September 21, 2026

SUBMITTED ELECTRONICALLY

Dr. Mehmet Oz, 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 Dr. Oz:

The undersigned members of the Consortium for Constituents with Disabilities (CCD) Health Task Force and other CCD members appreciate the opportunity to provide comments on the above referenced proposed rule, specifically, "Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes."

CCD is the largest coalition of national organizations working together to advocate for Federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

Medicaid is the foundation of the disability care infrastructure in the United States. It finances home and community-based services (HCBS), personal care, behavioral health services, and the direct support workforce that make community living possible. Provider taxes are not a minor financing detail. Nearly every state uses them, and they represent a significant part of the state share of Medicaid budgets.[1] P.L. 119-21, also known as the "One Big Beautiful Bill Act" (OBBBA), has already imposed substantial new restrictions on this longstanding source of Medicaid financing. The proposed regulations substantially exceed those statutory requirements and further reduce states' capacity to sustain Medicaid coverage and services. This rule is not a technical financing change: CMS itself estimates these proposals will cut federal Medicaid spending by roughly $246 billion over ten years, over $63 billion higher than CBO's estimated impact for the statutory requirements alone.[2] The effects reach directly into HCBS systems, provider networks, and the people who depend on those services.

We urge CMS to not finalize this rule as proposed, as it exceeds the requirements in OBBBA. More specifically, we ask CMS to preserve states' ability to use permissible provider taxes, retain the longstanding 75/75 compliance test, avoid extending new restrictions to entities and revenue Congress did not address, minimize compliance uncertainty that could push states to cut Medicaid financing pre-emptively, and assess the rule's cumulative effects on HCBS, providers, and family caregivers before finalizing it.[3]

I. Provider Tax Restrictions Will Impede Access to Care for People with Disabilities

States have long used provider tax revenue to support state Medicaid expenditures. When that financing option is restricted, states have a history of cutting the very supports that matter most to people with disabilities. Many of the most critical services for people with disabilities are “optional” for states, including HCBS, personal care, respite for family caregivers, durable medical equipment, and physical and occupational therapy.[4] Because Medicaid is the primary payer for these services, they also make up a relatively large share of Medicaid expenditures. An estimated 86 percent of Medicaid's optional-service spending funds services for people with disabilities and older adults.[5] This makes them a frequent target when state budgets tighten.

Between 2010 and 2012, when federal Medicaid funding was reduced, every state and the District of Columbia cut spending in at least one HCBS program.[6] Waiting lists for those programs grew as a result.[7] States facing renewed financing pressure have only limited available options: reducing payments to providers generally; cutting reimbursement rates specifically for HCBS providers; reducing or restricting access to services like HCBS; or tightening financial eligibility rules and/or lengthening HCBS waiting lists so fewer people qualify for coverage at all. Any of these responses can increase reliance on unpaid family caregivers, cause preventable hospitalizations, and increase the risk of unnecessary institutionalization.[8] The proposed rule will massively increase state budget hardships and put people with disabilities’ Medicaid coverage and access at risk.[9]

The proposed restrictions would also worsen persistent shortages of direct care workers who provide HCBS. This shortage stems largely from low reimbursement rates that do not support competitive wages. When Medicaid financing shrinks due to federal restrictions, provider payment rates are often the first target for savings. That would worsen this workforce shortage and make it harder to find available providers. Budget shortages also often lead to service cuts, which increases pressure on unpaid family caregivers. CMS should weigh the proposed rule's effect on the HCBS provider network and workforce, not just on aggregate Medicaid expenditures.

II. CMS Should Not Exceed the OBBBA-mandated Changes to Provider Taxes

In several respects, the proposed rule reaches further than Section 71115 of OBBBA requires.[10] Georgetown University's Center for Children and Families has identified multiple provisions, discussed below, that go beyond statutory requirements.[11] States are already absorbing substantial reductions in federal Medicaid funding from other provisions of the same law. The proposed additional restrictions will only make it harder for states to adequately fund their Medicaid programs and maintain sufficient access to care for people with disabilities who rely on Medicaid services, a likely consequence of proposed changes that CMS's analysis in the proposed rule does not adequately explore.

