AMERICA'S PHYSICIAN GROUPS

September 21, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via Regulations.gov

Re: Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes, 42 CFR Part 433, CMS-2452-P, RIN 0938-AV93

Dear Administrator Oz:

America's Physician Groups (APG) appreciates the opportunity to respond to the proposed regulation cited above and welcomes the agency's openness to stakeholder input and its ongoing commitment to improving health care for all Americans.

Although APG supports CMS's efforts to prevent improper hold-harmless arrangements and protect the integrity of federal Medicaid funding, APG has significant concerns about implementation of the proposed rule and its likely unintended consequences for Medicaid enrollees and the physicians and other clinicians who serve them.

In addition to the comments provided herein, APG has already expressed concerns regarding CMS' Rule on State Directed Payments (SDP) and the Community Engagement and Work Requirements Interim Final Rule. The combined impact of these three rules and the underlying legislation will clearly cause potentially millions of currently enrolled individuals to lose Medicaid coverage; constrain state budgets and create financial and operational issues for Medicaid managed care organizations and their contracted networks; and cause drastic cuts in payment rates to health care providers, further eroding clinical quality and achievement of MCO performance metrics. APG is further concerned that the three rules combined will severely undercut – if not destroy -- the entire managed Medicaid model and the goals of bringing more value-based, accountable care into Medicaid, as well as stall or undercut CMS's stated goal of enhancing membership in aligned D-SNP Plans in Medicare Advantage (MA) that serve some of the nation's most vulnerable populations: those dually eligible for Medicare and Medicaid.

Below, APG provides (I) background on our organization and its physician groups' care for Medicaid enrollees; (II) a summary of the proposed rule; (III) a summary of APG's recommendations; (IV) APG's deeper analysis of the proposed rule's potential effects on Medicaid financing, physician participation, patient access, payment

innovation, and state administrative operations in ten principal areas of concern; and (V) more discussion on APG's recommendations intended to preserve program integrity while protecting access to care, supporting value-based payment, and allowing states sufficient flexibility and time to implement any required changes.

I. Background on America's Physician Groups (APG)

APG is a national association whose membership comprises more than 300 physician groups, and whose approximately 260,000 physicians and other clinicians provide care to an estimated 1 in 4 Americans. APG's members care for patients across the full range of accountable, value-based care models, including multiple ones created over the years by the Centers for Medicare & Medicaid Services and its Innovation Center and that are fully backed by the current administration, as well as multiple Medicaid managed care arrangements across many states. Although APG member organizations care for Medicaid enrollees under multiple payment arrangements, including fee-for-service, the preponderance of Medicaid enrollees whom they see as patients are through our groups' participation in Medicaid managed care contracts with MCOs. In addition, APG groups care for an estimated 1 in 3 Medicare Advantage (MA) enrollees, and therefore millions of patients enrolled in MA Special Needs Plans, including dually eligible individuals covered by both Medicaid and MA and enrolled in Dual Eligible Special Needs plans (D-SNPs).

APG's motto, 'Taking Responsibility for America's Health,' represents our members' commitment to clinically integrated, coordinated, value-based health care in which physician groups are accountable for the costs and quality of patient care, as in the case of our groups' partnerships with Medicaid managed care organizations and Medicaid ACOs and participation in D-SNP plans. APG is fully committed to these care and payment models and believes that these are the arrangements most consistent with CMS's commitment to having most Americans in accountable care models providing high quality, cost-effective care.

II. Summary of proposed rule

Provider taxes are an important component of the financing structure that states use to support Medicaid, with 49 of the states and the District of Columbia employing them as a means of financing the state's share of Medicaid funding. States are projected to raise $98.6 billion in Medicaid provider taxes during calendar year 2026, with $61.8 billion (the largest overall share) raised by provider taxes on hospitals; $28.1 billion raised by such taxes on Medicaid managed care organizations (MCOs); and approximately $8.7 billion raised by provider taxes on other provider classes, such as nursing homes and intermediate care facilities.[1] The 2025 reconciliation law, signed by President Trump on July 4, 2025, imposed new restrictions on states' ability to generate Medicaid provider tax revenue, as follows:

- Federal rules long allowed states to use provider taxes and matching payment arrangements as long as the tax did not exceed 6 percent of a provider's net patient revenue – the so-called "hold harmless" rate, under which provider taxes were allowed. The 2025 law effectively prevented the enactment of any new provider taxes by establishing a hold harmless limit of 0 percent for any taxes that were not in effect as of July 4, 2025. It also prevented any increases to existing provider taxes, which were capped at their rates in effect as of July 4, 2025.

