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September 18, 2026

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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010
Attention: CMS-2452-P

Submitted electronically via Regulations.gov, Docket No. CMS-2026-2476

RE: CMS-2452-P — Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes (91 Fed. Reg. 46562, July 23, 2026)

Dear Dr. Oz,

The Arizona Hospital and Healthcare Association (AzHHA), on behalf of our more than 70 member hospitals and health systems, submits these comments in response to the Centers for Medicare & Medicaid Services (CMS) proposed rule, *Medicaid Program: Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes* [CMS-2452-P].[1] Our members range from urban academic and safety-net systems and behavioral health hospitals to the critical access and rural hospitals that are the only source of inpatient and emergency care across much of our state.

Arizona's stake in this rule is unusually direct. Arizona is an expansion state under the WFTC legislation,[2] and its hospitals — not the state general fund — finance the non-federal share of coverage for the Proposition 204 and adult expansion populations through the hospital assessment established under A.R.S. § 36-2901.08.[3] AHCCCS combines that assessment with federal matching funds to cover nearly 700,000 Arizonans.[4] A second assessment, established under A.R.S. § 36-2999.72, funds the Health Care Investment Fund (HCIF), which supports the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) directed payments and physician and dental fee schedule increases.[5] Both assessments apply to inpatient and outpatient hospital

[1]Pub. L. 119-21, § 71115 (July 4, 2025) (the "Working Families Tax Cut" or "WFTC" legislation); *Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes*, 91 Fed. Reg. 46562 (July 23, 2026) (hereinafter "Proposed Rule"). Comments are due September 21, 2026.

[2]Pub. L. 119-21, § 71115(a)(1)(D)(iii); Proposed Rule, preamble § II.A (proposed 42 C.F.R. § 433.52, "Expansion State").

[3]Ariz. Rev. Stat. § 36-2901.08, https://www.azleg.gov/ars/36/02901-08.htm (hereinafter "A.R.S. § 36-2901.08"), subsections (A)–(B), (F); Joint Legislative Budget Committee, *FY 2025 Appropriations Report*, Arizona Health Care Cost Containment System, at "Hospital Assessment," https://www.azjlbc.gov/25AR/axs.pdf (hereinafter "JLBC FY 2025 Appropriations Report") (the assessment funds the state costs of these populations not otherwise covered by voter-approved tobacco revenues and other state funds).

[4]AHCCCS, Notice of Proposed Exempt Rulemaking, A.A.C. R9-22-730 (Hospital Assessment Fund) (posted Sept. 14, 2026), https://www.azahcccs.gov/shared/Downloads/Reporting/ProposedStateRules/2026/NPER_Title9_Chapter22_Article7_HAF.pdf (hereinafter "AHCCCS HAF Notice (2026)"), item 9.

[5]AHCCCS, Notice of Proposed Exempt Rulemaking, A.A.C. R9-22-731 (Health Care Investment Fund) (posted Sept. 14, 2026), https://www.azahcccs.gov/shared/Downloads/Reporting/ProposedStateRules/2026/NPER_Title9_Chapter22_Article7_HCIF.pdf (hereinafter "AHCCCS HCIF Notice (2026)"), items 6 and 9; AHCCCS, Proposed State Rules (archive of rulemaking notices, 2013–2026), https://www.azahcccs.gov/PlansProviders/CurrentProviders/State/proposedrules.html (hereinafter "AHCCCS Proposed State Rules") (FFY 2021 entry describing HCIF uses; FFY 2024 entry reporting that HEALTHII payments represent an annual net increase of more than $1.7 billion).

classes, use the same peer groups and exclusions, and are recalibrated annually by rule on a federal fiscal year (FFY) cycle.[6] State law directs AHCCCS to assess only what is needed to fund the covered populations and bars hospitals from passing the cost of the assessment on to patients or third-party payers.[7] Any provision that destabilizes hospital assessment revenue in Arizona destabilizes coverage itself.

AzHHA supports CMS's goal of ensuring that health care-related taxes comply with federal statutory requirements, and we recognize that the WFTC legislation obligates CMS to make substantial revisions to provider tax policy. We appreciate that several CMS proposals reflect existing practice, limiting disruption for states and their Medicaid providers, including the revised treatment of tax waivers and the retention of the longstanding net patient revenue (NPR) denominator.[8] We are concerned, however, that **core elements of this proposal go well beyond the WFTC legislation and, if finalized as proposed, would place the financing of Arizona's Medicaid coverage at risk.** In particular, the proposed rule:

- **Is inconsistent with federal statute in key areas,** including the elimination of the 75/75 test and the application of the WFTC legislation's reduced thresholds to a provider class that did not exist on May 1, 2025.
- **Alters longstanding policies outside the scope of the WFTC legislation,** including the shift to retrospective compliance monitoring and the assertion that health care-related taxes outside a designated class are impermissible.
- **Generates substantial and unnecessary financial uncertainty for states and health care providers alike** by setting binding limits years after the tax years to which they apply.
- **Imposes a costly administrative burden on states, CMS, and the hospitals that supply the underlying data,** without corresponding oversight benefit.
- **Diminishes state flexibility while failing to strengthen enforcement of pre-existing hold harmless restrictions.**

Priority Recommendations

Based on the concerns described above, AzHHA offers four priority recommendations for CMS to consider. More detailed feedback follows in the "Detailed Feedback" section.

