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Advancing Health in America

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September 21, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding the indirect hold harmless threshold of healthcare-related taxes.

Provider taxes are a longstanding, legitimate and vital source of financing states' non-federal share of Medicaid expenditures. Congress expressly authorized healthcare-related taxes as a permissible source of Medicaid financing in 1991. Thus, states have relied on this authority for more than three decades to sustain their Medicaid programs. Provider taxes enable states to support their Medicaid programs, including to finance investments in program integrity, fraud control, eligibility and enrollment systems, and to finance supplemental payment programs that help offset Medicaid's chronically low base payment rates. These activities are critical to maintaining a program that serves over 70 million people and ensuring that the people who depend on Medicaid have access to care. Without this financing mechanism, many states would face significant budget shortfalls that could force reductions in Medicaid eligibility, covered benefits or provider payment rates, with serious consequences for patient access, particularly in rural communities.

Section 71115 of Public Law 119-21 (P.L. 119-21) imposed new limits on Medicaid provider taxes. Beginning in federal FY 2027, the law prohibits all states from increasing the provider tax indirect hold harmless threshold above the rate that was in place on the date of enactment. The law also reduces the hold harmless threshold for expansion states beginning in FY 2028 by 0.5 percentage points annually. The hold harmless threshold will be the lower of the existing percentage in a state or: 5.5% in federal FY 2028, 5.0% in federal FY 2029, 4.5% in federal FY 2030, 4.0% in federal FY 2031, and 3.5% for federal FY 2032 and subsequent years.

The proposed rule would implement these changes, including establishing new state and provider class-specific indirect hold harmless threshold percentages for existing provider taxes. The rule proposes substantial changes to how the indirect hold harmless threshold is calculated and how states and CMS monitor it. This includes a shift from the longstanding prospective estimate-based approach to a retrospective reconciliation methodology. CMS also proposes significant new one-time and ongoing reporting requirements that will impose substantial administrative burden on states, providers and CMS itself.

As such, the AHA is concerned that some proposals in this rule could create serious financial and operational disruption for states, hospitals and the patients they serve. We are particularly concerned that CMS' proposal to require retrospective reconciliation of actual tax collections and net patient revenue will create significant unpredictability for state Medicaid programs, as well as unnecessary and costly administrative burden for states, providers and the agency. Moreover, we are concerned that other proposals in this rule would unnecessarily compound the financial and operational impact of the statutory changes already required under P.L. 119-21. Specifically, we:

- Urge CMS to preserve the prospective, estimate-based approach for ongoing compliance monitoring and limit the retrospective actual-data requirement to the one-time threshold calculation mandated by statute.
- Ask CMS to delay the Dec. 31, 2026, interim reporting deadline to allow the agency sufficient time to deliberate on comments, finalize the rule and issue the detailed guidance necessary for accurate and complete data submission.
- Strongly oppose CMS' proposal to sunset the 75/75 test, which exceeds CMS' statutory authority, as Congress codified the test in 2006 and did not repeal it in P.L. 119-21.
- Encourage CMS to allow states flexibility to align the administrative calendar year used as the basis for the threshold calculation with other state administrative calendars, such as state or federal fiscal year, subject to CMS review and approval.
- Request additional clarification on the proposed health insurer permissible class, including its distinction from the existing Managed Care Organization (MCO) permissible class, and its application to taxes not used to finance the non-federal share of Medicaid expenditures.

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have any questions, or have a member of your team contact Ben Finder, AHA vice president of coverage policy, bfinder@aha.org, or Krista Geier, AHA senior associate director of Medicaid policy, at kgeier@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

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Enacted and Imposed

The proposed rule implements Section 71115 of P.L. 119-21, which imposed new limits on states' indirect hold harmless threshold. Under the law, states are prohibited from increasing taxes beyond the rate that was in place on the date of enactment of the law. Expansion states will see their threshold reduced incrementally beginning in FY 2028, ultimately falling to 3.5% in FY 2032 and beyond.

