Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

VIA ELECTRONIC SUBMISSION

September 11, 2026

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2452-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments to CMS-2452-P
Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes

The Center for Children and Families (CCF), part of the McCourt School of Public Policy at Georgetown University, is an independent, nonpartisan policy and research center that conducts research, develops strategies, and offers policy solutions to support access to high-quality, comprehensive, and affordable health coverage for the nation's children and families, particularly those with low- and moderate-incomes. Thank you for the opportunity to make the following comments to this Centers for Medicare & Medicaid Services (CMS) proposed rule, which are based on our deep expertise in health policy and in the Medicaid program.

In H.R. 1 (P.L. 119–21), under section 71115, Congress set new restrictions on the longstanding state use of provider taxes to finance their share of Medicaid costs. The limitations set out in section 71115 of H.R. 1 will lead to harmful state funding losses that will result in an estimated $191.1 billion over ten years (2025-2034) in reduced federal spending according to the Congressional Budget Office (CBO).[1] On July 23, 2026, CMS published a Notice of Proposed Rulemaking on Amending the Indirect Hold-Harmless Threshold of Health Care-Related Taxes (the "NPRM").[2]

[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,

The NPRM is ostensibly implementing section 71115 of H.R. 1 but actually goes far beyond the provider tax restrictions established by H.R. 1 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 practice and with state understanding. This will lead to far greater funding cost shifts to states, which will lead to more reduced access to needed care for not only low-income individuals enrolled in Medicaid but also those enrolled in state-based Marketplace plans and those benefiting from other state health programs.

As part of its Regulatory Impact Analysis, CMS estimates that the NPRM would result in a decline in state revenues raised by provider taxes by $198.7 billion over ten years (2026-2035), a reduction of 17.2 percent relative to prior law. But in the tenth year (2035), states would see their provider tax revenues fall by 27.1 percent, compared to the revenues they would have received to finance Medicaid and other health care spending in the absence of H.R. 1 and the proposed rule. Overall, CMS expects the combined effect of H.R. 1's provider tax provision in section 71115 and the proposed rule would cut federal Medicaid spending by $245.8 billion over ten years. As explained below, these estimates likely understate significantly the harmful impact of the NPRM.

As discussed further below, we recommend that CMS *not* finalize numerous provisions of the NPRM that go beyond the requirements of H.R. 1, which will further shift costs to states and lead to even more harmful cuts affecting individuals and families who rely on Medicaid and other state health programs, as described further below. Instead, CMS should finalize only the provisions of the rule that are specifically required by section 71115 of H.R. 1, are consistent with the statute, longstanding CMS policy and practice, and state understanding, and in consideration of the vital coverage and access needs of Medicaid-enrolled individuals as well as individuals who rely on other state health programs and initiatives.

* * *

Vital Importance of Provider Taxes to State Financing of Medicaid and the Harmful Impact of H.R. 1

States have flexibility in how they finance their share of Medicaid costs, so long as they contribute at least 40 percent of the state share. This can include traditional revenue sources such as income and sales taxes as well as contributions from local governments (whether direct funding transfers or through certified public expenditures). States can also rely on taxes and assessments on health care providers such as hospitals, nursing homes, and managed care plans (known as "provider taxes") so long as they comply with federal statutory and regulatory requirements that have been in place since the early 1990s. The

---

https://www.federalregister.gov/documents/2026/07/23/2026-14897/medicaid-program-amending-the-indirect-hold-harmless-threshold-of-health-care-related-taxes.

three major federal requirements are that the taxes must be broad-based and uniform and cannot directly or indirectly hold taxpaying providers harmless. States can satisfy the prohibition against an indirect hold harmless guarantee under a two-prong test: (1) the size of the tax does not exceed a safe harbor threshold (which was equal to 6 percent of net patient revenues under the law prior to enactment of H.R. 1) or (2) the tax passes a 75/75 test under which less than 75 percent of taxpayers receive less than 75 percent of their tax payments back in increased Medicaid or other state payments.

