September 21, 2026

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

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

We, the undersigned Attorneys General of Maryland, Colorado, Arizona, California, Connecticut, Delaware, District of Columbia, Hawai‘i, Illinois, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, Washington, and Wisconsin ("the States"), write to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes, 91 Fed. Reg. 46562 (proposed July 23, 2026). Several aspects of CMS's proposed rule exceed the limits established by Congress governing Medicaid provider taxes and threaten to unduly interfere with States' authority to regulate and finance health coverage. We urge CMS to abandon these aspects of its proposal.

This comment focuses on a few issues of particular concern to our States: the proposed redefinition of "health care related taxes" to encompass taxes on health insurers; the proposed application of the hold harmless threshold provisions of Public Law No. 119-21, 139 Stat. 72 (2025) to taxes on health insurers; the elimination of the 75/75 test for identifying hold harmless arrangements; and the calculation of hold harmless thresholds based on retrospective reporting that will be onerous for state agencies. These elements of the proposal exceed the bounds of the governing statutes, and they are not supportable as a matter of policy. This comment is not intended to be exhaustive. Many of our States are additionally submitting comments through our state agencies or through organizations that represent our state agencies.

I. Statutory Background

Medicaid is a joint federal-State program that provides health coverage to low-income individuals and families. Each State operates its own Medicaid program within boundaries set by federal law. The federal government and state governments each contribute funding to support the program. *See, e.g.*, *Medina v. Planned Parenthood S. Atl.*, 145 S. Ct. 2219, 2226–27 (2025).

Federal law limits the extent to which a State can collect donations or taxes from Medicaid providers and then use those amounts to pay the State's share of Medicaid expenditures. This helps ensure that such arrangements do not skew the distribution of costs between the state and federal governments. *See, e.g.*, Alison Mitchell, Cong. Rsch. Serv., RS22843, Medicaid Provider Taxes 2 (2024) (explaining how, in the 1980s, such arrangements could result in increased federal funding). Under section 1903(w) of the Social Security Act, 42 U.S.C. § 1396b(w), in the computation of the federal matching funds a State will receive for its Medicaid program, the State's Medicaid expenditures are reduced by the amount of any "health care related taxes" imposed by the State

unless those taxes meet certain conditions: (1) they must apply to a permissible "class" of health care items and services, *see id.* § 1396b(w)(3)(B), (7)(A); (2) they must apply to all providers within the class, *see id.* § 1396b(w)(1)(A)(iii), (3)(B); (3) they must tax all providers at a uniform rate, *see id.* § 1396b(w)(3)(B)(ii), (C)–(D); and (4) they must not "hold [providers] harmless," meaning they cannot be structured in a way that channels tax payments back to the providers that paid them, *see id.* § 1396b(w)(4).

The term "health care related taxes" is not limited to taxes; it also includes other fees, assessments, and payments that are not in the form of taxes. *See id.* § 1396b(w)(7)(F). For convenience, this comment follows the statute and uses the term "tax" in all its forms to refer to taxes as well as fees, assessments, and payments other than taxes.

Current statutes and rules establish a safe harbor such that if a tax amounts to a proportion of net patient revenue below 6 percent—the "hold harmless threshold"—the tax will not be treated as a "hold harmless" arrangement. 42 C.F.R. § 433.68(f)(3)(i)(A).

Public Law No. 119-21, enacted July 4, 2025, directs that, for each permissible class defined in regulations as of May 1, 2025, the hold harmless threshold will be reduced to the rate (the percentage of net patient revenue for the class) imposed by taxes in existence as of the date of the enactment of the statute, or 0 percent if there is no such tax in existence. Pub. L. No. 119-21, § 71115(a), 139 Stat. at 301–02 (to be codified at 42 U.S.C. § 1396b(w)(4)(C)(ii), (D)). In addition, for States that expanded Medicaid eligibility under the Affordable Care Act ("expansion States"), the maximum applicable hold harmless threshold will be reduced by 0.5 percentage points each year from 2028 to 2032 such that it will be 3.5 percent by 2032. *Id.*

II. Comments on the Proposed Rule

On July 23, 2026, CMS published a notice of proposed rulemaking in which it proposed regulatory changes to implement the provisions of Public Law No. 119-21 and also proposed additional changes that are not required by Public Law No. 119-21. This letter responds to CMS's request for comments.