The rule proposes a revised interpretation of the phrase "such State has enacted a tax and imposes such tax on such class" in Section 71115 of P.L. 119-21. CMS' interpretation carries substantial practical consequences, as it determines both the revised threshold applicable to a state's existing tax and whether the state may continue to rely on that tax going forward to finance the non-federal share of its Medicaid program. The AHA appreciates that CMS responded to stakeholder feedback on the preliminary interpretation described in its November 2025 Dear Colleague Letter. In particular, the AHA appreciates CMS' clarifications that "enacted" means that the state or local authorizing body has completed the process necessary to authorize the tax and does not depend on subsequent federal administrative approvals, and that "imposes" does not require a state or local government to have already collected revenue under the tax. **The AHA requests that CMS finalize the proposed definition of "enacted," which provides that on July 4, 2025, a state or locality had the authority to administer or assess the tax.**

By contrast, the AHA has serious questions about CMS' interpretation of the word "imposes." Three features of the statute cast serious doubt on CMS' reading. The agency must convincingly address these features if it is going to move forward with its proposed interpretation of that provision.

First, CMS reads "imposes" (at 46,571) as establishing a timing requirement. It states: "We propose that a tax is imposed as of July 4, 2025, if it was in effect. In other words, the State or locality (directly or by way of a delegated administrative agency), imposed on taxpayers a legally enforceable obligation to pay as of July 4, 2025." The AHA does not dispute that the statutory term "enacted" has a temporal meaning. It is far less clear that "imposed" does.

Read in context, the word "imposes" appears to focus on *what* the tax applies to — not *when* it must have applied. The full statutory phrase is: "imposes such tax on such class," with the words "such class" referring back to the language earlier in the same provision: "a class of health care items or services described in Section 433.56(a) of title 42, Code of Federal Regulations." 42 U.S.C. § 1396b(w)(4)(D)(i). The full phrase therefore appears directed at identifying *who or what bears the tax*, rather than establishing an additional temporal effective-date requirement. Put another way, when reading the statute in its entirety, "imposes" is more about *what* the tax applies to — the class of healthcare items and services — than by *when* it was implemented. *Cf. Slodov v. United States*, 436 U.S. 238, (1978) ("When, in 1954, Congress added the phrase

modifying "person" — "Any person required to collect, truthfully account for, and pay over any tax imposed by this title" — it was not seeking further to describe the class of persons defined in § 6671(b) upon whom fell the responsibility for collecting taxes, but was attempting to clarify *the type of tax to which the penalty section was applicable*." (emphasis added)).

Second, Congress' choice of verb tenses raises similar doubts about CMS' interpretation. *E.g.*, *United States v. Wilson*, 503 U.S. 329, 333 (1992) ("Congress' use of a verb tense is significant in construing statutes."). The relevant statutory provisions read: "if, on July 4, 2025, the … State or unit of local government in such State has enacted a tax and imposes such tax on such class." *Id*. Noticeably, Congress did *not* say: "has enacted a tax and *has imposed* such tax." The tenses shift. For one statutory verb, Congress used the present perfect tense: "has enacted." For the other, it uses the simple present tense: "imposes."

This verb tense change cannot be ignored. The different tenses provide strong textual evidence that Congress used each word to do different work. On the one hand, "has enacted" asks about a completed legislative event: had the state enacted the tax by July 4, 2025? *See Barrett v. United States*, 423 U.S. 212, 216 (1976) (holding that Congress used the present perfect tense to "denot[e] an act that has been completed"). On the other hand, "imposes" asks about the present legal operation of that enactment: does the tax enacted by July 4, 2025, impose a tax on the specified class ("a class of health care items or services")? In other words, "imposes" (in the simple present tense) more naturally describes *what the law does*, not a second historical governmental act that must already have occurred by a particular date. Had Congress intended two completed acts by July 4, it knew how to say so: "has enacted a tax and has imposed such tax." Instead, the different verb tenses suggest that Congress required one completed act — enactment — and then described the resulting tax by reference to what it "imposes." *See generally Carr v. United States*, 560 U.S. 438, 448 (2010) (distinguishing the present tense "travels" from the past and present-perfect forms "traveled" and "has traveled").

