September 21, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: 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

Submitted electronically via: https://www.regulations.gov/commenton/CMS-2026-2476-0001

Dear Administrator Oz,

We appreciate the opportunity to comment on the proposed rule implementing section 71115 of Public Law 119-21, [CMS-2452-P], Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes. We urge CMS not to impose consequences on states and providers beyond those the statute requires, which we believe the proposed rule would do. A more restrained rule would reduce administrative burden on states while protecting coverage for the older adults our members serve.

LeadingAge, together with our state partners, represents more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with state partners whose members are active in 50 states, the District of Columbia, and Puerto Rico, we use advocacy, education, applied research, and community building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care.

Summary of Recommendations
Our comments and recommendations address five areas of the proposed rule. In brief, we urge CMS to:

1. Eliminate the disallowance of federal matching for all revenue from a tax whose collections exceed the hold harmless threshold.
2. Allow states more time to submit interim data, no less than 180 days from the effective date of a final rule.

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3. Revert to CMS' long-held practice of measuring compliance with established thresholds on the state's own fiscal year rather than requiring states to transition to the federal fiscal year.
4. State expressly that the threshold calculated from data on taxes imposed and in effect on July 4, 2025 is a fixed ceiling, not an ever-decreasing target, apart from the statutory phase-down.
5. Retract the addition of "services of health insurers" as a defined and permissible taxable class, which Public Law 119-21 does not require.

1. CMS Should Not Disallow All Revenue from a Permissible Class When the Class Threshold Is Exceeded

LeadingAge urges CMS to provide, in regulatory text, that where aggregate collections on a permissible class exceed the applicable threshold, the reduction to medical assistance expenditures under § 433.70(b) is limited to the revenue attributable to the excess. The text should also make clear that a health care-related tax that independently satisfies section 1903(w) of the Act is not impermissible solely because it is aggregated with another tax on the same class. We further ask CMS to codify a de minimis corridor and a cure period, and to adopt an adjustment for cases in which a class exceeds its threshold solely because net patient revenue declined.

Section 1903(w)(1)(A) of the Act directs the Secretary to reduce a state's medical assistance expenditures before calculating federal financial participation by the sum of any revenues from health care-related taxes that do not meet the requirements of section 1903(w). That language is implemented at § 433.70(b). It operates on revenues from *a tax that does not meet the requirements*. CMS reads that reference to mean that no revenue from the tax may be matched, because exceeding the regulatory limit puts the entire tax out of compliance. That reading is most troubling where taxes are assessed in the aggregate by class. For example, in a state that imposes both a statewide and a local levy on nursing homes, CMS indicates that all revenue would be impermissible if the combined collections exceed the stated threshold. LeadingAge concedes that the thresholds would be meaningless if taxes were not assessed in the aggregate, but disallowing every dollar of revenue from the tax is unnecessarily harsh.

CMS should consider alternatives to address situations where taxing structures imposed by multiple sectors of government combine to drive collections over a threshold. In these situations, CMS should establish a hierarchy to determine which portion of the revenue is reduced to bring the aggregate into compliance. CMS could disallow the excess revenue from the most recently amended tax structure or apply a proportional but minimal reduction across each tax until the total falls below the hold harmless threshold. CMS and states could also offset a single year's overage through reductions in the following year's collections, with federal matching adjusted accordingly. There are many options available to bring aggregated overages into compliance without disallowing all generated revenues.

Taxes on nursing facilities are uniquely vulnerable to breaching the hold harmless threshold. The denominator calculation of net patient revenues hinges on census and payer mix across the class.

Where a state's tax is based on beds or bed days, collections do not move linearly with payer mix, so the tax can slide over the threshold if net patient revenue (the denominator) falls while collections (the numerator) hold steady. Utilization review and prior authorization in Medicare Advantage are pressuring nursing homes to discharge residents earlier, shortening Medicare-funded stays and reducing net patient revenue. Similarly, contracted rates paid by Medicare Advantage plans are typically below rates paid by Medicare fee for service. An increase in Medicare Advantage-paid days will result in a decrease in net patient revenues while sustaining level or increased bed days. If a nursing home tax breaches a threshold because of these utilization changes rather than any flaw in the tax structure, states should be given a period to remedy it rather than being penalized by losing all of the revenue as matchable.