1. **Allow each state to select any 12-month measurement period that includes July 4, 2025.** This choice is substantial: in Arizona, for example, the state fiscal year containing July 4, 2025 combines parts of two assessment years, causing the grandfathered amount to shift by about $50 million depending on the window chosen—even though the tax itself does not change. Such variation reflects the calendar, not the nature of the tax. CMS should keep the SFY containing July 4, 2025 as the default, let states select the most representative period, and apply adjustments for changes after July 4, 2025 at the class level, net of offsets.
2. **Preserve prospective compliance.** CMS should allow states to continue trending tax collections and NPR forward from a prior period. If CMS retains a retrospective framework, it should finalize thresholds

[6] AHCCCS HAF Notice (2026), R9-22-730(B), (C), (L); AHCCCS HCIF Notice (2026), R9-22-731(B), (C), (L).

[7] A.R.S. § 36-2901.08, subsection (G); AHCCCS HAF Notice (2026), R9-22-730(R); AHCCCS Proposed State Rules (FFY 2023 and FFY 2024 Hospital Assessment Fund entries: "it is the Administration's objective to assess only as much as is necessary").

[8] CMS, Dear Colleague Letter, "Section 71115 and 71117 of Working Families Tax Cuts Legislation on Provider Taxes" (Nov. 14, 2025), https://www.medicaid.gov/medicaid/downloads/providertax_dcl_11142025.pdf; Proposed Rule, preamble §§ II.A, II.C.2.a.

before FFY 2027 closes, treat interim thresholds as a binding safe harbor, and limit any reduction in federal financial participation (FFP) to revenue above the threshold rather than the full value of every tax on the class.

3. **Measure hospital taxes on a combined inpatient and outpatient basis.** Allocating hospital NPR between two classes is inherently imprecise and, under frozen thresholds, ordinary shifts in utilization can breach one class's limit while the total hospital tax burden falls.
4. **Withdraw the proposals that exceed the statute.** CMS should retain the 75/75 test, withdraw the new "services of health insurers" class and its interpretation that health care-related taxes outside a designated class are impermissible, and apply any discretionary policy changes no earlier than the first FFY beginning one year after the final rule.

AzHHA appreciates CMS's consideration of these comments and looks forward to continued collaboration with our federal partners to strengthen and stabilize the Medicaid program.

Detailed Feedback

Measurement Period for the New Threshold — 42 C.F.R. § 433.68(f)(3)(ii)(A)(4)

CMS Proposal: Because the WFTC legislation does not specify a period for calculating a state's historical tax level, CMS proposes to use the SFY containing July 4, 2025 — for most states, SFY 2026. States would deduct revenue attributable to increases enacted or imposed after July 4, 2025, and CMS states that it "will consider" using an alternate period where later changes reduced collections. CMS considered, but did not propose, FFY 2025, calendar year 2025, or four consecutive quarters including July 4, 2025.[9]

Feedback: AzHHA supports CMS's effort to identify a clear and administrable methodology. Because the statute does not specify a measurement period, however, CMS should give states flexibility to select one. A single SFY window can misstate the tax structure lawfully in effect on July 4, 2025, wherever a state's tax year does not align with its fiscal year.

Arizona illustrates the point. It levies assessments on an FFY cycle, with rates set each year for the four quarters beginning October 1.[10] The SFY containing July 4, 2025 runs from July 1, 2025 through June 30, 2026, and therefore includes one quarter from the assessment year in which the annual amount was approximately $1.42 billion and three quarters from the assessment year in which the annual amount was approximately $1.52 billion, producing a blended amount of roughly $1.49 billion. The FFY containing July 4, 2025 would weigh three quarters at the lower figure and one quarter at the higher, and would grandfather an amount roughly $50 million lower.[11] Nothing about Arizona's tax structure differs between those two windows; the only difference is the calendar. A threshold that can move by $50 million in a single state based solely on which 12 months are selected is not measuring the characteristics of a tax, and the direction of that swing will vary from state to state depending on when each state's tax year falls.

A related problem arises where a state imposes more than one tax on the same permissible class. The statute sets a threshold for each class, and CMS applies it, class by class.[12] Where separate taxes on a single class

[9] Proposed 42 C.F.R. § 433.68(f)(3)(ii)(A)(4); Proposed Rule, preamble § II.C.2.b.

[10] AHCCCS HAF Notice (2026), R9-22-730(B), (C); AHCCCS HCIF Notice (2026), R9-22-731(B), (C).