Third, a neighboring provision reinforces this reading. Section 1396b(w)(4)(D)(i)(I)(bb) addresses what happens if a non-expansion state "has not enacted or does not impose a tax with respect to such class." Not only does this negative formulation of the key statutory phrase use the same verb-tense distinction, but its use of "with respect to such class" tightens the link between "imposes" and *the subject* of the tax. It sharpens the focus on what the tax is about, not when it was applied. *See Khan v. United States*, 548 F.3d 549, 556 (7th Cir. 2008) ("Synonyms for 'with respect to' include 'pertaining to' and 'concerning.'"); *see also Jennings v. Rodriguez*, 138 S. Ct. 830, 856 (2018) (Thomas, J., concurring in part and in the judgment) ("The phrase 'with respect to' means 'referring to,' 'concerning,' or 'relat[ing] to.'" (quoting Oxford American Dictionary & Language Guide (1999 ed.))).

To be sure, these provisions are "far from a *chef d'oeuvre* of legislative draftsmanship." *King v. Burwell*, 576 U.S. 473, 497 (2015). But "statutes, no matter how impenetrable, do—in fact, must—have a single, best meaning." *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 400 (2024). **The AHA respectfully submits that the textual features discussed above raise serious questions about CMS' temporal gloss on the word "imposed." CMS must grapple with these features — and convincingly justify its interpretation in light of them — if it chooses to finalize the proposed reading of the statute.** After all, if CMS finalizes an overly restrictive reading of "imposes," states with legitimate tax arrangements in place as of July 4, 2025 could be deemed not in compliance with the proposed rules, removing from the states a financing tool they relied on in good faith. The consequences of an overly restrictive interpretation would ripple directly into Medicaid program stability, supplemental payment levels, and ultimately access to care for the millions of patients who depend on this program. It is therefore even more important that CMS not impose a textual reading, as it appears to do so here.

Defining Net Patient Revenue

CMS proposes adding a formal definition of "Net Patient Revenue" to § 433.52. CMS states that this definition is intended to restate the description of the term that currently appears within the indirect hold harmless calculation methodology at §433.68(f)(3)(i)(A), and notes that it should be viewed as synonymous with "net patient services revenue" as used in prior rules and guidance, including the 2008 final rule.

The AHA asks CMS to clarify in the final rule that Medicare cost reports are an acceptable and sufficient source of net patient revenue data for purposes of the indirect hold harmless threshold calculation. Medicare cost reports are a standardized, public and widely accepted source of hospital financial data, and states and providers already compile and submit this information to CMS annually. To the extent that cost report data requires adjustment to align with the permissible class structure proposed in this rule, we recommend that CMS provide explicit, standardized guidance on how to make those adjustments. For example, CMS should provide guidance on how to disaggregate combined inpatient and outpatient hospital revenue reported on the Medicare cost report into their respective permissible classes for purposes of the hold harmless calculation.

Retrospective Reconciliation of Net Patient Revenue and Tax Collections

CMS proposes to replace the longstanding practice of allowing states to use projected or estimated data to demonstrate compliance with the indirect hold harmless threshold with a new retrospective reconciliation methodology. The new methodology requires states to calculate the hold harmless percentage using actual tax revenues collected and actual net patient revenue for the applicable measurement period. Under this proposal, states would no longer be permitted to use trended figures, prior period data or other reasonable estimates. This represents a departure from the approach that CMS

has historically accepted. Instead, states must submit actual data to CMS by Dec. 31, 2026, for interim threshold purposes and by June 30, 2028, for final threshold calculations, and must, going forward, monitor their actual tax collections against their applicable threshold on an ongoing federal fiscal year basis. States whose actual collections exceed the applicable threshold would be required to refund excess collections to taxpayers in proportion to each taxpayer's total tax payments or risk a reduction in federal matching funds equal to the excess amount.