CMS states in the preamble that it does not intend to pursue disallowance for immaterial overages where a state's historical estimate-based methodology would have shown compliance. We appreciate that intent, but states need stronger protections and assurances than a statement of intent provides. We ask CMS to place those protections in the regulatory text. Options include a de minimis tolerance below which CMS would not enforce a full disallowance and a defined period in which a state could remedy an over-collection without losing federal match on the entire tax. CMS could also specify how states may cure over-collections and assure states that good-faith efforts to comply will not result in punitive withholding.

We respect CMS' interest in state compliance with the new thresholds, but a state's exposure is catastrophically out of proportion to a small overage in collections, regardless of its cause. A provider class could face significant changes in net patient revenues resulting from a global pandemic, changes in policies unrelated to Medicaid financing rules, or demographic and preference shifts. States facing the possibility of losing an entire class's tax revenue will set tax rates well below the ceiling by whatever margin their actuaries consider prudent, and that margin will widen as retrospective measurement makes the target less predictable. By codifying enforcement discretion, CMS can stabilize state expectations and provider rates and give states room to respond to shifts in utilization and other unpredictable factors.

2. CMS Should Allow No Less Than 180 Days from the Effective Date of a Final Rule for Interim Data Reporting

LeadingAge urges CMS to provide that the interim data submission is due no earlier than 180 days after the effective date of a final rule, rather than on the fixed date of December 31, 2026, and to extend the final actual data submission correspondingly. We further ask that CMS establish a defined correction window and a documented reconsideration process before a calculated threshold becomes binding on a state.

As proposed, states must submit interim data by December 31, 2026. Depending on when a final rule publishes and takes effect, states may be required to assemble and certify this submission against a specification that is not yet final, or that becomes final so close to the deadline that the work cannot be completed thoroughly, accurately, and on time. States may not have all of the

necessary data to submit for interim reporting. States may need to seek clarification or documentation from providers, on an impossibly quick turnaround. Asking states to build a data submission file to the specifications of a proposed rule is not a sound use of limited state capacity, additional provider administrative burden, and it may produce data of uncertain quality that wastes the time of both states and CMS.

The interim submission calls for significant data and coordination among state agencies and municipalities that are not subject to federal reporting timelines or penalties. In some instances, the data necessary to complete the report to CMS may not be immediately available. For the newly included class of health insurers, states' departments of insurance or other administering agencies may not have the requisite information on revenues, exempt providers, or other necessary data. For existing taxes calculated based on net patient revenues, other unrelated audit and reporting timetables could hinder data availability or integrity. In states where both a statewide and municipal tax are imposed on the same class, states will need to coordinate with municipalities that have no obligation to cooperate and may not be collecting the necessary data. Affording states the most generous available timelines for data submission would limit duplicative effort, increase efficiency, and promote program integrity across the Medicaid program.

Relatedly, CMS grossly underestimates what this reporting will cost states. CMS assumes that clerical staff will retrieve, aggregate, and enter the data. That may hold for those tasks, but the estimate accounts for nothing else: actuarial review of the data, fiscal auditing to confirm its accuracy, or the legal review that most states conduct on nearly every submission to CMS. We urge CMS to reconsider these burdens when establishing a timeline for interim reporting, release a more accurate estimate of the cost, and to allow no less than 180 days, with an opportunity for states to seek good-faith extensions where data is difficult to obtain, audit, and verify.

3. CMS Should Retain the State Fiscal Year as the Period for Measuring Threshold Compliance

LeadingAge urges CMS to retain its long-standing practice of measuring a state's compliance with the indirect hold harmless threshold over the state's own fiscal year, and to say so expressly in the regulatory text at § 433.68(f)(3)(ii). Section 71115 establishes when the new thresholds take effect and which applicable percent governs a given fiscal year.

