



September 21, 2026
Page 1 of 9

September 21, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via *regulations.gov*

RE: Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes

Dear Administrator Oz,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,500 family physicians and medical students across the country, we appreciate the opportunity to comment on the [proposed rule](#) discussing Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes in the Medicaid program, published in the July 23, 2026 issue of the *Federal Register*.

Medicaid is a vital payer for family physicians, particularly in rural and underserved communities where primary care capacity is often limited, and family physicians frequently serve as patients' primary source of comprehensive care.ⁱ In 2021, 76 percent family physicians were accepting new Medicaid patients, significantly more than many other specialties.ⁱⁱ And by 2023, just one-third of primary care physicians delivered 90 percent of all Medicaid office visits, underscoring the outsized role family medicine plays in sustaining access to care.ⁱⁱⁱ Thus, any policy that threatens Medicaid's stability directly jeopardizes the care family physicians provide to millions of patients nationwide. As the AAFP has previously noted in our [comments](#) in response to CMS' proposed rule regarding health care-related taxes in 2025, provider taxes and managed care organization (MCO) taxes are foundational components of Medicaid financing and are utilized by nearly every state to finance the non-federal share of Medicaid expenditures. These arrangements support provider reimbursement, supplemental payments, workforce investments, and coverage expansions that have enabled millions of Americans to access care.

The AAFP recognizes CMS' responsibility to implement Section 71115 of H.R. 1 and appreciates the agency's efforts to establish a framework for administering the statutory changes to Medicaid provider taxes. However, we are concerned that several provisions in the proposed rule exceed what Congress required, limit states' ability to sustain Medicaid

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aaafp.org
(800) 794-7481
(202) 232-9033

www.aaafp.org

September 21, 2026
Page 2 of 9

financing, and could ultimately undermine access to primary care for millions of Medicaid beneficiaries. Medicaid financing policies that result in reduced state revenue, provider payment cuts, or coverage losses directly affect the ability of family physicians to continue serving vulnerable patients.

As CMS finalizes this rule, we urge the agency to prioritize maintaining access to care, preserving provider participation, and adhering closely to the statutory direction provided by Congress. **Specifically, the AAFP recommends CMS:**

- Retain the longstanding 75/75 test and refrain from imposing financing restrictions beyond those required by section 71115 of H.R.1;
- Withdraw or substantially revise the proposed "services of health insurers" tax class and clarify that assessments used exclusively for non-Medicaid purposes are not subject to Medicaid provider-tax requirements;
- Ensure implementation timelines and enforcement policies reflect state operational realities and systems readiness; and
- Limit state reporting and compliance requirements to those necessary to administer section 71115.

Classes of Health Care Services and Providers Defined (§ 433.56)

CMS proposes to create a new permissible class of health care-related taxes for the "services of health insurers." The proposed class would include commercial insurers, Marketplace issuers, dental plans, vision plans, short-term limited-duration plans, and other health insurance products. CMS proposes applying the section 71115 threshold framework to this newly established provider tax class.

AAFP Comments

The AAFP appreciates CMS' interest in strengthening oversight of health care-related taxes. We note, however, that section 71115 of H.R. 1 modifies the indirect hold harmless thresholds applicable to permissible classes but does not establish "services of health insurers" as a new class. CMS separately proposes to create the class under section 1903(w)(7)(A)(ix) of the Social Security Act and then apply the section 71115 thresholds to it. This distinct policy proposal warrants careful consideration of its scope and potential effects.

