRM. Please contact Bethany Lilly (Bethany.lilly@bloodcancerunited.org) with any questions.

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[10] Adam Searing and Joan Alker, "The Future of ACA's Medicaid Expansion: What Do Changes in HR1 Mean?," *Say Ahhh! Blog*, Georgetown University Center for Children and Families, November 10, 2025, https://ccf.georgetown.edu/2025/11/10/the-future-of-acas-medicaid-expansion-what-do-changes-in-hr1-mean/.

[11] See, for example, Vernon Smith et al., "Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn," KFF, September 2008, https://files.kff.org/attachment/report-headed-for-a-crunch-an-update-on-medicaid-spending-coverage-and-policy-heading-into-an-economic-downturn-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-year-2008-and-2009.

Respectfully submitted,

AiArthritis
American Cancer Society Cancer Action Network
American Diabetes Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Autoimmune Association
Blood Cancer United
Cancer Nation
Cancer Support Community
CancerCare
Cystic Fibrosis Foundation
Epilepsy Foundation of America
Family Voices National
Legal Action Center
Lupus Foundation of America
Lutheran Services in America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Bleeding Disorders Foundation
National Health Council
National Kidney Foundation
National Multiple Sclerosis Society
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The Coalition for Hemophilia B
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