The AHA is concerned that the proposed shift to retrospective reconciliation represents a significant and unnecessary departure from decades of established practice that will create serious financial and operational instability for states and the hospitals and health systems that depend on Medicaid supplemental payments. Under the prior prospective approach, states used best available hospital data and applied reasonable trend methodologies to project compliance with the applicable threshold in advance. This approach gave states the predictability and flexibility needed to design and administer tax programs responsibly and efficiently.

The proposed retrospective approach eliminates that predictability. For example, net patient revenue could grow more slowly than anticipated, or tax collections run ahead of projections due to timing or administrative factors. States that designed their tax programs in good faith and in full compliance with prior CMS guidance could find themselves out of compliance when measured against actual data for the same period. As the AHA understands it, states in this position would be required to refund excess tax collections to taxpaying providers, potentially while simultaneously confronting state budget shortfalls created by the loss of those revenues. In practice, states may respond by reducing or recouping Medicaid payments to providers, creating a situation in which hospitals face both a return of tax revenues and a reduction in supplemental payments at the same time. This outcome directly contradicts the goal of maintaining stable Medicaid financing for the patients and communities hospitals serve.

Beyond the financial instability this methodology would create, the AHA is concerned that the retrospective reconciliation approach would impose a substantial administrative burden on all parties involved, including multiple state agencies, hospitals and health systems, and CMS. Compiling and reconciling actual tax collection and net patient revenue data on a permissible class basis is a complex undertaking that goes well beyond anything previously required. It will require significant new resources and coordination across government and the provider community alike. We are also concerned that this new framework would be in direct conflict with the administration's stated commitment to reducing regulatory burden. Imposing a new layer of retrospective data collection, reconciliation and enforcement at this level of complexity, at the same time states are implementing sweeping changes to Medicaid eligibility, enrollment and payment policy, is inconsistent with that commitment and risks overwhelming the administrative capacity of state Medicaid agencies and the providers who depend on these programs.

The AHA urges CMS to preserve the prospective, estimate-based approach for ongoing compliance monitoring using reasonable trends reviewed and approved by CMS. P.L. 119-21 does not require CMS to abandon the prospective compliance framework that has governed state tax programs for decades. Allowing states to continue using projected data and reasonable trend methodologies for ongoing compliance monitoring would preserve the operational predictability states need to administer their tax programs responsibly, reduce the risk of involuntary overcollections and the destabilizing refund obligations they would create, and align ongoing compliance monitoring with the administrative capacity of state Medicaid agencies. At a minimum, if CMS proceeds with retrospective reconciliation, we recommend that CMS protect states from enforcement actions. For example, if a state designed and administered its tax program consistent with prior CMS guidance and accepted practice, CMS should not penalize it for the inherent difference between estimates and actual results. We also encourage CMS to provide states with clear, standardized methodologies for calculating actual tax collections and actual net patient revenue to reduce the risk of inadvertent errors that could trigger refund obligations or reductions in federal matching funds, including explicit guidance on disaggregating revenue by permissible class.

If CMS proceeds with the retrospective reconciliation framework as proposed, we also recommend CMS ensure that the process operates symmetrically for states. The proposed rule provides detailed guidance on the importance of refunding excess tax collections above the applicable threshold once actual net patient revenue is known but does not stipulate what a state may do if post-period calculations reveal that actual tax collections were below the applicable threshold. States have historically been permitted to reconcile taxes owed to actual costs when actual costs become known later. CMS should clarify that post-period calculations made pursuant to pre-existing state authority and established methodologies are permitted under the regulation. Absent such clarification, states face a one-sided framework in which the retrospective methodology is used to penalize overcollection but provides no corresponding benefit when actual data demonstrate that collections were conservative.