We are particularly concerned that the proposed class may encompass state insurer assessments used for purposes unrelated to Medicaid financing, including State-Based

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aaafp.org
(800) 794-7481
(202) 232-9033

www.aaafp.org

September 21, 2026
Page 3 of 9

Marketplace administration, insurance regulation, premium assistance, and reinsurance programs. Several states have exercised comparable authority, including California, the District of Columbia, and Washington.^{iv,v} The proposed rule does not clearly indicate whether the class would apply only to assessments used to support the non-federal share of Medicaid expenditures or more broadly to assessments imposed on covered insurers regardless of how the revenue is used. **We are concerned that applying Medicaid provider tax requirements based principally on the identity of the assessed entity, without a clearly defined connection to Medicaid financing, could create uncertainty for state programs that support coverage affordability and market stability.**

States often use health insurer assessments and premium taxes to support non-Medicaid functions, including insurance regulation, Marketplace administration, premium assistance, reinsurance, and public health initiatives. Subjecting these assessments to Medicaid provider tax restrictions could require states to restructure existing financing arrangements, replace lost revenue, or redirect resources from other health priorities, even where the assessments do not implicate the Medicaid financing concerns addressed by section 71115. Such changes could weaken programs that promote coverage affordability and market stability, potentially disrupting continuity of care, increasing uncompensated care, and imposing additional administrative burdens on family physicians. The AAFP therefore urges CMS to evaluate these potential effects and ensure that any final policy preserves state financing arrangements that support affordable coverage and timely access to primary care.

We therefore encourage CMS to withdraw or substantially revise the proposed “services of health insurers” class. If CMS proceeds, the final rule should expressly exclude assessments used exclusively for non-Medicaid purposes, define the required connection to Medicaid financing, and provide clear implementation guidance and appropriate transition protections. A carefully tailored approach would advance CMS’ oversight objectives while avoiding unintended effects on state programs that support affordable coverage and access to care.

C. Permissible Health Care-Related Taxes (§ 433.68)

Under current regulations, a health care-related tax generally does not create an indirect hold harmless arrangement if aggregate tax collections for the permissible class do not exceed 6 percent of the class’s net patient revenue. If collections exceed that threshold, CMS applies the second prong of the indirect hold harmless test, commonly known as the 75/75 test, to determine whether an impermissible arrangement exists.

Section 71115 of H.R. 1 replaces the uniform 6 percent threshold with state- and class-specific thresholds for federal fiscal years beginning on or after October 1, 2026. For each

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aaafp.org
(800) 794-7481
(202) 232-9033

www.aaafp.org

September 21, 2026

Page 4 of 9

permissible class subject to a tax enacted and imposed as of July 4, 2025, CMS proposes to calculate the threshold by dividing aggregate tax collections for the class by the class's total net patient revenue during the state fiscal year that includes July 4, 2025. That percentage would become the maximum threshold for the class. If no tax was enacted and imposed on a permissible class by July 4, 2025, the threshold would be zero.

For Medicaid expansion states, section 71115 also phases down the applicable threshold beginning in FFY 2028. For most permissible classes, the statutory ceiling would decline by 0.5 percentage points annually, from 5.5 percent in FFY 2028 to 3.5 percent in FFY 2032 and subsequent years. Taxes on nursing facility services and intermediate care facility services for individuals with intellectual disabilities would remain subject to their July 4, 2025-based thresholds but would not undergo the phase-down.

Separately, CMS proposes to eliminate the 75/75 test for federal fiscal years beginning on or after October 1, 2026. Under that proposal, exceeding the applicable state- and class-specific threshold would itself establish an indirect hold harmless arrangement, with no alternative analysis of whether 75 percent of taxpayers receive 75 percent or more of their tax costs back through Medicaid or other state payments.

AAFP Comments

The AAFP recognizes that section 71115 of H.R.1 requires substantial changes to the indirect hold harmless threshold. We are concerned, however, that the combined effect of the new state-specific thresholds, the phase-down in expansion states, and CMS' discretionary elimination of the 75/75 test would further constrain state Medicaid financing and place provider payment and patient access at risk.

The indirect hold harmless threshold establishes the maximum level at which a provider tax may be used to support Medicaid financing without triggering federal concern that providers are being repaid for the taxes they remit. As such, the threshold directly affects the amount of state revenue available to finance Medicaid and draw federal matching funds. Since 2011, the uniform 6 percent threshold has provided states with a predictable financing framework and the flexibility to adjust provider tax structures as enrollment, health care costs, workforce needs, delivery systems, and state fiscal conditions evolve and fluctuate. However, the proposed rule would replace that framework with provider-class-specific thresholds tied to tax structures that existed on July 4, 2025. As a result, **states' future financing capacity will increasingly be determined by static, historical tax arrangements rather than the current and evolving health care needs of more than 20 million Americans across the 41 Medicaid expansion states.**^{vi} A tax structure that was sufficient in 2025 may not remain

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aaafp.org
(800) 794-7481
(202) 232-9033

www.aaafp.org

September 21, 2026
Page 5 of 9

sufficient as patient needs, provider shortages, service-delivery models, and state fiscal conditions evolve.

