NAMD
National Association of Medicaid Directors

September 21, 2026

Dr. Mehmet Oz
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on the Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes Notice of Proposed Rulemaking, which seeks to effectuate provisions in section 71115 of Public Law 119-21, the One Big Beautiful Bill Act (OBBBA), also referred to as the Working Families Tax Cut (WFTC) legislation.

NAMD is a professional community of state and territory leaders who provide health insurance to almost 75 million individuals and families through Medicaid and the Children's Health Insurance Program (CHIP) in each of the 50 states, the District of Columbia, and the U.S. territories. NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives. In addition to supporting Medicaid Directors, NAMD serves over 500 Medicaid leaders, including convenings with subject matter experts in finance and budget, technology, eligibility policy, and communications to share operational expertise, support policy implementation, and exchange promising practices across states and territories.

As a nonpartisan membership association, NAMD does not endorse specific policies or engage in litigation. When NAMD comments on federal regulations, as we do in this letter, our comments originate from and reflect the operational experience of all state and territory Medicaid programs and are developed such that they are representative of the range of viewpoints across our members.

NAMD understands and appreciates the importance of the federal, state, and territory role in appropriately stewarding public resources to ensure the fiscal sustainability of Medicaid and CHIP and safeguard access to high-quality services to the over 70 million Americans these programs serve. We offer these comments to enhance CMS's efforts in balancing these objectives. Key themes include:

- **Support for CMS's proposed definitions of "enacted" and "imposed"** health care-related taxes as of July 4, 2025
- **Need for additional regulatory clarity and appropriate transition time for the proposed "health insurers other than MCOs" class** to allow Medicaid agencies and other units of state government to more accurately assess impact and a transition period of at least three state fiscal years for states to adjust existing tax arrangements, in the event that CMS chooses to finalize this new class.
- **Support for either:**

    - **Allowing the continued use of prospective methodologies to assess indirect hold harmless thresholds** rather than shifting to a retrospective compliance framework reliant on actual tax revenue and net patient revenue data**;** or
    - If CMS elects to move forward with the retrospective compliance framework, **utilizing compliance actions that limit disallowances to the amount in excess of the retrospectively calculated indirect hold harmless threshold.**
- **Maintain the 75/75 test** as federal law continues to authorize it and sunsetting it would have adverse implications for states that use the method.

NAMD appreciates CMS's consideration of Medicaid agencies' perspectives on these matters. We remain committed to serving as a trusted partner to CMS and look forward to continued collaboration on behalf of all Medicaid agencies.

***Support for Definitions of "Enacted" and "Imposed" for Purposes of Implementing Statutory Requirements***

NAMD supports CMS's proposed definitions of "enacted" and "imposed" health care-related taxes for purposes of determining that a tax was in place as of July 4, 2025. These proposed definitions are responsive to Medicaid agency feedback on CMS's preliminary November 2025 guidance.

That preliminary guidance indicated that a tax that needed a broad-based and/or uniformity tax waiver from CMS must have had the waiver approved as of July 4, 2025 in order to be considered enacted; and revenue associated with the tax must have been actively collected in order to be considered imposed. These initial definitions caused significant concern among states, particularly those whose legislatures created new taxes or amended existing taxes shortly before the enactment of OBBBA.

NAMD appreciates CMS's acknowledgement in the preamble of the feedback it received on the preliminary guidance. In response, CMS in this rule proposes to define:

- "enacted" by referring to the completion of legislative processes that grant authority to the state or locality to impose a tax on or before July 4, 2025;
- "imposed" as a legally enforceable obligation is imposed by the state or locality on taxpayers, and
- that if a CMS waiver approval is necessary, it must either have been approved by July 4, 2025 or have had an effective date retroactive to July 4, 2025 or earlier.

NAMD supports these proposed definitions and clarification, which reflect longstanding CMS practice with Medicaid agencies in using the first of the month of a quarter in which an action is submitted for state plan and waiver actions as the retroactive effective date.