One-time and Ongoing Reporting Requirements

CMS proposes substantial new one-time and ongoing reporting requirements to support implementation and enforcement of the revised indirect hold harmless thresholds. **The AHA is concerned that the reporting requirements, as proposed, will create an unnecessary burden on states and providers and put provider payments at greater risk due to procedural challenges faced by both states and CMS.**

Under the rule, states must first submit information and best available data on the tax structure enacted and imposed as of July 4, 2025, to CMS by Dec. 31, 2026, for CMS to calculate an interim threshold. States must then submit actual data for the same period by June 30, 2028, for CMS to determine a final threshold by Oct. 1, 2028. However, states will be subject to the new threshold beginning Oct. 1, 2026, which creates two

years of uncertainty and unnecessary administrative burden for states implementing their provider tax programs. Additionally, beginning the federal fiscal year (FFY) 2027, states will be required to submit quarterly reports to CMS on all state and local provider taxes, including actual tax collections and net patient revenue by tax and permissible class.

Quarterly reporting of provider tax data introduces a new volume of administrative work for which states and providers have not prepared, nor have the capacity to undertake, given the other simultaneous Medicaid program changes and funding reductions. Many provider tax programs are structured annually, and some states collect taxes more or less frequently than quarterly, meaning that quarterly data may experience significant fluctuations and delays, particularly when annual reconciliation processes result in prior-year adjustments being combined with current tax collections. As a result, comparing taxes collected in a specific quarter against quarterly net patient revenue may not accurately reflect compliance with an annual tax limit and could lead to misinterpreted reporting.

Furthermore, Medicare cost reports, which are a potential source of net patient revenue data, are filed annually, not quarterly. CMS should clarify whether prorated cost reports could satisfy quarterly reporting requirements, or whether states and providers would be required to develop entirely new data collection and reporting infrastructure. The burden would be particularly significant for certain hospitals that have less experience filing Medicare cost reports or report data in a non-standardized manner. While not acknowledged in CMS' regulatory impact analysis, hospitals and health systems would also face additional burden due to the data states need to collect from them to calculate net patient revenue at the class level.

Additionally, the AHA asks CMS to consider delaying the initial data submission, proposed to be due on Dec. 31, 2026. Delaying the interim reporting deadline would give CMS the opportunity to carefully deliberate over the comments it receives, finalize the rule and develop and promulgate the detailed guidance necessary for states and providers to submit accurate and complete data. This is especially important given the significant and long-lasting implications this policy has for state fiscal planning and Medicaid financing.

Consequences for Exceeding the Threshold or Failing to Comply with Reporting Requirements

Under the rule, exceeding the indirect hold harmless threshold would result in a deduction of the state’s claimed medical expenditure by the total amount of revenue raised from all taxes within a permissible class. This would put a significant amount of program funding at risk. As states seek to comply with the unique threshold requirements and phase-down schedule, **the AHA recommends that CMS only deduct the amount exceeding the threshold from the state’s claimed medical assistance expenditures.**

To enforce the new reporting requirements, CMS proposes two levers. First, if a state fails to report properly, CMS would reduce the state's future quarterly grant funding by the amount of federal matching funds it estimates were generated by the unreported tax, and it may impose deferrals or disallowances in equivalent amounts for the affected quarters. Second, CMS may refuse to approve state directed payment (SDP) preprints while the state is out of compliance.

The AHA is concerned that CMS' second compliance lever will create significant financial hardship for providers. Hospitals rely on timely SDPs to pay for services provided to Medicaid patients, and SDPs operate under a review framework and timeline that is separate and apart from CMS' proposed provider tax reporting requirements. This proposal would threaten the stability of these payments for providers due to a reporting process for which they have no responsibility or access. **Therefore, the AHA urges CMS to rescind its proposal to condition SDP preprint approval on provider tax reporting compliance.**

75/75 Test

The rule proposes to discontinue application of the second prong of the indirect hold harmless test, or the "75/75 test," in the regulations that apply to FFYs beginning on or after Oct. 1, 2026. The "75/75 test" is a longstanding component of the federal hold harmless framework and can be critical to determine whether a guarantee to hold taxpayers harmless exists. While P.L. 119-21 amended the indirect hold harmless thresholds pursuant to the first prong of the indirect hold harmless test, it did not make any modifications to this second prong.

