National
MLTSS
Health Plan Association

July 14, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2448-P
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule

Dear Administrator Oz,

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to provide input on the Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule.[1]

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and take risk for long-term services and supports (LTSS), including home and community-based services (HCBS), provided under Medicaid.[2] Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Our members currently cover the large majority of all enrollees in MLTSS plans and integrated plans, including national plans and regional and community-based plans.

The MLTSS Association appreciates CMS' efforts to strengthen the oversight and quality of Medicaid programs. Our comments offer key considerations for CMS on the timeline and implementation of its proposals, as well as specific impacts on individuals receiving LTSS.

Overarchingly, we express concern over the timelines proposed in this rule, and the administrative burden placed onto states. Under the current rule, states may need to reassess and potentially overhaul their provider tax frameworks to align with the timelines outlined in this proposed rule. Specifically, there is currently no transition period for states that have had waivers approved within the last two years of the effective date of this rule. Additionally, states with waivers in effect for more than two years must, within one year of the beginning of their next fiscal year, submit updated tax waivers that fully comply with this rule. This timeline and complex nature of the proposed rule will require states to redesign their provider tax systems under pressing deadlines, imposing significant administrative and

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[1] Federal Register: Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule

[2] Members include Aetna, AlohaCare, AmeriHealth Caritas, CareSource, Centene, Commonwealth Care Alliance, Elevance Health, Florida Community Care, Humana, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, United Healthcare, UPMC Community Health Choices

fiscal pressure on state governments. While CMS did inform several states with recently approved waivers that it plans to implement new regulations which would make certain provider taxes non-compliant in the future, these notifications did not instruct states to immediately discontinue or modify their tax structures. Additionally, at the time of notification, states were unaware of any forthcoming changes to the Medicaid program via federal reconciliation and may have initiated alternative financing strategies involving new provider taxes.

Overall, The MLTSS Association recommends the following changes to this proposed rule:

1. CMS extend the transition period to three years, regardless of a state's current waiver approval status.
2. CMS provide clear implementation guidance and robust technical assistance to states that will need to amend existing waivers or financing structures in response to the rule.
3. CMS postpone the finalization of this proposed rule, to the extent possible under current laws, until further research is conducted on how states utilize provider-related taxes, comprehensive data is gathered, and the potential consequences of the rule are assessed.

The Use of Provider Taxes

Since the inception of Medicaid, states have employed provider taxes as a mechanism to finance their share of Medicaid costs.[3] As of 2025, 49 states and the District of Columbia implement at least one provider tax, with 39 states utilizing three or more distinct types. Among the 49 states that have a provider tax in place, 46 states levy a tax on nursing facilities, 45 levy a tax on hospitals, 32 place a tax on intermediate care facilities, 20 impose a tax on Managed Care Organizations, and 17 place a tax on ambulance services.[4]

Collectively, provider taxes contributed approximately 36.9 billion dollars annually in 2018, accounting for about 17% of the state share of Medicaid expenditures.[5] These funds are instrumental in supporting payment rates, safety-net providers, those in rural areas, and LTSS services.

Eliminating or reducing provider taxes would pose significant state fiscal challenges, compelling states to either raise funds via alternative revenue sources or reduce Medicaid benefits and payments. Given that Medicaid is the largest single payer of LTSS in the United States (exceeding 206 billion dollars in 2021) any changes to this policy with swift timelines for compliance cause concern for the MLTSS Association.[6]

State Impacts

Provider taxes offer states access to a source of Medicaid funding that is imperative in operating their Medicaid program.[7] Altering existing provider tax policies would significantly challenge states by creating financial constraints that disrupt the funding and structure of state Medicaid programs and reduce payments to Medicaid providers and MCOs.

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[3] Health Care-Related Taxes in Medicaid | MACPAC
[4] 5 Key Facts About Medicaid and Provider Taxes | KFF
[5] Medicaid Provider Taxes: A Critical Source of Medicaid Funding for States | Center For Children and Families
[6] Who Pays for Long-Term Services and Supports | Congressional Research Service
[7] Provider Taxes Are Essential for State Budgets, Patients' Access to Care | Modern Medicaid Alliance

Sudden and substantial fluctuations in provider tax revenues could compel states to confront challenging fiscal decisions and disrupt state economies. Provider taxes currently allow states the opportunity to fund a portion of their Medicaid programs while mitigating direct taxpayer costs.[8] Cuts or caps on provider taxes can leave large holes in state Medicaid budgets. To make up for these losses, states may have to raise general taxes—placing added burdens on taxpayers. States may also tighten Medicaid eligibility requirements, limiting the number of individuals qualified to enroll or re-enroll in their state Medicaid programs - ultimately increasing the number of uninsured individuals within the state.