All states but Alaska rely on revenues raised by provider taxes to finance a portion of their share of Medicaid costs, with 41 states having three or more provider taxes. States report that in their state fiscal year 2026 budgets, such provider tax revenues accounted for 18 percent of the state share. States have used new or increased provider taxes to finance their overall Medicaid program as well as to specifically support eligibility expansions including the 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]

H.R. 1 would sharply restrict the longstanding, widespread use of provider taxes by states to finance their Medicaid programs. Section 71115 of H.R. 1 includes two major elements. First, it effectively prohibits all states from raising additional state revenues through new provider taxes or increases in existing provider taxes upon date of enactment (as of July 4, 2025). (H.R. 1 institutes these restrictions by setting the safe harbor threshold to zero for new taxes and to the size of an existing tax that was in place before enactment, effective October 1, 2026.) This means states are restricted to their existing taxes, even if they have applied taxes only to certain providers like hospitals and nursing homes but not to intermediate care facilities for individuals with intellectual disabilities, ambulances and managed care plans. They are also confined to the current size of their provider taxes even if they were below the prior safe harbor threshold of 6 percent. As a result, states are now unable to raise additional revenues to finance improvements in their Medicaid programs or to avert any budget shortfalls including during an economic downturn or recession.

Second, section 71115 reduces the permissible size of most existing provider taxes but only in expansion states (starting October 1, 2027). In states that have adopted the Medicaid expansion, the prior safe harbor threshold of 6 percent is reduced to 5.5 percent in federal fiscal year 2028, 5 percent in 2029, 4.5 percent in 2030, 4 percent in 2031 and then to 3.5 percent in fiscal year 2032 and thereafter. The lower thresholds apply to existing provider taxes except for those applying to nursing homes and intermediate care facilities for individuals with intellectual disabilities. At least 31 expansion states will have to shrink the size of existing provider taxes as such taxes now exceed the 3.5 percent threshold and thus will have considerably less revenues available to finance Medicaid over time. Seventeen expansion states will have to reduce their provider taxes as of October 1, 2027 because

[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/.

some of those taxes now equal between 5.5 and 6 percent of net patient revenues.[4] As a result, states will have to raise other taxes such as income taxes or sales taxes, cut other parts of their budget like K-12 education, or, as is most likely, dramatically cut their Medicaid programs. 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 H.R. 1 provider tax restrictions as why it may be unable to financially sustain its Medicaid expansion in the future.[5] (Section 71117 of H.R. 1 includes an additional provider tax restriction, prohibiting certain existing "uniformity waiver" provider taxes. A rule related to section 71117 was already finalized by CMS in January 2026 and is therefore not addressed in this NPRM.[6])

According to CBO estimates of H.R. 1, section 71115's provider tax restrictions will cut federal Medicaid spending by $191.1 billion over ten years (2025-2034).[7] CBO also estimates that section 71115 of H.R. 1 will by itself increase the number of uninsured by 1.1 million by 2034, relative to CBO's January 2025 baseline under prior law.[8]

NPRM Includes Many Elements Going Beyond H.R. 1 Requirements that Worsen Cost-Shifts to States and Lead to More Severe Medicaid and Other Health Spending Cuts

Definition of Net Patient Revenue (§433.52)

Under longstanding regulations and policy, for purposes of determining compliance with the safe harbor threshold, net patient revenue (labeled "net patient service revenue" in current regulations) is calculated by including all patient revenue received by the providers in the taxed class. The NPRM replaces "net patient service revenue" with "net patient revenue" (as that is the term used in section 71115) but defines this term consistent with current CMS regulations, policy, and practice, and state understanding (unlike how other elements of the NPRM, as discussed below, constitute major departures from longstanding CMS regulations, policy, practice, and state understanding). As a result, states will continue to count all patient revenues, irrespective of payer source and irrespective of some

---

[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.

[6] Center for Medicare & Medicaid Services, "Medicaid Program: Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole," February 2, 2026, 91 Fed. Reg. 4794, https://www.federalregister.gov/documents/2026/02/02/2026-02040/medicaid-program-preserving-medicaid-funding-for-vulnerable-populations-closing-a-health.

[7] 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*

[8] Congressional Budget Office, "CBO's Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, Public Law 119-21," August 11, 2025, https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx.