Further, while states may continue to enact new provider taxes under state law, assigning a zero-percent threshold eliminates the utility of new provider taxes as future Medicaid financing mechanisms. If finalized, this proposed rule would functionally freeze future Medicaid financing innovation by limiting states to provider tax structures that existed on a single date in 2025, regardless of how the health needs of Medicaid beneficiaries evolve. This restriction may become increasingly challenging as states seek to address emerging provider shortages, behavioral health needs, maternal health challenges, and new models of care delivery that may not fit neatly within provider tax classes existing today.

Health care-related taxes have been critical in expanding coverage and maintaining payment stability. Provider taxes are a critical funding source for Medicaid, accounting for 32 percent of state Medicaid funding in 2024 and generating \$37 billion annually for states' non-federal share.^{vii,viii} In some states, provider taxes contribute up to 17-30 percent of Medicaid financing.^{ix}

Beyond program financing, provider taxes help sustain payment adequacy for physicians. When states face financing shortfalls, reductions in payment or supplemental support can make it more difficult for practices to accept new Medicaid patients, retain staff, invest in care coordination, or maintain services in low-volume communities. These pressures are likely to be most acute in rural and underserved areas, where family physicians may be among the few available sources of comprehensive care.^x Given that Medicaid payments to family physicians already average just 72% of Medicare rates, and are even lower in some states, further reductions would threaten access to care.^{xi}

CMS' economic [analysis](#) projects that prohibiting new provider tax capacity would reduce state provider tax revenue by \$51 billion from 2026 through 2035 and that phasing down the applicable thresholds in expansion states would reduce such revenue by an additional \$147.7 billion, for a combined reduction of approximately \$198.7 billion over that period. Further, CMS acknowledges that the resulting spending reductions could affect provider payments, covered services, and enrollment. The proposed rule [states](#) that they "estimate that this proposed rule would have no effect on enrollment and that all reductions in spending would be made through reductions in provider payments and benefits provided." However, we are concerned that enrollment stability does not necessarily demonstrate stable access if lower payments reduce physician participation or benefit reductions limit covered services. Moreover, CBO has separately estimated that the statutory provider tax changes will increase the number of uninsured individuals by 1.2 million by 2034.^{xii} Although CBO's estimate

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aaafp.org
(800) 794-7481
(202) 232-9033

www.aaafp.org

September 21, 2026
Page 6 of 9

addresses the statute at large rather than this proposed rule in isolation, it reinforces the need for CMS to evaluate both coverage and access effects of this proposed rule.

As such, we encourage CMS to supplement the final rule with an economic and regulatory impact analysis addressing, at minimum, the effect of this proposed rule on physician participation and acceptance of new Medicaid patients; appointment availability and wait times; managed care network adequacy; continuity of care; primary care capacity in rural and medically underserved communities; access to maternal, pediatric, behavioral health, and chronic care services; and the cumulative effects of this rule and other Medicaid financing changes enacted in H.R. 1.

Further, we are concerned that the phase-down of thresholds in Medicaid expansion states will reduce permissible tax levels and associated federal matching funds that those revenues support. As provider taxes generate both state financing and federal financial participation, the loss of even a portion of provider tax revenue may produce disproportionately larger reductions in total Medicaid resources available to support patient care.

The final rule should therefore establish a transparent and administratively reviewable process for calculating, communicating, and correcting the thresholds prior to states facing reductions in federal financial participation. At a minimum, we encourage CMS to:

- Issue preliminary threshold determinations with sufficient time for meaningful state review before those determinations become final;
- Provide technical assistance and a reasonable opportunity for remediation before reducing federal financial participation; and
- Monitor changes in provider payment, physician participation, network adequacy, and beneficiary access throughout implementation.

