



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

September 21, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes, File Code: CMS-2452-P, RIN 0938-AV93, 91 Fed. Reg. 46562 (published July 23, 2026)

Dear Administrator Oz:

On behalf of the Massachusetts Medical Society (MMS), which represents more than 20,000 physicians, residents, and medical students, we appreciate this opportunity to comment on the above-referenced proposed rule. Specifically, we write to oppose numerous aspects of the proposed rule and urge the Centers for Medicare & Medicaid Services (CMS) to withdraw or substantially revise it before finalization. MMS also asks CMS to resolve a specific and consequential ambiguity in the rule, regarding the proposed indirect hold harmless framework, that would prohibit or restrict states from increasing state licensing fees that are unrelated to Medicaid financing, including fees associated with physician licensure.

Background

The proposed rule would implement section 71115 of Public Law 119-21, the “Working Families Tax Cut” (WFTC) legislation, by replacing the current uniform 6 percent “indirect hold harmless threshold” for state health care-related taxes under section 1903(w) of the Social Security Act with a new threshold calculated separately for each state and each permissible class of health care items and services, based on the tax structure the state had “enacted and imposed” as of July 4, 2025. For expansion states, including Massachusetts, the rule further imposes a mandatory phase-down of that threshold beginning in fiscal year 2028, declining from 5.5 percent to 3.5 percent by FY 2032. The rule also eliminates the existing “75/75” test that, since 1993, has allowed states to demonstrate that a tax exceeding the safe-harbor percentage is not, in practice, an impermissible hold-harmless arrangement; adds a new permissible class covering services of health insurers; and, imposes substantial new one-time and ongoing quarterly reporting requirements. By CMS’ own estimate, 49 states and the District of Columbia currently rely on provider taxes to help finance the state share of Medicaid expenditures, together generating an estimated \$98.6 billion in calendar year 2026, which is approximately 26 percent of projected state Medicaid spending nationwide. This reliance on critical funds for state Medicaid programs underlines the magnitude of the impact that any potential changes to rules governing provider taxes may have on these safety net programs that provide care for our most vulnerable patients. The MMS submits the following detailed comments outlining our concerns with the new rule and its timeline and seeking clarification to outstanding questions pertaining to potential interpretations of the language.

Concerns with the Proposed Rule

1. The rule would substantially and needlessly reduce Medicaid financing capacity at a time when access to care is already strained.

CMS' own regulatory impact analysis projects that this rule would reduce state provider tax revenue by approximately \$198.7 billion over the ten-year period from 2026 through 2035, a 27 percent reduction relative to current law, and would reduce total Medicaid spending by \$384.0 billion over that same period (\$245.8 billion in federal spending and \$138.2 billion in state spending). These provider tax changes are not simply modest, technical adjustments; they represent one of the largest reductions in the history of state Medicaid financing capacity.

Physicians and hospitals throughout Massachusetts already operate in an environment of thin or negative operating margins and workforce shortages. Reductions in Medicaid financing of this magnitude translate directly into reduced provider payment rates, restricted service lines, and, ultimately, reduced access to care for MassHealth beneficiaries, including children, pregnant patients, individuals with disabilities, and older adults who rely on Medicaid for long-term services and support. MMS urges CMS to more fully assess and disclose, in any final rule, the anticipated clinical and access consequences of financing reductions of this scale, not merely their fiscal effects on federal and state budgets.

2. Massachusetts and other Medicaid expansion states face a disproportionate, compounding impact.

Because Massachusetts is an expansion state, it is subject not only to the new class- and state-specific threshold but also to the mandatory phase-down beginning in FY2028. Expansion states are therefore required to reduce, on a fixed statutory schedule, revenue collections without regard to a state's actual fiscal circumstances, the health needs of its Medicaid population, or the availability of alternative non-federal financing sources. This phase-down applies in addition to, not instead of, the tax-structure freeze, compounding the reduction in available financing specifically for states that expanded Medicaid coverage under the Affordable Care Act. This rule, as proposed, effectively penalizes states such as Massachusetts for coverage decisions that Congress and CMS have otherwise encouraged.

3. Freezing tax structures as of July 4, 2025 removes essential state flexibility and penalizes states with lower current tax rates.

