



September 21, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

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

The Children's Hospital Association (CHA) is the nation's leading advocate for children's health, uniting children's hospitals to improve care and amplify impact. On behalf of the more than 200 children's hospitals and the millions of children and families we serve, we appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS's) proposed rule regarding Medicaid provider taxes. Medicaid is vital to ensuring that every child, regardless of income—whether covered by Medicaid or not—, has access to timely, comprehensive health care. **We urge CMS to consider our concerns regarding the proposed changes to Medicaid provider tax policies and to preserve the state financing flexibility necessary to ensure that children nationwide continue to have access to high-quality, specialized pediatric care.**

Medicaid and the Children's Health Insurance Program (CHIP) provide essential health care coverage to approximately 35 million children in the United States.¹ This includes coverage for 42% of all U.S. children with special health care needs² and approximately 37% of children with cancer³. In 2023, 40.6% of children in small towns and rural areas were enrolled in Medicaid and CHIP.⁴ Medicaid is also an essential source of coverage for nearly 3 million Medicaid-eligible children in military-connected families.⁵

Children's hospitals are dedicated to the health and well-being of our nation's children. Children's hospitals include both freestanding children's hospitals, which operate as independent pediatric institutions, and children's hospitals embedded within larger health systems, which also provide specialized pediatric services and expertise while operating within integrated hospital networks. They play a vital role in their communities by providing specialized clinical care for infants, children, and adolescents, including treatment for complex and rare conditions. Children's hospitals act as major referral centers at the state and regional levels,

¹ "February 2026: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot," U.S. Centers for Medicare and Medicaid Services, May 2026.

² "5 Key Facts About Children with Special Health Care Needs and Medicaid," KFF, April 2025.

³ Ji, Xu, et al., "Narrowing Insurance Disparities Among Children and Adolescents With Cancer Following the Affordable Care Act," JNCI Cancer Spectrum: Vol. 6, No. 1, 2022.

⁴ "Medicaid's Role in Small Towns and Rural Areas," Georgetown University McCourt School of Public Policy Center for Children and Families, January 2025.

⁵ "Medicaid: A Vital Resource for Nearly 3 Million Military-Connected Children," FTI Consulting, 2023.



supporting smaller providers and ensuring access to high-level care across broad geographic areas. They are also hubs for training the next generation of pediatric clinicians and advancing research that drives innovation in child health. Children's hospitals are often the only source of specialized care for children and without them and the Medicaid support they rely on, there would be no other options for children to receive needed care.

Beyond clinical care, children's hospitals also lead community health programs that focus on prevention, early intervention, and identifying and addressing community conditions that contribute to otherwise preventable childhood illnesses and increased health care costs, often partnering with schools, local organizations, and public health agencies. These hospitals provide critical mental and behavioral health services and outreach to underserved and vulnerable populations, helping ensure that children have the opportunity to grow, learn, and thrive. By supporting children's health and well-being from an early age, children's hospitals help lay the foundation for healthier adults who can fully participate in their communities and contribute to the nation's future workforce. Through these efforts, children's hospitals play many roles in their communities, strengthening health systems, improving outcomes, and promoting healthier lives for children and families.

Provider taxes play a vital role in preserving children's access to care by supporting Medicaid funding, which is the largest source of coverage for many children and the primary payer for children's hospitals. By helping offset the gap between Medicaid payments and the actual cost of care, provider taxes enable children's hospitals to maintain essential pediatric services, invest in specialized care for medically complex children, and ensure that all children can access high-quality care. We offer the comments below to help inform implementation of the proposed provider tax policies in a manner that minimizes adverse impacts on children and the hospitals that serve them.

In our comments, we:

- Appreciate CMS's proposed revisions to the definitions of "enacted" and "imposed," which more closely align with the intent of H.R. 1. We also ask CMS to reconsider the definition of "imposed" to incorporate a reasonable expectation standard.
- Urge CMS to withdraw its proposal to implement a retrospective approach for determining provider tax thresholds and monitoring compliance.
- Ask CMS to adopt a state fiscal year-based implementation approach for the indirect hold harmless provisions.
- Recommend CMS withdraw its proposal requiring states to report quarterly on changes to a provider tax that affect whether public providers are subject to the tax.
- Urge CMS to evaluate the cumulative impact of state directed payment policies and provider tax restrictions on children and children's hospitals.

