



September 21, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2452-P; Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes

Submitted electronically via <http://www.regulations.gov>

Dear Administrator Oz,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-2452-P. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 133,000 colleagues and nearly 40,000 physicians and clinicians caring for diverse communities across 23 states. Nationally recognized for care excellence and patient experience, the Trinity Health system includes 91 hospitals, 101 continuing care locations, and the second largest Program of All-Inclusive Care for the Elderly (PACE) in the country. Trinity Health has 15 medical groups with 8,900 medical group physicians and providers. With headquarters based in Livonia, Michigan, its annual operating revenue is \$25.4 billion with \$2.9 billion returned to its communities in the form of charity care and other community benefit and community impact programs.

Trinity Health has 12 Clinically Integrated Networks (CINs) that are accountable for 1.8 million lives across the country through alternative payment models. Our health care system participates in 10 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 8 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participated in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). In addition, we participated for many years in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts. In addition, Trinity Health owns a non-profit, mission-focused Medicare Advantage plan—MediGold—that plays a vital role in our integrated delivery network and provides care coordination for patients while using fair practices.

We are eager to work with Congress and the Department of Health and Human Services (HHS) on alternative payment models that enable providers to move away from fee-for-service and assume responsibility for total cost of care and outcomes for populations served by public programs. Our participation in Medicare demonstration projects, our MediGold MA plan and our PACE programs demonstrate our ability to effectively manage cost and outcomes.

Medicaid plays a critical role in our ability to care for the communities we serve with 17% of our patients being covered by the program. Provider taxes have long served as a lawful and essential component of Medicaid financing, helping states fund their share of program costs and sustain access to care for millions of beneficiaries. Since Congress authorized healthcare-related taxes as a permissible Medicaid financing source in 1991, states have relied on this tool to support the stability and effectiveness of their Medicaid programs. Provider tax revenues help fund critical program functions, including eligibility and enrollment systems, program integrity initiatives, fraud prevention efforts, and supplemental payment programs that help address Medicaid's historically inadequate base reimbursement rates. These resources are vital to maintaining a strong Medicaid program, supporting providers that care for vulnerable populations, and ensuring that Medicaid beneficiaries can access needed healthcare services in their communities.

The proposed rule extends well beyond the statutory changes required under the One Big Beautiful Bill Act (OBBA) by introducing new reporting and measurement obligations, removing an established compliance pathway, and creating significant retrospective compliance exposure. The extent of how much further CMS is going is evident by the \$246B regulatory estimate produced by HHS actuaries, compared to the \$183B impact of the OBBA legislation. Trinity Health is concerned that some proposals in this rule could create serious financial and operational disruption for states, hospitals and the patients they serve.

In our detailed comments below, we urge CMS to:

- Maintain state's ability to use projected, estimated, or trended data to demonstrate compliance with the indirect hold harmless threshold.
- Withdraw proposed complex and administratively burdensome reporting requirements.
- Delay the interim reporting deadline
- Withdraw proposal tying the state directed preprint approvals to provider tax reporting compliance.
- Maintain the 75/75 test as an option for states to demonstrate compliance with the indirect hold harmless prohibition.

Retrospective Reconciliation

CMS is proposing a significant change to how states demonstrate compliance with the indirect hold harmless threshold. Rather than allowing the use of projected, estimated, or trended data, as has historically been permitted, CMS would require states to use a retrospective reconciliation approach based solely on actual tax revenues collected and actual net patient revenue during the applicable measurement period.

Under the proposed methodology, states would no longer be able to rely on trend assumptions, prior-period experience, or other reasonable estimates to calculate compliance with the hold harmless threshold. This marks a notable departure from CMS's longstanding practice. Instead, states would be required to submit actual data to CMS by December 31, 2026, for interim threshold determinations and by June 30, 2028, for final threshold calculations. Going forward, states would also be expected to continually monitor actual tax collections against the applicable threshold throughout each federal fiscal year. If a state's actual tax collections exceed the allowable threshold, the state would be required to return the excess amounts to taxpayers on a proportional basis according to each taxpayer's share of total tax payments. Failure to refund the excess collections could result in a reduction of federal matching funds equal to the amount that exceeds the threshold.

The proposed shift to retrospective reconciliation represents a significant and unnecessary departure from decades of established practice that will create serious financial and operational instability for states and the hospitals and health systems that depend on Medicaid supplemental payments. Under the

prior prospective approach, states used best available hospital data and applied reasonable trend methodologies to project compliance with the applicable threshold in advance. This approach gave states the predictability and flexibility needed to design and administer tax programs responsibly and efficiently. **Trinity Health urges CMS to preserve the prospective, estimate-based approach for ongoing compliance monitoring using reasonable trends reviewed and approved by CMS.**

One-time and Ongoing Reporting

The proposed reporting framework would impose significant new administrative requirements on states and providers while creating prolonged uncertainty around provider tax compliance and Medicaid financing. **The combination of extensive data submissions, quarterly reporting obligations, and a multi-year reconciliation process extends well beyond what is necessary to implement the revised indirect hold harmless thresholds and will create an unnecessary burden on states and providers and put provider payments at greater risk due to procedural challenges faced by both states and CMS. We urge CMS to withdraw this proposal.**

Under the proposal, states would be required to submit initial tax structure and financial data to establish an interim threshold, followed by a second submission nearly two years later to support CMS's determination of a final threshold. Yet states would be expected to comply with the new requirements before those final thresholds are established. This approach creates an extended period of uncertainty that would complicate state budgeting, provider tax administration, and long-term planning for Medicaid-funded services.

