Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

September 21, 2026

The Honorable Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-2452-P

Dear Dr. Oz,

The Catholic Health Association (CHA) appreciates the opportunity to submit these comments in response to the Centers for Medicare & Medicaid Services (CMS) proposed rule, Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes [CMS-2452-P].

CHA is the national leadership organization representing more than 2,200 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations. Our ministry is present in all 50 states and the District of Columbia, with one in every seven patients in the United States cared for in a Catholic hospital each year. As health care providers who directly serve patients with Medicaid, we know that Medicaid coverage is essential for people to be able to receive the medical care they need and to protect patients around the country.

Guided by Catholic social teaching and our commitment to uphold the inherent dignity of every person, Catholic health care providers serve all who seek care, with particular attention to those who are poor, vulnerable, and underserved. Catholic hospitals serve millions of Medicaid beneficiaries each year and frequently operate in communities facing significant health and economic challenges. Reductions in or instability surrounding Medicaid financing can jeopardize the ability of providers to maintain critical services, undermining efforts to promote human flourishing, advance the common good, and ensure access to care for those most in need.

CHA recognizes that CMS is responsible for implementing the provider tax provisions enacted by Congress in the Working Families Tax Cut (WFTC) legislation. We further understand that the WFTC legislation obligates CMS to design and carry out a series of substantial revisions to Medicaid provider tax policy and retains important discretion in how it implements these provisions.

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We are concerned, however, that **core elements of this proposal go beyond the WFTC legislation and create unnecessary administrative burden on and uncertainty for CHA members, and that if finalized as proposed would create a greater funding crisis for the Medicaid program**, resulting in fewer resources available to support care for Medicaid beneficiaries. At a time when Medicaid providers, long-term care facilities, and safety-net hospitals are already facing substantial financial strain, the proposed rule risks accelerating reductions in services, limiting access to care, and undermining the stability of providers serving high-Medicaid populations.

Additionally, we have concerns that the proposed rule:

- Is inconsistent with federal statute in key areas.
- Alters current policies that are outside the scope of the WFTC legislation.
- Generates substantial and unnecessary financial uncertainty for states and health care providers alike – ultimately limiting providers' ability to best serve their populations.
- Imposes a costly and inefficient administrative burden on states, taxpayers, and CMS that does not correspond to meaningful oversight benefits.
- Diminishes state flexibility while failing to strengthen enforcement of pre-existing hold harmless restrictions.
- Risks reducing Medicaid-financed patient care services by creating additional pressure on provider payments already affected by recent federal Medicaid financing changes.
- May contribute to reduced access to care for Medicaid beneficiaries, particularly in rural, underserved, and medically complex communities.
- Creates uncertainty that could delay state efforts to maintain provider participation in Medicaid and preserve access to care.

We are concerned these policies will ultimately decrease resources available to hospitals, long-term care providers, and other organizations serving Medicaid beneficiaries. When Medicaid financing is destabilized, providers are frequently forced to delay investments, reduce services, limit expansion efforts, or absorb growing uncompensated care costs. The resulting strain is felt most acutely by Medicaid enrollees, who depend on a stable network of providers for timely access to care.

Priority Recommendations

Based on the concerns described above, we provide several priority recommendations for CMS's consideration. We provide additional, more detailed feedback in the "Detailed Feedback" section that follows.

1. **Prospective Monitoring.** CHA recommends reverting to a prospective monitoring framework, in alignment with current practice for determining compliance with the 6% hold harmless threshold. CMS's proposed shift to retrospective monitoring marks a significant departure from today's framework, under which states demonstrate

compliance by projecting tax collections and/or net patient revenue (NPR) forward from a prior period. The proposed retrospective monitoring will create financial uncertainty not only for states but also for hospitals that pay the tax in question and/or hospitals that receive Medicaid payments financed by the tax. Hospitals may retrospectively be at risk under the proposed CMS framework, disrupting financial planning and stability.

2. **Threshold Measurement Period.** CHA recommends that CMS allow states to use any 12-month measurement period that includes the highest tax rate that was "enacted" and "imposed" as of July 4, 2025. This would ensure states can select the time period that most accurately reflects the tax in place July 4, 2025.
3. **Restrictions Beyond WFTC.** We recommend CMS not finalize the proposed 75/75 test which goes beyond the letter and intent of WFTC.
4. **Protect Beneficiary Access**. CMS should evaluate implementation options through the lens of maintaining beneficiary access to care and should avoid policies that create avoidable reductions in Medicaid-financed provider payments. Where multiple implementation approaches are available, CMS should adopt those that minimize disruption to providers serving high numbers of Medicaid beneficiaries and preserve access to medically necessary services.