[1] See https://www.kff.org/medicaid/5-questions-and-answers-about-medicaid-and-provider-taxes/

- The law imposed even harsher limits on provider taxes in states that adopted the Affordable Care Act (ACA) Medicaid expansion. Beginning in fiscal 2028, the law will gradually reduce the hold harmless limit for states that have adopted the ACA expansion by 0.5 percent annually until the safe harbor limit reaches 3.5 percent fiscal 2032. The new limits apply to all provider taxes except for those levied on nursing facilities and intermediate care facilities. In addition, the law prohibited states from using so-called uniformity waivers -- federal permissions that allow states to charge non-uniform or non-broad-based provider taxes to help finance the state share of their Medicaid programs – effective July 5, 2025, if the provider tax charged higher or lower rates based on the volume of Medicaid revenues or patients that a given provider received or cared for.

Because states implicitly use the proceeds of provider taxes as the state's share of Medicaid funding and thus use them to draw down federal matching dollars, these reductions in allowed provider taxes will reduce the federal matching dollars provided to states. The Congressional Budget Office (CBO) estimated that the provider tax policy changes from the 2025 reconciliation law would thus reduce federal Medicaid spending by $226 billion between 2025 and 2034.

The proposed rule implements these hold-harmless provisions of the law but also includes some provisions that were not required under the law. Under the proposed rule, CMS would recognize provider taxes as being in effect as of July 4, 2025 or earlier if they had been enacted by that date. Although not required by the 2025 reconciliation law, the rule also proposes to add a new "health insurer" provider class to expand CMS oversight of health-care related taxes that goes beyond the existing "managed care organization" (MCO) provider class, including health maintenance organizations and preferred provider organizations. Such taxes would be subject to all other requirements governing Medicaid provider taxes, including new limits in the 2025 reconciliation law.

The proposed rule would also discontinue the so-called 75/75 test beginning in fiscal 2027, under which taxes exceeding the hold harmless limit could remain permissible as long as no more than 75 percent of taxpaying providers did not receive more than 75 percent of the tax back through enhanced Medicaid or other state payments. In addition, the proposed rule would significantly expand state reporting requirements and introduce retrospective CMS review to determine ongoing state compliance with the new hold harmless limits.

As noted above, APG's member organizations across the nation participate as providers with multiple Medicaid MCOs and in related state-based efforts to improve the quality of care provided to Medicaid patients. They note that, in anticipation of implementation of the provisions of the 2025 reconciliation law and attendant regulations, states are already taking steps to pare back some of these quality programs that enhance the ability of APG groups to participate in risk arrangements aimed at increasing their accountability for the care provided to Medicaid enrollees. They anticipate further difficulties as more Medicaid enrollees lose coverage; Medicaid MCOs experience growing rates of churn in their covered populations; and the entire construct of Medicaid managed care loses ground, potentially reverting to a fee-for-service system that covers far fewer people and provides worse care.

III. Summary of APG's recommendations

A. Recommendation: CMS should conduct and publish a detailed analysis of the proposed rule's effects on physician participation, Medicaid payment rates, rural and underserved communities, specialty access, behavioral health, and patient outcomes. CMS should not finalize the rule unless it can

demonstrate that states will be able to comply without materially reducing access to medically necessary care.

B. Recommendation: CMS should preserve maximum flexibility consistent with federal law and should permit states to maintain financing and payment arrangements that do not guarantee providers a return of their tax payments and that are demonstrably connected to Medicaid services. CMS should also establish a process for states to request waivers or transitional relief when strict application of the thresholds would threaten access to care.

C. Recommendation: CMS should retain the 75/75 compliance test. At a minimum, CMS should explain in detail its statutory authority for eliminating the test, identify the number and types of existing arrangements that would be affected, and provide a meaningful transition period for any state that would be required to modify an arrangement currently recognized as permissible.

