July 14, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-2448-P; Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole Proposed Rule

Dear Administrator Oz:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members, we are pleased to present comments on the Centers for Medicare & Medicaid Services' (CMS') proposed rule entitled Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole Proposed Rule.

Arizona's hospital assessments play a vital role in supporting our Medicaid program and the hospitals that care for Arizona's most vulnerable residents. These funds help cover the cost of Arizona Health Care Cost Containment System coverage for nearly 500,000 Arizonans and financially support providers to ensure access to quality healthcare in Arizona.

We agree with CMS' overarching goal of furthering the financial integrity of the Medicaid program, and we acknowledge that identical language to the proposed rule's text has been encoded by the passage of the in P.L. 119-21. However, we are concerned that the proposed rule introduces excessive subjectivity into the evaluation of provider taxes, lacks an adequate transition period, and fails to account for the new statutory mandates enacted since the proposed rule was published. These combined changes will significantly affect Arizona's Medicaid financing framework and pose serious risks to healthcare access if implemented without clearer guidance and more time for states to adjust. Our comments urge CMS to adopt specific regulatory safeguards to reduce subjectivity, provide states the full transition period authorized by statute, and reissue the rule to align with the new federal law.

CMS SHOULD MITIGATE THE SUBJECTIVITY INTRODUCED BY THE STATUTORY LANGUAGE

Proposed 433.69(e)(3)(iii) (mirrored in P.L. 119-21) provides that a tax will not be deemed generally redistributive if "the tax excludes or imposes a lower tax rate on a taxpayer or tax rate group defined by or based on any characteristic that results in the same effect as described in 433.68(e)(3)(i) or (ii) above."

We are concerned that this language is overly subjective and introduces excessive uncertainty for states when designing and implementing provider tax programs. In particular, the clause "results in the same effect" appears vague in the context of a Medicaid-based classification. This catchall phrasing allows the federal government too much discretion to unilaterally withdraw a critical source of funding for a state's healthcare program without providing the state with an opportunity to provide information or participate in discussions. A determination by

CMS that a provider tax arrangement is no longer compliant without notice and involvement by the state would throw the healthcare community and the state budget process into chaos. It may also deter states from developing otherwise sound tax programs that would assist the state in improving healthcare for its residents, out of fear of CMS retroactively disapproving them.

To mitigate this uncertainty, we request that CMS consider the following suggestions.

CMS could affirmatively state that objective, service-based classifications (e.g., inpatient bed days, discharges, net revenues, or outpatient visits) will be presumed compliant if not explicitly tied to Medicaid utilization, unless CMS can demonstrate otherwise after a comprehensive process including discussions with the state in question, providing the state with adequate opportunity to provide documentation, and consideration of all the circumstances. This stays within the boundaries of the statute while offering more regulatory predictability.

CMS could include in the rule that the determination of whether a characteristic of a provider tax "results in the same effect" must be based solely upon quantitative data that the state submits—not on national trends or retrospective correlations. This is consistent with the statute and would reduce the possibility of decisions being made that are not fully informed.

CMS could publish a non-exclusive list of acceptable classifications for reduced taxes or tax exclusions. We are aware that CMS does not intend to prevent states from designing tax rate groups to achieve legitimate public policy goals as long as they do not prevent the tax from being generally redistributive. For example, a state may seek to exclude rural providers from taxation as a means of helping preserve beneficiary access to care in rural areas. To that end, if a classification is independently justifiable, it should not trigger §433.68(e)(3)(iii). CMS could consider designating exempt classifications based on the following:

- Facility size;
- Teaching status;
- Rural location;
- Trauma level; and/or
- Medicare utilization.

CMS SHOULD ADOPT THE FULL THREE-YEAR TRANSITION PERIOD ALLOWED BY STATUTE

Most taxes that could run afoul of proposed § 433.68(e)(3) would receive no transition at all if the program were approved in the last two years, and only a single state fiscal-year grace period otherwise. This is barely enough time for a legislature to draft and enact a replacement source of revenue, let alone for providers to retool their budgets. Section 44134(b) of P.L. 119-21 allows the Secretary of CMS to provide a transition period of up to three fiscal years, and we urge CMS to allow states the full three-year window.

If a state's provider tax that supports its Medicaid program with many millions of dollars each year is invalidated, the resulting cash-flow shock would cause wide-ranging implications. A shortfall of that magnitude would inevitably drive the Legislature toward painful options—freezing or cutting Medicaid enrollment, trimming optional adult benefits such as behavioral health, and/or reducing already-low provider rates. Facilities that barely make ends meet today, like rural providers, critical-access hospitals, and urban safety-net hospitals, would struggle to keep doors open, eroding access and worsening health outcomes in precisely the communities that Medicaid is meant to protect.

The implications of a short time frame to fill a vast budget hole are greatly compounded by the new law's requirement that CMS phase down the provider-tax safe-harbor cap from 6 percent to 3.5 percent beginning in FFY 2028 and simultaneously cap state-directed payments at 100 percent of Medicare rates for expansion states (110 percent in non-expansion states). States need the full three-year fiscal runway to coordinate across provider-tax changes and state-directed payment provisions. States must have adequate time to model alternatives, secure legislative approval, and implement replacement financing without cuts that would harm the state's providers and patients. Exercising the maximum transition period is not a luxury; it is the only practicable way to uphold Congress's goal of restricting provider taxes without destabilizing Medicaid coverage and the hospitals that deliver it.

CMS SHOULD REISSUE THE PROPOSED RULE TO ACCOUNT FOR THE NEW STATUTORY MANDATES OF P.L. 119-21

Given the enactment of the P.L. 119-21 since CMS issued this proposed rule, we respectfully request that CMS consider withdrawing and reissuing the proposed rule to reflect the significant changes in the law, or at a minimum, to issue an interim final rule with a comment period.

While the new statute codifies much of the policy CMS proposed, it also introduces new statutory mandates not addressed in the proposed rule, including a phased reduction in the safe harbor cap as well as caps on Medicaid state-directed payments. These changes reshape the policy and legal landscape and will materially affect how states design and sustain their Medicaid financing systems going forward.

A reissued or interim final rule would enable CMS to update its proposed regulatory framework in a manner fully aligned with the statute, providing stakeholders with an opportunity to comment on the implementation challenges arising from the combined effect of the rule and the new law. Re-proposing would also help clarify areas of potential overlap or ambiguity, including the scope of CMS's transition authority and how the agency intends to reconcile proposed regulatory text with new statutory language. In light of the complexity of these intersecting provisions and their profound fiscal implications for states and providers, reopening the comment process would promote clarity and transparency.

We appreciate your consideration of these comments.

Sincerely,

Helena Whitney
Senior Vice President of Policy and Advocacy
Arizona Hospital & Healthcare Association