A. Proposed redefinition of "health care related taxes" to encompass taxes on health insurers

CMS proposes to redefine "health care related taxes" under 42 U.S.C. § 1396b(w)(3) such that the definition will extend to taxes on health insurers, and to establish a new permissible class for "services of health insurers" at 42 C.F.R. § 433.56(a)(19). This proposal would conflict with the statute and is not justified as a matter of policy.

A tax may qualify as a "health care related tax" under § 1396b(w)(3) if it either "(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services," or "(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities." 42 U.S.C. § 1396b(w)(3)(A). In the proposed rule, CMS stated that taxes on health insurers meet this definition because health insurance is "related to . . . payment for . . . health care items or services" under

§ 1396b(w)(3)(A)(i) or, alternatively, because such taxes qualify under § 1396b(w)(3)(A)(ii). 91 Fed. Reg. at 46568.

Both rationales are flawed. First, CMS has previously recognized that taxes on health insurers generally do not fit within § 1396b(w)(3)(A)(i), because health *insurance* is a service distinct from health *care*. *See* 57 Fed. Reg. 55118, 55121 (Nov. 24, 1992) ("Payments for health care insurance and HMO enrollment premiums are made to the insurer or HMO, for their use and to ensure coverage. Such payments may or may not be used to purchase or provide health care items or services for that individual or group."). Consistent with that long-established understanding, 42 C.F.R. § 433.55(e) specifies that health care insurance and HMO premiums are not considered payments for health care items and services. Under CMS's longstanding interpretation, taxes on health insurers qualify as "related to . . . payment for [health care] items or services" only if they are taxes on health care payments—for example, if a State levies a tax on the amounts that a health insurer pays to health care providers for health care items or services. *See* 58 Fed. Reg. 43156, 43160 (Aug. 13, 1993) (explaining that "a tax on health care payments made by payers (that is, insurance payers or patients)" is considered a health care related tax).

For similar reasons, taxes on health insurers do not generally fit within § 1396b(w)(3)(A)(ii). That section encompasses only taxes levied on "individuals or entities . . . providing or paying for" health care items or services. So like § 1396b(w)(3)(A)(i), it includes only direct taxes on health care payments made by health insurers—not taxes on health insurers more generally.

Furthermore, several important principles disfavor reading § 1396b(w)(3) to encompass taxes on health insurers when there is no clear indication that it reaches that broadly. Such an interpretation would run counter to the McCarran-Ferguson Act, which provides that a federal statute should not be construed to "invalidate, impair, or supersede" state regulation of insurance, including state laws that "impose[] a fee or tax" on insurers, unless the federal statute "specifically relates to the business of insurance." 15 U.S.C. § 1012(b). Along the same lines, the Supreme Court "expect[s] Congress to speak clearly when authorizing an agency to exercise powers of vast economic and political significance." *Nat'l Fed'n of Indep. Bus. v. Dep't of Labor*, 142 S. Ct. 661, 665 (2022) (per curiam) (quoting *Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs.*, 141 S. Ct. 2485, 2489 (2021) (per curiam)). The text of § 1396b(w) does not clearly contemplate pervasive interference with States' regulation of health insurers. The Spending Clause of the Constitution, U.S. Const. art. I, § 8, cl. 1, also demands that conditions of federal spending programs be set forth unambiguously. *See Medina*, 145 S. Ct. at 2232 & n.4. The Social Security Act does not clearly provide notice to States that they must surrender control of taxes on health insurers to participate in Medicaid.

Expanding the meaning of "health care related taxes" in the manner that CMS suggests would also introduce uncertainty about what other forms of taxes fall within the definition besides taxes on health insurers. CMS has not identified a clear limiting principle on its proposed new and broader interpretation.

In addition to contravening federal law, CMS's proposal is unjustified. CMS has not provided sufficient reasons for abandoning its prior longstanding interpretation of § 1396b(w)(3).

CMS also has not adequately weighed the implications of treating taxes on health insurers as "health care related taxes" under § 1396b(w)(3) and has not adequately explored alternatives.