D. Recommendation: CMS should provide clear, objective, prospective definitions and examples. CMS should also establish a formal pre-clearance process through which states and affected stakeholders can obtain a binding determination before a tax or related financing arrangement is implemented or modified. CMS should not apply new interpretations retroactively to arrangements previously approved or accepted by the agency.

E. Recommendation: CMS should use prospective enforcement wherever possible. Before imposing a deferral, disallowance, repayment obligation, or refund requirement, CMS should provide notice, a meaningful opportunity to cure, and an administrative appeal process. CMS should also clarify that providers will not be subject to recoupment or repayment solely because a state's tax arrangement is later determined to be noncompliant.

F. Recommendation: CMS should streamline the reporting requirements, permit reasonable estimates where actual data are not yet available, allow states to use existing reporting systems, and provide standardized templates and technical assistance before enforcement begins. CMS should also allow sufficient time for states and providers to test reporting processes and correct data-quality problems.

G. Recommendation: CMS should provide the longest transition period permitted by law and should phase in any reduction prospectively. States should be permitted to maintain existing arrangements during the transition while they develop replacement financing and payment methodologies. CMS should also provide additional transition relief where a state demonstrates that immediate compliance would threaten access to care.

H. Recommendation: CMS should require state impact analyses that evaluate effects by specialty, geography, practice size, Medicaid payer mix, and patient population. CMS should consider safeguards for rural and safety-net providers, including targeted transition relief and mechanisms to prevent disproportionate reductions in Medicaid payment rates.

I. **Recommendation**: CMS should clarify the statutory and regulatory authority for creating the new class of "health insurer" provider taxes and should explain how creation of this new class would interact with existing permissible classes and federal financial-participation requirements. CMS should not finalize the new class without additional stakeholder consultation, clear definitions, and an analysis of its effect on Medicaid managed-care payments and physician reimbursement.

J. **Recommendation:** CMS should expressly clarify that legitimate value-based payments, quality incentive payments, care-coordination payments, and outcome-based arrangements are not presumed to constitute an impermissible hold-harmless arrangement merely because they benefit providers that are subject to a health care-related tax. CMS should evaluate the arrangement based on its actual structure, performance requirements, quality measures, and relationship to patient care. CMS should also preserve existing value-based payment arrangements during any transition period and require an analysis of how the proposed rule would affect Medicaid quality, care coordination, health equity, and physician participation in alternative payment models.

IV: APG's Analysis of Components of the Proposed Rule and Recommendations for Revisions

A. Importance of Provider Taxes And Need for Further Analysis of Impact of Proposed Rule

As noted above, **p**rovider taxes are an important component of the financing structure that states use to support Medicaid. The proposed rule would replace the current applicable six-percent indirect hold-harmless threshold with state- and provider-class-specific thresholds based on taxes enacted and imposed as of July 4, 2025. It would also impose additional limitations on Medicaid expansion states beginning in federal fiscal year 2028.

The proposed reduction and eventual phase-down of allowable tax thresholds could create significant budgetary pressure for states. States may respond by reducing Medicaid payment rates, limiting covered services, tightening eligibility, or reducing payments to physicians and other providers. These consequences would be particularly serious in rural and underserved communities, where Medicaid patients already face difficulty finding participating physicians. Reductions in Medicaid payment rates could cause additional physicians to limit Medicaid participation, close practices, reduce services, or leave areas with existing workforce shortages.

Recommendation A: CMS should therefore conduct and publish a detailed analysis of the proposed rule's effects on physician participation, Medicaid payment rates, rural and underserved communities, specialty access, behavioral health, and patient outcomes. CMS should not finalize the rule until it confirms that states will be able to comply without materially reducing access to medically necessary care.

B. The Variation in Circumstances Among States And Need For Transitional Relief

Although the proposed rule is intended to implement statutory requirements, the resulting restrictions could limit states' ability to respond to changing workforce conditions, rising practice costs, and local access needs, all of which may vary sharply from one state to another. Medicaid financing and delivery systems also vary by state, such that a financing arrangement that is sustainable in one state may be inadequate in another, particularly where physician practices serve large Medicaid populations or operate in high-cost environments.

Recommendation B: CMS should therefore preserve maximum flexibility consistent with federal law and should permit states to maintain financing and payment arrangements that do not guarantee providers a full return of their tax payments and that are demonstrably connected to Medicaid services. CMS should also establish a process for states to request waivers or transitional relief when strict application of the thresholds would threaten access to care.