III. CMS Should Retain the 75/75 Test

The proposed rule would eliminate part of the existing indirect hold-harmless test, known as the 75/75 test. If the tax exceeds the applicable threshold of 6%, CMS applies the 75/75 test, which assesses whether 75% or more of the providers subject to the tax receive 75% or more of their tax costs back (through enhanced Medicaid payments or other state payments). If that happens, CMS concludes that the state is effectively holding the providers harmless, and the tax fails the test. Congress previously codified the 75/75 regulatory provision in 2006 through Section 403 of the Tax Relief and Health Care Act of 2006, which incorporated into the Medicaid statute the version of 42 C.F.R. § 433.68(f)(3)(i) in effect at that time. That regulation included the 75/75 test. Congress did not eliminate or modify this compliance pathway in OBBBA.[12] CMS therefore should not eliminate a statutory compliance pathway through this rulemaking.

Removing such a longstanding regulatory option could cause states to reduce or restructure provider taxes beyond what the statute requires, as states seek to avoid the risk of federal financial penalties.

The undersigned CCD Health Task Force members urge CMS to retain the 75/75 test. At minimum, CMS should provide a stronger justification for eliminating it and assess its effects on state financing before finalizing the rule.

IV. CMS Should Reconsider Its Compliance and Reporting Approach

The proposed rule would newly classify taxes on health insurers as a Medicaid provider tax class subject to the new restrictions. This would apply OBBBA's moratorium on new or increased provider taxes and its reduced hold harmless threshold in Medicaid expansion states to longstanding taxes and fees whose revenue support non-Medicaid priorities such as a state's insurance department, Marketplace administration, or state tax credits for private insurance premiums.[13] Congress did not specify that section 71115, which focuses on

Medicaid financing, should extend to funding mechanisms for other health care programs. The resulting constraints on state budget planning will make it harder for states to maintain a stable healthcare ecosystem during times of rising health costs and uninsurance. CMS fails to provide a compelling justification for extending Medicaid-specific requirements to taxes and fees that are unrelated to Medicaid in the absence of clear Congressional direction.

We are also concerned about the proposed retrospective, quarterly-reporting compliance system, under which any determined excess over the applicable threshold would render the entire tax's revenue impermissible.[14] States have no way of prospectively ensuring they will not exceed the cap, given the many factors that can change projected tax revenue. For example, a state could reasonably project its net patient revenue and set a tax rate designed to land at its applicable threshold, only to see that revenue come in lower than expected later in the year for reasons entirely outside the state's control, including coverage losses from other OBBBA provisions. The same tax collection that looked compliant when set could then retroactively exceed the cap once actual, lower revenue is known, exposing the state to repayment of funds it has already spent or a penalty on the tax's full value rather than just the overage.[15] States would be penalized for a compliance failure they could not have detected in real time. Facing that risk, states may reduce otherwise permissible taxes simply to avoid the risk of a compliance penalty. That would further shrink the state share of Medicaid financing, and the associated federal match, below the limits set by Congress under OBBBA.

CMS' compliance mechanism should avoid penalizing states for revenue changes they could not reasonably anticipate. Instead, the rule should appropriately accommodate the prospective nature in which provider tax revenues are projected. This includes policies like reasonable de minimis allowances, clear definitions, and advance guidance. At minimum, if CMS proceeds with a retrospective compliance framework, it should specify how quickly interim thresholds will be issued to states and should protect good-faith revenue projections from penalty when actual results fall short for reasons beyond a state's control.

V. The Regulatory Impact Analysis Is Deeply Flawed

The proposed rule's deeply flawed regulatory impact analysis is based on unfounded assertions, selective analysis, and opaque data sources. Further, it largely ignores likely impacts on Medicaid beneficiaries. As a result, CMS fails to present the public with a meaningful opportunity to comment on the full effects of the proposed rule.

For example, CMS claims that the proposed rule would have "no effect" on Medicaid enrollment. This assertion ignores substantial evidence that states rely on provider taxes to support enrollment and coverage, including to expand Medicaid and to care for an aging population.[16] Moreover, it conflicts directly with multiple estimates that OBBBA's provider tax changes – not including the proposed changes that go beyond the law – will drive significant coverage loss.[17] When states face Medicaid budget shortfalls, they may respond not only by reducing provider payments and benefits, but

also by restricting eligibility or making it more difficult for eligible individuals to enroll or renew coverage. For people with disabilities, such coverage losses can disrupt access to HCBS and other services that are essential to community living.