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)

On a longstanding basis, states have imposed various taxes and fees on health insurers (usually set at a percentage of premiums) to finance the operations of their health insurance departments and commissions that oversee and regulate such insurers (and not just for licensing or certification). More recently, states use these types of premium-based assessments to finance administration of their state-based Marketplaces (typically known as "Marketplace user fees") and reinsurance programs, and to provide state-funded subsidies to supplement federal premium tax credits for the purchase of Marketplace plans under the Affordable Care Act. H.R. 1's provider tax restrictions did not include any provisions limiting or otherwise addressing these kinds of health insurer taxes.

The NPRM, however, would newly and expressly define such taxes on health insurers as constituting a provider class subject to not only all general Medicaid provider tax rules but also the *new* H.R. 1 restrictions in section 71115, irrespective of whether such taxes are used to finance Medicaid or not. (This would not include managed care plans, which are already subject to the provider tax rules.) This means, for example, that states would now be barred from imposing any new premium taxes or increasing the size of their existing taxes. They would also be subject to the H.R. 1 phasedown of the permissible size of existing taxes if they are expansion states. If health insurer premium taxes are determined to be out-of-compliance with the provider tax rules and restrictions, states would either have to eliminate or reduce such taxes or be subject to financial penalties in their Medicaid program even if such taxes are wholly unrelated to Medicaid.

First, this is inconsistent with the statutory language in H.R. 1 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, while the statutory definition (in section 1903(w)(3)) of what constitutes a health care related tax is broad, it is our understanding that CMS has not required states to report on these kinds of health insurer taxes (as part of states' general reporting on Medicaid provider taxes and on how they are financing their state share) 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. For example, states have been reporting information about some of these taxes such as state-based Marketplace user fees to other non-Medicaid parts of CMS — the Center for Consumer Information and Insurance Oversight (CCIIO) related to administration of the Marketplaces — without any objection or concerns raised by CMS. The preamble itself acknowledges that states "may not have understood certain health insurer taxes constitute health-care related taxes for purposes of section 1903(w) of the Act" and the "longstanding existence of these taxes in multiple" states. It also acknowledges

that only in late 2025 did CMS even make an effort to ascertain some information from states about some of these taxes. Notably, Marketplace user fees are applied only to health insurers operating in the Marketplace. They therefore are not broad-based and would require a broad-based waiver from CMS if they are subject to the Medicaid provider tax rules. But because states understood based on longstanding practice that such assessments were not subject to Medicaid provider tax rules, they never applied for and received broad-based waivers from CMS. And as discussed below, only taxes with waivers that were already approved as of the date of enactment (or would retroactively be in effect as of the date of enactment so long as a waiver application was submitted as of October 2025) would be considered an existing tax for purposes of the H.R. 1 restrictions in section 71115. This would similarly be the case for health insurer premium taxes that are applied on a non-uniform basis, with differential tax rates based, for example, on type of ownership (for-profit versus non-profit insurers). That would require a uniformity waiver under Medicaid provider tax rules if they now apply.

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. Unlike the federal government, states must balance their budgets. States would either have to identify alternative revenues or, as is more likely, cut state spending financed by these health insurer tax revenues. This could include eliminating or reducing state subsidies that supplement the federal premium tax credits available to individuals and families for purchase of Marketplace plans, eliminating reinsurance programs, scaling back operations of state-based Marketplaces, reducing oversight of health insurers and enforcement of state health insurance laws, and dropping consumer education, outreach, and protection initiatives.

As a result, for these kinds of premium taxes and assessments on insurers unrelated to Medicaid, the NPRM is a massive departure from longstanding CMS policy and practice and the understanding of states in what taxes are subject to Medicaid provider tax rules and in how states must comply with such rules. 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 H.R. 1 restrictions. In fact, CMS, in the preamble, only expresses concern about where such taxes may have "possibly provided the non-Federal share for Medicaid expenditures" which would not be the case for these types of premium taxes. **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 H.R. 1 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 farther 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; for example, some states have

instituted assessments on pharmacy benefit managers (PBMs) to finance initiatives aimed at prescription drug affordability and supporting community pharmacy access (outside of Medicaid). Other states have also imposed taxes, assessments, and fees on third-party administrators, benefit consultants, and manufacturers of opioid drugs to finance a variety of state health-based initiatives (all outside of Medicaid). As with health insurer taxes, if states are forced to eliminate these taxes, states would likely have to eliminate such health programs and initiatives financed by these revenues. **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 H.R. 1 restrictions) if they are unrelated to financing of states' share of Medicaid costs.**