CHA appreciates CMS's consideration of these comments and looks forward to continued collaboration with our federal partners to strengthen and stabilize the Medicaid program.

Detailed Feedback

- ***The proposed rule provides a welcome broadening of the definition of "enacted" and "imposes."***

The WFTC legislation permits certain existing provider taxes to be "grandfathered" if the state "has enacted such tax and imposes such tax on such class" by July 4, 2025. CMS proposes that a tax is considered **enacted** if a state had completed all legislative actions necessary to authorize the tax – including creating a new tax or increasing the rate of an existing tax, by that date. CMS further proposes that **"imposes"** means that the tax was in effect and created a legally enforceable obligation to pay as of July 4, 2025. Additionally, taxes that require a broad-based or uniformity waiver would need to have an effective date on or before July 4, 2025. Because such waivers are retroactive to the beginning of the calendar quarter in which they are submitted, states would need to submit waiver requests to CMS by September 30, 2025, to qualify for grandfathering.

- ***The proposed rule's calculation of provider tax rates unnecessarily complicates hospital tax rate compliance.***

The proposed rule would clarify and formalize CMS's longstanding approach for calculating provider tax rates without changing the underlying methodology. Under this methodology, provider tax rates are calculated for each permissible provider class by dividing total tax collections (the numerator) by total NPR (the denominator). For the denominator, CMS proposes

to codify existing practice requiring that total NPR include revenue from all providers within the permissible provider class, regardless of whether a provider is subject to the tax. At the same time, revenue that cannot be attributed to the permissible class would be excluded.

CHA supports continuing to measure net patient revenue across the full permissible provider class, including providers that are not subject to the tax, as this approach has served as the foundation of CMS's provider tax oversight framework for many years and will promote continuity and reduce disruption as states adjust to the provider tax changes enacted under the WFTC legislation.

CHA recommends that CMS combine the inpatient and outpatient hospital service classes to simplify calculation of tax rates and indirect hold harmless thresholds. Many states assess hospitals using a single methodology that applies uniformly across hospital operations rather than distinguishing between inpatient and outpatient activity. Under the historical 6% indirect hold harmless threshold, fluctuations in the relative mix of inpatient and outpatient utilization generally did not create material compliance concerns because many state taxes were sufficiently under the 6% threshold for both inpatient and outpatient services. Under the WFTC legislation, routine utilization shifts could cause one category to exceed its threshold even when aggregate hospital taxes remain well below historical levels, particularly because the respective inpatient and outpatient thresholds would be set based on recent historical tax rates.

This issue is relevant for hospital taxes because hospitals often report NPR on a combined basis across inpatient and outpatient services. Since federal regulations treat inpatient and outpatient hospital services as separate permissible classes, states must allocate a hospital's NPR between those service categories when calculating tax rates. Combining the two service classes would better align the measurement framework with how many states structure their hospital taxes, reduce administrative burden, and minimize the risk that normal year-to-year changes in utilization patterns create unintended compliance issues. It also avoids the risk of disincentivizing hospitals from shifting from inpatient care models to outpatient care models, where appropriate and beneficial for patient care over time.

Importantly, this approach will not create an opportunity for states to increase hospital taxes beyond historical levels if CMS calculates each state's hospital threshold using its combined historical inpatient and outpatient tax collections. Evaluating inpatient and outpatient hospital taxes as separate provider classes appears to add significant administrative complexity for states and CMS without providing a clear policy benefit beyond what could be achieved through a combined assessment of hospital taxes. Because the underlying policy objective is to limit hospital tax rates to historical levels, it is unclear that maintaining separate inpatient and outpatient thresholds provides meaningful additional program integrity protections.

CHA supports CMS's proposed methodology for calculating provider tax rates, with one modification: CMS should measure hospital taxes on a combined basis across inpatient and outpatient hospital services, rather than treating the two service classes separately.