These safeguards would maintain the statutory thresholds, while ensuring that states do not incur substantial, and potentially continuing, financing losses due to correctable data errors. Given the consequences for provider payment and beneficiary access, procedural accuracy will be essential for sound implementation of this proposed policy.

Finally, the AAFP strongly opposes the proposed elimination of the 75/75 test. Congress amended the indirect hold harmless threshold through section 71115 of H.R. 1 but did not direct CMS to repeal the longstanding second prong of the analysis. Eliminating that pathway would therefore impose an additional restriction on state Medicaid financing beyond the changes Congress enacted.

The 75/75 test serves an important and distinct program-integrity function. Rather than relying solely on a percentage threshold as a proxy, it permits CMS to conduct a fact-specific assessment that examines whether, in the aggregate, 75 percent of taxpayers receive 75

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aaafp.org
(800) 794-7481
(202) 232-9033

www.aaafp.org

September 21, 2026
Page 7 of 9

percent or more of their tax costs back through enhanced Medicaid payments or other state payments. This enables CMS to distinguish between arrangements that hold providers harmless, and those that exceed the applicable percentage threshold.

CMS contends that retaining the test could enable states to circumvent the new statutory limits. The proposed rule, however, does not identify an arrangement that has used the 75/75 test to evade section 71115, quantify the asserted Medicaid program integrity risk, or demonstrate why targeted reporting, documentation, or additional safeguards would be insufficient. **Absent such evidence, we believe the possibility of future circumvention does not provide an adequate basis for eliminating the longstanding, fact-specific compliance methodology of the 75/75 test, particularly when Congress amended the threshold calculation without directing CMS to eliminate the second prong.**

Repealing the 75/75 test would also fundamentally change the role of the threshold. Under the existing framework, exceeding the threshold triggers further analysis of whether an indirect hold harmless arrangement actually exists. Under the proposal, exceeding the new state- and class-specific threshold would itself establish noncompliance. The proposal would thus convert a proxy for potential hold harmless activity into a conclusive rule, regardless of whether providers are actually repaid for the taxes they remit. This change would narrow the range of provider tax arrangements permissible under federal law and further restrict state financing flexibility beyond the limits expressly enacted by Congress. The AAFP therefore strongly urges CMS to retain the 75/75 test in the final rule.

E. Reporting Requirements (§ 433.74)

CMS proposes ongoing quarterly reporting requirements related to provider tax collections, net patient revenue, threshold compliance, structural changes to provider tax arrangements, and additional documentation necessary to administer and enforce the revised threshold framework.

AAFP Comments

The AAFP supports appropriate federal oversight and transparency in Medicaid financing. We are concerned, however, that the proposed reporting and compliance framework may impose substantial operational demands beyond those necessary to implement section 71115. Requiring states to report actual provider tax collections and net patient revenue each quarter would require ongoing data collection, validation, and reconciliation across multiple provider classes, even where final data may not be available on a quarterly schedule.

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aaafp.org
(800) 794-7481
(202) 232-9033

www.aaafp.org

September 21, 2026
Page 8 of 9

The operational burden would extend well beyond submitting data to CMS. States may need to modify information systems, develop new data interfaces, establish internal controls and reconciliation procedures, train staff, update guidance, and coordinate among Medicaid agencies, revenue departments, local governments, providers, and contractors. These activities require specialized personnel, technical infrastructure, and contractor support that cannot be developed immediately or without cost.

These requirements also should not be considered in isolation. State Medicaid agencies are simultaneously implementing substantial eligibility, financing, payment, systems, and reporting changes under H.R. 1 and related federal actions. Community engagement requirements involve new verification processes, notices, appeals, outreach, and eligibility determinations. State-directed payment proposals would require clinician-level data, service-level benchmarks, detailed validation methodologies, and actuarially certified analyses. Section 1115 demonstrations are also subject to new budget-neutrality requirements. These concurrent requirements draw upon the same finite pool of state personnel, information systems, actuarial expertise, and financial oversight resources, and therefore risk diverting limited state resources away from critical eligibility operations, provider payment, beneficiary assistance, program integrity, and other core Medicaid functions.

