THE PARTNERSHIP FOR MEDICAID

July 14, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2448-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2448-P. Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule

Dear Administrator Oz,

On behalf of the Partnership for Medicaid—a nonpartisan, nationwide coalition made up of organizations representing clinicians, health care providers, safety net plans, and counties— the undersigned organizations appreciate the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS') "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole" proposed rule. Our comments below highlight our concerns with the proposed requirements within the rule and the negative impact these changes would have on access to health care for Medicaid beneficiaries.

Medicaid is jointly financed by states and the federal government, and states must raise revenue to finance their share. States do this in a variety of ways, including through general fund revenue and taxes on health care providers. Provider taxes are widely used by states, with all states except Alaska having implemented at least one health care related tax. According to the Government Accountability Office, 17% of overall state Medicaid funds come from provider taxes.[1]

Restricting states' uses of provider taxes will cause major strain on state budgets and will put access to care at risk for millions of people who rely on Medicaid, including children, seniors, and people with disabilities. If limits are placed on provider taxes, states would face significant financing gaps and would need to consider cuts to their Medicaid program, including cuts to benefits and services. This would also include cuts to rates that directly impact access to care for Medicaid enrollees. States would be unable to replace these revenues with other taxes, making it difficult for states to find other funding streams for their share of Medicaid expenditures. This would lead to cuts in Medicaid or other areas of the state budget, like education. Pressure on state budgets creates the greatest risks for optional programs, like prescription drugs, or the services that people with disabilities and older adults use to stay in their homes and communities, in addition to rates to providers who provide access to care for Medicaid enrollees, including 37 million children. It is critical for states to have the ability to

[1] https://www.gao.gov/products/gao-21-98, pg. 17

continue designing and implementing permissible provider tax arrangements and ensure that access to care for millions of people covered by Medicaid is not compromised.

Clarifying Requirements for Provider Taxes to be Considered Generally Redistributive

We recommend that CMS clarify the proposed language regarding the requirements for which provider taxes will be considered generally redistributive and therefore permissible. The proposed rule states that provider taxes that either (1) imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes or (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service will be prohibited. In addition to those requirements, the rule also states that any provider tax that would have the "same effect" as these two new prohibitions would also be impermissible. This language is vague and creates significant uncertainty in which provider taxes are permissible for states to implement and which are not.

We also ask for clarification regarding the provision that would prohibit states seeking provider tax waivers from using a substitute definition, measure, attribute, or the like as a proxy for Medicaid in order to impose a higher tax rate on Medicaid taxable units than on non-Medicaid taxable units. The terminology and characteristics that states would be prohibited to apply in their provider taxes are unclear in the rule, causing further confusion as to what provider tax arrangements are permissible and which are not.

For states to design and implement permissible provider tax arrangements, it is necessary that provider tax regulations are clear and specific. Any ambiguity in what is considered a permissible provider tax and what is not will make it difficult for states to budget and finance their Medicaid programs.

Extending Deadlines for States to be Compliant with New Requirements

We urge CMS to provide all states with an extended transition period to comply with the proposed changes, regardless of when a state's provider tax arrangement was approved. CMS proposes to provide some states with transition periods and will not provide one to states who have received approvals within the past two years. For states that would receive the proposed transition period, they would have at least one full state fiscal year to come into compliance with these new requirements. These short timeframes are not sufficient for states to assess which provider taxes need to be altered, in addition to taking the necessary steps to become compliant.

It takes a considerable amount of time for states to implement new or alter existing provider taxes, including receiving state legislature approval, submitting applications to CMS, as well as the time needed to get CMS approval. In addition, some states have two-year legislative cycles, which would hinder them from being able to comply with the proposed requirements within the proposed timeframe. Every state should have the opportunity to comply with the requirements, regardless of when their provider tax arrangements were approved.

It is critical that states are given enough time to adequately navigate and assess the effects of these new provider tax requirements on their Medicaid programs, including the impact of these changes on Medicaid beneficiaries, benefits, coverage and provider payments. Any potential reductions to state Medicaid funding resulting from a state's inability to comply with the proposed changes would negatively impact access to care for millions of Medicaid beneficiaries.

The Partnership for Medicaid welcomes the opportunity to work with you to ensure that the Medicaid program continues to provide access to care for the millions of people who rely on it. Please contact Milena Berhane at milena.berhane@childrenshospitals.org or (202) 753-5521 with any questions.

Sincerely,

American Academy of Family Physicians
American Dental Education Association
American Network of Community Options and Resources
American Nurses Association
America's Essential Hospitals
Association for Community Affiliated Plans
Catholic Health Association of the United States
Children's Hospital Association
LeadingAge
Medicaid Health Plans of America
National Association of Pediatric Nurse Practitioners
National Rural Health Association