CMS justifies this proposal based on actions it perceives states will take under the new statutory framework and the lack of utilization of this test in the past. The AHA respectfully disagrees with both rationales. Low historical utilization is the result of the 6% safe harbor threshold, under which few taxes ever crossed the first prong and required second-prong analysis. As states and CMS implement the complex statutory threshold phase-down to 3.5%, a substantially larger share of taxes could fall above the first prong and require analysis under the second. Nor do we agree with CMS' assertion that if this test is maintained, states "may try to manipulate a way to increase tax revenue collections in order to maintain existing levels of non-[f]ederal share generated through health care-related taxes." States may unintentionally exceed the threshold due to factors outside their control, such as declines in net patient revenue, changes in patient volume or payer mix or hospital closures that change the makeup of a class. In these circumstances, the second prong is what distinguishes a tax that exceeds the threshold from one that actually holds taxpayers harmless. This action also conflicts with CMS' proposed treatment of taxes that "slightly exceed" the threshold. Without this test, and absent any further definition of "slightly

exceeds," a tax that minimally exceeds the threshold but would otherwise satisfy the second prong would be considered impermissible.

In addition to the AHA's concerns on CMS' rationale, CMS' proposal to sunset the "75/75 test" exceeds its statutory authority. First implemented in an interim final rule in 1992, the "75/75 test" was later affirmatively codified in statute in 2006. Specifically, Congress provided: "a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, '5.5 percent' shall be substituted for '6 percent' each place it appears, and for fiscal years beginning on or after October 1, 2026, the applicable percent determined under subparagraph (D) shall be substituted for '6 percent' each place it appears." 42 U.S.C. § 1396b(w)(4)(C)(ii). Critically, Congress codified both prongs of the indirect guarantee test in effect on Nov. 1, 2006 — including the "75/75 test" that CMS proposes to now eliminate.

CMS cannot lawfully eliminate this provision. By codifying the "75/75 test," Congress removed any CMS discretion to eliminate it. Any change to that test would require congressional legislation — not notice-and-comment regulation.

What's more, as the proposed rule acknowledges, Congress amended 1396b(w)(4)(C)(ii) in the Working Families Tax Cut Act, see Pub. L. No. 119-21, § 71115, 139 Stat. 301–03, H.R. 1, 119th Congress (2025), but it did not change the portion of the provision that codified the "75/75 test." In fact, Congress made this amendment after the Office of Inspector General issued the Nov. 8, 2018, report on which the proposed rule relies to support its proposed elimination of the "75/75 test." [1] This is especially significant because Congress could have changed the "75/75 test" had it wanted to, but it did not. **CMS cannot now change that statutory provision itself.**

Federal and State Fiscal Year Considerations

[1] There is no plausible basis for treating Congress as unaware of the 75/75 test or its consequences. The Government Accountability Office (GAO) and Health and Human Services Office of the Inspector General repeatedly scrutinized Medicaid provider-tax arrangements and reported their concerns to Congress and policymakers, and GAO expressly described the "75/75 test" and how it operated. *See generally NASA v. FLRA*, 527 U.S. 229, 246–47 (1999) ("explaining that IGs are to keep Congress "fully and currently informed" concerning problems and corrective recommendations). Congress nevertheless continued to leave that test intact, including when it again substantially amended Section 1903(w) in 2025 and modified the percentage applicable to the indirect-hold-harmless framework.