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***Additional Clarity on New "Health Insurers Other Than MCOs" Class is Necessary for States to Assess Fiscal Impacts***

***NAMD recommendations:***

- **Provide more specificity in defining the "health insurers other than MCOs" class**
- **Allow a transition period of at least three state fiscal years to determine which taxes may fall within the regulatory definition, permit states to project fiscal impact of the new class, and adjust existing taxes to comply with CMS requirements**

CMS proposes to establish a new permissible class of health care items and services at new 435.56(a)(19) defined as "Services of health insurers (other than services of managed care organizations (including health maintenance organizations and preferred provider organizations) as specified in paragraph (a)(8) of this section)." In the preamble discussion, CMS indicates it believes this class is necessary to address existing taxes on entities in this class whose revenues may be financing the state share of Medicaid expenditures, and that absent this new class CMS may need to initiate compliance actions for non-permissible tax arrangements. Further, CMS declines to propose a narrow definition of "health insurer" and instead offers examples of the kinds of entities intended to be captured, such as group and/or individual market issuers, limited benefit plans, and Medicare plans. Lastly, CMS proposes to apply the health care-related tax provisions at section 71115 of OBBBA to this new class.

NAMD understands and appreciates CMS's goals around exercising appropriate oversight of the sources of state and territory revenue for their fiscal contributions to the Medicaid program. However, the term "health insurers other than MCOs" does not give enough guidance to Medicaid agencies as to the intended applicability of the class and may unintentionally be overbroad in its application. Discussions facilitated by NAMD with Medicaid fiscal leaders reveal significant confusion on the implications of this class for existing tax arrangements, particularly those that are operated wholly outside of the Medicaid agency's scope and which finance other state priorities that are entirely distinct from the Medicaid program. Nonexclusive examples of these include fees or assessments to fund state-based marketplace operations, structures to fund reinsurance programs, and structures to fund uncompensated care pools. Similar feedback has been shared with NAMD by other state-facing organizations representing other functions of state government, and we encourage CMS to reference comments from these organizations to fully appreciate the challenges posed by this proposal.

Stated plainly, this lack of clarity and consequent uncertainty in how to model fiscal impacts associated with the proposal directly impacts the ability of states to provide CMS with granular feedback on this aspect of the proposed rule. There is significant risk that CMS will not have necessary and critical input from state governments to refine its regulatory approach in a manner that achieves its goals while minimizing unintended and potentially overbroad fiscal and operational implications for states, both within Medicaid and other state programs.

While the illustrative examples of insurers falling under the class are helpful, CMS does not sufficiently address uncertainty around the mechanics of the class for existing tax

and revenue structures. The same can be said for CMS's examples of the types of tax structures it intends to capture in the definition, such as assessments on premium revenue or covered lives. While helpful for illustrating CMS's broad intent, these examples are insufficient to allow states to fully assess the universe of tax arrangements that could be implicated under the definition.

We further note that OBBBA section 71115's amendments to statutory indirect hold harmless thresholds make specific reference to permissible classes in effect as of May 1, 2025. CMS in the preamble argues that, because the statute is silent on how to treat new permissible classes created after May 1, 2025, there is latitude under its existing regulatory authority to apply section 71115's policies to the newly proposed "health insurers other than MCOs" class. On behalf of its members, NAMD respectfully disagrees.

As discussed above, states are challenged by the lack of clarity of the definition to fully understand which taxes are affected. This challenge is exacerbated by CMS's proposal to limit the authority of states to adjust their tax structures to comply with unanticipated regulation via application of OBBBA's statutory ceilings on health care-related taxes to this new class retroactive to July 1, 2025. The practical outcome of this policy approach would be permanent disparities in state tax structures. States that, for historical reasons predating OBBBA, levied taxes on this class could continue to do so under CMS's approach, while states that did not would be permanently prohibited from doing so despite having no ability to anticipate the creation of this class or a federal prohibition on taxing entities within it following its creation.

To address this uneven playing field, CMS should provide more clarity on which tax structures it considers necessary to regulate. This clarity must further be paired with a transition period of **at least three state fiscal years** for states to respond to final CMS regulation in this area. This will allow states to fully analyze how extant tax structures and revenue mechanisms are affected by CMS regulation and give sufficient runway for thoughtful adjustments, including completing legislative processes, to achieve compliance without unduly disrupting state programs funded by these mechanisms.