- ***The proposed rule unnecessarily limits state flexibility to define the measurement period for calculating the new threshold.***

As the WFTC does not specify what time period states should use to calculate their historical tax rates, CMS proposes using the state fiscal year (SFY) containing July 4, 2025 as the reference period for establishing each state's indirect hold harmless threshold.

CHA supports CMS's effort to identify a clear and administrable methodology for calculating states' historical provider tax levels. However, because the legislation does not specify a measurement period, we believe that CMS should provide states with additional flexibility to define one.

Limiting the calculation to the SFY containing July 4, 2025, could understate a state's lawfully effective tax rate in cases where, as of that date, the state had enacted a higher tax rate and imposed the legal obligation on providers to pay the tax, but the tax was not effective until a later time period. In this case, the tax meets CMS's proposed definitions of "enacted and imposed". However, the proposed reference period for the effective tax rate calculation precedes the rate's effective date and would not capture the state's already-authorized increase.

To address situations like these, **we request CMS permit states to calculate their new hold harmless threshold using the 12-month period that includes the highest tax rate that was "enacted" and "imposed" as of July 4, 2025.** This approach would promote consistency with congressional intent while accommodating differences across states. By better aligning the threshold with historical tax levels, states would be able to prevent potential short-term disruption in Medicaid payments to hospitals. Avoiding payment disruption is particularly important because Medicaid-funded hospitals frequently operate with narrow margins while serving disproportionate numbers of low-income patients. Even temporary payment instability can have downstream consequences for patient access, workforce retention, and service availability. Ensuring indirect hold harmless threshold calculations do not inadvertently undermine hospital payments in the short term is critical, particularly given hospital finances across the country are already strained.

- ***The proposed rule's timeline for issuing final indirect hold harmless thresholds is too late.***

Since the data needed to calculate states' new indirect hold harmless thresholds is only available retrospectively, CMS has proposed a two-step approach for setting these thresholds, including setting "interim" thresholds that would not be binding, and setting "final" thresholds by no later than September 30, 2028. After final thresholds are set, any state whose taxes exceed its threshold would need to take retroactive corrective action by refunding part of the tax to tax-paying providers or risk losing federal financial participation (FFP).

This delay stems directly from CMS's proposal to measure taxes retrospectively, based on actual tax collection and NPR figures, which CHA urges CMS to reconsider, as discussed further in the next section. Several alternative approaches could avoid this drawn-out timeline, including the

method many states already use of projecting NPR based on historical trends. This approach would allow CMS to establish an interim threshold almost immediately, spend one to two quarters working with states to align data sources and calculation methods, and finalize the new indirect hold harmless thresholds before the first effective year (FFY 2027) even closes out. States and providers would gain far greater financial predictability as a result, as states could adjust their taxes before the fiscal year ends rather than discovering problems two years down the road.

Should CMS finalize its proposal, CHA would support CMS's proposal to set a non-binding, interim threshold during the initial rollout of the WFTC legislation's new limits on provider taxes. Because policymakers have only had a brief period between WFTC legislation enactment and the effective date of the new provider tax limits, a non-binding estimated threshold would give both CMS and states flexibility to establish a methodology that is both fair and accurate for meeting these new requirements.

That said, CMS's proposed timeline—finalizing states' indirect hold harmless thresholds by September 30, 2028—is set far too late. That date falls two years after the new provider tax limits take effect, which means states could inadvertently overtax providers for a full two years before learning of their noncompliance with CMS requirements. States would then be obligated to repay any excess tax collected, potentially leaving them with substantial retroactive funding shortfalls, and potentially putting provider Medicaid payments retrospectively at risk – a significant concern for hospital financial planning and sustainability.

CHA would support CMS's two-step process for establishing new provider tax limits but recommends that final thresholds be established sooner based on an alternative, prospective methodology that mirrors the methodology used today.

- ***The proposed rule's retrospective compliance framework diverges from current practice and introduces significant, unnecessary risk for states and providers.***

CMS proposes to monitor compliance with the new WFTC legislation thresholds on a retrospective basis, evaluating compliance using the taxes a state actually collected and its actual NPR over the relevant period. If a state remained over the threshold after a two-year reconciliation window, CMS would require it to deduct the full value of the tax from matchable expenditures and return the associated FFP.