[11] Figures reported by the Arizona Health Care Cost Containment System. [AzHHA to confirm the citation to AHCCCS's comment letter on CMS-2452-P before filing.]

[12] Pub. L. 119-21, § 71115(a); Proposed Rule, preamble § II.C.2 ("each permissible class within a State would have its own threshold").

changed in different directions after July 4, 2025, a tax-by-tax adjustment that deducts increases while treating decreases as discretionary produces a threshold below the burden the class actually bore on the statutory date. The adjustment should follow the same class-level logic as the threshold itself.

Recommendation: AzHHA recommends that CMS (1) **permit states to elect any 12-month measurement period that includes July 4, 2025, retaining the SFY containing that date as the default where a state does not elect otherwise** — an approach consistent with CMS's current practice of permitting states to demonstrate compliance using the most recent four quarters or the most recent tax period, and with the alternative CMS itself considered of four consecutive quarters that include July 4, 2025;[13] (2) **codify in regulation text, rather than leave to case-by-case discretion, the availability of an alternate period where changes after July 4, 2025 caused the default window to misstate the tax structure in effect on that date, whether the resulting variance runs in the state's favor or against it;** and (3) **measure any adjustment for post-July 4, 2025 changes at the permissible class level, net of offsetting changes among taxes on that class.**

"Enacted" and "Imposes" as Applied to Assessments Set by Rule — 42 C.F.R. § 433.68(f)(3)(ii)(A)(1)

CMS Proposal: CMS would treat a tax as "enacted" if the legislative process authorizing it were complete by July 4, 2025, and as "imposed" if taxpayers were subject to a legally enforceable obligation to pay as of that date. The preamble states that a tax may be enacted but not imposed where a legislature has given an administrative agency standing authority to impose a tax, or an increase, "at an unspecified, discretionary time."[14]

Feedback: AzHHA supports CMS's decision to address waiver timing under "imposes" rather than "enacted," and to credit waivers with an effective date on or before July 4, 2025.[15] We ask CMS to confirm, however, that the "standing authority" discussion does not reach assessments that a legislature has mandated and directed the Medicaid agency to administer by rule. Arizona's assessments are not discretionary: the legislature required both — the hospital assessment has been collected since January 1, 2014, and the HCIF assessment since October 1, 2020 — and directed AHCCCS to set the method and amount by rule, subject to federal approval.[16] AHCCCS updates rates, peer groups, and data years annually and adds newly licensed hospitals to the assessment base, which is necessary to keep the tax broad-based.[17] Those recalibrations move in both directions and track what state law requires the agency to collect: for FFY 2026, AHCCCS reduced the hospital assessment from $993.50 to $628.25 per discharge and from 2.4785 to 1.7723 percent of outpatient net patient revenue for short-term hospitals not assigned to another peer group.[18] A state that adjusts an assessment downward because less revenue is needed, and back upward when more is needed, is administering a single enacted tax — not imposing a new one.

Recommendation: AzHHA recommends that CMS state in the final rule that (1) **a legislatively mandated assessment whose amount is set by agency rule was enacted and imposed as of July 4, 2025 at the rate structure legally enforceable on that date;** and (2) **for FFY 2027 and later, annual administrative recalibration**

[13] Proposed Rule, preamble § II.C.2.b.

[14] Proposed Rule, preamble § II.C.2.a; proposed 42 C.F.R. § 433.68(f)(3)(ii)(A)(1).

[15] Proposed Rule, preamble § II.C.2.a; 42 C.F.R. § 433.72(c).

[16] A.R.S. § 36-2901.08, subsections (A)–(B); AHCCCS HAF Notice (2026), R9-22-730(B); AHCCCS Proposed State Rules (FFY 2021 entry: A.R.S. §§ 36-2999.72 and 36-2999.73 "require AHCCCS to establish a second hospital assessment beginning October 1, 2020").

[17] AHCCCS HAF Notice (2026), item 6, R9-22-730(M), (R).

[18] AHCCCS, Notice of Proposed Exempt Rulemaking, A.A.C. R9-22-730 (comment period ending Sept. 15, 2025; effective with invoices issued Oct. 15, 2025), https://www.azahcccs.gov/shared/Downloads/Reporting/ProposedStateRules/2025/NoticeOfProposedRulemaking_R9-22-730.pdf (hereinafter "AHCCCS HAF Notice (2025)"), R9-22-730(B); AHCCCS Proposed State Rules (FFY 2023 and FFY 2024 Hospital Assessment Fund entries).

of rates, peer groups, and data sources, and the addition of newly licensed providers, is not a new or increased tax so long as class-level collections remain at or below the applicable threshold. The statute limits the percentage of NPR a class may bear, not a state's rate schedule, and CMS itself reminds states that "the tax rate and the indirect hold harmless threshold are not the same."[19]

Calculating the Tax Rate and Measuring Hospital Taxes — 42 C.F.R. § 433.68(f)(3)(ii)(A)