C. The Need to Reconsider Elimination of the 75/75 compliance test

The 75/75 test provides an additional means of demonstrating that a tax does not hold providers harmless, over and above the hold harmless threshold. CMS proposes to eliminate the 75/75 test, such that the new class-specific threshold would become the primary compliance pathway for most provider taxes. But eliminating the 75/75 test option could invalidate financing structures that satisfy the test and thus could reduce states' ability to design applicable, redistributive financing mechanisms. The proposal also appears to remove a regulatory option that Congress did not expressly eliminate in Section 71115 of Public Law 119-21, in another instance in which the proposed regulation would create new policy above and beyond the statute.

Recommendation C: CMS should retain the 75/75 compliance test. At a minimum, CMS should explain in detail its statutory authority for eliminating the test, identify the number and types of existing arrangements that would be affected, and provide a meaningful transition period for any state that would be required to modify an arrangement currently recognized as permissible.

D. The Need to Clarify The Terms "Enacted and Imposed" and "Net Patient Revenue"

The proposed rule would establish important consequences based on whether a provider tax was "enacted and imposed" as of July 4, 2025. It would also define and apply "net patient revenue" in calculating the applicable thresholds. These concepts can be difficult to apply when and where a tax required federal approval, had a delayed effective date, was collected periodically, or was administered through a complex state financing structure. Ambiguity in these definitions could produce inconsistent results across states and provider classes. It could also result in retroactive findings that a financing arrangement was impermissible, even where the state and affected providers acted in reliance on prior CMS guidance or approvals.

Recommendation D: CMS should provide clear, objective, prospective definitions and examples of these terms. CMS should also establish a formal pre-clearance process through which states and affected stakeholders can obtain a binding determination before a tax or related financing arrangement is implemented or modified. CMS should not apply new interpretations retroactively to arrangements previously approved or accepted by the agency.

E. The Need to Limit Retrospective Review and Punitive Consequences

The proposed rule would expand state reporting requirements and permit CMS to conduct retrospective compliance reviews based on actual tax collections and net patient revenue. States could face federal payment deferrals, disallowances, repayment obligations, or requirements to refund tax payments if CMS later determines that a tax exceeded the applicable threshold. This approach could create substantial uncertainty for states, physicians, Medicaid managed-care organizations, and other providers. Providers should not be required to bear the consequences of a state financing determination that was later questioned by CMS. Retrospective

adjustments could also disrupt physician practices' financial planning and destabilize Medicaid payment arrangements.

Recommendation E: CMS should use prospective enforcement wherever possible. Before imposing a deferral, disallowance, repayment obligation, or refund requirement, CMS should provide notice, a meaningful opportunity to cure, and an administrative appeal process. CMS should also clarify that providers will not be subject to recoupment or repayment solely because a state's tax arrangement is later determined to be noncompliant.

F. The Need to Reduce Administrative Burden and Streamline Reporting Requirements

The proposed rule would require states to compile and submit extensive data, potentially including quarterly information on tax revenue and provider-class net patient revenue. These requirements could be costly and difficult to administer, particularly for states with multiple tax structures, managed-care arrangements, or provider classes whose fiscal years do not align with the federal fiscal year. Additional administrative complexity may divert state resources from eligibility operations, provider support, and efforts to improve Medicaid access.

Recommendation F: CMS should streamline the reporting requirements, permit reasonable estimates where actual data are not yet available, allow states to use existing reporting systems, and provide standardized templates and technical assistance before enforcement begins. CMS should also allow sufficient time for states and providers to test reporting processes and correct data-quality problems.

G. The Need To Provide Adequate Transition Periods

The changes set forth in the proposed rule could require states to amend tax statutes, modify Medicaid payment methodologies, renegotiate contracts, revise managed-care arrangements, and adjust provider payments on a compressed timeline. Abrupt changes could result in payment reductions or interruptions that affect physicians and patients before states have an opportunity to develop alternative financing.

Recommendation G: CMS should provide the longest transition period permitted by law and should phase in any reduction prospectively. States should be permitted to maintain existing arrangements during the transition while they develop replacement financing and payment methodologies. CMS should also provide additional transition relief where a state demonstrates that immediate compliance would threaten access to care.