***Operational Complexity and Unclear Need for Use of Actual Revenue Data to Calculate Indirect Hold Harmless Thresholds***

***NAMD Recommendations:***

- **Continue to use the current practice of accepting estimates and trended figures rather than actual revenue data for monitoring, reporting, and compliance purposes, as this approach is well understood and operationally streamlined compared to CMS' proposed changes.**
- **Use each tax's designated tax year to calculate the indirect hold harmless threshold, as well as for monitoring, reporting, and compliance purposes, to promote administrative simplicity for states.**
- **Limit disallowances to the excess amount over the final indirect hold harmless threshold, consistent with historic CMS practice.**
- **If CMS finalizes its proposed actual revenue data approach, then:**

- **Extend the proposed interim and final one-time reporting timeline by two quarters.**
- **Allow at least a four-year remediation period, as states will need more than two years to collect actual net patient revenue data.**

To establish new indirect hold harmless limits for each permissible class, CMS proposes using actual revenue collected and actual net patient revenues from the state fiscal year containing July 4, 2025. CMS is also proposing that ongoing compliance rely on actual (not estimated) tax revenue collected and net patient revenue assessed on a federal fiscal year basis rather than the state fiscal year. NAMD is concerned about the operational complexity of discordant reporting periods linked to the use of actual revenue data to calculate indirect hold harmless thresholds and monitor ongoing compliance with the thresholds. Below, we review implementation considerations for state Medicaid agencies related to 1) setting the indirect hold harmless threshold; 2) compliance with the threshold; 3) timelines; and 4) enforcement actions. Based on the complexity of the proposed CMS approach, we also recommend that in instances of noncompliance CMS limit disallowances to the excess amount over the final indirect hold harmless threshold, as has been its historic practice.

Tying the final threshold and cap to a single year of actual cash collections, rather than tax liability or structure, may lock in artificially low thresholds for states with collection lags or experiencing changes in their healthcare delivery system. Combining this snapshot approach with an interim structure that leaves states without a known compliance target for up to two years makes the framework difficult to implement and budget against, creating uncertainty and potential fiscal instability for Medicaid programs and state budgets writ large.

Additionally, using actual data for the fiscal year that includes July 4, 2025, can create discrepancies between tax collected and tax assessed. Advanced or delayed receipt of revenue could result in inaccurate calculations of net patient revenue and indirect hold harmless thresholds. States may also be unable to collect taxes due to unforeseen changes in the healthcare delivery system. For example, a state cannot collect taxes on a facility that closes mid-year, resulting in a gap between assessed and actual collected revenue. There are numerous reasons why cash received may not reflect the tax liability incurred. States with atypical collection lags in this specific fiscal year may be permanently held at a lower ceiling despite having the same underlying tax policy. CMS' proposed approach would also rely on the use of interim thresholds, which creates unnecessary operational complexity and uncertainty for states.

To streamline and create a more operationally feasible process, we recommend CMS calculate the indirect hold harmless threshold by 1) allowing states to use estimates or historic data on net patient revenue and taxes assessed and 2) use each tax's own individual tax year rather than the state fiscal year. Allowing states to use estimates or historic data on net patient revenue and taxes assessed would eliminate the need to reconcile the interim and final hold harmless threshold, making the process more operationally feasible and giving states greater certainty in ensuring compliance. Even though using individual tax years may result in differences across states, it would be simpler and more practical. This would align current reporting and review processes so states would not need to prorate or annualize rates. Additionally, CMS has already indicated flexibility to establish indirect hold harmless thresholds across different time periods because states have different fiscal years.

NAMD appreciates CMS' efforts to reduce administrative burden by aligning monitoring and compliance activities with existing reporting. However, the proposed approach, which relies on quarterly reporting and assessing compliance on a federal fiscal year basis using actual revenue data, is operationally unfeasible for many states and creates uncertainty to ensure compliance with the indirect hold harmless threshold. For example, states may have to use incomplete cost report data to meet quarterly reporting requirements. In addition, many states do not have the infrastructure in place to report granular and real-time data, as proposed. Finally, depending on the schedule and cadence for each tax, states would have to reconfigure their data to meet reporting requirements and assessment with the final threshold, because their data may only be available on a state fiscal year or calendar year basis.

In light of these operational challenges, we respectfully request that, for monitoring, reporting, and compliance purposes CMS 1) accept estimates and trended figures rather than actual revenue data, and 2) use each tax's own individual tax year, rather than using the federal fiscal year. CMS has historically accepted estimates and trended figures to comply with the six percent hold harmless threshold, so leveraging this existing practice ensures compliance with new requirements without creating unnecessary complexity or diverting staff time and resources to meet new reporting requirements. Maintaining this historic practice also fosters greater budget certainty, because states would know their compliance position in advance rather than relying on remediation after the fact. Finally, by using each tax's own individual tax year for reporting and compliance purposes, this recommended framework would align with the tax's renewal, collection, and reporting cadence that the state may have with taxpayers but also other partners responsible for approving or administering the tax. Ultimately, this approach reduces administrative burden, complexity, and potential inaccuracies.

