The Hospital + Healthsystem Association of Pennsylvania

September 21, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2452-P
P. O. Box 8010
Baltimore, MD 21244-8010

RE: CMS-2452-P, Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 235 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes, which implements key provisions of the Working Families Tax Cut Act (WFTCA).

The proposed rule formally implements requirements of section 71115 of WFTCA by imposing new limits on provider taxes by amending the indirect hold harmless threshold, effective October 1, 2026. However, this proposed rule goes far beyond the statutory requirements enacted by Congress. Specifically, CMS proposes to:

- Eliminate the "75/75 test," removing regulatory flexibility that could otherwise allow states to exceed the applicable thresholds or avoid the phase-down requirements.
- Expand the definitions of enacted and imposed provider taxes.
- Impose substantial new reporting requirements to support implementation and enforcement of the new revised provider tax standards, including changing established practice for how states determine if they are compliant with indirect hold harmless thresholds.
- Establish a new permissible tax class for services of health insurances.

As proposed, CMS projects federal savings of approximately $246 billion, substantially exceeding the estimated $183 billion associated with the statutory changes enacted by Congress. This significant increase reflects the broader restrictions and requirements included in the proposed rule and raises concerns that CMS is exceeding the scope and intent of the underlying legislation.

CMS also assumes that states will offset 30 percent of the reductions resulting from the rule and the WFTCA through alternative revenue sources. This assumption fails to recognize the mounting fiscal pressures states are already facing as they implement other WFTCA requirements, including community engagement provisions, increased state share of

supplemental nutrition assistance program (SNAP) costs, and more frequent eligibility redeterminations. In reality, reductions in provider tax revenue are likely to result in lower Medicaid payments to providers and may force states to reevaluate covered services and benefits, ultimately affecting Medicaid beneficiaries' access to care.

Health care-related taxes and Medicaid supplemental payment programs are longstanding tools used to address chronically inadequate base Medicaid payment rates. Changes to these financing systems and related provider payments will have significant and tangible negative consequences for access to care. In Pennsylvania, provider taxes fund hospital payments that support access to care, delivery, and quality improvements for Medicaid beneficiaries.

The Medicaid program provides coverage for nearly a quarter of all Pennsylvanians—children, seniors, people with disabilities, and hardworking individuals who lack access to affordable coverage. HAP and our members share CMS' goal of ensuring the fiscal integrity of the Medicaid program so that it can remain strong and sustainable for those who depend on it. However, changes to financing mechanisms can have ripple effects on state budgets, provider payments, managed care financing, and long-term Medicaid strategy.

In Pennsylvania, Medicaid reimburses hospitals at only 87 cents for every dollar spent. When Medicaid professional services reimbursement and uninsured care are included, hospitals recover only 71 cents for every dollar of care provided. Provider taxes are utilized to fund hospital supplemental payments that address this chronic underfunding. Without supplemental payments, hospitals are only reimbursed 52 cents on the dollar.

Further reductions in hospital reimbursement jeopardize hospital financial sustainability and increase the risk of closures or cuts to essential services such as maternal health. More than 40 percent of the commonwealth's acute care hospitals are currently operating with insufficient margins for long-term stability; nearly 30 percent are operating in the red. Over the past decade, 26 hospitals have closed statewide and as many as an additional 12–14 hospitals are projected to close by 2030 due to declining reimbursement and rising costs.[1] Hospital closures and service losses impact everyone in the community, not just those individuals who are served by the Medicaid program.

We appreciate CMS' efforts to implement statutory requirements while preserving the integrity of the Medicaid program. However, we believe the proposed rule, as drafted, risks significant unintended consequences for Medicaid financing, provider stability, and beneficiary access to care. **HAP urges CMS to adopt a more measured approach that adheres closely to congressional intent, preserves state flexibility, minimizes administrative burden, and avoids disruption to the essential health care services upon which millions of Americans rely.**

[1] Report: Time to Act: What The Future Holds for Pennsylvania's Hospitals, Patients, and Communities

Thank you for your consideration of HAP's comments regarding this proposed rule and its impact to hospitals and the patients they serve in Pennsylvania. Additional detail on our concerns is attached.