CMS indicates that it intends to measure compliance on the federal fiscal year, but it does not adequately assess the challenges that change would impose on states and providers. Both states and providers have well-established budgeting practices that attribute provider tax obligations and revenues to state fiscal years. Providers use these established timelines in their budgeting process. Changing the standard would needlessly burden providers and states without improving CMS's ability to assess compliance.

When CMS last implemented a statutory change to the hold harmless threshold, it addressed this question directly and answered it in favor of the state fiscal year. In the February 2008 final rule implementing the reduction of the safe harbor to 5.5 percent, CMS wrote that "the collection threshold test is an annual test and while the effective date of this change does not coincide with

the beginning of any State's fiscal year the test must still be performed on an annual basis," and instructed that "[b]eginning with State fiscal year 2009 the 5.5 percent tax collection will be measured on an annual State fiscal year basis." *Medicaid Program; Health Care-Related Taxes, 73 Fed. Reg. 9685, 9686 (Feb. 22, 2008)*.

That has been the administrative practice for nearly two decades and states have built their tax structures, rate-setting cycles, and reconciliation processes around it. The proposed rule would reverse it. The preamble does not identify anything in section 71115 that compels the change, and we are aware of nothing in the statute that does. An agency departing from a long-standing interpretation on which regulated parties have relied should explain the reason for the change and address the reliance interests at stake. We ask that CMS either supply that explanation or, preferably, retain the existing approach.

CMS will itself calculate the baseline threshold using a state fiscal year. Shifting to a different measurement period once that baseline is set creates an avoidable transition and invites reporting errors.

4. CMS Should State Expressly That the Established Threshold Is a Fixed Ceiling, Not a Declining Target

LeadingAge urges CMS to add to § 433.68(f)(3)(ii) an express statement that the threshold established from the baseline period is a fixed ceiling for the permissible class; that collections below the threshold in any subsequent period do not reduce it; that a reduction, suspension, lapse, expiration, or restructuring of a tax after July 4, 2025 does not reduce or forfeit it; and that a state may return to that threshold at any time, subject only to the applicable percent required by section 71115 for classes and states to which the phase-down applies.

The preamble describes the newly calculated threshold as a ceiling and says nothing about reducing it, but the regulatory text is silent on the point. Our concern is with the threshold to be calculated from taxes enacted and imposed as of July 4, 2025. Even with no change to a tax, the percentage could fall because the makeup of the taxed class changed. A state might then want to revamp its tax structure to collect up to the allowable threshold. If CMS treats that revision as a new tax rather than a restructuring, the state would be barred from making it.

The final rule implementing section 71117 of Public Law 119-21, effective April 3, 2026, requires states to restructure health care-related taxes that are not generally redistributive, on transition deadlines running through state fiscal year 2029. Some states will need to comply by reducing, replacing, or re-enacting a tax, which could beg questions about compliance with the thresholds established by this rule and section 71115.

If a reduction undertaken to comply with section 71117 permanently lowers the section 71115 ceiling, CMS's two rules impose contradictory obligations: compliance with one forfeits capacity protected by the other. We ask CMS to state expressly in the final rule that a reduction, restructuring, repeal, or re-enactment undertaken to comply with section 71117, with the

requirements of § 433.68(e), or with any other federal requirement does not reduce the class threshold established under section 71115.

Congress expressly enacted protections for taxes on more vulnerable providers like nursing facilities. Exempting nursing facilities and intermediate care facilities from the phase-down reflects congressional intent to allow ongoing state revenue and rate augmentation for nursing homes and intermediate care facilities.

We also ask CMS to clarify that the ceiling and threshold apply to a particular permissible class of providers, not to a particular tax structure or device. For taxes on nursing homes especially, fluctuation in the provider class, census, or revenue streams could push a tax structure out of compliance. This clarification would allow states flexibility to repeal existing taxes, restructure based on necessary changes to comply with all taxing regulations and maintain legislative intent.

5. CMS Should Withdraw the Proposed Permissible Class for "Services of Health Insurers"
LeadingAge urges CMS to withdraw the proposed addition of "services of health insurers (other than services of managed care organizations)" to the list of permissible classes at 42 C.F.R. § 433.56(a). Section 71115 of Public Law 119-21 neither requires nor contemplates the creation of a new permissible class, and CMS does not claim that it does. If CMS wishes to pursue this classification, it should do so through a separate rulemaking that identifies the taxes affected and analyzes the consequences for state financing.