If CMS does elect to finalize the proposed approach of using actual revenue data to establish, monitor, and enforce compliance with the threshold, NAMD strongly recommends that CMS provide:

- a longer window for one-time reporting requirements. Medicaid programs will have to work with multiple sources and across agencies to report even the interim threshold elements. This commends using a submission date of June 30, 2027, which would give Medicaid programs two additional quarters to coordinate, collect, and submit appropriate data elements across state and local agencies to CMS. Moreover, because it takes more than two years to collect actual net patient revenue data, we recommend that deadline for submission of final net patient revenue and tax collection data for one-time reporting requirements be extended to December 31, 2028. This would give states just over two years after the effective date to submit actual revenue data.
- a remediation period. We also recommend at least a four-year remediation period to allow for enough time to collect net patient revenue data. This would allow at least a three-year remediation period after final hold harmless thresholds are released for the first year of implementation, and a four-year remediation window for all other years.

Lastly, CMS proposes assessing impermissibility on the entire tax rather than the amount of revenue collected above the threshold. We encourage CMS to revisit this and instead limit disallowances to the excess amount over the final indirect hold harmless threshold, consistent with its historic practice.

The proposed enforcement approach introduces fiscal uncertainty for Medicaid programs, especially because CMS' proposal for setting the indirect hold harmless threshold, complying with the indirect hold harmless threshold, and introducing the new permissible class of "services of health insurers other than services of managed care organizations" introduces significant complexity to ensure compliance with the threshold. There may be instances where states invertedly tax above their threshold due to errors, data lags, and miscommunication across agencies. While CMS notes this approach has been technically allowable in the past, it is inconsistent with general and historic practices. Traditionally, CMS applies penalties proportionally and is targeted towards compliance issues, with an aim towards resolution. This would be consistent with the proportional nature of the underlying compliance metric.

***Maintain the 75/75 Test for Assessing Hold Harmless Arrangements***

Under regulations finalized in 1993, CMS established a second prong of the indirect hold harmless test that assesses whether a tax produces revenues above the applicable 6 percent threshold (the 6 percent test, or the first prong of the indirect hold harmless test), then determines whether 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back from Medicaid payments or other payment arrangements from the state. CMS extensively discusses the limited use of the 75/75 test since its establishment and its belief that the test allows states to circumvent the statutory hold harmless thresholds. Related, CMS proposes to sunset this test starting October 1, 2026, but to allow states that have taxes above a 6 percent hold harmless threshold and also met the 75/75 test to meet the applicable threshold for purposes of OBBBA section 71115.

NAMD does not support sunsetting the 75/75 test, either before or after October 1, 2026, on both practical and statutory authority grounds. Some states report that their licensing and certification fees and similar assessments are reliant on the 75/75 test to demonstrate that these assessments do not present a hold harmless arrangement, particularly when they are periodically adjusted to reflect evolving conditions in a state's healthcare landscape. These states do not see an obvious pathway outside of the 75/75 test to account for these assessments and are concerned that its removal will inhibit the ability to create new licensing fees ongoing.

Additionally, federal law, unchanged by OBBBA, specifically continues to authorize the historical use of the 75/75 test. Section 403 of the Tax Relief and Health Care Act of 2006 incorporates CMS regulations at CFR 42 section 433.68(f)(3)(i) in effect on November 1, 2006 directly into the Social Security Act at section 1903(w)(4)(c)(ii). These regulations explicitly include the 75/75 test at 433.68(f)(3)(i)(B). OBBBA does not remove or otherwise override this existing language at 1903(w)(4)(c)(ii) and the reference to CMS's November 2006 regulations remain in statute.

***Conclusion***

NAMD appreciates CMS's consideration of the informed operational perspectives of Medicaid agencies on this proposed rule. Our members share the federal government's

commitment to good stewardship of public resources. We encourage a targeted approach that meets this objective in a manner that is operationally feasible and does not introduce unnecessary fiscal risk for states. We look forward to continuing collaboration with CMS on these important issues.

Sincerely,

Stuart Portman

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NAMD Board President
Georgia Medicaid Director

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NAMD Board President Elect
Iowa Medicaid Director