Elimination of the 75/75 Prong for Compliance with the Hold Harmless Requirement (§433.68)

Under regulations that have been in place since 1992-1993 (§433.68(f)(3)(i)(B)), states can demonstrate that there is not an indirect hold harmless arrangement in two ways: (1) under the first prong, the provider tax is at or below the safe harbor threshold and (2) under the second prong, less than 75 percent of taxpayers receive less than 75 percent of their tax payments back in increased Medicaid or other state payments. The NPRM simply eliminates the 75/75 prong starting October 1, 2026, with no legal requirement to do so in H.R. 1, in violation of the Medicaid statute, and with no adequate rationale for this major change.

In the preamble, CMS correctly acknowledges that section 71115 of H.R. 1 does not eliminate or otherwise require CMS to modify the 75/75 prong. CMS, however, actually has no authority to eliminate or modify the 75/75 prong as Congress has previously codified the 75/75 regulatory provision as part of the Tax Relief and Health Care Act of 2006 (P.L. 109-432). Section 403 of such Act amended section 1903(w)(4)(C) of the Social Security Act to require that any determination of whether there is an indirect hold harmless guarantee will be made under 42 CFR § 433.68(f)(3)(i) that was in effect on November 1, 2006 (which included the 75/75 prong as it stands today). In other words, eliminating the 75/75 prong is in direct violation of the Medicaid statute.

According to our understanding, we agree with CMS that very few states currently use the 75/75 prong or have used the 75/75 prong in the past to comply with the hold harmless requirement. CMS tries to justify the elimination of the 75/75 prong by arguing that otherwise states could exceed the lowered safe harbor threshold in expansion states as well as generally institute new or increased taxes in "circumvention" of H.R. 1. First, as noted above, Congress could have but did not remove the 75/75 prong as part of H.R. 1 and the 75/75 prong has been codified into the Medicaid statute since 2006. Second, the intent of the statute is to ensure that there is no indirect hold harmless arrangement, not to simply make it more difficult for states to finance their share of Medicaid costs under the federal-state financial partnership (as the preamble implies throughout). By definition, under the 75/75 prong, any provider tax that satisfies this test is a tax under which a substantial share of providers paying the tax are not receiving a substantial share of the benefits (if the tax is being used to finance higher Medicaid reimbursement rates, for

example). In fact, the preamble also acknowledges this as a reason why states have typically opted to satisfy the hold harmless requirement through the first prong (the safe harbor threshold). And it is why the 75/75 prong was included in the original 1992-1993 regulations in the first place as one reasonable and rational approach for states to demonstrate there is no indirect hold harmless arrangement. Third, CMS offers no evidence the 75/75 prong has been used by states to somehow inappropriately violate the hold harmless requirement, justifying a major departure from longstanding regulations.

Because elimination of the 75/75 prong is not authorized by H.R. 1 and has been previously codified and because the 75/75 prong constitutes a reasonable, appropriate option for states to demonstrate that there is no indirect hold harmless guarantee, CMS should entirely drop this provision.

Definition of Enacted and Imposed (§433.68)

Under H.R. 1, 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 stated it would consider a tax as already imposed only if the tax was "actually implemented" and the state (or local government) "was actively collecting revenue" from such tax as of July 4, 2025.[9] The guidance also required that CMS must have approved any necessary waivers related to a provider tax before the date of enactment. This would have likely resulted in a number of provider taxes and provider tax increases that states instituted prior to H.R. 1's enactment being unexpectedly barred by H.R. 1, as states would not have had time to obtain any necessary waivers and/or fully implement these taxes.