The proposed rule would generally cap each state's permissible tax rate, for each class of health care items and services, at the rate "enacted and imposed" as of July 4, 2025 with a threshold of zero percent for any permissible class not taxed as of that date, meaning no new taxes are permitted. In Massachusetts, that means a number of new classes of licensees that were established after July 5, 2025 cannot now be implemented. States that have historically maintained lower-than-maximum provider tax rates, held rate increases in reserve for future budget needs, or had not yet imposed a tax on a newly recognized permissible class (such as the proposed new class for health insurer services) would be permanently disadvantaged relative to states that had already reached higher rates by that date. This approach affords no mechanism for a state to respond to changed circumstances – whether that be a public health emergency, a demographic shift, an unanticipated increase in the cost of care – by adjusting its health care-related tax structure without risking a reduction in federal financial participation, which would be devastating for the financial stability and sustainability of the program. MMS urges CMS to retain a mechanism, subject to appropriate safeguards against genuine hold-harmless arrangements, for states to adjust health care-related tax rates prospectively to meet emerging Medicaid financing needs.

4. Eliminating the 75/75 test impermissibly exceeds the language of the WFTC legislation.

The WFTC legislation includes modifications to the hold harmless threshold, but notably, the legislation made no changes to the 75/75 test. In the Proposed Rule however, CMS proposes to eliminate the 75/75 test altogether.

The 75/75 test serves an important function when tax revenues are used for purposes unrelated to Medicaid financing. A tax may exceed the applicable hold harmless threshold even though the state does not use the resulting revenue to make Medicaid or other state payments that return the cost of the tax to taxpayers. By examining whether taxpayers receive their tax costs back, the 75/75 test helps distinguish arrangements that effectively hold taxpayers harmless from taxes used to generate revenue for other legitimate state purposes. Eliminating the test could therefore subject taxes that do not finance Medicaid and do not involve a hold harmless arrangement to Medicaid's restrictions on health care-related taxes, unnecessarily limiting states' ability to fund other obligations and initiatives.

The MMS believes that eliminating the 75/75 test is inconsistent with the statutory framework Congress chose to enact and would be premature at this time. The 75/75 test is codified in the Medicaid statute, which provides (even after the amendments made by the WFTC legislation) that the existence of a hold harmless guarantee shall be determined pursuant to regulations "as in effect on November 1, 2006," which included the 75/75 test.¹ Although use of the 75/75 test has been limited to date, that could change following the implementation of the WFTC legislation's modifications to the hold harmless threshold, which previously functioned as the primary safe harbor for states to demonstrate that a hold harmless guarantee did not exist.

The fact that Congress chose not to adjust the 75/75 test when it modified the hold harmless threshold suggests that Congress is satisfied with the 75/75 test as a mechanism for showing compliance with Medicaid's prohibition on hold harmless guarantees and is comfortable with the possibility that more states might rely on this secondary test as the hold harmless threshold is lowered. As CMS has stated previously, the 75/75 test strikes a balance between ensuring that taxpayers are not held harmless in violation of the Medicaid statute and allowing states needed flexibility to set their own tax policies.²

Further, CMS' stated concern that states may use the 75/75 test to circumvent the new thresholds is speculative. As the Proposed Rule acknowledges, the test has been used only rarely, and CMS does not identify an existing state tax arrangement that abuses it. Eliminating longstanding flexibility based on the possibility of future circumvention is particularly unwarranted before CMS has observed how states respond to the new statutory limits. If evidence of abusive arrangements emerges, Congress can amend the statute accordingly or CMS may address those arrangements through targeted oversight or rulemaking.

Once the WFTC legislation's changes to the hold harmless threshold have been implemented, CMS can assess states' responses and determine whether further revisions are in order. However, considering the codification of the 75/75 test in statute, the substantial changes to the rules governing health care-related taxes enacted by the WFTC legislation, and absent any evidence that the 75/75 test has enabled states to circumvent the prohibition on hold harmless guarantees, the MMS urges CMS to retain the test. We believe it remains an important safeguard that preserves states' ability to generate revenue for Medicaid and other state priorities without permitting arrangements that actually hold taxpayers harmless.

5. The compressed implementation timeline and reliance on an unfinalized "interim" threshold create serious operational and budgetary risk for states.

The proposed rule would require states to begin complying with new indirect hold harmless thresholds effective October 1, 2026, before CMS will have calculated, or even announced, the final threshold

¹ See section 1903(w)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1396b(w)(4)(C)(ii)).

² Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 57 Fed. Reg. 55118, 55129 (November 24, 1992).

applicable to each state and permissible class. In the interim, states would be expected to self-monitor compliance using thresholds CMS itself describes as non-binding based on data states must first assemble and report by December 31, 2026. This sequencing asks states and, as a result, also the providers and patients who depend on state Medicaid programs, to operate for up to two years under substantial financial uncertainty, with the risk of retroactive reductions in federal financial participation once final thresholds are set. MMS urges CMS to ensure that no state incurs a reduction in federal financial participation for any period during which a final, CMS-confirmed threshold was not yet available and to provide a reasonable transition period once final thresholds are announced.

