MACPAC

Advising Congress on
Medicaid and CHIP Policy

September 21, 2026

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

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

Dear Administrator Oz,

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the notice of proposed rulemaking on amending the indirect hold harmless threshold of health care-related taxes published on July 23, 2026 (CMS 2026). MACPAC is a nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program.

Pursuant to Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act), the proposed rule revises the indirect hold harmless threshold, often referred to as the safe harbor threshold, for determining whether an indirect hold harmless arrangement exists for a health care-related tax. In addition, the proposed rule would sunset the second prong of the hold harmless determination, often referred to as the 75/75 test, such that only health care-related taxes that are below the safe harbor threshold would not be considered to have an indirect hold harmless arrangement. Finally, the proposed rule creates a new permissible class of providers for health insurers that do not already meet the definition of managed care organization already established in regulations.

MACPAC appreciates this opportunity to share insights from our extensive body of work on Medicaid financing. In the Commission's June 2024 report to Congress, we provided recommendations on improving the transparency of Medicaid through the collection and public reporting of comprehensive information on states' Medicaid financing methods and the amount of the non-federal share of spending derived from specific providers that includes:

- a description of the methods used to finance the non-federal share of Medicaid payments, including the parameters of any health care-related taxes;
- a state-level summary of the amounts of Medicaid spending derived from each source of non-federal share; and,

- a provider-level database of the costs of financing the non-federal share of Medicaid spending, including administrative fees and other costs that are not used to finance payments to providers.

Transparency into Medicaid financing is needed to better understand how much providers are paid under currently permissible financing mechanisms. The amount providers pay in health care-related taxes can be considered additional costs that effectively reduce the gross payments. As such, the net payment that providers can use to cover the cost of providing services is lower than the gross amount initially received. Understanding both gross and net payment amounts is needed to appropriately assess whether payments are consistent with the statutory goals of efficiency, economy, quality, and access (§ 1902(a)(30)(A) of the Social Security Act (the Act)).

The Commission supports provisions within the proposed rule to require ongoing reporting of health care-related taxes, including information on the amount of tax collections and what the taxes are used to fund, that align with MACPAC recommendations. The Commission asks the Centers for Medicare & Medicaid Services (CMS) to collect additional reporting elements, such as provider-level information, that would allow for more comprehensive analyses of how gross and net payments may relate to policy goals of economy, efficiency, access, and quality. The Commission has concerns that the combination of the newly proposed provider class and elimination of the 75/75 test removes a pathway for states to raise revenues more broadly when the tax revenues have a minimal tie to Medicaid expenditures.

Reporting requirements

Medicaid statute does not consider expenditures funded by health care-related taxes to be permissible when there is a hold harmless provision in effect (§ 1903(w)(1)(A)(iii) of the Act). A hold harmless provision may apply if the state or other unit of government imposing the tax provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold the taxpayer harmless for any portion of the costs of the tax (§ 1903(w)(4)(C) of the Act). These arrangements are not considered an indirect guarantee so long as the total tax amount as a percentage of the provider's net patient revenue is below a statutorily defined threshold (currently set at 6 percent), commonly referred to as the safe harbor.

The 2025 Budget Reconciliation Act amended Section 1903(w)(4) of the Act to substitute a new safe harbor threshold in place of 6 percent for fiscal years (FYs) beginning on or after October 1, 2026. Beginning October 1, 2026, the safe harbor threshold will be capped at existing levels. Specifically, the safe harbor threshold will be equal to the applicable percent of net patient revenue attributable to taxes imposed as of July 4, 2025, and in expansion states, subject to a potential phase down of the safe harbor threshold starting in FY 2028.

To calculate and ensure compliance with the new hold harmless safe harbor thresholds established by the 2025 Budget Reconciliation Act, CMS proposes both one-time and ongoing reporting requirements for health care-related taxes. To calculate the safe harbor threshold that applies beginning October 1, 2026, the proposed rule requires states to submit data and documentation on all health care-related taxes enacted and imposed as of July 4, 2025 that includes each permissible class, tax revenue collection amount, and net patient revenue associated with both state and local taxes for all providers in the permissible class. States have until June 30, 2028 to finalize and submit the data.