Against this backdrop, CMS's [estimate](#) that provider tax reporting and data processing would require only 15 additional minutes per state each quarter does not appear to account fully for the upstream work necessary to obtain, standardize, and validate actual tax-collection and net-patient-revenue data across provider classes and governmental entities. This is particularly significant because the proposal replaces summary reporting with tax- and permissible-class-specific actual data, requires attribution to prior reporting periods when collections are delayed, and permits financial and payment-approval consequences for reporting deficiencies.

Accordingly, we encourage CMS to evaluate the cumulative operational burden on states of overlapping H.R.1 implementation requirements rather than assess the proposed reporting obligations in isolation. Further, we urge CMS to limit ongoing reporting to information directly necessary to administer section 71115, and provide sufficient implementation flexibility, technical assistance, and transition support to states.

Thank you for the opportunity to provide comments on this important matter. For additional questions, please contact Sahana Chakravarti, Regulatory and Policy Strategist, at schakravarti@aaafp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "J. B. Smith, M.D.", is written over a large, stylized loop.

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aaafp.org
(800) 794-7481
(202) 232-9033

www.aaafp.org

September 21, 2026
Page 9 of 9

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

-
- ⁱ Rosenblatt, R. A., & Hart, L. G. (2000). Physicians and rural America. *The Western journal of medicine*, 173(5), 348–351. <https://doi.org/10.1136/ewjm.173.5.348>
- ⁱⁱ Medicaid and CHIP Payment and Access Commission. (2021, June). *Physician acceptance of new Medicaid patients: Findings from the National Electronic Health Records Survey*. <https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf>
- ⁱⁱⁱ Edwards, B. C., Lashbrook, A., Zaw, K., Candon, M., Cannuscio, C. C., & Polsky, D. (2023). *Medicaid patients concentrated in office practices providing high-quality primary care*. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/medicaid-patients-office-practices-high-quality-primary-care>
- ^{iv} Cal. Gov't Code § 100503(n); D.C. Code § 31-3171.03; Wash. Rev. Code § 43.71.060.
- ^v Ryan J. Rosso, *State Innovation Waivers: Frequently Asked Questions*, Congressional Research Service Report R44760, updated May 5, 2026; Colo. Rev. Stat. §§ 10-16-1201 through 10-16-1208.
- ^{vi} Kaiser Family Foundation. (n.d.). *How many uninsured are in the coverage gap and how many could be eligible if all states adopted the Medicaid expansion?* <https://www.kff.org/medicaid/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/>
- ^{vii} Kaiser Family Foundation. (2024). *5 key facts about Medicaid and provider taxes*. <https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/>
- ^{viii} Medicaid and CHIP Payment and Access Commission. (2020, January). *Health care-related taxes in Medicaid*. <https://www.macpac.gov/publication/health-care-related-taxes-in-medicaid/>
- ^{ix} Medicaid and CHIP Payment and Access Commission. (2020, January). *Health care-related taxes in Medicaid*. <https://www.macpac.gov/publication/health-care-related-taxes-in-medicaid/>
- ^x Fogarty, C. T., Byun, H., & Huffstetler, A. N. (2025). Family Physician Workforce Trends: The Toll on Rural Communities. *Annals of family medicine*, 23(6), 535–538. <https://doi.org/10.1370/afm.240549>
- ^{xi} Medicaid and CHIP Payment and Access Commission. (2025, January). *Evaluating the effects of Medicaid payment changes on access to physician services*. <https://www.macpac.gov/publication/evaluating-the-effects-of-medicaid-payment-changes-on-access-to-physician-services/>
- ^{xii} Congressional Budget Office. (2025). Medicaid provisions in Public Law 119-21. https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid_0.pdf

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aaafp.org
(800) 794-7481
(202) 232-9033

www.aaafp.org