If you require any additional information, please contact me at **jcalla@haponline.org** or (717) 561-5308.

Sincerely,

Jolene H. Calla, Esq.
Vice President, Finance & Legal Affairs

Attachment

HAP Comments—Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes

State-specific Indirect Hold Harmless Thresholds

The proposed rule would codify the new thresholds established by WFTCA. Beginning October 1, 2026, each state and provider tax class would be subject to a unique threshold based on the level of provider taxes enacted and imposed as of July 4, 2025. For states without a provider tax in effect as of that date for a service class, the threshold generally would be zero percent, effectively prohibiting the creation of new provider taxes in those classes.

In general, CMS proposes to apply the existing formula used to calculate whether a tax exceeds the indirect hold harmless threshold: dividing the total amount of tax revenue collected for the permissible class by the net patient revenue attributable to that class, resulting in a single percentage per permissible class per state. To calculate the numerator, CMS proposes that the state would add all revenue actually collected for each provider tax imposed on that class, including any locality taxes (imposed by cities, counties, parishes, etc.) imposed on the same class, penalty amounts collected, and delinquent taxes later recovered. CMS articulates that locality tax revenue would include funds transferred to the state Medicaid agency via an intergovernmental transfer. For the denominator, CMS proposes that a state would add the net patient revenue attributable to all providers in the class, including those who are not subject to the tax.

CMS clarifies that revenues from a different class of items or services cannot be included in the calculation; this includes inpatient and outpatient hospital revenue, which are treated as separate classes.

Interim Indirect Hold Harmless Threshold Process

CMS proposes to require states to submit data to determine an interim hold harmless threshold, which would serve as an early indication of the indirect hold harmless thresholds that may ultimately apply and provide states with insight as they transition to the new provider tax framework. In proposing the process, CMS acknowledges that final tax collection and net patient revenue data will not be available by the time the new threshold framework takes effect on October 1, 2026. CMS clarifies that the interim threshold would not be binding.

Utilizing an interim hold harmless threshold with future reconciliation to actual tax collection and net patient revenue creates the risk that states could be required to refund excess tax collections to hospitals. The collected amounts may have already been utilized to draw down federal funds to support Medicaid payments necessitating clawback of those payments or state general fund revenue to cover the amount due back to both providers and CMS.

Prospective calculations have historically been utilized by states and accepted by CMS for purposes of determining the reasonability with the 6 percent limit. The proposed rule's true up to actual net patient revenue and level of precision goes well beyond this historical precedent

and creates administrative burden and uncertainty that are unnecessary and not required by WFTCA. **HAP urges CMS to allow states to utilize the estimated prospective threshold calculated at the beginning of the fiscal year as the final safe harbor threshold for that period.**

Phase Down of Provider Taxes in Expansion States

P.L. 119-21 reduces the hold harmless threshold for expansion states beginning in federal fiscal year (FFY) 2028 by 0.5 percentage points annually. The hold harmless threshold will be the lower of the calculated threshold in a state or 5.5 percent in FFY 2028, 5.0 percent in FFY 2029, 4.5 percent in FFY 2030, 4.0 percent in FFY 2031, and 3.5 percent for FFY 2032 and subsequent years. This phasedown would not apply to taxes on nursing facility services or intermediate care facility services for individuals with intellectual disabilities, which would remain subject to their July 4, 2025, calculated thresholds. CMS proposes to codify this phase-down schedule. Non-expansion states retain their July 4, 2025, calculated threshold for each permissible class, and are not subject to a phase down.