Treating all taxes on health insurers as "health care related taxes" would effectively penalize States when they impose any such taxes on health insurers. Many States have previously imposed taxes on health insurers and count on revenues from such taxes for purposes of fiscal planning. Those States reasonably relied on CMS's prior interpretation of § 1396b(w)(3) as assurance that imposing those taxes would not threaten federal Medicaid contributions. Moreover, the statute does not authorize retroactive rulemaking. Accordingly, CMS cannot apply its new interpretation of "health care related taxes" to reduce federal contributions based on States' imposition of new or increased taxes on health insurers prior to issuance of the final rule. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208–09 (1988). CMS should not use a 2026 regulatory interpretation to alter the legal consequences of financing decisions States lawfully made before CMS announced its new interpretation.

Although CMS states that its proposal was motivated by States imposing taxes on health insurers to offset their share of Medicaid expenditures, *see* 91 Fed. Reg. at 46567, the proposal is not limited to state taxes that have that intent or effect. Many taxes and assessments on health insurers serve state and federal objectives other than reducing state Medicaid expenditures, and CMS has failed to consider the effects of the proposal on those other objectives. For example, the Affordable Care Act requires States to ensure that their health exchanges are "self-sustaining," and toward that end explicitly authorizes States to impose assessments or user fees on participating health insurance issuers to support the operation of the exchanges. 42 U.S.C. § 18031(d)(5)(A) ("In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations."). Penalizing States for imposing such assessments would undermine that policy. CMS also has not explored alternatives such as a more narrowly targeted rule that would not unduly interfere with important state taxes that are not connected to Medicaid funding.

Finally, CMS's proposed rule also does not provide an adequate opportunity to comment in that CMS has not made public the technical studies and data underlying its proposal. CMS states, "We are aware that several States utilize taxes imposed on health insurers as the source of non-Federal share to finance Medicaid expenditures, including taxes based on health insurance premiums revenue or other insurance-related measures . . . ." 91 Fed. Reg. at 46567. But CMS has not identified the particular States or state taxes that informed the proposal and has not disclosed its studies of those taxes. If CMS decides to consider the proposal further, it should disclose the pertinent information and materials and provide an additional opportunity for public comment.

CMS's proposal to establish a new permissible class for "services of health insurers" at 42 C.F.R. § 433.56(a)(19) presupposes that taxes on such services properly qualify as "health care related taxes." Because it would be improper to change the definition of "health care related taxes" for all the reasons discussed above, it would also be improper to establish a new permissible class.

B. Proposed application of the hold harmless threshold provisions of Public Law No. 119-21 to taxes on health insurers

CMS also proposes to make taxes on health insurers subject to the provisions of § 71115 of Public Law No. 119-21 pertaining to hold harmless thresholds. This is contrary to the statute. By their terms, those new provisions apply only to classes defined in the regulations in effect May 1, 2025. CMS cannot apply the requirements to a newly created class for taxes on health insurers.

CMS asserts that Public Law No. 119-21 is "silent" regarding its application to classes established after May 1, 2025, and therefore CMS has discretion to apply the § 71115 framework to the new class for health insurers. 91 Fed. Reg. at 46569. But CMS misreads the statute. The plain terms of § 71115 explicitly limit its scope to classes defined in the regulations in effect as of May 1, 2025. Any more recently created classes are not governed by § 71115 and instead are governed by the more general provisions of 42 U.S.C. § 1396b(w)(4)(C)(ii).

The provision governing the hold harmless threshold, 42 U.S.C. § 1396b(w)(4)(C)(ii), provides generally that the hold harmless threshold shall be determined as specified in 42 C.F.R. § 433.68(f) as in effect on November 1, 2006. The referenced regulation established a hold harmless threshold of 6 percent. 42 C.F.R. § 433.68(f)(3)(i) (2006). The general rule established by (4)(C)(ii) is followed by an exception: "*except that* for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011," the threshold is 5.5 percent. 42 U.S.C. § 1396b(w)(4)(C)(ii) (emphasis added). Public Law No. 119-21 appended an additional exception to subparagraph (4)(C)(ii): "*and* for fiscal years beginning on or after October 1, 2026, the applicable percent determined under subparagraph (D) shall be substituted" in place of the usual 6 percent threshold. Pub. L. No. 119-21, § 71115(a)(1), 139 Stat. at 301 (to be codified at 42 U.S.C. § 1396b(w)(4)(C)(ii)) (emphasis added).