While CMS admits that provider tax cuts are likely to result in reduced provider reimbursement, it fails to investigate how the cuts would affect beneficiaries, including people with disabilities. Cuts of the magnitude CMS proposes would restrict access to covered services for Medicaid beneficiaries. Rate reductions will force providers out of the program, while providers that rely more heavily on Medicaid payments (such as providers of HCBS) are likely to face financial distress. As noted elsewhere in these comments, HCBS rate cuts and resulting access to care issues are a predictable outcome when federal funding for Medicaid is reduced.[18] Ignoring the effects of these proposals on those the Medicaid program is intended to serve is an unacceptable omission that deprives stakeholders of an opportunity to comment on the true impact of the proposed rule.

VI. CMS Should Provide States Implementation Flexibility

States need adequate time, clear methodologies, and meaningful technical assistance to comply with these requirements. That includes the opportunity to correct reporting errors, protection against retroactive reinterpretation, and forbearance where states have made good-faith compliance efforts. States should not be forced into premature financing cuts because of uncertainty about how CMS will enforce the new rules.

This rule cannot be evaluated in isolation. States are simultaneously implementing other Medicaid changes under OBBBA, including work requirements and state-directed payment restrictions. Before finalizing this rule, CMS should analyze its combined effect, together with these other changes, on HCBS waiver services, provider reimbursement, workforce retention, family caregiving, HCBS waiting lists, and the risk of institutionalization for people with complex support needs.

VII. Conclusion

CMS should not finalize this rule as proposed and should not exceed the OBBBA-mandated changes without justification or analysis of the likely effects on Medicaid recipients, including people with disabilities. This includes:

- retaining the 75/75 test;
- declining to extend restrictions to entities and revenue Congress did not specify;
- adopting a compliance approach that does not pressure states to cut permissible financing pre-emptively;
- providing adequate implementation flexibility, and

- evaluating the cumulative consequences of multiple regulatory changes proposed since July 2025 for Medicaid beneficiaries, HCBS, providers, direct support professionals, and family caregivers before finalizing this rule.

For people with disabilities, these financing decisions can determine whether Medicaid, HCBS and other essential supports remain available, whether providers can continue serving Medicaid beneficiaries, and whether people can live successfully in their homes and communities.

Thank you for the opportunity to submit these comments.

Sincerely,

Access Ready, Inc.
Allies for Independence
American Association on Health and Disability
American Therapeutic Recreation Association
Autistic Self Advocacy Network
Autistic Women & Nonbinary Network
Bazelon Center for Mental Health Law
Caring Across Generations
Center for Medicare Advocacy
Deaf Equality
Disability Rights Education and Defense Fund (DREDF)
Epilepsy Foundation of America
Family Voices National
Huntington's Disease Society of America
Lakeshore Foundation
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Academy of Elder Law Attorneys (NAELA)
National Disability Rights Network (NDRN)
National PLAN Alliance
TASH
The Arc of the United States

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[1] Manatt Health for State Health and Value Strategies, *CMS Releases Provider Tax Proposed Rule* (July 31, 2026), https://shvs.org/resources/cms-releases-provider-tax-proposed-rule/.
[2] CMS, *Fact Sheet: Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes Proposed Rule (CMS-2452-P)* (July 21, 2026), https://www.cms.gov/newsroom/fact-sheets/amending-indirect-hold-harmless-threshold-health-care-related-taxes-proposed-rule-cms-2452-p; Congressional Budget Office (CBO), *Supplemental Cost Estimate: Public Law 119-21, to Provide for Reconciliation*

Pursuant to Title II of H. Con. Res. 14 Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid, 5 (Oct. 28, 2025), www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid_0.pdf.

[3] Section 71115 of the One Big Beautiful Bill Act, Pub. L. No. 119-21.

[4] Medicaid.gov, *Mandatory & Optional Medicaid Benefits* (Last visited Sept. 21, 2026), https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits.

[5] Kaiser Commission on Medicaid and the Uninsured, *Medicaid: An Overview of Spending on 'Mandatory' vs. "Optional" populations and Services* (June 2005), https://www.kff.org/wp-content/uploads/2013/01/medicaid-an-overview-of-spending-on.pdf.

[6] Jessica Schubel et al., *History Repeats? Faced With Medicaid Cuts, States Reduced Support for Older Adults and Disabled People,* HEALTH AFFAIRS FOREFRONT *(Apr. 16, 2025), https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled* (reporting that when federal Medicaid funding declined between 2010 and 2012, every state cut home and community-based services to some degree and waiting lists grew substantially).

[7] *Id*.

[8] Edwin Park, *CMS Issues New Rule Again Going Beyond H.R. 1 Requirements to Further Restrict State Use of Medicaid Provider Taxes*, CCF Blog (July 27, 2026), https://ccf.georgetown.edu/2026/07/27/cms-issues-new-rule-again-going-beyond-h-r-1-requirements-to-further-restrict-state-use-of-medicaid-provider-taxes/.