6. Classifying all taxes and fees as health care-related taxes goes beyond the WFTC legislation, would create significant new budgetary and operational burdens for states, and does not address the fiscal integrity of the Medicaid program

In addition to MMS' overarching opposition to this rule, MMS urges CMS not to classify all taxes and fees on health care services, including health insurance services, as health care-related taxes. Such classification goes well beyond the WFTC legislation and would create significant additional burdens for states while failing to address the fiscal integrity of the Medicaid program.

Existing regulations at 42 CFR 433.55(a)(3) define 'health care-related tax' to include, among other things, a "licensing fee ... that is related to ... the payment for health care items or services[.]" The proposed rule does not amend this definition, but it would freeze the permissible rate for every "health care-related tax" at the structure each state had enacted and imposed as of July 4, 2025, with a threshold of zero for any category not so taxed.

MMS is concerned that the impact of the rule as applied to the current definitional framework will have profound unintended consequences on patient safety. A plain reading of the rule, utilizing existing definitions of what constitutes a provider tax, could prohibit changes to ordinary state professional and facility licensing fees that have no connection to Medicaid financing. For example, the fees Massachusetts and other states charge physicians for initial licensure and license renewal through their boards of registration in medicine, or fees charged for hospital, clinic, or other health facility licensure. These fees typically fund licensing board operations, credentialing, investigations, and discipline, and bear no relationship to a state's non-federal share of Medicaid expenditures, rather they ensure accountability of clinicians and health care entities, protecting and promoting high-quality care and patient safety. Such an interpretation and implementation of this rule is not aligned with the spirit and intent of Section 71115 of H.R. 1, which was designed to promote the fiscal integrity of the Medicaid program.

In August of 2025, Massachusetts established a Medical Peer Support Trust Fund, funded by a licensing fee surcharge, to provide financial support for a physician health program authorized by the Board of Registration in Medicine as a diversionary program.³ Such physician health programs are an indispensable public good, providing free confidential consultation and support to approximately 36,000 physicians and medical students in the Commonwealth and addressing a spectrum of concerns, from burnout and mental health to professionalism issues and substance use disorders. Physician health programs offer education, prevention, assessment, referral to treatment, and, by virtue of being authorized as a diversionary program for BORIM, monitoring services, which ensure that physicians who are proactively engaged in treatment and monitoring are able to remain in the workforce. Physician health programs do not have any relation to the Medicaid program and are not used to finance the nonfederal share of Medicaid expenditures.

³ Section 6, Chapter 14 of the Acts of 2025.

Yet, because ‘licensing fee’ appears on the face of the existing statutory and regulatory definition of “health care-related tax,” and because the proposed rule does not expressly exclude such fees from the new hold-harmless threshold, states, medical boards, and licensees currently have no assurance that an increase in a routine licensing fee—or the establishment of a surcharge as described above—would not be treated as an impermissible increase in a health care-related tax, potentially subjecting the state to a reduction in federal Medicaid financial participation.

MMS therefore respectfully requests that CMS confirm explicitly, in any final rule or accompanying guidance, that the term ‘licensing fee’ as used in the definition of ‘health care-related tax’ under 42 CFR 433.55(a)(3), and as applied through the frozen indirect hold harmless threshold proposed at 42 CFR 433.68(f)(3)(ii), is **not** intended to reach general state professional and facility licensing fees that are not designed or used to finance the non-federal share of Medicaid expenditures.

Absent such clarification, MMS is concerned that this rule could have the unintended effect of constraining states’ longstanding authority to set professional and facility licensing fees, authority that is unrelated to and has never before been treated as part of the Medicaid provider tax policy.

Conclusion

For the foregoing reasons, MMS urges CMS to withdraw this proposed rule. At a minimum, CMS should substantially revise the rule to: (1) preserve a mechanism for states to adjust health care-related tax rates prospectively to meet emerging Medicaid financing needs; (2) retain the 75/75 test, or another comparable safeguard, as an alternative means of demonstrating compliance; (3) ensure that no state’s federal financial participation is retroactively reduced based on an interim threshold that is later superseded by a different final threshold; and, (4) expressly clarify, consistent with the request set out above, that ordinary state professional and facility licensing fees unrelated to Medicaid financing fall outside the scope of the indirect hold harmless threshold.

MMS appreciates the opportunity to comment on this proposed rule and welcomes the opportunity to provide additional information or to discuss these comments further. If you have any questions, please reach out to Casey Rojas, MMS Federal Relations Director, at CRojas@MMS.org or (781) 434-7082.

Sincerely,

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President, Massachusetts Medical Society