States may also be forced to reduce non-mandatory Medicaid benefits, many of which impact LTSS beneficiaries. Under LTSS, only nursing facility services and home health services are federally required.[9] All other LTSS services - including home and community-based services (HCBS) - are optional and subject to each state's discretion. Despite their non-mandatory nature, every state offers some degree of HCBS coverage. States offer this coverage out of recognition for individuals' preferences to maximize their personal autonomy and maintain connections to their homes and lives in lieu of being institutionalized. Fundamental changes to state revenue streams have the opportunity to undermine the progress that has been made in rebalancing the delivery of care away from institutional settings.

State Medicaid programs rely on provider taxes to appropriately support and reimburse providers and MCOs. Changes to Medicaid provider taxes would increase the potential for rates that are not actuarially sound. Actuarial soundness is the payment standard for managed care. One of the requirements of actuarial soundness is that payment rates are appropriate for the covered population and services.[10] Reductions in MCO payment rates from Medicaid provider tax cuts would likely impact this aspect of actuarial soundness, which may threaten the viability of MCOs in their markets.

Of the 20 states that have taxes on MCOs, many utilize provider tax revenue to fund increased payment rates to the class of providers responsible for paying the provider tax.[11] In response to Medicaid provider tax cuts, Medicaid programs may reduce payments to providers and MCOs. Lower provider rates may exacerbate provider shortages, as providers facing uncompensated care costs and reimbursement rate cuts would likely be unincentivized to remain in state Medicaid or MCO networks.[12] If a substantial number of providers withdraw from Medicaid MCO networks, plans could fail to meet CMS's minimum provider to enrollee ratio requirements under network adequacy rules. MCOs out of compliance face penalties including corrective action plans, monetary fees, or plan termination.[13] Beyond MCOs facing regulatory penalties, Medicaid beneficiaries may experience diminished access to care and reduced treatment quality due to a smaller pool of in-network providers.

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[8] Provider Taxes Are Essential for State Budgets, Patients' Access to Care | Modern Medicaid Alliance
[9] Mandatory and optional benefits | MACPAC
[10] Managed Care Rate Setting and Actuarial Soundness | MACPAC
[11] Medicaid Primer - Legislative Service Commission | State of Ohio
[12] Medicaid Provider Taxes: A Critical Source of Medicaid Funding for States | Center For Children and Families
[13] Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes | KFF

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Recommendations

Recommendation 1: The MLTSS Association recommends that CMS extend the transition period to three years, regardless of a state's current waiver approval status. This uniform extension would provide states with the necessary time to evaluate the fiscal implications of the proposed changes, draft or revise new provider tax statutes, obtain state legislative and CMS approval, and implement the waiver. Given the complexity of Medicaid financing and the variation in state legislative calendars, this additional time is essential to avoid disruption in funding streams that support access to care for the vulnerable populations the MLTSS Association serves. Without an adequate transition period, states may be forced to make adjustments that could result in unintended coverage or service impacts.

Recommendation 2: Additionally, The MLTSS Association recommends that CMS provide clear implementation guidance and robust technical assistance to states that will need to amend existing waivers or financing structures in response to the rule. This could include tax waiver templates, explanatory materials outlining acceptable tax structures, and illustrative examples of compliant arrangements. Targeted guidance and ongoing support will be critical to ensuring compliance while maintaining stability in Medicaid programs nationwide.

Recommendation 3: Lastly, the MLTSS Association recommends that CMS postpone the finalization of this proposed rule until further research is conducted on how states utilize provider-related taxes, comprehensive data is gathered, and the potential consequences of the rule are assessed. While CMS anticipates these changes to impact tax structures across seven states, our interpretation of the language suggests the potential for impact across a larger number of states. The MLTSS Association also recommends stronger collaboration with states and stakeholders to help CMS create solutions that effectively address its concerns while preserving state flexibility in Medicaid programs.

Conclusion

Overall, the National MLTSS Health Plan Association appreciates CMS' efforts to improve transparency and accountability within the Medicaid program. Given the significant efforts needed by states, we recommend CMS offer additional time to enable states to implement these changes in a way that allows for the un-interruption of benefits for beneficiaries. We welcome the opportunity to work with CMS in providing additional feedback and operationalizing the policy changes proposed within this rule. If you have any questions, please contact me at mkaschak@mltss.org.

Sincerely,

Mary Kaschak
Chief Executive Officer