CMS acknowledges that states have fiscal years that do not align with the FFY. CMS outlines two approaches that expansion states may use to administer provider taxes on permissible classes subject to the statutory phase down when the applicable indirect hold harmless threshold decreases during a state fiscal year (SFY). States may either apply differentiated tax rates to different portions of the SFY or prorate aggregate net patient revenues for all providers for the entire SFY.

HAP does not support utilization of the FFY, which would require many states to disaggregate and reconstruct data from reporting periods that may not align with how provider taxes are authorized, assessed, collected, or reported. Such an approach would increase administrative burden, introduce unnecessary complexity, and increase the risk of reporting inconsistencies without improving the accuracy of the threshold calculation. HAP urges CMS to allow states to calculate thresholds based upon the SFY.

Elimination of the "75/75 Test"

CMS invites "…comment on the proposed revisions to the second prong of the indirect hold harmless threshold, including additional or different revisions." HAP opposes CMS' proposal to prospectively eliminate the second prong of the indirect hold harmless test. Section 71115 of the WFTCA legislation modified the first prong of the indirect hold harmless test by replacing the historical 6 percent standard with class-specific threshold percentages and a phase-down schedule for applicable expansion states. However, Congress did not amend, prohibit, or otherwise address the second prong of the test. CMS acknowledges that "the changes made by the WFTCA legislation do not address the 75/75 test." 91 FR 46581.

Because Congress specifically amended one element of the indirect hold harmless framework while remaining silent regarding the second prong, we believe CMS should exercise caution before eliminating a regulatory pathway that has existed for decades and that Congress left

undisturbed when enacting section 71115. The absence of a statutory directive to remove the second prong suggests that Congress intended the existing regulatory framework to continue except where expressly modified by statute.

We further note that CMS itself acknowledges that the 75/75 test has been used extremely rarely and that only one health care-related tax has ever relied upon the second prong to permissibly exceed the indirect hold harmless threshold, 91 FR 46581. Because utilization of the second prong has been limited, we question whether its elimination is necessary to implement section 71115 or to address a demonstrated program integrity concern.

Should CMS continue to have concerns regarding states' potential future reliance on the 75/75 test, we respectfully recommend that CMS consider targeted safeguards in lieu of eliminating the test. Such safeguards could include preserving the second prong while requiring additional documentation or state-specific review. This approach would preserve longstanding regulatory flexibility while ensuring that CMS maintain appropriate oversight mechanisms to address program integrity and policy considerations.

Accordingly, HAP recommends that CMS retain the second prong of the indirect hold harmless test or, at a minimum, provide a more detailed explanation of the statutory authority and program integrity concerns that necessitate its elimination despite Congress' decision not to address the second prong in section 71115.

Definition of Enacted and Imposed Provider Taxes

CMS revised definitions from its November guidance of when a provider tax is considered "enacted" and "imposed" for purposes of establishing the new provider tax thresholds.

CMS proposes that a tax would be considered "enacted" if the state or local government completed the legislative process necessary to authorize the tax by July 4, 2025. CMS clarifies that this means the state or locality had the legal authority to impose the tax on July 4, 2025. CMS also clarifies that administrative or legislative adjustments (such as an increase) to a tax structure authorized after July 4, 2025, would not qualify, even if it retroactively applied before that date.

CMS proposes that a tax can be considered "imposed" if it was in effect on July 4, 2025, meaning providers were subject to a legally enforceable obligation to pay the tax. According to CMS, a state can demonstrate that providers were subject to a legally enforceable obligation to pay the tax as of July 4, 2025, through legislative language that includes an effective date and language that July 4, 2025, falls within the applicable period, or through other documentation such as billing information or collection activity.

As part of CMS' definition of imposed, for taxes requiring a federal waiver, the waiver must have been approved by or have an effective date of July 4, 2025, or earlier. This could include approved tax waivers submitted to CMS on or before September 30, 2025, with an appropriate effective date.