CMS proposes to calculate each state's indirect hold harmless threshold using the state fiscal year (SFY) that contains July 4, 2025, as the measurement period. Under this proposal, both actual tax collections and actual net patient revenue would be drawn from that full state fiscal year. CMS acknowledges that state fiscal years vary and that the SFY containing July 4, 2025, may not readily provide a full year of data in all circumstances.

The SFY is only one of several time periods that could reasonably serve as the measurement period for calculating the indirect hold harmless threshold. States manage a number of overlapping administrative calendars that govern different aspects of their Medicaid programs. For example, a state could operate separate calendars for the state fiscal year, a Medicaid managed care plan year, a state rating period for SDP programs, a Section 1115 waiver demonstration year and the federal fiscal year. The choice of measurement period has direct and material consequences for how the threshold is calculated, how it aligns with existing state planning and operations and CMS review processes. To add to the complexity, Medicare cost reports are based on providers' fiscal year, which may not align with any of the other administrative calendars described above.

The AHA urges CMS to consider allowing states to choose which administrative calendar year to use as the basis for the threshold calculation, subject to CMS review and approval. Providing states this flexibility would allow CMS and each state to identify the measurement period that most closely aligns with that state's existing data systems and administrative operations, producing a more accurate and workable threshold. It also would have the practical benefit of staggering data submissions and CMS review across the calendar year, rather than requiring all fifty states and the District of Columbia to submit data simultaneously, potentially reducing the administrative burden on CMS and states alike in a meaningful way. This approach is consistent with the flexibility CMS has previously provided to states in analogous contexts, including in the SDP rule, in which CMS allowed states to benchmark the SDP limit to the higher of two SDP preprints. Moreover, CMS should allow states to use their 2025 state fiscal year if they so choose.

New Health Insurer Permissible Class

CMS proposes adding "services of health insurers" as a new permissible class under § 433.56(a)(19), separate and distinct from the longstanding managed care organization (MCO) permissible class at § 433.56(a)(8). CMS provides examples of the types of insurers this would apply to, including some examples from the group, individual, and Medicaid markets, including some from some Medicaid premium assistance programs. CMS solicits comment on whether the proposed class captures all appropriate services of health insurers. This proposal revives a similar provision that was included in the 2019 Medicaid Fiscal Accountability Rule, which was subsequently withdrawn without being finalized.

The AHA requests that CMS clarify the distinction between the proposed health insurer permissible class at § 433.56(a)(19) and the existing MCO permissible class at § 433.56(a)(8). In the preamble, CMS acknowledges there is potential overlap between the two classes but asserts that they are nonetheless distinct. However, CMS does not provide sufficient detail to allow states and other stakeholders to clearly understand the differences between the two classes. This lack of clarity creates significant operational uncertainty for states that currently tax managed care organizations or health insurers, since a misclassification of a taxed entity could result in a tax being assessed against the wrong permissible class with potentially significant consequences for the applicable threshold and federal matching fund calculations. We urge CMS to provide clear, concrete guidance in the final rule delineating which entities fall within the MCO permissible class, which fall within the new health insurer permissible class and how states should treat entities that may have characteristics of both, for example, managed care organizations that also offer commercial insurance products outside of their Medicaid contracts.

The AHA also requests that CMS clarify the scope of application of the proposed health insurer permissible class with respect to taxes not used to finance the non-federal share of Medicaid expenditures. The statutory authority for these regulations, Section 1903(w) of the Social Security Act, is explicit that the hold harmless rules apply to health care-related taxes that a state uses to generate the non-federal share of Medicaid payments for which federal matching funds are claimed. However, some stakeholders may interpret the preamble to mean that CMS intends to apply hold-harmless restrictions to taxes that are used to fund non-Medicaid expenses, such as supporting individual market coverage or general revenue funds. If, as we believe to be the case, these rules apply only to taxes used to finance the non-federal share of Medicaid expenditures, we urge CMS to state that explicitly in the final rule to avoid unnecessary confusion and compliance burden for states and health insurers.