CMS Proposal: CMS would codify its longstanding methodology: total tax collections for a permissible class divided by total NPR for that class, with NPR measured across all providers in the class whether or not they are taxed, and revenue not attributable to the class excluded. Because inpatient and outpatient hospital services are separate classes, states must allocate hospital NPR between them. CMS states that more than one allocation methodology may be acceptable, that it intends to work collaboratively rather than pursue enforcement over attribution, and that a state must then apply its chosen methodology consistently.[20]

Feedback: AzHHA supports codification of the existing methodology, including measurement of NPR across the full permissible class. That approach has anchored CMS's oversight framework for years and will limit disruption as states adjust.[21] Arizona's assessments exclude hospitals owned by the state, the federal government, or tribes; urban public acute care hospitals; rehabilitation hospitals; and smaller psychiatric hospitals.[22] A denominator limited to taxed providers would overstate Arizona's ratio for reasons unrelated to any hold harmless arrangement.

We ask CMS to confirm that it will not penalize states for minor errors in the provider universe used to calculate NPR. Participation in a class is not static — facilities open, close, merge, change ownership, or fall behind on enrollment updates, and some providers do not routinely submit the data sources states rely on. States may therefore find immaterial discrepancies after reporting. CMS has historically resolved such issues collaboratively, and the final rule should say so.

We also ask CMS to measure hospital taxes on a combined basis. Allocating hospital NPR between inpatient and outpatient services is inherently imprecise: charge-based and cost-based approaches can produce materially different results from the same financial data. Arizona derives outpatient NPR by applying each hospital's ratio of gross outpatient to gross total patient revenue to its total net patient revenue, and both Arizona assessments are levied across inpatient discharges and outpatient revenue under a single methodology.[23] Under the historical 6 percent threshold, shifts in the inpatient-outpatient mix raised no compliance concern. Under frozen, class-specific thresholds, ordinary year-to-year utilization shifts — including the continuing migration of care to outpatient settings — could push one class above its threshold even when the aggregate hospital tax burden is well below historical levels. Combining the classes for threshold purposes would create no new room for states if CMS calculates the hospital threshold from combined historical inpatient and outpatient collections, and it would spare states, CMS, and hospitals a costly dispute over the "correct" allocation method that does not affect the total tax burden.

Recommendation: AzHHA supports CMS's proposed methodology with two modifications: (1) **CMS should confirm that it will work collaboratively with states to resolve minor inaccuracies in the provider lists used to**

[19] Proposed Rule, preamble § II.C.2.

[20] Proposed Rule, preamble §§ II.A, II.C.2.b.

[21] Proposed Rule, preamble § II.A (citing 73 Fed. Reg. 9685, 9695 (Feb. 22, 2008)).

[22] AHCCCS HAF Notice (2026), R9-22-730(L); AHCCCS HCIF Notice (2026), R9-22-731(L).

[23] AHCCCS HAF Notice (2026), R9-22-730(A)(5), (B); AHCCCS HCIF Notice (2026), R9-22-731(B).

calculate NPR, rather than pursue compliance action for immaterial, good-faith discrepancies; and (2) **CMS should measure hospital taxes on a combined basis across the inpatient and outpatient hospital classes, calculating each state's threshold from its combined historical collections.**

Process for Establishing Interim and Final Thresholds — 42 C.F.R. § 433.68(f)(3)(ii)(B)(4)

CMS Proposal: CMS would set non-binding interim thresholds from data states submit by December 31, 2026, without specifying when those figures would be released, and would publish final, binding thresholds no later than September 30, 2028. States exceeding a final threshold would take retroactive corrective action or risk loss of FFP.[24]

Feedback: AzHHA supports using a non-binding interim threshold during the initial rollout. However, the September 30, 2028 date for final thresholds falls two full years after the new limits take effect. States could over-collect for two years before learning, then owe refunds they have already spent. The delay follows directly from CMS's decision to measure retrospectively. Alternatives exist — including the projection method states use today — that would let CMS issue an interim threshold almost immediately, spend a quarter or two aligning with states on data sources, and finalize thresholds before FFY 2027 closes.

The timing problem is immediate in Arizona. AHCCCS has already proposed FFY 2027 assessment rates for invoices issued in October 2026, before any federal threshold — interim or final — exists.[25] Hospitals will pay those assessments without knowing whether the revenue will ultimately be treated as permissible.