Provider tax programs vary from state to state in how they operate. Some states authorize provider taxes for a defined time period with a reauthorization process occurring at the end of that defined time period. This allows the state and providers to negotiate terms that promote the objectives of the Medicaid program, ensuring access to quality care for beneficiaries. Programs that were enacted and imposed as of July 4, 2025, for a defined time period will require future legislative language changes as a part of the normal reauthorization process.

HAP recognizes the authority of CMS to implement these provisions of H.R. 1. **HAP urges CMS to specify that reauthorizations of existing enacted and imposed provider taxes will not be considered a new tax, permitting the well-established reauthorization process to continue.**

Health Insurer Provider Tax Class

CMS invites "…comment on any further ways we could make the existing regulations [§433.68] more organizationally clear, or if any of our proposed changes would create unintended operational difficulties."

HAP recommends that CMS minimize unnecessary structural changes to §433.68 and clearly identify any revisions that are intended to be organizational rather than substantive. Even non-substantive reorganization could create operational difficulties and unintended complications for states, including the need to revise existing assessment programs, update waiver materials, reporting templates, systems logic, and internal guidance, while also providing additional training to all levels of staff. These challenges may be compounded because implementation timelines do not align with state legislative cycles, appropriations processes, system update schedules, or the availability of finalized net patient revenue data and assessment data.

Additionally, HAP requests that CMS clarify how the proposed class-specific indirect hold harmless thresholds would apply to the existing licensing and certification fee class, currently codified at 42 CFR §433.56(a)(19) and proposed to be redesignated as §433.56(a)(20).

In the 1993 final rule, CMS established the licensing and certification fee class because these fees were fundamentally different from traditional provider taxes. CMS recognized that licensing and certification fees are generally imposed to fund the administration of state licensing and certification programs rather than to finance Medicaid expenditures.

For that reason, CMS limited the class by requiring that aggregate collections do not exceed the state's estimated costs of operating the licensing or certification program. The practical effect was that the allowable level of collections was tied to regulatory program costs rather than to Medicaid financing considerations.

CMS' 2026 proposed rule appears to apply the new class-specific indirect hold harmless threshold framework to all permissible classes identified in §433.56(a). Under proposed §433.68(f)(3)(ii), CMS would establish a state-specific threshold for each permissible class

based on taxes enacted and imposed as of July 4, 2025, and would apply that threshold prospectively.

As written, this appears to subject the licensing and certification fee class to two independent limitations:

1. The longstanding requirement that aggregate fee collections do not exceed the state's estimated licensing or certification program costs.
2. The new state- and class-specific indirect hold harmless threshold established under proposed §433.68(f)(3)(ii).

As a result, the effective ceiling for licensing and certification fees would become the lower of these two limits. CMS does not discuss this consequence in the proposed rule, nor does the preamble address whether such an outcome is consistent with the original rationale for establishing the licensing and certification fee class.

Provider licensing and certification activities are foundational to program integrity efforts by verifying provider qualifications, preventing fraud, waste, and abuse, and protecting patient safety and quality of care. CMS established this provider class because licensing and certification fees were viewed as regulatory cost-recovery mechanisms rather than traditional Medicaid financing taxes. Applying both a cost-recovery cap and a separate indirect hold harmless threshold would fundamentally alter the treatment of this class and could subject it to a more restrictive framework than CMS originally contemplated when establishing the class in the 1993 final rule. The proposed approach also fails to account for the continuous evolution of health care, and the corresponding costs states incur to license and certify providers to deliver those services. Imposing a ceiling on states' ability to recover those costs could inadvertently undermine program integrity efforts by limiting the resources available to conduct effective provider oversight.

This issue is particularly significant because the proposed rule provides that where no tax was enacted and imposed as of July 4, 2025, the applicable threshold percentage is zero. If CMS applies this provision to the licensing and certification fee class, states that did not have a qualifying class (19)/(20) fee enacted and imposed as of July 4, 2025, could effectively be precluded from establishing new licensing or certification fees that rely upon recognition of the licensing and certification fee provider class under §1903(w). The applicable threshold for the class would be zero percent when combined with CMS' proposal to prospectively eliminate the second prong of the indirect hold harmless test addressed separately later in these comments. This outcome would apply even where such fees are otherwise permissible under the longstanding requirements of the class and are limited to recovering regulatory program costs.