The new subparagraph (D) in turn addresses hold harmless thresholds "in the case of . . . a class of health care items or services described in section 433.56(a) of title 42, Code of Federal Regulations (as in effect on May 1, 2025)" in either "a non-expansion State" or "an expansion State." Pub. L. No. 119-21, § 71115(a)(2), 139 Stat. at 301–02 (to be codified at 42 U.S.C. § 1396b(w)(4)(D)).

CMS asserts that subparagraph (D) does not address classes newly established after May 1, 2025, and concludes that the statute is "silent" regarding such classes. 91 Fed. Reg. at 46569. But that conclusion violates traditional principles of statutory construction in several ways. The terms of subparagraph (D) explicitly limit the new requirements to cases involving "a class of health care items or services described in section 433.56(a) of title 42, Code of Federal Regulations (as in effect on May 1, 2025)." That means the new requirements do not and cannot apply to classes newly established after May 1, 2025. *Cf. Jennings v. Rodriguez*, 583 U.S. 281, 300 (2018) (reasoning under the principle *expressio unius est exclusio alterius* that the statement of one exception implied the absence of other exceptions). CMS's proposed interpretation also violates the canon against surplusage in that it fails to give effect to the limiting language quoted above. The limiting language is repeated twice in the statute and cannot simply be swept aside. A third way that CMS's proposed interpretation violates principles of statutory construction is that it reads subparagraph (D) to cover cases that it does not in fact cover. *See* Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 93–106 (2012) (discussing the "omitted-

case canon": "Nothing is to be added to what the text states or reasonably implies . . . . That is, a matter not covered is to be treated as not covered.").

Subparagraph (D) does not affect hold harmless thresholds for classes newly established after May 1, 2025, and the terms of subparagraph (D) in fact foreclose application to such newly established classes. This reading does not create a lacuna in the statute. The structure and wording of subparagraph (4)(C)(ii) make clear that the default rule is to follow 42 C.F.R. § 433.68(f) as it existed in 2006, and subparagraph (D) supplies alternative thresholds to be "substituted" in special cases. When subparagraph (D) provides nothing to "substitute[]," the governing threshold is simply the 6 percent hold harmless threshold stated in 42 C.F.R. § 433.68(f) in 2006.

Thus, even if taxes on health insurers were properly considered "health care related taxes"—which they are not—such taxes should not be subject to the new requirements defined in § 71115.[1]

CMS's proposed approach would also amount to impermissible retroactive rulemaking. It would effectively render impermissible state taxes that were created, or that increased as a proportion of net patient revenues, between July 1, 2025, and the effective date of the final rule. Making matters worse, CMS proposes to take the position that any requests for waivers under 42 U.S.C. § 1396b(w)(3)(E) and 42 C.F.R. § 433.72 would have to have been received by September 30, 2025, even for taxes not previously treated as health care related taxes. *See* 91 Fed. Reg. at 46571–72. That would make waivers effectively unavailable even though 42 U.S.C. § 1396b(w)(3)(E) and 42 C.F.R. § 433.72(a)(1) require CMS to entertain waiver requests.

C. Proposed elimination of the 75/75 test for identifying hold harmless arrangements

CMS also proposes to entirely eliminate the longstanding second prong of the hold harmless test, known as the 75/75 test. *See* 91 Fed. Reg. at 46581–82. Under current regulations, if a state tax produces revenues greater than 6 percent of net patient revenue, an indirect hold harmless relationship will be found to exist only "if 75 percent or more the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments." 42 C.F.R. § 433.68(f)(3)(i)(B). This second prong of CMS's hold harmless analysis has been consistently maintained for over 30 years, since its promulgation in agency regulations in 1992. *See* 57 Fed. Reg. at 55129–30.