Recommendation: AzHHA supports the two-step process but recommends that CMS **establish final thresholds before the close of FFY 2027 using a prospective methodology that mirrors current practice.** If CMS retains the proposed timeline, it should **(1) release interim thresholds within 60 days of a state's submission; (2) treat an interim threshold as a binding safe harbor for FFY 2027 and FFY 2028 absent fraud or material misreporting; (3) take no enforcement action for any FFY that closes before final thresholds are published; and (4) permit variances for those years to be corrected prospectively.**

Retrospective Monitoring and Enforcement — 42 C.F.R. §§ 433.70, 433.74(b)(3)

CMS Proposal: CMS would monitor compliance retrospectively, using actual collections and actual NPR, with a two-year reconciliation window after each FFY in which states may issue refunds. A state still above its threshold after that period would deduct the full tax amount from matchable expenditures and return the associated FFP.[26]

Feedback: This is a significant departure from a framework that lets states demonstrate compliance prospectively. Under the proposal, a state cannot confirm compliance until after the year closes, and can breach a threshold because collections, tax rates, or NPR moved in ways it could not anticipate. NPR is a particularly unstable denominator: it moves with payment rates, utilization, and market events such as closures and expansions, and CMS acknowledges that a state's ratio can rise even when its rates do not change.[27]

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[24] Proposed 42 C.F.R. §§ 433.68(f)(3)(ii)(B)(4), 433.74(b)(2)–(3); Proposed Rule, preamble § II.C.2.b; American Hospital Association, *CMS Releases Proposed Rule on Provider Taxes* (Regulatory Advisory, July 22, 2026) (hereinafter "AHA Regulatory Advisory"), at 3, 5.

[25] AHCCCS HAF Notice (2026), item 6; AHCCCS HCIF Notice (2026), item 6.

[26] Proposed Rule, preamble §§ I.B, II.C.3.a; proposed 42 C.F.R. § 433.70(b); Myers and Stauffer, *CMS Proposes Rule Implementing New Provider Tax Hold Harmless Thresholds* (Client Alert, Aug. 11, 2026), https://myersandstauffer.com/insights/client-alerts/medicaid-provider-tax-hold-harmless-thresholds/ (hereinafter "Myers and Stauffer Alert").

[27] Proposed Rule, preamble § II.C.3.a.

Arizona illustrates the difficulty. AHCCCS builds each year's assessment on cost report and uniform accounting data that are two years old; the FFY 2027 assessment rests on 2024 data.[28] Actual class-level revenue for any FFY will not be known until long after it ends. Meanwhile, the WFTC legislation will itself depress Arizona hospital revenue in ways that are difficult to forecast: work requirements and six-month renewals for expansion adults beginning January 2027, eligibility changes for certain immigrants beginning October 2026, and state-directed payment reductions beginning January 2028.[29] A state acting in good faith on the best available data could still be found noncompliant years later.

The consequences of that finding fall on providers. A state deemed noncompliant must return taxes already spent on Medicaid, which requires either a new non-federal funding source or retroactive reductions to the payments the tax financed — neither of which is straightforward, and both of which may require new legislative authority and amendments to approved state plan amendments or directed payment preprints. This exposure is most acute in states where provider tax funds the non-federal share of Medicaid expansion and general fund appropriations are unavailable for that population. In Arizona, hospital assessment revenue is deposited in the Hospital Assessment Fund and spent on coverage for the expansion populations; the financing design deliberately keeps those costs off the general fund; and hospitals may not recover the assessment from patients or other payers.[30] Because the WFTC legislation ratchets grandfathered thresholds down annually in expansion states, states would face this cycle every year.

The proposed penalty compounds the problem. CMS would deduct the full value of every tax on a class — state and local combined — when aggregate collections exceed the threshold by any amount.[31] Arizona levies two assessments on the same hospital classes. A small variance, whether from either assessment or from a decline in NPR, could disallow the FFP tied to the entire class, reaching the revenue that finances expansion coverage and the revenue that finances HEALTHII at the same time. CMS has already recognized in the preamble that it has discretion not to pursue reductions for modest excesses,[32] and that discretion should appear in the regulation.

Recommendation: AzHHA recommends that CMS **preserve current practice by allowing states to trend tax amounts and NPR forward from a prior period to demonstrate compliance**, with added standardization — such as a defined historical baseline and a designated inflation index — if CMS seeks greater national consistency. If CMS finalizes a retrospective framework, it should provide in regulation that: **(1) a state that sets its tax using reasonable projections from the best available data is compliant for that FFY; (2) variances are corrected prospectively through the following year's rates rather than retroactive refunds; (3) variances within a defined tolerance [e.g., 0.10 percentage point] are not violations; (4) any reduction in FFP is limited to revenue above the threshold rather than the full value of every tax on the class; and (5) a state whose actual collections fall below its threshold may make a corresponding upward adjustment**, a circumstance the proposed rule does not address.

[28] AHCCCS HAF Notice (2026), R9-22-730(A)–(B).

[29] AHCCCS, *H.R. 1 Overview: Changes Are Coming to Medicaid*, https://www.azahcccs.gov/AHCCCS/Initiatives/HR1/ (hereinafter "AHCCCS H.R. 1 Overview").

[30] A.R.S. § 36-2901.08, subsections (F)–(G); JLBC FY 2025 Appropriations Report.

[31] Proposed 42 C.F.R. § 433.70(b); Myers and Stauffer Alert.