In addition, HAP recommends that CMS clarify that revenues attributable to the licensing and certification fee class are not to be included in the numerator used to calculate indirect hold harmless thresholds for any other permissible class. The proposed rule calculates indirect hold harmless thresholds on a permissible-class basis.

Accordingly, revenues attributable to the licensing and certification fee class should be evaluated solely within that class and should not be aggregated with revenues associated with classes (1) through (18) or the proposed health insurer class. Clarification is necessary to ensure that regulatory licensing and certification fees do not inadvertently reduce available tax capacity within unrelated provider classes.

Because the licensing and certification fee class was established as a distinct provider class to accommodate regulatory fees that fund state licensing and certification activities, fees within that class should not be treated as Medicaid financing taxes for purposes of calculating allowable tax capacity under other provider classes. Failure to maintain this separation could (1) result in regulatory licensing and certification fees being used to increase the indirect hold harmless percentage applicable to unrelated permissible classes, which would be inconsistent with CMS' original rationale for establishing a separate licensing and certification fee class, and (2) impact states' capacities to perform licensing and certification activities introducing increased risks of fraud, waste, and abuse in health care, including Medicaid.

CMS' proposal could unintentionally eliminate or substantially impair a provider class that CMS originally created to accommodate regulatory licensing and certification fees designed to support state oversight, licensure, certification, inspection, and compliance activities rather than Medicaid financing.

HAP is now asking that CMS consider the following:

1. Expressly exclude the licensing and certification fee class from the class-specific threshold framework in §433.68(f)(3)(ii).
2. Expressly exclude revenues attributable to licensing and certification fees from the numerator used to calculate indirect hold harmless thresholds for all other permissible classes.
3. Clarify the only threshold applicable to the licensing and certification fee class is that it may not exceed the amount necessary to recover the state's estimated licensing and certification program costs.

Reporting Requirements

CMS proposes substantial new reporting requirements to supplement implementation and enforcement of the revised provider tax standards. States will be required to comply with one-time interim reporting requirements by December 31, 2026, one-time final reporting requirements by June 30, 2026, and ongoing quarterly reporting requirements.

CMS proposes to require states to submit quarterly reports on all state and local provider taxes, including tax collections and net patient revenue by tax and permissible class, how the tax collections are utilized, including specific Medicaid payments, and whether government providers were exempted and any additional information requested by CMS. Tax collections would be reported for the period the tax obligation applies rather than when the payment is

received, and reporting would include state and local taxes within a class. States would be permitted to amend previously reported provider tax data for up to two years.

Requiring states to submit quarterly data based upon period will impose significant administrative burden on states. CMS is already aware of what payments are funded in full or in part by provider taxes. As part of the state-directed payment (SDP) preprint approval process, states are required to provide information on provider taxes and intergovernmental transfers utilized to fund the non-federal portion of SDPs. State plan amendments submitted for fee-for-service payments are reviewed by CMS to determine whether states have an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) and 1923 of the Social Security Act and the applicable implementing federal regulations.

As net patient revenue for hospitals is calculated based upon cost reports, states will not have real time net patient revenue data to submit quarterly. States would need to develop a mechanism to collect this data from providers as the only visibility they have is to Medicaid claims data. The Pennsylvania statewide hospital assessment is based upon historical net patient revenue, is calculated annually, and is invoiced in four even payments. In practice, however, hospitals may submit payments after the scheduled due date, or invoicing may be delayed because of state- or federal-approval timelines. As a result, quarterly net patient revenue reporting would have little relevance to the administration of the tax and could distort effective tax rate calculations by comparing data elements that are not aligned. This reporting could create a misleading picture of the tax rates actually imposed and may be incorrectly compared to annual hold harmless calculations, leading to inaccurate conclusions about program compliance. **We urge CMS to eliminate the requirement to submit data on a quarterly basis which is administratively burdensome and would not improve program integrity or oversight in any meaningful way.**