[9] Allie Gardner, Center on Budget and Policy Priorities, *Trump Administration's New Spending Cuts Package Is Clearly Illegal* (Executive Action Watch, July 21, 2026), https://www.cbpp.org/research/federal-budget/executive-action-watch?item=30710.

[10] CMS-2452-P, 91 Fed. Reg. 46562, implementing § 71115 of Pub. L. No. 119-21.

[11] Edwin Park, *supra* note 8.

[12] Georgia Goodman, LeadingAge, *CMS Medicaid Provider Tax Proposed Rule Implements HR 1's Hold Harmless Phasedown* (July 30, 2026), https://leadingage.org/cms-medicaid-provider-tax-proposed-rule-implements-hr-1s-hold-harmless-phasedown/; Manatt Health, *supra* note 1.

[13] Edwin Park, *supra* note 8; Ctr. on Budget and Policy Priorities, *Administration Policies Go Beyond 2025 Republican Reconciliation Law, Deepening Its Harm* (Aug. 4, 2026), https://www.cbpp.org/blog/administration-policies-go-beyond-2025-republican-reconciliation-law-deepening-its-harm.

[14] Manatt Health *supra* note 1; Alliance of Safety-Net Hospitals, *CMS Proposes Medicaid Provider Tax Regulation* (July 24, 2026), https://safetynetalliance.org/cms-proposes-medicaid-provider-tax-regulation/ (warning that, as proposed, the rule would limit states' ability to fund their Medicaid programs and could lead to dramatic reductions in Medicaid services and payment rates).

[15] Anne Karl and Avi Herring, The 80 Million (Manatt Health), *CMS' Provider Tax Proposed Rule: More Grandfathering Than States Expected, Paired with New Financing Risk* (Aug. 5, 2026), https://80million.substack.com/p/cms-provider-tax-proposed-rule-more (illustrating, with a hypothetical example for an expansion state in FFY 2028, how a drop in actual net patient revenue relative to projections, including from coverage losses tied to other H.R. 1 provisions, can push an already-collected tax retroactively above the applicable cap, and recommending that CMS specify how quickly interim thresholds will be issued and protect good-faith revenue projections from penalty).

[16] *See* Congressional Research Service, *Medicaid Provider Taxes* (Updated Dec. 30, 2024), https://www.congress.gov/crs-product/RS22843; Robin Rudowitz, et al., KFF, *Medicaid Enrollment and Spending Growth: FY 2019 and 2020* (Oct. 2019), https://www.kff.org/medicaid/medicaid-enrollment-spending-growth-fy-2019-2020; N.C. Gen. Stat. § 108A-54.3B (2026), *available at* https://www.ncleg.gov/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-54.3B.html and Jada Raphael, et al., KFF, *A Closer Look at North Carolina's Implementation of the 2025 Reconciliation Law Medicaid Provisions and Other Changes Amid Medicaid Budget Shortfalls* (May 29, 2026), https://www.kff.org/medicaid/a-closer-look-at-north-carolinas-implementation-of-the-2025-reconciliation-law-medicaid-provisions-and-other-changes-amid-medicaid-budget-shortfalls/; Rudi Keller, Mo. Indep., *Senate battle over taxes that fund Missouri Medicaid leaves state budget in*

limbo (Apr. 22, 2024), https://spectrumlocalnews.com/mo/st-louis/news/2024/04/22/missouri-senate-taxes-medicaid-budget (noting that a provider tax bill that was ultimately enacted would "supply $50 million toward the cost of Medicaid expansion" in 2025); Emma Morris, OK Pol'y Inst., *The 2021 session proved a mixed bag for health issues* (June 10, 2021), https://okpolicy.org/the-2021-session-proved-a-mixed-bag-for-health-issues (identifying an increase in the state's hospital provider tax as one of several funding sources for Oklahoma's Medicaid expansion).

[17] CBO *supra* note 2, at 4 (estimating that 1.1 million people will become uninsured due to the implementation of § 71115 of OBBBA); *see also* Preethi Rao, et al., RAND, *State-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act*, 8 (June 18, 2026), https://www.rand.org/pubs/research_reports/RRA4098-1-v2.html (predicting that the provider tax changes under OBBBA would cause 1.5 million Medicaid beneficiaries to lose coverage).

[18] *See* Jessica Schubel et al. *supra* note 6.