CMS's proposed shift to retrospective monitoring marks a significant departure from today's framework, which lets states demonstrate compliance by projecting tax collections and/or NPR forward from an earlier period. Under the proposed model, a state could not confirm compliance until it reconciled its actual figures against the threshold after the year had already closed. As a result, a state could breach the threshold simply because collections, tax rates, or NPR moved in ways it could not anticipate. And NPR can be a particularly unstable measure – it changes with payment rate changes, shifts in utilization, and broader market events like facility closures or expansions. With other WFTC provisions expected to impact revenue growth going forward,

projecting future levels will only become more difficult. The practical result is that a state could pursue compliance in good faith and still be deemed noncompliant once its final rate-year data becomes available.

If deemed noncompliant, many states would need to return taxes that they have already spent on Medicaid. Replacing those dollars would mean either securing an entirely new non-federal funding source or retrospectively reducing Medicaid payments the taxes originally supported, introducing significant downstream financial risk to Medicaid providers, threatening their financial sustainability under the proposed retrospective framework.

Neither option would be straightforward and both could hinge on new legislative authority and changes to previously approved state plan amendments (SPAs) or state-directed payment (SDP) preprints. Since federal rules will soon bar retroactive SDP preprint amendments, it is unclear how a state could obtain federal authority needed to reduce payments retroactively.

Because the WFTC legislation will ratchet grandfathered provider taxes down annually, states – and providers receiving Medicaid payments financed by provider taxes – will face this risk each cycle.

Preserving the current method – trending historical data forward to the current year – would lessen the risk of destabilizing Medicaid funding for states and providers. CMS could keep this framework and layer on greater standardization, such as directing states to build their NPR projections from a defined historical baseline and a designated inflation index. This would drive consistency nationwide while still letting states manage compliance prospectively instead of making adjustments after the fact.

Instead of establishing a two-year remediation period, CHA urges CMS to preserve the current practice of allowing states to trend tax amounts and/or NPR forward from a prior period to demonstrate compliance with the new hold harmless thresholds.

- ***Proposed reporting requirements introduce unnecessary burden without strengthening oversight.***

Beyond the proposed quarterly CMS-64 reporting of tax collections and NPR, CMS wants states to report two more things each quarter: (1) any changes to a provider tax that alter whether public providers are subject to the tax; and (2) how the funds collected from each provider tax are actually being used.

We understand CMS's concern that states may attempt to avoid the new provider tax limits by carving public hospital systems out of a provider tax and then having those hospitals send intergovernmental transfers to fund Medicaid spending instead – effectively opening extra room under the revised hold harmless threshold. However, we see no legal authority that would enable CMS to prevent that kind of arrangement, so long as the tax that remains is not itself an impermissible hold harmless arrangement and otherwise meets provider tax rules. As a result,

collecting this information would add significant administrative burden to states and CMS without clear enforcement value. We urge CMS to instead limit its data collection to areas that will determine whether the tax is permissible under federal provider tax rules.

CHA recommends CMS drop these additional reporting requirements, since they would require states to report information on arrangements that the law does not actually prohibit.

- ***Eliminating the 75/75 test as proposed would unnecessarily prohibit taxes that do not function as indirect hold harmless arrangements.***

Starting in FY 2027, CMS is proposing to eliminate the 75/75 test. Under that test, a tax exceeding the 6% threshold is not treated as a hold harmless arrangement, provided no more than 75% of the taxpayers in the class received back 75% or more of their total tax costs through enhanced Medicaid payments or other state payments.

The 75/75 test distinguishes taxes that finance substantial payments back to taxpaying providers — leaving them with little or no net financial burden — from taxes that impose a genuine cost on providers. Eliminating it would deny states a pathway to impose taxes above their hold harmless thresholds even when those taxes are consistent with the WFTC legislation's goals (i.e., when they raise revenue for purposes largely unrelated to financing the non-federal share of Medicaid payments back to providers). CMS itself acknowledges in the proposed rule's preamble that the test has rarely been invoked since its creation, identifying only one instance in which a state relied on it to justify a tax above the applicable threshold. That limited use indicates the test operates as a narrow compliance pathway, not a loophole for circumventing federal requirements.