At that time, CMS explained that the 75/75 test is "a reasonable parameter to ensure that States do not use Medicaid rates to repay providers for tax costs in a way not permitted under the statute, and at the same time, permit States flexibility in the design of their tax and payment programs." 58 Fed. Reg. at 43166. However, in this proposed rule, CMS now proposes to "eliminat[e]" this test entirely. 91 Fed. Reg. at 46581. This proposal is both contrary to law and arbitrary and capricious.

[1] While this section focuses on taxes on health insurers, the reasons discussed in this section would also preclude CMS from applying the § 71115 requirements to any other newly created class.

First, the elimination of the 75/75 test is contrary to law because the test is explicitly codified in statute. Under § 1396b(w)(4)(C)(ii), a hold harmless determination by CMS "shall be made" pursuant to 42 C.F.R. § 433.68(f)(3)(i) "as in effect on November 1, 2006," *id.*, with only two exceptions: First, "for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011" the statute substitutes a threshold of 5.5 percent instead of 6 percent. Second, Public Law No. 119-21 provides for substitution of the applicable threshold percentages in certain specified cases after October 1, 2026. *See* 42 U.S.C. § 1396b(w)(4)(C)(ii) (stating that the 2006 regulations must be followed, "except" for these adjustments to the applicable tax percentages). These exceptions modify only the applicable percentage thresholds; the statute otherwise mandates that CMS follow the hold harmless regulations that were in effect as of November 1, 2006. *Id*.

The regulations in effect as of November 2006 incorporated the 75/75 test. *See* 42 C.F.R. § 433.68(f)(3)(i) (2006) (stating that that CMS will consider "a hold harmless provision to exist if 75 per cent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments"). Accordingly, CMS is required by statute to apply the 75/75 test, and the proposal to eliminate this test is contrary to law.

Second, CMS's proposal to eliminate the 75/75 test is also arbitrary. CMS purports to justify its proposal by inconsistent and unsupported speculation concerning how States could react to Public Law No. 119-21. That is, CMS claims that because the new law will further limit certain healthcare related taxes, "States *may* have greater incentives to rely on the 75/75 test as a mechanism that permits collections above the threshold otherwise established under the first prong." 91 Fed. Reg. at 46581 (emphasis added). CMS similarly "anticipate[s] States *may* try to manipulate a way to increase tax revenue collections in order to maintain existing levels of non-Federal share generated through health care-related taxes." *Id*. (emphasis added). However, elsewhere in the notice of proposed rulemaking, in discussing alternatives to "retiring the 75/75 prong," CMS asserts that "this regulatory pathway *is being considered* as a means to circumvent the limitations on provider taxes created by section 71115." *Id*. at 46595 (emphasis added). Yet CMS provides no support for the claim that the 75/75 test is actually being considered as a means of circumvention, nor who or what is considering such action.

CMS thus fails to explain whether increased reliance on the 75/75 test is actually likely, and fails to provide any analysis of the potential costs and benefits of removing this prong of the hold harmless analysis. At most, CMS vaguely notes that, since 1992, "the use of health care-related taxes has increased dramatically" and States have used "increasingly complex mechanisms" in their "tax programs." *Id*. at 46581. CMS again declines to give a single example of such a "complex mechanism[]," explain how they "could create opportunities for States" to create "arrangements that satisfy the regulatory second prong," *id*., or explain why these developments should be considered problematic. CMS's suggestion that States are likely to abuse the 75/75 test is inconsistent with its argument that the 75/75 test is unnecessary because the test "has been utilized extremely rarely," *id.* And CMS has not adequately explained how any speculative benefits outweigh the need to limit undue interference with lawful and valid state policies.

CMS concludes that eliminating the 75/75 test "would better align the indirect hold harmless framework with the operation of section 71115 and reduce opportunities for circumvention of the threshold limitations established by that provision." *Id*. But, as noted above,

CMS cannot plausibly rely on the legislation to support its proposed changes, since the test has been previously codified in law, and section 71115 does not disturb that prior codification. *See id.* (conceding that "The changes made by [§ 71115] do not address the 75/75 test.").