Importance of Provider Taxes for Children's Hospitals

As major Medicaid providers, children's hospitals rely on provider taxes to help ensure access to care for children nationwide. Although children's hospitals represent less than 5% of the nation's



hospitals, they account for nearly half of all hospital days for Medicaid-enrolled children,⁶ yet Medicaid reimbursement, including base and supplemental payments, covers less than 80% of the cost of care on average.⁷ Provider taxes help mitigate this chronic underpayment by supporting Medicaid financing and helping preserve funding that children's hospitals depend on to care for low-income and medically complex children.

Provider taxes are a critical financing tool that helps support the stability and sustainability of the Medicaid program and the hospitals that care for millions of children. Because Medicaid is the largest payer for children's hospitals, provider tax-supported funding helps offset the costs of treating children with complex medical needs and sustaining essential pediatric services, including neonatal intensive care, specialty care, and behavioral health. Maintaining provider taxes is vital to preserving children's access to high-quality care and ensuring children's hospitals can continue serving all children in their communities, regardless of insurance coverage.

Proposed Changes to Provider Taxes

Definitions of "Enacted" and "Imposed" for Grandfathered Provider Taxes

We appreciate CMS' proposal to align the definitions of "enacted" and "imposed" for grandfathered provider taxes more closely with the intent of H.R. 1. As CMS notes, its November 2025 preliminary provider tax guidance, if finalized, would have invalidated a significant number of provider taxes enacted in the months leading up to H.R. 1's passage. We therefore appreciate CMS's acknowledgment that the proposed enacted and imposed criteria are intended to grandfather a greater number of taxes under H.R. 1. By preserving existing provider tax arrangements and providing states with greater certainty regarding compliance, the proposal will help maintain stable Medicaid financing and avoid disruptions that could undermine children's access to care.

However, we recommend that CMS consider revising its interpretation of when a grandfathered provider tax is considered "imposed." As proposed, the definition requires that a tax be in effect with a legally enforceable obligation for providers as of July 4, 2025, which may not fully capture circumstances in which states had already taken definitive steps to establish a tax and providers reasonably understood that they would be obligated to pay it. One approach CMS should consider is to define "imposed" to include circumstances in which taxpayers were subject or reasonably expected to be subject to a legal obligation to pay the tax as of July 4, 2025, whether based on official state actions (including regulatory notices, rulemaking, governing board decisions, or other formal governmental actions), as well as state representations and communications regarding the tax's implementation and applicability. Such an approach would recognize that the establishment of provider taxes often occurs through a series of statutory, regulatory, and administrative actions that may create binding expectations before the first assessment is issued or payment is due. Incorporating a reasonable

⁶ Children's Hospital Association's Analysis of Kids' Inpatient Database (KID), Healthcare Cost and Utilization (HCUP), Agency for Healthcare Research and Quality, 2019.

⁷ Annual Benchmark Report Fiscal Year 2023, Freestanding and Children's Hospital in Hospital Cohort, Children's Hospital Association. 2025.



expectations standard could help ensure that grandfathering protections are applied consistently across states that had taken comparable substantive steps to establish provider taxes, even where the timing of final administrative actions differed.

CMS should also consider that states move through regulatory, approval, and implementation processes on different timelines for administrative reasons that are often unrelated to policy choices. As a result, some states may have completed the key substantive steps needed to establish a provider tax before July 4, 2025, but had not yet finalized administrative processing, publication requirements, or effective dates. To account for these differences, CMS should give appropriate weight to a state's interpretation of its own laws, regulations, and taxing authority when determining whether a legal obligation to pay the tax existed. A reasonable expectations standard, grounded in official state actions, representations, and communications, would provide an objective framework for recognizing situations in which providers reasonably understood that they would be required to pay the tax, while also promoting consistent treatment of similarly situated states for grandfathering purposes.

More broadly, we encourage CMS to apply the grandfathering provisions in a manner that reflects the practical realities of state implementation and avoids distinctions based solely on administrative timing. A reasonable expectations standard would promote consistent treatment of similarly situated states, preserve stable Medicaid financing arrangements, and minimize the risk of funding disruptions. Maintaining these financing arrangements is particularly important for children's hospitals to ensure continued access to high-quality care for all children.

Measurement Period for New Threshold

H.R. 1 prohibits Medicaid expansion states from imposing provider taxes that exceed the lower of (1) the state's historical tax rate or (2) a statutory net patient revenue-based threshold that declines over time. Because the legislation does not identify a specific period for determining historical tax rates, CMS proposes using the SFY that includes July 4, 2025, as the baseline for establishing each state's indirect hold harmless threshold. CMS also seeks feedback about whether an alternative annual period would be more appropriate.