[32] Proposed Rule, preamble § II.C.2.a; Myers and Stauffer Alert (noting that CMS's stated enforcement restraint appears only in the preamble and is not codified).

Elimination of the 75/75 Test — 42 C.F.R. § 433.68(f)(3)(i)(B)

CMS Proposal: Beginning October 1, 2026, CMS would discontinue the second prong of the indirect hold harmless test, under which a tax exceeding the threshold is not treated as a hold harmless arrangement unless 75 percent or more of the taxpayers in the class receive back 75 percent or more of their total tax costs through enhanced Medicaid or other state payments.[33]

Feedback: Eliminating the test would be inconsistent with the underlying statute, which incorporates it by reference. Section 403 of the Tax Relief and Health Care Act of 2006 added section 1903(w)(4)(C)(ii) of the Social Security Act, which provides that an indirect hold harmless determination "shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006."[34] As of that date, 42 C.F.R. § 433.68(f)(3)(i) expressly included the second prong: "When the tax or taxes are applied at a rate that produces revenues in excess of 6 percent of the revenue received by the taxpayer, CMS will consider a hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments."[35] Because Congress incorporated that version of the regulation into statute, CMS lacks authority to remove the test through rulemaking absent a corresponding statutory amendment. The WFTC legislation made significant changes to the provider tax framework but did not amend section 1903(w)(4)(C)(ii) or authorize elimination of the test.

The test also does what the statute asks: it distinguishes taxes that return substantial payments to taxpaying providers, leaving them with little net burden, from taxes that impose a genuine cost. CMS acknowledges that the test has been invoked only rarely, identifying a single instance.[36] Rare use indicates a narrow compliance pathway, not a loophole. The 2018 Office of Inspector General report CMS cites recommended re-evaluating the safe harbor framework as a whole, including the threshold itself — not removing the second prong while leaving everything else in place.[37]

Recommendation: AzHHA recommends that CMS **retain the 75/75 test** in light of its statutory codification, and instead monitor more frequently whether it is being applied in ways CMS views as improper. If CMS concludes the standard is inadequate, it should pursue a more targeted alternative — such as a more stringent ratio — that preserves a state's ability to show a tax is not an indirect hold harmless arrangement.

"Services of Health Insurers" as a New Provider Class — 42 C.F.R. § 433.56

CMS Proposal: CMS would establish a new permissible class, "services of health insurers," separate from the existing class for services of managed care organizations (MCOs), and would subject taxes on the new class to the same requirements as other classes, including the limits enacted under the WFTC legislation and the expansion-state phase-down.[38]

Feedback: AzHHA has significant concerns with subjecting a newly created class to the WFTC legislation's reduced thresholds. Section 71115 expressly references "a class of health care items or services described in section 433.56(a) of title 42, Code of Federal Regulations (as in effect on May 1, 2025)." That regulation did not

[33]Proposed Rule, preamble §§ I.C, II.C.1, II.C.4; AHA Regulatory Advisory, at 4.

[34]Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, div. B, § 403, 120 Stat. 2922, 2991-92 (2006).

[35]42 C.F.R. § 433.68(f)(3)(i) (2006).

[36]Proposed Rule, preamble §§ I.C, II.C.2.

[37]Proposed Rule, preamble § I.C (citing HHS Office of Inspector General, *Although Hospital Tax Programs in Seven States Complied with Hold-Harmless Requirements, the Tax Burden on Hospitals Was Significantly Mitigated*, A-03-16-00202 (Nov. 8, 2018)).

[38]Proposed 42 C.F.R. § 433.56(a)(19); Proposed Rule, preamble § II.B.

include a class for health insurers' services on that date. By tying the new restrictions to the regulation as it existed on a specified date, Congress limited them to the classes then identified rather than authorizing CMS to extend them to classes created later. CMS itself acknowledges that the statute is silent on subsequently established classes.[39]

The proposal would also create substantial administrative burden. Insurance markets are organized differently across states, and many carriers offer products that do not fall cleanly into either class — preferred provider organization (PPO) products, for example, are commonly offered under general health insurance licenses rather than a distinct licensure category, yet PPOs are listed within the existing MCO class. States would face real difficulty classifying products and allocating collections and premiums between the two classes. The resulting questions would land on CMS during a period of major program change.