Without Public Law No. 119-21 as the impetus for eliminating the 75/75 rule, CMS also points to a nearly eight-year-old Office of Inspector General report as the reason it is "re-evaluating the appropriateness of the 75/75 test." *Id*. at 46564. As CMS recounts, the 2018 OIG report found that certain States had mitigated tax burdens on hospitals, even though the tax rates were below the 6 percent safe harbor threshold, and were thus permissible. *Id.*

The Office of Inspector General explained that governing statutes were "intended to limit, not eliminate, States' use of health-care-related taxes," and as a consequence the Office of Inspector General recommended that CMS reevaluate the safe harbor analysis, "such as the reduction or elimination of the safe harbor threshold or *adjusting* the 75/75 requirement, and take appropriate action." Gloria L. Jarmon, Dep't of Health & Hum. Servs. Off. of Inspector Gen., Although Hospital Tax Programs in Seven States Complied with Hold-Harmless Requirements, the Tax Burden on Hospitals Was Significantly Mitigated 13–14, A-03-16-00202 (2018) (emphasis added). The Office of Inspector General did not recommend or even suggest the complete elimination of the 75/75 test. Given the absence of any recommendation to eliminate the 75/75 test, the report does not support CMS's proposal to do so.

At bottom, CMS's scattershot discussion as to the 75/75 test consists solely of unsupported speculation and unexplained reasoning, and is thus arbitrary and capricious.

The States also have not had an adequate opportunity to comment on the proposal, because CMS has not disclosed its factual analysis for comment, including the evidence and analysis supporting its assertions that use of the 75/75 provision is "rare," that use of health care related taxes "has increased dramatically," and that "States have become more sophisticated in structuring health care related tax programs using increasingly complex mechanisms." 91 Fed. Reg. at 46581. If CMS does not abandon this proposal, it should disclose the details of its analysis and provide an opportunity for further comment.

D. Proposed calculation of hold harmless thresholds based on retrospective reporting that will be onerous for state agencies

The proposed rule would establish an expansive new reporting and compliance framework that is not required by statute and would impose substantial, ongoing administrative burdens on States. *See* 91 Fed. Reg. at 46583–86.

First, in order to calculate the final indirect hold harmless threshold for each permissible class, the proposed rule requires States to submit a comprehensive, retrospective final report in 2028. *Id.* at at 46583. This final report must contain state and local tax collection data and net patient revenue data for all providers in each permissible class for the state fiscal year containing July 4, 2025, and must substantiate whether each tax was "enacted" and "imposed" by that date. *Id.* at 46583–84. Reconstructing accurate historical data at this level of granularity, and documenting enactment and imposition dates in a manner never previously required, constitutes a substantial new burden created by the proposed rule.

Second, beginning October 1, 2026, the proposed rule imposes an indefinite quarterly reporting obligation requiring States to supply for all State and local health care related taxes: total tax revenue collections, by tax and permissible class in its entirety; net patient revenue by permissible class; information on how tax revenues are used (including for non-Medicaid purposes); and documentation of any exemptions granted to public providers. *Id.* at 46584–85.

Requiring retrospective reporting and compliance based on actual data rather than estimates, projections, or other statistical methods creates significant uncertainty that could require States to adjust tax collection based on a moving target of net patient revenue or face penalties for unpredictably exceeding the hold harmless threshold. CMS acknowledges this uncertainty, explaining that "tax revenue collected as a percentage of net patient revenue may increase even if tax rates remain unchanged." *Id.* at 46576. But it does not adequately consider the practical difficulty of requiring States to retroactively respond to fluctuations in net patient revenue or the severity of the impact that suggested remediation, such as tax refunds, would have on States' fiscal planning. CMS fails to explain why less burdensome alternatives to quarterly, retrospective reporting requirements—such as prospective estimates or projections or annual reconciliations—were not considered.

