September 21, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

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

Dear Administrator Oz:

Provider taxes are a cornerstone of state Medicaid financing with nearly every state relying on them to finance a portion of the non-federal share of Medicaid spending. The One Big Beautiful Bill Act (OBBBA) fundamentally reshaped this financing mechanism by freezing or reducing permissible provider tax thresholds, restricting new or expanded provider taxes and tightening hold harmless requirements. These changes will significantly reduce states' ability to finance Medicaid at a time when states already face substantial pressure to maintain access to care for the millions of Americans who rely on the program. The Alliance of Community Health Plans (ACHP) implores CMS to implement OBBBA without imposing additional restrictions that further reduce state financing flexibility.

ACHP is the only national organization promoting the unique payer-provider aligned model in health care. ACHP member companies collaborate with their provider partners to deliver higher-quality coverage and care to tens of millions of Americans across 46 states and D.C. ACHP's member companies serve all lines of business, including Medicaid, where they collectively cover more than four million Medicaid enrollees.

ACHP appreciates CMS' efforts to provide states with clarity as they implement OBBBA. We particularly support CMS' proposed interpretation of "enacted and imposed," which preserves more existing provider taxes than CMS' earlier guidance suggested. However, CMS also proposes changes that OBBBA does not require, including a new retrospective compliance framework and elimination of the 75/75 test. These proposals would further constrain an essential source of Medicaid financing and increase pressure on state budgets, provider payments and access to care.

As community-based and provider-aligned health plans, ACHP member companies understand firsthand that stable Medicaid financing supports a strong Medicaid program. When states lose financing, the effects ultimately reach the people Medicaid serves through pressure on provider payments, managed care rates, benefits and access to care. CMS should avoid extending OBBBA's restrictions beyond those Congress enacted.

Preserve a Prospective Compliance Framework

The proposed rule would require CMS to evaluate provider tax compliance using actual tax collections and actual provider revenues after the close of the fiscal year. States could reasonably design a provider tax, collect and spend the associated revenue, and then learn years later that changing market conditions caused the tax to exceed the applicable threshold.

This proposal creates financing uncertainty that OBBBA does not require. States cannot control future changes in provider revenues, utilization, enrollment or market conditions. Even a carefully designed provider tax may exceed the applicable threshold because actual provider revenues differ from reasonable projections. Under the proposed rule, that uncertainty falls entirely on states. In response to this uncertainty, states may collect fewer taxes to avoid the risk of future enforcement actions. The result will be larger restrictions on provider tax revenue than OBBBA requires and additional pressure on Medicaid provider payments, managed care financing and beneficiary access to care.

The proposed enforcement framework compounds that uncertainty. CMS would require states to submit actual tax collections and provider revenue data after the close of the fiscal year, review compliance retrospectively and, if it determines that a tax exceeded the applicable threshold, require states to unwind financing decisions made years earlier. The proposal gives states little certainty that a provider tax deemed reasonable at the time of collection will remain compliant after CMS completes its retrospective review.

This certainty is particularly important as states redesign existing provider taxes to comply with OBBBA. States should be able to structure new financing arrangements around the statutory requirements with confidence that reasonable, good-faith compliance decisions will not create unexpected financial exposure years later. **ACHP urges CMS to preserve the longstanding prospective compliance approach, which allows states to demonstrate compliance using reasonable projections and established methodologies before collecting provider taxes.**

If CMS retains retrospective compliance, it should provide meaningful protections for states acting in good faith, including at a minimum:

- Make interim thresholds binding for states that reasonably rely on them.
- Establish a clear de minimis standard for minor exceedances.
- Give states a meaningful opportunity to correct inadvertent noncompliance before imposing financial penalties.
- Limit financial remedies to the amount by which a provider tax exceeds the applicable threshold.

Retain the 75/75 Test

OBBBA lowers the indirect hold harmless thresholds but does not eliminate the longstanding 75/75 compliance pathway. The test allows a state whose tax exceeds the applicable threshold to demonstrate that it does not hold taxpayers harmless if fewer than 75 percent of taxpayers receive at least 75 percent of their tax costs back through Medicaid or other state payments.

The proposed rule notes that states may use this pathway to circumvent OBBBA's new thresholds. But eliminating the test would further restrict state financing flexibility beyond the limits Congress enacted. **ACHP requests that CMS retain the 75/75 test while continuing to ensure that provider tax arrangements comply with federal hold harmless requirements.**

Finalize the Proposed Interpretation of "Enacted and Imposed"

ACHP supports the proposed interpretation of "enacted and imposed." OBBBA bases a permissible class's grandfathered threshold on whether a state had a tax "enacted and imposed" as of July 4, 2025. CMS proposes to treat a tax as enacted when the state completed the legislative process necessary to authorize it and as imposed when taxpayers had a legally enforceable obligation to pay it, regardless of whether the state had begun collecting the tax.

This interpretation appropriately preserves taxes that states had legally established before OBBBA's cutoff date, allowing those taxes to retain a grandfathered threshold. CMS should finalize this interpretation and provide clear examples to help states apply it consistently. **Additionally, ACHP requests that CMS clarify that states may modify existing provider taxes as necessary to comply with OBBBA without causing an otherwise grandfathered tax to be treated as a new tax.**

Clarify the Scope of the New Health Insurer Class

CMS proposes creating a new permissible class for health insurer services, excluding services already covered by the existing managed care organization class. This proposed definition could also capture insurer assessments that do not finance Medicaid, including user fees that support State-Based Exchanges or assessments that fund Section 1332 waiver programs. These assessments serve distinct purposes and, in some cases, support state programs expressly authorized under federal law. Applying Medicaid provider tax restrictions to them could unintentionally limit states' ability to operate Exchanges, support reinsurance programs or pursue other state-based coverage initiatives, with downstream effects on plan costs, market stability and consumer access. **ACHP urges CMS to clarify that fees used exclusively for non-Medicaid purposes fall outside the Medicaid provider tax framework and define what the new class would cover.**

Preserve Legitimate Intergovernmental Transfer Arrangements

CMS proposes new notification requirements when a state exempts a public provider from an existing provider tax and indicates that related intergovernmental transfer arrangements may warrant additional review. Legitimate intergovernmental transfer arrangements can support provider payment stability and help states sustain adequate financing for hospitals and other public providers that serve Medicaid members.

ACHP recommends that the final rule limit additional reviews to cases that present specific evidence of an improper hold harmless relationship and clarify that notification alone does not trigger a presumption of noncompliance or a new approval requirement. This approach will strengthen oversight without creating unnecessary pressure on provider payments, plan rates and access to care.

Conclusion

OBBBA makes significant changes to states' use of provider taxes, an important source of Medicaid financing. As states adjust to these new requirements, CMS should preserve flexibility and certainty wherever the statute allows. Additional restrictions beyond those required by Congress could further constrain Medicaid financing, creating downward pressure on benefits and access for the millions of children, older adults, people with disabilities and low-income Americans who rely on the program. ACHP urges CMS to implement OBBBA faithfully without unnecessarily limiting the financing tools available to states.

We appreciate the opportunity to comment and look forward to continuing to work with CMS to implement these important reforms. Please contact Emma Liebman, Associate Director of Policy, ACHP (eliebman@achp.org) with any questions.

Sincerely,



Ceci Connolly
President and CEO
Alliance of Community Health Plans