CMS invites "…comment on the appropriate number of decimal places to use in determining the indirect hold harmless threshold, and whether it should be higher or lower than nine." HAP respectfully disagrees with CMS' proposal to round indirect hold harmless thresholds to nine decimal places and recommends that CMS retain a one decimal place standard for indirect hold harmless thresholds. While HAP supports establishing a uniform rounding methodology, CMS has not demonstrated that a level of precision extending to nine decimal places is necessary to administer provider tax programs or determine compliance with the indirect hold harmless threshold. Additionally, the one decimal place approach aligns with the precision reflected in Section 71115 of the WFTCA legislation and would provide a clear, administrable standard for states and CMS while avoiding immaterial compliance disputes.

CMS states that it selected nine decimal places because that is the limit used for resource proxies in Medicaid eligibility determinations. 91 FR 46570. However, Medicaid eligibility determinations and provider tax financing arrangements serve different purposes and rely on fundamentally different data sources. Provider tax compliance is based upon tax collections and net patient revenue information that often originates from provider financial statements, Medicare cost reports, Medicaid cost reports, and other sources that are not consistently reported or audited at a precision approaching nine decimal places. Therefore, the proposed

level of precision exceeds the practical precision of the underlying data used in the calculation particularly because the data utilized most commonly originates from sources and accounting standards that are subject to allocation, estimation, reconciliation, late adjustments, and amendment.

HAP is concerned that a nine decimal place standard creates administrative complexity without improving program integrity. Under the proposed rule, a tax could become noncompliant based on a variance in the ninth decimal place, even though the underlying net patient revenue and tax collection amounts are derived from large-scale financial reporting systems that necessarily involve estimates, final reconciliations, late adjustments, and reporting corrections. For example, an assessment of 3.500000000 percent applied to net patient revenue totaling $28,571,428,571.43, would result in an assessment amount of $1,000,000,000.00, collecting just $0.29 more, $1,000,000,000.29 would result in an assessment percentage of 3.500000001, and therefore would be deemed impermissible under the proposed rule. Under §433.70, CMS would deduct the full $1,000,000,000.29, not just $0.29 from the state's Medical Assistance expenditures. HAP does not believe that this result would advance the program integrity objectives of CMS.

HAP further notes that the proposed rule would require states and CMS to operationalize state- and class-specific thresholds using financial data that may not be available or final at the time quarterly reporting is due. In practice, states may be required to convert SFY assessments to FFY reporting periods, allocate collections across reporting timeframes, and rely on estimates until provider cost reports and net patient revenue data are finalized. Since final data may not be available for months, or even years, after the applicable reporting period, states could identify trivial threshold variances only after the fact, when waiver or assessment changes may no longer be feasible. HAP believes this would increase administrative burden for both states and CMS.

For these reasons, HAP recommends that CMS adopt a less burdensome, one decimal place standard, for calculating and applying indirect hold harmless thresholds and percentages. A one decimal place standard is consistent with the precision Congress used in Section 71115 of the WFTCA legislation**,** including the phase-down percentages of 5.5 percent, 5 percent, 4.5 percent, 4 percent, and 3.5 percent. It would also provide sufficient precision to ensure compliance with statutory limits while reducing administrative burden, promoting transparency, and focusing federal oversight on material financing arrangements rather than inconsequential rounding differences.

Alternatively, if CMS retains a more granular rounding standard, HAP requests that CMS establish a reasonable de minimis tolerance when evaluating compliance with the indirect hold harmless threshold. Such an approach would better align the precision of the calculation with the precision of the underlying financial data and focus oversight on meaningful departures from statutory limits rather than immaterial rounding differences.