These burdens would be particularly onerous for States pertaining to the proposed new permissible class for health insurers. Because the indirect hold harmless threshold must be calculated separately for each permissible class, states would have to produce class-specific tax collection and "net patient revenue" data for health insurers. But "net patient revenue" is a provider-based measure tied to reimbursements for furnishing care—not an insurer accounting concept. Insurers do not bill for or receive payments for health services; they collect premiums. The proposed rule fails to specify how "net patient revenue" would be calculated for health insurers. States would be required to develop entirely new reporting methodologies, construct a proxy metric for net patient revenue for insurers, and obtain financial data from insurers that States have never previously collected or validated. These uncertainties, which would affect every quarterly reporting obligation, are exacerbated with respect to the requirement that States retrospectively construct and report insurer-specific tax and revenue data for the state fiscal year containing July 4, 2025, as part of the calculation of each State's final indirect hold harmless threshold.

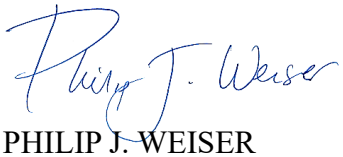
The purpose of provider tax oversight is to prevent arrangements under which providers are effectively guaranteed repayment of their health care related tax costs through their Medicaid payments or other state payments. However, the proposed rule would newly require States to collect and report the required information for health insurers that are not Medicaid providers and do not receive Medicaid reimbursement linked to taxable revenue. CMS provides no rationale for why monitoring the taxation of all health insurers is relevant to identifying hold harmless arrangements. As such, imposition of the hold harmless threshold and associated reporting requirements on health insurer taxes creates a substantial burden on States without any corresponding benefit to the purpose of the proposed rule.

Because CMS's proposed rule exceeds statutory limits, disregards longstanding agency interpretation, conflicts with other federal requirements, and imposes retroactive and unadministrable burdens on States, we urge CMS to withdraw or substantially revise the proposed

provisions. At a minimum, CMS should publish all underlying data and analyses and provide a meaningful opportunity for comments addressing such data and analyses.

Sincerely,

ANTHONY G. BROWN
Attorney General of Maryland



PHILIP J. WEISER
Attorney General of Colorado

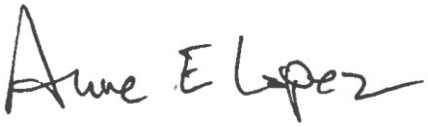
KRISTIN K. MAYES
Attorney General of Arizona

ROB BONTA
Attorney General of California

WILLIAM TONG
Attorney General of Connecticut

KATHLEEN JENNINGS
Attorney General of Delaware

BRIAN L. SCHWALB
Attorney General of the District of Columbia



ANNE E. LOPEZ
Attorney General of Hawai‘i

KWAME RAOUL
Attorney General of Illinois

AARON M. FREY
Attorney General of Maine

ANDREA JOY CAMPBELL
Attorney General of Massachusetts

DANA NESSEL
Attorney General of Michigan

KEITH ELLISON
Attorney General of Minnesota

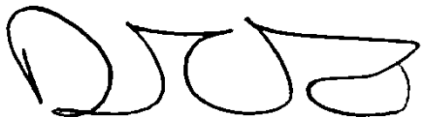
AARON D. FORD
Attorney General of Nevada

JENNIFER DAVENPORT
Attorney General of New Jersey

RAÚL TORREZ
Attorney General of New Mexico

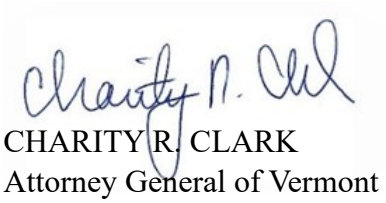
LETITIA JAMES
Attorney General of New York

JEFF JACKSON
Attorney General of North Carolina

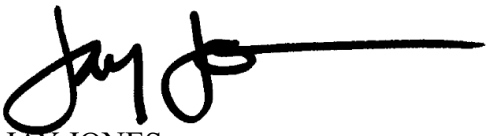


DAN RAYFIELD
Attorney General of Oregon

PETER NERONHA
Attorney General of Rhode Island

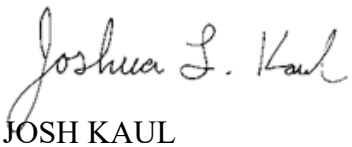


CHARITY R. CLARK
Attorney General of Vermont



JAY JONES
Attorney General of Virginia

NICHOLAS W. BROWN
Attorney General of Washington



JOSH KAUL
Attorney General of Wisconsin