The NPRM would significantly modify the November guidance. Specifically, a provider tax would be considered to be imposed so long as there was a legally enforceable obligation on providers to pay (as opposed to active collection of the tax) on the date of enactment. Moreover, provider taxes that needed waivers would be considered imposed if the waivers were subsequently approved with an effective date back to July 4, 2025 or before (so long as states applied for such waivers before October 1, 2025). The NPRM would therefore appropriately protect most or all of the provider taxes states instituted before enactment from the H.R. 1 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.**

However, there is one additional issue that remains outstanding. The NPRM would define an enacted tax as a tax where the entire necessary legislative process authorizing the tax

[9] 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.

has been completed. It would not encompass taxes that are subsequently modified by administrative or legislative adjustments after July 4, 2025 even if the adjustments are made retroactive to July 4, 2025. This raises the issue of H.R. 1's separate prohibition against certain "uniformity waiver" taxes under section 71117. A state could modify an existing uniformity tax — by equalizing tax rates between Medicaid- and non-Medicaid providers including managed care plans — to come into compliance with section 71117.[10] The final uniformity waiver rule (91 Fed. Reg. 4794[11]) and this NPRM, however, do not clarify that such a modification is permissible and does not run afoul of section 71115's prohibition against new taxes or increases in existing taxes because as subsequently adjusted after the date of enactment, they may not be considered enacted as of July 4, 2025. The Regulatory Impact Analysis states that the NPRM would allow states to establish new taxes or modify existing taxes so long as the tax rate does not exceed the applicable safe harbor threshold (including the phased-down threshold in expansion states). But that does not actually appear in the regulatory language or the main part of the preamble describing the substantive elements of the NPRM. As a result, the NPRM does not explicitly offer states a path to comply with section 71115 without violating section 71115. This seemingly puts states in a regulatory trap, where states may have no lawful means of complying with both H.R. 1 sections at the same time, which CMS neither acknowledges nor rationally resolves (and therefore does not constitute a faithful implementation of such sections.) **The clarification in the Regulatory Impact Analysis 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, complex, burdensome, and punitive 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. (This would relate to compliance with both the prohibition on increases in existing taxes and the phasedown of the safe harbor threshold in expansion states.) If states are determined by CMS to have provider taxes in excess of the H.R. 1 limits, they will be required to refund taxpaying providers, reimburse the federal government for matching funds related to the taxes, or be explicitly subject to federal deferrals and disallowances.

Moreover, for purposes of determining compliance, states would also be newly required to report on a quarterly basis *actual* data (including revenues from the provider tax and the net patient revenues received by providers within the class subject to the provider tax), rather than rely on prospective estimates, projections, or other statistical methods allowed under longstanding CMS policy. States would have to establish complex reporting systems that do not currently exist in order to collect this data. Because actual tax revenues and

[10] Edwin Park, "CMS Issues Final Rule Implementing H.R. 1's Prohibition of Certain Uniformity Waiver Provider Taxes," *Say Ahhh! Blog*, Georgetown University Center for Children and Families, February 2, 2026, https://ccf.georgetown.edu/2026/02/02/cms-issues-final-rule-implementing-h-r-1s-prohibition-of-certain-uniformity-waiver-provider-taxes/.

[11] Center for Medicare & Medicaid Services, "Medicaid Program: Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole," *op cit*.

providers' net patient revenues may vary in unanticipated ways from what states originally estimated due to market conditions and other factors outside states' control, this may result in CMS determining that states' provider taxes exceeded the safe harbor threshold two years or more after a particular fiscal year. Net patient revenues among providers will not only decline significantly but also be particularly volatile in coming years due to the impact of H.R. 1's massive Medicaid cuts (including not just restrictions on provider taxes but also cuts to state-directed payments and the impact of coverage losses from Medicaid work reporting requirements and more frequent renewals, among other provisions.)[12] CMS' regulatory language makes no allowance, exception, or consideration for states whose reasonable estimates, projections, or other methods ended up being imperfect. (The preamble states that if states exceed the threshold by "slight" or "minimal" amounts, that may not be considered to be out-of-compliance. CMS would only consider "significant excesses" yet CMS does not define any of these terms or actually provide for any de minimis exception in the regulatory language.)