Finally, the proposal would sweep in state assessments that raise none of the concerns the hold harmless rules were designed to address, including assessments that fund insurance department oversight, marketplace operations, and consumer affordability programs. Revenue from those assessments is not returned to taxpayers through enhanced Medicaid payments. Arizona imposes a general premium tax across insurance lines and applies a tax to AHCCCS contractors equal to 2 percent of their AHCCCS payments.[40] A tax that treats health care entities the same as other taxpayers is not health care-related under CMS's own regulation, and codifying a parallel rate in a separate statutory section should not change that result.[41]

Recommendation: AzHHA recommends that CMS **withdraw its proposal to create a new "services of health insurers" class and subject it to the indirect hold harmless restrictions enacted under the WFTC legislation.** If CMS nevertheless finalizes the class, we request that CMS (1) **clarify that the class is not subject to the WFTC legislation's new thresholds or phase-down, given that section 71115 reaches only classes described in § 433.56(a) as in effect on May 1, 2025;** (2) **move PPOs out of the MCO class and into the new class** so states can delineate which products belong where; and (3) **confirm that a premium tax applied at the same rate across insurance lines is not a health care-related tax.**

Treatment of Health Care-Related Taxes Outside a Federally Defined Class

CMS Proposal: The preamble asserts that a health care-related tax that does not fall within one of the permissible classes in § 433.56 is impermissible, and that CMS will enforce that view from now on.[42]

Feedback: CMS has administered the provider tax rules through a set of classes, most of which were established more than three decades ago, and in practice has not prohibited taxes with little or no connection to Medicaid financing. Enforcing this position now would damage states without improving fiscal oversight. The health care sector has diversified dramatically since 1993, when care was largely confined to physical settings and licensed encounters. Today it also reaches software, devices, retailers, homes, and phones, and a broader set of non-traditional providers. Taxes on pharmacy benefit managers, third-party administrators, and telehealth platforms could all be characterized as health care-related while falling outside any listed class.

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[39] Proposed Rule, preamble § II.B; State Health and Value Strategies, *Overview of the CMS Provider Tax Proposed Rule: Marketplace Considerations* (webinar, Sept. 2, 2026), https://www.shvs.org/ (hereinafter "SHVS Webinar").

[40] Joint Legislative Budget Committee, *Tax Handbook*, "Insurance Premium Tax," https://www.azjlbc.gov/23taxbook/inspremiumtax.pdf; A.R.S. § 36-2905; AHCCCS, ACOM Policy 304, https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/304.pdf. [AzHHA to confirm rate parity across lines with the Arizona Department of Insurance and Financial Institutions before filing.]

[41] 42 C.F.R. § 433.55(c); Proposed Rule, preamble § II.B.

[42] Proposed Rule, preamble § I.B ("the baseline assumption is that all health care-related taxes are impermissible, with limited exceptions"); SHVS Webinar; AHA Regulatory Advisory, at 1.

Many entities outside the current list would satisfy the criteria CMS established in 1993 for recognizing new classes: the class's revenue is not predominantly from Medicaid or Medicare, the class is clearly identifiable, and it is nationally recognized rather than unique to one state.[43] Their absence reflects an outdated taxonomy, not evidence that these taxes should be prohibited. Finalizing this interpretation would leave states uncertain whether a tax is health care-related and therefore prohibited, and would constrain state revenue at a time when states are absorbing severe federal funding reductions — without advancing the fiscal integrity of the Medicaid program.

Recommendation: AzHHA encourages CMS to **(1) withdraw its interpretation that a health care-related tax outside a class defined in § 433.56 is impermissible; or (2) establish additional permissible classes and clarify that the WFTC legislation's limits do not apply to them because they were not classes in effect as of May 1, 2025.** Creating additional classes would preserve state flexibility while allowing those taxes to be evaluated under the broad-based, uniformity, and hold harmless standards.

Reporting Taxes Through the CMS-64 — 42 C.F.R. § 433.74(b)(4)–(5)

CMS Proposal: States would report tax collections and NPR quarterly on the CMS-64, by tax and permissible class, for the period in which the tax is imposed rather than collected, and would be bound to the NPR methodology used for the one-time threshold calculation in all ongoing reporting.[44]

Feedback: As proposed, these requirements would impose substantial administrative burden without meaningfully strengthening oversight. Tax collections are often not final at the close of the quarter in which the tax was imposed, and NPR is generally reported once a year through cost reports. Arizona's assessments rely on Medicare cost reports and Arizona Department of Health Services uniform accounting reports filed annually, with outpatient NPR derived from gross charge ratios.[45] State Medicaid agencies may also lack real-time visibility into taxes collected by other state agencies. And binding states permanently to a methodology developed under compressed timelines would prevent adoption of better data sources as they emerge.

These requirements ultimately run on data that hospitals produce, and the burden falls hardest on Arizona's rural hospitals and critical access hospitals, which are assessed under both programs and have the smallest finance teams to absorb new reporting demands.[46]

Recommendation: AzHHA recommends that CMS **(1) issue detailed guidance on quarterly NPR reporting, including where providers report NPR only annually or on a schedule that does not align with the FFY; (2) permit states to update NPR methodologies as better data sources emerge, subject to CMS review; (3) create safe harbors allowing estimates or provisional reporting where actual data are not yet available, paired with later reconciliation; and (4) give states adequate time to collect and validate data for taxes not collected by the Medicaid agency.** We also ask CMS to confirm, as the preamble states, that it will not pursue enforcement over good-faith misattribution between classes.[47]

[43] 58 Fed. Reg. 43169 (Aug. 13, 1993); Proposed Rule, preamble § I.E.