H. The Need to Evaluate the Differential Impact on Rural and Safety Net Providers and Others With High Volumes of Medicaid Patients

A uniform provider-class analysis may not capture the different effects of provider taxes on individual practices. A physician practice that serves a high proportion of Medicaid patients, provides emergency or behavioral-health services, or operates in a rural community may face greater financial exposure than a practice with a broader commercial payer mix.

Recommendation H: CMS should require state impact analyses that evaluate effects by specialty, geography, practice size, Medicaid payer mix, and patient population. CMS should consider safeguards for rural and safety-net providers, including targeted transition relief and mechanisms to prevent disproportionate reductions in Medicaid payment rates.

I. The Need to Reconsider Creation of a New "Services of Health Insurers" Provider Tax Class

As noted above, CMS proposes to establish "services of health insurers" as a new permissible provider-tax class. The proposed class could expand federal oversight of taxes imposed on health insurers and create uncertainty regarding the treatment of managed-care organizations, insurers, and other entities involved in Medicaid financing.

Recommendation I: CMS should clarify the statutory and regulatory authority for creating this new class and should explain how it would interact with existing permissible classes and federal financial-participation requirements. CMS should not finalize the new class without additional stakeholder consultation, clear definitions, and an analysis of its effect on Medicaid managed-care payments and physician reimbursement.

J. The Need to Protect Value-Based Payment and Quality-Improvement Arrangements

Provider-tax revenues may support Medicaid payment arrangements created by states or by Medicaid ACOs that promote quality, care coordination, prevention, and improved outcomes, including supplemental payments, quality incentive payments, accountable-care arrangements, and other value-based models. These arrangements can be especially important for physicians caring for patients with complex or chronic conditions, where traditional fee-for-service payment may not adequately support care management, team-based care, or investment in health information technology.

If states are required to reduce or restructure provider-tax financing, they may also reduce or discontinue value-based payments. This outcome could undermine ongoing quality-improvement initiatives, discourage physician participation in alternative payment models, and shift Medicaid payment policy back toward fee-for-service care volume-based reimbursement. In so doing, it would fly in the face of CMS's multiple efforts to extend accountable care elsewhere in health care, such as in the traditional Medicare program. In addition, uncertainty regarding whether quality-based payments constitute a return of provider-tax proceeds could discourage states and providers from developing innovative payment models.

Recommendation J: CMS should expressly clarify that legitimate value-based payments, quality incentive payments, care-coordination payments, and outcome-based arrangements are not presumed to constitute an impermissible hold-harmless arrangement merely because they benefit providers that are subject to a health care-related tax. CMS should evaluate the arrangement based on its actual structure, performance requirements, quality measures, and relationship to patient care. CMS should also preserve existing value-based payment arrangements during any transition period and require an analysis of how the proposed rule would affect Medicaid quality, care coordination, health equity, and physician participation in alternative payment models.

Conclusion

APG member physician organizations appreciate the agency's careful consideration of its analysis and the recommendations listed above. APG fully supports CMS's efforts to promote integrity, transparency, and shared responsibility in Medicaid financing. However, the proposed rule should not undermine the stability of Medicaid coverage, physician participation in the program, patient access, or innovative payment arrangements that improve quality and outcomes.

APG urges CMS to revise the proposal to preserve appropriate state financing flexibility, retain the 75/75 compliance option, clarify key definitions and permissible payment arrangements, protect value-based and quality-based payments, limit retrospective enforcement, reduce administrative burdens, and provide adequate transition periods. CMS should also conduct a comprehensive assessment of the Proposed Rule's effects on physician practices, rural and underserved communities, Medicaid beneficiaries, and health-care quality before issuing a final rule.

APG offers these recommendations in the fervent hope that CMS will recognize how its actions work at substantial cross-purposes to its own wisely stated core priorities to advance accountability across much of U.S. health care. CMS' Proposed Rule will certainly cripple the financial sustainability of value-based care arrangements in Medicaid, erode quality performance, and stall progress on dual-eligibility coordination within Exclusively Aligned Enrollment D-SNPs, among other deleterious consequences.

Thank you for the opportunity to comment on this proposed rule.

Sincerely,

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