To make matters worse, 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. This system would likely lead to states further reducing the size of their existing taxes — even if those taxes otherwise comply with H.R. 1 restrictions including the safe harbor threshold phasedown in expansion states — in order to avoid the risk that they are later determined to have breached the applicable thresholds and be subject to potentially large and punitive financial penalties. None of these additional reporting, compliance, and penalty requirements are necessitated under H.R. 1. **The new reporting and compliance system should therefore be entirely dropped 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.**

Special Reporting Related to Exclusion of Public Providers from Provider Tax (§433.74)

Under longstanding federal law and regulations, states can rely on funds transferred from local governments to help pay for their share of Medicaid costs, so long as states contribute at least 40 percent of the required state share. These "intergovernmental transfers" (IGTs) can include direct funding transfers from counties, cities, and other local government entities as well as certified public expenditures (CPEs) under which public hospitals and other public providers furnish services to Medicaid patients (and whose operations are

[12] 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/.

funded by counties and other local governments). H.R. 1 (in section 71115 or elsewhere) did not include any provision addressing or restricting IGTs. They remain allowable under both the Medicaid statute and regulations.

The NPRM, however, would require states to newly notify CMS if any existing provider tax subsequently exempts a public provider from the tax. (Such an exclusion of public providers from a tax does not require a waiver of the broad-based requirement under section 1903(w)(3)(B)(i) of the Social Security Act, as public providers are exempt from such requirement.) In the preamble, CMS states that such a notice will then trigger particular scrutiny and oversight especially if the state then establishes a new IGT related to that exempted public provider. CMS baselessly claims that this is because of greater risk of non-compliance with the hold harmless requirement (even though the public provider is being exempted from paying a tax and therefore cannot actually be held harmless from paying such a tax because they are not paying it in the first place and even though any such actions on the part of states are completely permissible and would be in compliance with the new safe harbor thresholds.) CMS indicates it will then "look closely at," "scrutinize" and provide "close oversight" of any arrangements reported under this provision, but without any description of the criteria for such review or how and why such permissible arrangements would somehow no longer be considered in compliance with federal statutory and regulatory requirements. This instead appears to be inappropriately setting the stage for CMS to restrict some legitimate IGTs (that are not provider taxes and not subject to any H.R. 1 restrictions at all) in the future, somehow using provider tax compliance with H.R. 1 restrictions and this rule, if finalized, as justification without any basis. **CMS should drop this new notice and review provision.**

Significant Concerns with the Regulatory Impact Analysis

First, according to CBO, section 71115 of H.R. 1 reduces federal Medicaid spending by $191.1 billion over ten years (fiscal years 2025-2034)[13] and increases the number of uninsured by 1.1 million by 2034.[14] 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 increased provider taxes to help fund adoption of the Medicaid expansion (most recently in states like North Carolina[15] but also in states

[13] 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.*

[14] 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.*

[15] 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,

like Arizona and Missouri) as well as other improvements such as greater access to home- and community-based services. This unsupported and untenable CMS assumption is also highly inconsistent with the Congressional Budget Office estimate of a 1.1 million increase in the uninsured as a result of section 71115's provider tax restrictions implemented by the proposed rule and the fact that states do typically cut eligibility or make it harder for eligible people to enroll or renew their Medicaid coverage in response to Medicaid-specific and overall budget deficits.[16] And the resulting increase in the number of uninsured would likely be even larger than the CBO estimate if the proposed rule is finalized, as the rule goes well beyond the requirements of the H.R. 1 provider tax restrictions in section 71115, as explained above.

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 able to identify significant alternative revenues to offset a portion of the cost-shift to states under H.R. 1 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 H.R. 1 (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 H.R. 1 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.**

* * *

Thank you again for the opportunity to make the above comments to the NPRM. Please contact us at Edwin.Park@georgetown.edu if you have any questions or if we can be of further assistance.

---

https://ccf.georgetown.edu/2025/11/10/the-future-of-acas-medicaid-expansion-what-do-changes-in-hr1-mean/.

[16] 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,

Edwin Park
Research Professor
Center for Children and Families
McCourt School of Public Policy
Georgetown University