[44] Proposed 42 C.F.R. § 433.74(b)(4)–(5); Myers and Stauffer Alert; AHA Regulatory Advisory, at 5.

[45] AHCCCS HAF Notice (2026), R9-22-730(A), (P)–(Q).

[46] AHCCCS HAF Notice (2026), R9-22-730(B)(2)(a)–(b); AHCCCS HCIF Notice (2026), R9-22-731(B)(2)(a)–(b).

[47] Proposed Rule, preamble § II.C.2.b.

Additional Reporting on Public Providers and Use of Funds — 42 C.F.R. § 433.74(b)(4)

CMS Proposal: Beyond quarterly collections and NPR, states would report each quarter any change to a provider tax affecting whether public providers are subject to it, and how the revenue from each tax is used. The preamble signals heightened scrutiny of arrangements in which public providers are removed from a tax and instead finance the non-federal share through intergovernmental transfers.[48]

Feedback: We understand the concern that a state could carve public hospitals out of a tax and rely on intergovernmental transfers instead, creating room under a frozen threshold. CMS does not, however, identify the legal authority that would let it prohibit such an arrangement where the remaining tax satisfies the provider tax rules and is not itself a hold harmless arrangement. Collecting this information would add administrative burden for states and CMS without clear enforcement value.

Arizona's exclusions — state, federal, and tribal hospitals and urban public acute care hospitals — predate July 4, 2025 and have operated under approved waivers.[49] Hospitals should not face uncertainty about whether an assessment is permissible because of exclusions CMS has long approved.

Recommendation: AzHHA recommends that CMS **drop these additional reporting requirements** and, at minimum, confirm that exemptions in effect on July 4, 2025, **under approved waivers are not grounds for a new hold harmless finding**, and **adopt any new standard governing such arrangements only through separate notice-and-comment rulemaking that identifies its legal basis.**

Effective Date, Transition, and Cumulative Impact

CMS Proposal: CMS would make its discretionary policies — elimination of the 75/75 test, the new insurer class, and the new reporting and enforcement provisions — effective October 1, 2026, alongside the statutory threshold.[50]

Feedback: That date will likely precede publication of the final rule and leaves states no opportunity to amend state law where necessary; applying these policies to periods before the rule is final raises serious retroactivity concerns.[51] The financial stakes are large. CMS estimates the rule would reduce federal Medicaid spending by approximately $246 billion over ten years.[52] That reduction does not occur in isolation: CMS's pending state directed payment rule would limit the HEALTHII payments that Arizona's HCIF assessment finances,[53] and CMS's June 2026 guidance on section 1115 budget neutrality narrows the financing assumptions available to support demonstration initiatives.[54] In Arizona, the same assessment dollars finance both coverage and payment adequacy, so these actions compound.

Recommendation: AzHHA recommends that CMS **apply the statutory threshold as the WFTC legislation requires, but make discretionary policy changes effective no earlier than the first FFY beginning at least one year after publication of the final rule, and apply no provision retroactively.** We further ask that CMS **publish**

[48] Proposed 42 C.F.R. § 433.74(b)(4); Proposed Rule, preamble § II.B; Myers and Stauffer Alert.

[49] AHCCCS HAF Notice (2025), R9-22-730(L); AHCCCS HAF Notice (2026), R9-22-730(L).

[50] Proposed Rule, preamble §§ II.B, II.C.1, II.C.4; SHVS Webinar.

[51] SHVS Webinar.

[52] AHA Regulatory Advisory, at 1.

[53] Medicaid state directed payments proposed rule, CMS-2449-P, 91 Fed. Reg. 30400 (May 22, 2026); American Hospital Association, *Comments on HHS' Medicaid State-directed Payments Proposed Rule* (July 21, 2026), https://www.aha.org/2026-07-21-aha-comments-hhs-medicaid-state-directed-payments-proposed-rule (noting CMS scores that rule at $510.1 billion over ten years).

[54] CMS, State Medicaid Director Letter on budget neutrality for section 1115 demonstrations (June 11, 2026).

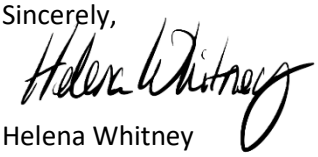
state-level impact estimates and its methodology, and account for the combined effect of its pending Medicaid financing actions before finalizing policies that exceed section 71115.

Conclusion

Arizona's hospitals have financed the state's expansion coverage for more than a decade under a structure built to comply with federal requirements and to collect only what is needed. AzHHA asks CMS to implement section 71115 in a way that measures Arizona's baseline accurately, gives states and providers a limit they can know in advance, and reserves its most severe penalties for arrangements that actually hold taxpayers harmless. These changes matter most to rural and critical access hospitals, which have the least capacity to absorb a retroactive refund or disallowance and the greatest responsibility for access in their communities.

Thank you for considering these comments

Sincerely,



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