National
MLTSS
Health Plan Association

September 21, 2026

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

RE: Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes Proposed Rule (CMS-2452-P)

Dear Administrator Oz:

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to comment on the *Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes* Proposed Rule.[1]

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid.[2] Our member plans assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service (FFS) system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Many MLTSS Association member plans are also leaders in integrated care for dually eligible individuals, offering Dual Eligible Special Needs Plans (D-SNPs) across the full spectrum of integration.

Overview

Since the inception of the Medicaid program, 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 have 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 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] For 2026 alone, CMS estimates $28.1 billion in revenue from MCO provider taxes.

[1] Federal Register; Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes

[2] Members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Highmark, Humana, Lakeland Care, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community Health Choices.

[3] Health Care-Related Taxes in Medicaid | MACPAC

[4] 5 Questions and Answers About Medicaid and Provider Taxes | KFF

These funds are instrumental in supporting payment rates for underserved populations, including individuals receiving LTSS. In this proposed rule, CMS states that it expects that reductions in provider tax revenue will lead to lower Medicaid benefit expenditures, but that it has not attempted to predict how states will distribute the impact of lost revenue across the program. CMS further states that it believes the changes in this proposed rule will not impact Medicaid enrollment but will instead result in reductions in provider payments and benefits provided – which may include LTSS.

The MLTSS Association appreciates CMS's efforts to strengthen the oversight and quality of the Medicaid program. Our comments offer key considerations for CMS on the timeline and implementation of its proposals, as well as specific impacts on individuals receiving LTSS. Overall, we express concern over the timelines proposed in this rule and the administrative burden placed on states and managed care plans and recommend that CMS provide guidance and technical assistance to states and MCOs as necessary to support successful implementation of these proposed changes.

Recommendations

Calculation of the Indirect Hold Harmless Threshold to Nine Decimal Places

In this proposed rule, when calculating the indirect hold harmless threshold, CMS proposes to amend § 433.68(f)(3) to round state threshold calculations to nine decimal places. In the proposed rule, CMS explains that nine decimal places was selected for this calculation as it is the limit currently used for resource proxies in eligibility calculations, and currently, no rounding policy exists for tax-related calculations. CMS also notes it specifies a rounding policy because calculating the indirect hold harmless threshold can produce a figure with numerous decimal places, making the threshold difficult to express and apply in practice. CMS invites comments on whether nine decimal places is appropriate.

Recommendation:

The MLTSS Association recommends that CMS reconsider its proposal to round thresholds to the ninth decimal place and adopt a lower number of decimal places. We believe that nine decimal places reflect a degree of precision the underlying data cannot support. The threshold is calculated from figures such as net patient revenue, which is derived from provider-submitted cost reports that are estimated at filing and subject to change through settlement and audit. Those adjustments routinely move the reported figure by amounts many orders of magnitude larger than a billionth of a percentage point. A threshold expressed at that level would therefore turn on ordinary variation in accounting data rather than on the design or operation of a state's tax program, while carrying the consequence of a full deduction of tax revenue from claimed expenditures.

Further, the rationale CMS provides in the rule does not fit this calculation. CMS chose nine decimal places because that is the limit it uses for resource proxies in eligibility determinations. But eligibility determinations rest on financial information about a single individual and can be corrected through redetermination or appeal. The indirect hold harmless threshold applies to an entire permissible class across a full fiscal year, rests on aggregate revenue figures in the hundreds of millions or billions of dollars, and results in a reduction of federal financial participation. Those differences bear directly on how many decimal places are appropriate, and the preamble does not address them.

Interim Indirect Hold Harmless Threshold Process

In this rule, CMS proposes to amend § 433.68 to establish an interim indirect hold harmless threshold, with the final threshold expected no later than September 30, 2028. In the rule, CMS also acknowledges that there may be various factors or unforeseen administrative challenges that may impact their ability to adhere to this timeline, and reserves the right to extend the interim period, if necessary. CMS expects that states will use the interim threshold for oversight and tax collection purposes. However, when the final threshold is calculated, states will be expected to reconcile payments and reporting and complete any necessary remediation steps. In practice, this means that states will be required to make decisions based on an interim threshold that is subject to change and may be retroactively penalized when the final threshold is established.

Recommendation: Given the complexity of Medicaid financing and the implications on state budgeting and managed care plans, the MLTSS Association recommends that CMS expand and clarify its guidance on how interim and final thresholds will be calculated and applied ahead of September 30, 2028. CMS should also offer technical assistance to states, and, where necessary, managed care plans, including explicit guidance on what data elements are being requested on what timeline and in what format. We also ask CMS to clarify how potential remediation after the final threshold is calculated may impact MCOs, specifically whether states would be permitted to retroactively adjust MCO payment arrangements, and how states should account for any potential provider tax changes within their rate development process.

Classes of Health Care Services and Providers Defined

CMS proposes to amend § 433.56(a) to expand the permissible class list to include a new permissible provider tax class for health insurers, which excludes services of MCOs such as HMOs and PPOs. CMS proposes that this new class could include insurers that issue policies for the group market and/or the individual market, including such coverage under high-deductible or “catastrophic” plans, as well as issuers of short-term limited-duration policies and issuers of

coverage for "excepted benefits," such as dental-only and vision-only policies – but ultimately defers to states to determine which entities are included within this class.

The MLTSS Association agrees with CMS's approach to use this new provider class to bring existing taxes into compliance. However, we are concerned that this approach may lead to state-to-state variation in how the new class is defined and applied, creating compliance challenges for plans that operate across multiple states.

Recommendation: The MLTSS Association recommends that CMS clearly define which entities and revenue streams fall within the "Services of Health Insurers" class, offer technical assistance to states as it classifies existing and new taxes under this category, and ensure that no tax or entity is counted within more than one class. Without this clarification, plans operating across multiple states may face inconsistent treatment of substantively similar taxes.

Conclusion

The National MLTSS Health Plan Association appreciates CMS's efforts to bring greater consistency and accountability to the indirect hold harmless threshold for provider taxes. Given the significant financial and administrative implications for states and managed care plans, we recommend CMS incorporate the changes outlined above to avoid unintended disruption to Medicaid financing and the LTSS members we serve. We welcome the opportunity to work with CMS in providing additional feedback and operationalizing the policy changes within this rule. If you have any questions, please contact me at mkaschak@mltss.org.

Sincerely,

Mary Kaschak

Chief Executive Officer