To ensure ongoing compliance with the safe harbor thresholds after October 1, 2026, states must submit to CMS, via the CMS-64 quarterly report, data for all health care-related taxes that includes: tax collections, by tax and permissible class; net patient revenue for each permissible class for each reporting period; and what each tax on each permissible class is used to fund. States must also notify CMS of the removal of one or more providers that are units of government from a tax assessment when a waiver of the broad-based and uniformity requirements was not sought. CMS also has the authority to request any additional information related to health care-related

taxes, taxes imposed on health care providers, and Medicaid and non-Medicaid expenditures funded by such taxes.

The Commission has long held that analyses of Medicaid payment policy require complete data on all Medicaid payments that providers receive as well as data on the costs of financing the non-federal share necessary to calculate net Medicaid payments at the provider level. These new reporting requirements align with the Commission's prior recommendations to collect data on the sources of Medicaid financing and how they are used to fund payments. However, CMS should consider collecting and reporting these data at the provider level such that the financing data could be combined with other data sources (e.g., claims data, supplemental payment validation file) to enable analysis of net payments for specific providers. This level of analysis will be important for policymakers and analysts to understand how the new provider tax limits implemented by the 2025 Budget Reconciliation Act may lead to changes in payment rates to specific providers and the subsequent effects on outcomes such as quality and access.

CMS may also want to consider the feasibility of states submitting some data elements quarterly on the CMS-64 report. In the proposed rule, CMS wrote that states must submit actual data without using estimates, projections, or other statistical methods to approximate the required data. While actual data may be available on a quarterly basis for certain data elements such as tax collections, it may be challenging for states to collect and report net patient revenues on a quarterly basis. Net patient revenue includes revenue from other payers, and states would not have immediate access to that information. All payer revenue may be available through other reports such as the Medicare hospital cost reports, but those are not submitted on a quarterly basis and are aligned with the hospital's rate year. As such, the annual report from all hospitals may not be available at the same time nor cover the exact same period of time. CMS should consider the existing data sources for information on elements such as net patient revenue and when those data are available to minimize the administrative burden on states in reporting those data.

Additionally, while the threshold will be calculated based on a state fiscal year of data, the threshold will be imposed on a federal fiscal year basis. This difference in alignment between federal fiscal year and the state fiscal years that may serve as the basis for taxing authority and data availability for certain information such as net patient revenue could create operational challenges for states to administer and oversee tax arrangements for compliance. CMS could consider whether there is additional flexibility that could be given to states in implementing the new thresholds, similar to how disproportionate share hospital payments are aligned based on state plan rate year to account for the varying fiscal periods between hospitals and states, as described in the preamble of the proposed rule.

New permissible provider class

This proposed rule adds a new class for services of health insurers other than services of managed care organizations (including health maintenance organizations and preferred provider organizations) that are already specified in 42 CFR 433.56(a)(8). In the preamble, CMS indicated that this new class would include insurers issuing policies for the group and/or individual market, including high-deductible or catastrophic plans; short-term limited-duration policies; and insurers providing coverage for excepted-benefit (e.g., dental or vision only). CMS also indicated that the class could include revenues from premiums paid under Medicare, such as premiums for private fee-for-service plans offered under Medicare Advantage Part C or premiums Part D premium revenue, and premiums paid on behalf of individuals as part of a Medicaid section 1115 demonstration waiver providing premium assistance to purchase coverage through the exchange.

The new safe harbor threshold established by the 2025 Budget Reconciliation Act applies to the class of health care items or services described in 42 CFR 433.56(a) on May 1, 2025. The proposed rule would also apply the new health care-related tax safe harbor threshold to this new provider class of health insurers even though this class was not described in regulations as in effect on May 1, 2025.