Importantly, eliminating the 75/75 test would be inconsistent with the underlying statute, which expressly incorporates the test by reference. Section 403 of the Tax Relief and Health Care Act of 2006 added section 1903(w)(4)(C)(ii) of the Social Security Act, which provides that an indirect hold harmless determination "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."[1] As of that date, 42 C.F.R. § 433.68(f)(3)(i) expressly included the 75-75 prong: "When the tax or taxes are applied at a rate that produces revenues in excess of 6 percent of the revenue received by the taxpayer, CMS will consider a hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments."[2] Because Congress specifically incorporated the November 1, 2006 version of the regulation into statute, CMS does not have the authority to remove the 75/75 test through rulemaking absent a corresponding statutory amendment. This is reinforced by the fact that the WFTC legislation made significant changes to the provider tax framework but did not amend section 1903(w)(4)(C)(ii) or otherwise authorize CMS to eliminate the 75/75 test.

[1] Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, div. B, § 403, 120 Stat. 2922, 2991-92 (2006).
[2] 42 C.F.R. § 433.68(f)(3)(i) (2006).

In addition, the 75/75 test was designed specifically to balance federal oversight against states' need for flexibility in structuring their health care-related taxes. It serves as an important tool for distinguishing taxes that finance substantial payments back to providers – leaving those providers with little or no net financial burden – from taxes that impose a genuine financial cost.

Although the preamble of the proposed rule frames the issue around taxes that return funds to providers, removing the 75/75 test would also affect taxes that do not operate that way – most notably taxes imposed for public purposes unrelated to Medicaid financing, such as those funding state health insurance marketplaces. Many such taxes have not previously been treated as health care-related taxes, meaning states have not needed to rely on either the 6% threshold or the 75/75 test to show they are not indirect hold harmless arrangements. CMS is now proposing to expand the definition of health care-related taxes to include "services of health insurers," bringing taxes on health insurers that previously fell into a gray area under federal provider tax rules. This makes preserving the 75/75 test even more important, so that states retain a means of demonstrating that such taxes do not function as indirect hold harmless arrangements.

CHA recommends that CMS retain the 75/75 test in light of its prior statutory codification and instead track whether it is being applied in ways CMS views as improper on a more frequent basis. Should CMS conclude that the existing standard falls short of providing adequate protections, it should pursue a more targeted alternative that preserves states' ability to show that a given tax does not amount to an indirect hold harmless arrangement, even where that tax exceeds the applicable threshold.

- ***The broader impact of the proposed rule could harm those whom Medicaid is intended to help.***

We are also concerned about the effects of these policies on vulnerable populations assisted by other health and social service providers, like the network of Catholic ministries that serve Medicaid beneficiaries including nursing facilities, behavioral health providers, and community-based organizations. Catholic health care and Catholic social service ministries share a commitment to uphold the inherent dignity of every person and demonstrate a preferential concern for those who are poor and vulnerable. Medicaid is a critical source of support for this mission. Beyond hospitals, Medicaid finances nursing facility services, behavioral health treatment, substance use disorder services, psychiatric care, case management, peer support, and home- and community-based services provided by Catholic organizations across the country. Should the proposed rule result in reduced state Medicaid revenues or financial penalties that further constrain Medicaid financing, the consequences would extend well beyond state budgets. Vulnerable individuals who rely on these services may face diminished access to care, delayed treatment, or loss of critical supports that enable them to live safely and with dignity in their communities. For example, our colleagues at Catholic Charities USA have expressed concern that constrained Medicaid budgets could mean loss of access to the medical and behavioral health services necessary to support clients in the Catholic Charities network in transitioning back into the workforce and maintaining long-term stability and self-sufficiency. We urge CMS

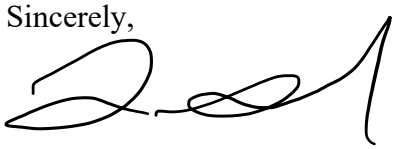
to carefully consider these downstream impacts on the individuals and families Medicaid is intended to serve.

Conclusion

CHA recognizes CMS's responsibility to implement statutory requirements enacted by Congress. However, implementation choices should be guided by the principle of preserving access to care for Medicaid beneficiaries and maintaining the financial stability of providers who serve them. We urge CMS to adopt implementation approaches that minimize disruption, preserve state flexibility, avoid unnecessary reductions in Medicaid-financed care, and ensure that vulnerable patients do not bear the consequences of financing changes that extend beyond the requirements of the statute.

Thank you for the opportunity to provide these comments. We look forward to continued engagement with CMS as implementation proceeds. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director, Public Policy, at 202-721-6300.

Sincerely,



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