This addition implements no part of Public Law 119-21. Neither the provider tax statute at section 1903(w)(7)(A) nor P.L. 119-21 speaks to the addition or modification of permissible classes. We believe CMS has not fully considered its implications and has not made clear the relationship to the Medicaid program.

By including the new classification, CMS both defines and prohibits the use of new taxes on "services of health insurers" in the same regulation. For states that have historically imposed levies on insurers that would now fall into this category, the change creates a new obligation to comply with every provider tax requirement. The administrative burden on states to submit state plan amendments, data, and compliance information to CMS on these taxes is significant. States also had no way to know that these arrangements might be subject to provider tax rules at all.

CMS admits in the preamble that many of these arrangements generate revenue from group and individual markets, meaning the revenues are unrelated to Medicaid and administered by entirely separate state agencies. Bringing that revenue within section 1903(w) would subject a body of state insurance and tax policy to Medicaid financing rules, administered by agencies that do not set these rules and often do not have access to the underlying data. CMS has not identified which existing state assessments it believes would fall within the class, has not estimated how many would fail any existing or newly imposed provider tax regulations, and has not described a compliance pathway for a state that finds itself out of compliance on the effective date. Affected parties cannot comment meaningfully on a classification whose scope and consequences the agency has not estimated.

Assessment revenues from these programs can supplement general fund dollars, supporting budget viability across states. When states face budgetary pressure, optional Medicaid services are the first to see rate reductions or service caps, including efficient, cost-effective services like adult day programs and PACE. Further limits on states' ability to raise the revenue their budgets require pose significant financing challenges for states already pressed to make ends meet with state constitutional mandates for balanced budgets.

Conclusion

The finalization of this rule, as proposed, will add budgeting stress, impose unnecessary administrative transition, and introduce uncertainty and financial exposure for all healthcare providers. Nursing homes, in states that impose taxes on the class, face changes to reporting timelines, and possible state reductions of collections, leading to decreased provider rates and add-on payments possibly making ongoing Medicaid nursing home care provision untenable. Nursing home Medicaid rates already fall below the cost to deliver care, further downward pressure on rates will cause more provider closures. For provider types like adult day and other optional community-based services, states are likely to cut rates or impose service caps to reign in state spending. These providers and the individuals they serve are vulnerable in times of state budget contraction.

Where states are stretched, their ability to administer efficient programs and maintain high standards of program integrity suffer. The proposed rule imposes significant and unnecessary burdens that exceed the scope of the statute. We urge CMS to reconsider the portions of the rule where a less restrictive and less punitive approach would ease state compliance with little effect on CMS' ability to implement statutory obligations.

In addition to the implications of this rule, states are simultaneously managing, among other responsibilities:

- Policy and systems changes to implement new Medicaid eligibility requirements, including more frequent redeterminations, work reporting requirements, and reductions in retroactive eligibility;
- Policy and information technology changes related to provider tax and state directed payment development and changes from other rules;
- Compliance with CMS directives on program integrity, including plans for off-cycle revalidations and assessments of the effectiveness of their Medicaid Fraud Control Units (MFCUs);
- Rolling out the Rural Health Transformation Fund;
- Ensuring alignment across agencies related to new requirements in Medicaid and the Supplemental Nutrition Assistance Program (SNAP);
- For some states, re-examining their section 1115 waivers or filing renewals in light of new guidance from CMS;
- The regular daily work of administering the Medicaid program; and
- Preparing for or managing decreased budgets to do all of this work.

As advocates for high-quality long-term services and supports across the aging services continuum, LeadingAge members will continue to serve the Medicaid population wherever they can. We support CMS's efforts to maintain Medicaid as a viable and vibrant program for older adults, wherever they call home, and we believe the recommendations above would advance that goal while limiting unnecessary administrative burden on states. Please contact Georgia Goodman (ggoodman@leadingage.org) with any questions.

Sincerely,

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