CMS should consider providing additional clarification through regulatory definitions and other guidance prior to the effective date of this new provision to clarify which insurers fall under this new class versus the existing class of managed care organizations. While the preamble provides some examples of the types of insurers that may fall under this new class, it is not a comprehensive list and there may be some confusion as to whether the tax collections and net patient revenue of specific insurers should be included in one class or the other. For example, CMS states in the preamble that this new class could include premiums for private fee-for-service plans offered under Medicare Advantage Part C. However, the definition of a Medicaid managed care organization in Section 1903(m)(1)(A) of the Act includes an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII of the Act. Because neither health insurer nor managed care organization have very specific definitions within 42 CFR 433.56(a), one could potentially consider private fee-for-service plans offered under Medicare Advantage Part C to be a managed care organization based on the statutory definition in Section 1903(m)(1)(A) of the Act or to be a health insurer in this newly proposed class based on the examples provided in the preamble.

Elimination of the 75/75 alternative compliance test

While virtually all health care-related taxes pass the indirect guarantee test by being below the safe harbor threshold, there is a second prong by which a state could demonstrate compliance with the hold harmless requirement. Under current regulations, a tax arrangement that exceeds the safe harbor threshold would be considered to have an indirect guarantee if 75 percent or more of the taxpayers receive 75 percent or more of their total tax costs back in Medicaid or other state payments. This test is referred to as the 75/75 alternative compliance test, or the 75/75 test. This proposed rule would eliminate the 75/75 test for fiscal years beginning on or after October 1, 2026.

CMS proposes to eliminate the 75/75 test so that states will not be able maintain or increase tax collections above the thresholds established under the 2025 Budget Reconciliation Act. While there would be the possibility of utilizing the 75/75 test to exceed the new safe harbor limits, CMS also acknowledged that most health care-related tax arrangements are designed to fund Medicaid payments back to the taxpayer class. As such, CMS noted that the 75/75 is typically impractical to pass and that only one permissible tax has ever been approved using the 75/75 test.

The Commission has concerns that the elimination of the 75/75 test, coupled with the freeze of existing taxes and prohibition of new taxes, potentially reduces states' flexibility to raise revenue that may be used for broader purposes than Medicaid. Without this second prong of the indirect guarantee test, an increase of an existing tax or an implementation of a new tax that primarily funds non-Medicaid expenditures may be considered impermissible if a single taxpayer receives any amount of Medicaid payment, even a dollar. This may be particularly true for the new health insurer provider class that would be added under this proposed rule. For example, many states use state assessments on commercial insurance premiums to help finance state-based marketplaces, reinsurance programs, and section 1332 waiver initiatives that are not Medicaid expenditures (HMA 2026). The elimination of the 75/75 test creates uncertainty as to whether states can change existing taxes or implement new taxes that are designed primarily to fund activities that are not related to Medicaid. CMS could consider maintaining the 75/75 test, or implement another similar process, by which states could implement tax arrangements that do not meet the new safe harbor thresholds. This would allow states to maintain some flexibility in developing tax arrangements that do not finance a substantial amount of Medicaid expenditures paid back to the taxpayers.

Conclusion

The reporting requirements included in the proposed rule are consistent with long-standing MACPAC recommendations for increased transparency around provider taxes. The Commission encourages CMS, while finalizing this rule, to consider additional reporting elements, such as provider-level information, that would allow for more comprehensive analyses of how gross and net payments may relate to policy goals of economy, efficiency, access, and quality consistent with MACPAC's recommendation. Additionally, these data on the sources of Medicaid financing should be made publicly available. This level of analysis will be important for policymakers and analysts to understand how the new provider tax limits implemented by the 2025 Budget Reconciliation Act may lead to changes in payment rates to specific providers and the subsequent effects on outcomes such as quality and access. In implementing reporting requirements, CMS should consider the availability of existing data sources for certain elements such as net patient revenue and when those data are available to minimize the administrative burden on states. The Commission remains committed to publishing research and analysis on Medicaid payment and financing and would welcome the opportunity to provide any further information that would assist CMS as it finalizes the rule.

Sincerely,

Verlon Johnson, MPA
Chair

References

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