We are particularly concerned by the proposed quarterly reporting requirements beginning in federal fiscal year 2027. Many provider tax programs are administered and reconciled on an annual basis, making quarterly reporting an imperfect measure of compliance. Quarterly collections can fluctuate significantly due to payment timing, annual reconciliations, and prior-year adjustments, potentially producing results that do not accurately reflect compliance with annual tax limits. As a result, the proposed reporting structure may generate misleading data while substantially increasing administrative workload for both states and providers.

Furthermore, Medicare cost reports, which are a potential source of net patient revenue data, are filed annually, not quarterly. CMS should clarify whether prorated cost reports could satisfy quarterly reporting requirements, or whether states and providers would be required to develop entirely new data collection and reporting infrastructure. The burden would be particularly significant for certain hospitals that have less experience filing Medicare cost reports or report data in a non-standardized manner. While not acknowledged in CMS' regulatory impact analysis, hospitals and health systems would also face additional burden due to the data states need to collect from them to calculate net patient revenue at the class level.

In addition, Trinity Health recommends CMS delay the initial data submission that is due on December 31, 2026. Delaying the interim reporting deadline would give CMS the opportunity to carefully deliberate over the comments it receives, finalize the rule and develop and promulgate the detailed guidance necessary for states and providers to submit accurate and complete data. This is especially important given the significant and long-lasting implications this policy has for state fiscal planning and Medicaid financing.

Consequences for Exceeding the Threshold or Failing to Comply with Reporting Requirements

Exceeding the indirect hold harmless threshold would result in a deduction of the state's claimed medical expenditure by the total amount of revenue raised from all taxes within a permissible class. This would put a significant amount of program funding at risk. **As states seek to comply with the unique threshold**

requirements and phase-down schedule, CMS should only deduct the amount exceeding the threshold from the state's claimed medical assistance expenditures.

CMS proposes two mechanisms to enforce the new provider tax reporting requirements. First, if a state fails to satisfy the reporting obligations, CMS would reduce future quarterly federal funding by the amount of federal matching funds that it estimates were generated from the unreported tax revenue. CMS could also impose corresponding deferrals or disallowances for the affected quarters. Second, CMS would have the authority to withhold approval of state directed payment (SDP) preprints until the state achieves compliance with the reporting requirements.

This second compliance lever will create significant financial hardship for providers. Hospitals depend on the timely approval of SDPs to support reimbursement for services provided to Medicaid beneficiaries, and the SDP review and approval process is separate from the proposed provider tax reporting framework. Conditioning SDP preprint approval on a state's reporting compliance could disrupt a critical source of funding for providers, even though hospitals have no direct responsibility for, or control over, the state's reporting activities. **Trinity Health urges CMS to withdraw its proposal to tie SDP preprint approvals to provider tax reporting compliance.**

Discontinuation of 75/75 Test

Current regulations use a two-prong test to determine whether a provider tax includes an impermissible indirect hold harmless arrangement. First, CMS compares tax revenues to the net patient revenue of taxed providers. If tax revenues exceed 6% of net patient revenue, CMS may presume an indirect hold harmless exists unless the tax satisfies the second prong. The second prong, known as the "75/75 test," assesses whether at least 75% of taxpayers receive 75% or more of their tax costs back through Medicaid or other state payments. If so, the arrangement is deemed an impermissible indirect hold harmless. CMS proposes to eliminate the 75/75 test prospectively, effective October 1, 2026.

The "75/75 test" is a longstanding component of the federal hold harmless framework and can be critical to determine whether a guarantee to hold taxpayers harmless exists. While OBBA amended the indirect hold harmless thresholds pursuant to the first prong of the indirect hold harmless test, it did not make any modifications to this second prong.

CMS should allow the 75/75 test to remain in effect as an option for states to demonstrate compliance with the indirect hold harmless prohibition. While the OBBA modifies the applicable indirect hold harmless thresholds, it does not require the removal of an existing regulatory mechanism that has been part of the provider tax framework for many years. Retaining the 75/75 test would preserve an important measure of state flexibility while continuing to protect against impermissible hold harmless arrangements.

The proposed elimination of this pathway would unnecessarily narrow the options available to states as they work to finance Medicaid and maintain access to care. Medicaid programs face increasing demands driven by rising healthcare costs, workforce shortages, behavioral health needs, and growing service requirements. States should retain flexibility to design financing arrangements that meet these challenges while remaining compliant with federal law.

Conclusion

Thank you for the opportunity to comment. We urge CMS to continue working with states to retain flexibility in designing Medicaid programs and financing structures to protect patient access. If you have any questions on our comments, please feel free to contact me at jennifer.nading@trinity-health.org.

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health