Because the legislation does not specify a measurement period, CMS should provide states with additional flexibility to define one. Limiting the calculation to the SFY containing July 4, 2025, could understate a state's lawfully effective tax rate in cases where, as of that date, the state had enacted a higher tax rate and imposed the legal obligation on providers to pay the tax, but the tax was not effective until a later time period. In this case, the tax meets CMS's proposed definitions of "enacted and imposed". However, the proposed reference period for the effective tax rate calculation precedes the rate's effective date and would not capture the state's already-authorized increase. To address situations like these, we request CMS permit states to calculate their new hold harmless threshold using the 12-month period that includes the highest tax rate that was "enacted" and "imposed" of July 4, 2025, with "imposed" defined to include the reasonable expectations standard described above.

Retrospective Approach to Establish H.R. 1 Thresholds and Monitor Compliance

We urge CMS to preserve the current method of projecting tax collections and net patient revenue forward from an earlier period to demonstrate compliance with the indirect hold harmless threshold. Unlike the current prospective methodology, the proposed retrospective approach would create significant uncertainty for states by making it difficult to determine whether provider taxes will ultimately comply with the new thresholds. The existing prospective framework provides states with the flexibility to use reasonable projections of tax amounts and net patient revenues to demonstrate compliance in advance, giving them clarity and confidence when developing Medicaid financing strategies and administering their programs.

This prospective approach has long provided states and providers with certainty regarding the amount of provider tax revenue that may be collected and used as the non-federal share of Medicaid financing. That predictability is essential to ensuring states can effectively fund and administer Medicaid programs and that providers do not face recoupment of payments appropriately earned for services delivered simply because aggregate net patient revenues were lower than anticipated. By contrast, the proposed retrospective methodology could result in provider tax recoupments if net patient revenues decline after payments have already been made, even when providers have fully complied with program requirements. Moreover, it would be impossible for individual providers to effectively plan for potential recoupments tied to changes in net patient revenues across an entire state, factors that are largely outside their control.

For children's hospitals, this uncertainty is particularly concerning given Medicaid's role as the largest payer for pediatric care and the longstanding gap between Medicaid reimbursement and the cost of providing care. Requiring children's hospitals to return payments they appropriately earned for services delivered, potentially up to two years after those services were provided, would create significant financial challenges and likely force hospitals to implement cost-saving measures. Such actions could have immediate and harmful consequences for patient access, reducing hospitals' ability to sustain the full range of services they currently provide. Preserving the current prospective compliance framework is therefore critical to supporting the financial stability of children's hospitals and ensuring children continue to have access to timely, high-quality care in their communities.

Interpretation of "Fiscal Year"

We respectfully urge CMS to adopt a state fiscal year (SFY)-based implementation approach for the indirect hold harmless provisions. H.R. 1 specifies only that the new threshold will apply for fiscal years beginning on or after Oct. 1, 2026, and Congress provided CMS with discretion to interpret "fiscal year" to mean either federal or state fiscal year. While CMS proposes to interpret the term as referring to the federal fiscal year (FFY), the agency acknowledges that, in other contexts, it has interpreted general statutory references to "fiscal year" to mean a state fiscal year or state plan rate year. Although we understand CMS' interest in establishing a uniform national implementation date, aligning implementation with the federal fiscal year would create significant operational and compliance challenges for states that administer provider taxes.



For children's hospitals, these implementation challenges are not merely administrative. States rely heavily on provider tax programs and managed care financing mechanisms to support Medicaid payments to pediatric providers, who care for a disproportionate share of Medicaid-covered children. Requiring states to modify provider tax structures on a timeline that is misaligned with state budget cycles, managed care rating periods, and Medicaid state plan administration could create unnecessary disruption and uncertainty in the funding streams that support children's hospitals. Aligning implementation with SFYs would reduce administrative burden, facilitate compliance, and promote a more orderly transition to the new requirements. This consideration is particularly important in Medicaid expansion states, where the indirect hold harmless threshold will be subject to a multi-year phase down and where states will already face substantial challenges in maintaining stable financing for providers that serve vulnerable pediatric populations. By adopting a SFY-based implementation approach, CMS can help preserve continuity in Medicaid financing and reduce the risk of unintended consequences for children's hospitals and the children they serve.

Provider Taxes that Include Public Providers

We recommend that CMS withdraw its proposal requiring states to identify when public providers are removed from a provider tax and replaced with intergovernmental transfers (IGTs), provided those providers were included in the tax when the state's H.R. 1 threshold was established. The proposal would create additional oversight that is not grounded in any statutory requirement and would impose unnecessary administrative burden on states without contributing to the determination of whether a health care-related tax complies with federal requirements. Federal law has long distinguished public providers from non-public providers for purposes of health care-related taxes and expressly permits states to exempt public providers from such taxes. Likewise, federal Medicaid law has consistently recognized IGTs as a permissible source of the non-federal share of Medicaid expenditures and has preserved states' ability to rely on local governmental entities, including public providers, in financing the Medicaid program.

Children's hospitals, whether public or private, depend on stable and sustainable Medicaid financing mechanisms to support the specialized services they provide to all children, not only those covered by Medicaid. In many states, provider taxes and IGTs work together as complementary financing tools that allow states to maintain critical Medicaid payment programs. H.R. 1's provider tax changes did not alter states' authority to exempt public providers from provider taxes or to utilize IGTs as a source of the non-federal share. Accordingly, CMS should avoid imposing conditions or scrutiny that are not necessary to evaluate the permissibility of a provider tax and that create additional administrative complexity without corresponding program integrity benefits.

CMS Should Consider the Cumulative Impact of State Directed Payment Policies and Provider Tax Restrictions on Children's Hospitals

In our recent response to the state directed payment (SDP) proposed rule, we stated our appreciation for CMS's recognition that Inpatient Prospective Payment System (IPPS)-exempt children's hospitals require a distinct methodology for purposes of implementing H.R. 1's SDP limits. Because children's hospitals are excluded from the Medicare IPPS and serve uniquely



complex pediatric populations, a cost-based methodology is more appropriate than an adult-focused Medicare benchmark and helps ensure they are not disadvantaged when states establish Medicaid SDP payment limits. **In our comments, we requested that CMS (1) establish a dedicated workgroup to develop and evaluate payment methodologies for IPPS-exempt institutions and include CHA and affected hospitals, and (2) undertake a separate rulemaking focused specifically on IPPS-exempt and other providers, including children's hospitals. To ensure that the impact on children is mitigated more broadly for children served outside of IPPS-exempt hospitals, we also asked CMS to work with children's hospitals and pediatric experts to develop a pediatric adjustor that reflects the higher cost and unique care provided in IPPS children's hospitals.**

CMS should carefully consider the interaction between the recently proposed SDP framework and this rule's proposed provider tax regulations. While the SDP proposal addresses the amount states may pay children's hospitals, the provider tax proposal directly affects states' ability to finance those payments. As CMS has recognized, provider taxes are a principal source of non-federal financing for Medicaid supplemental payment arrangements, including many SDP programs. Proposed restrictions on provider taxes are expected to reduce states' financing capacity over time, particularly in Medicaid expansion states.

As a result, preserving an appropriate payment benchmark for children's hospitals is necessary but may not be sufficient to maintain access to pediatric care. Even if a cost-based methodology establishes a higher and more accurate payment ceiling for children's hospitals, states may be unable to fully finance payments up to that ceiling if provider tax resources decline. In practice, the combined effect of the two policies could result in children's hospitals facing reductions in actual Medicaid reimbursement despite the availability of a more appropriate cost-based payment standard.

Children's hospitals are particularly vulnerable to this outcome. They care for a disproportionately high share of Medicaid beneficiaries, provide regional and highly specialized pediatric services unavailable elsewhere, and frequently operate with limited opportunities to offset Medicaid payment reductions through Medicare revenue given the pediatric populations they serve. Accordingly, any reduction in states' ability to finance supplemental Medicaid payments may have an outsized impact on children's hospitals and the patients who rely on them.

We therefore urge CMS to evaluate the cumulative impact of these SDP and provider tax proposals on children's hospitals and publish a pediatric-specific impact analysis of both proposals prior to finalizing either. While we strongly support the adoption of an appropriate cost-based methodology for IPPS-exempt children's hospitals as an important safeguard against inappropriately low payment limits, CMS should ensure that implementation of provider tax restrictions does not undermine the broader policy objective of maintaining adequate Medicaid payment levels for essential pediatric providers. These policies are inextricably linked: the SDP proposal establishes the payment benchmark that reflects children's hospitals' costs of care, while the provider tax proposal constrains the financing mechanisms states rely upon to support those payments. A sustainable Medicaid financing framework for pediatric providers requires both an appropriate payment methodology and sufficient state financing flexibility to make meaningful payments up to that benchmark. If states are unable to finance payments that



reflect children's hospitals' costs of care, the practical benefits of the proposed cost-based methodology will be substantially diminished. Failure to account for the combined effect of these proposals could ultimately jeopardize access to specialized pediatric services for Medicaid-covered children nationwide.

We appreciate the opportunity to comment on the proposed rule. Please contact Milena Berhane at milena.berhane@childrenshospitals.org or (202) 753-5521 with any questions or for more information.

Sincerely,

Aimee Ossman
Vice President, Policy