



600 13TH ST., NW, SUITE 500
WASHINGTON, DC 20005
p | 202-753-5500
f | 202-347-5147

16011 COLLEGE BLVD., SUITE 250
LENEXA, KS 66219
p | 913-262-1436
f | 913-262-1575

WWW.CHILDRENSHOSPITALS.ORG

July 14, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2448-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2448-P. Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule

On behalf of over 200 children's hospitals across the country, the Children's Hospital Association (CHA) appreciates the opportunity to provide comments on the proposed rule that aims to alter existing provider tax regulations. Provider taxes are important mechanisms used by many states to fund their Medicaid programs and support providers that treat a large volume of Medicaid patients, including children's hospitals. We urge the Centers for Medicare and Medicaid Services (CMS) to reconsider the proposed changes within the rule so that states are able to comply with the new provider tax requirements and mitigate impact on access to care for children.

Medicaid and CHIP provide essential health care coverage to 37 million children, including coverage for almost half of all U.S. children with special health care needs and three million children in military-connected families. In 2023, 40.6% of children in small towns and rural areas were enrolled in Medicaid and CHIP. Medicaid provides children access to a comprehensive set of services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This benefit ensures Medicaid covers the preventive services all kids need, which include immunizations, well-child checkups, vision, and dental services. Medicaid is also the nation's largest payer for behavioral health services. Millions of children rely on Medicaid to access a variety of health care services they need to help them grow into healthy and productive adults.

Medicaid, on average, provides health insurance coverage for over 50% of children's hospitals' patients and for some children's hospitals' patient mix, closer to 80%. Though children's hospitals account for only 5% of hospitals in the United States, they account for about 45% of all hospital days for children on Medicaid. Children's hospitals are regional centers for children's health, providing care across large geographic areas and serving children covered by Medicaid across state lines. In addition, children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services.

The care delivered by pediatric providers, including children's hospitals, needs to be valued. This means that these providers should receive adequate payment for the services they provide to ensure children can access all their health care needs. Medicaid rates are generally well below Medicare rates, which are below commercial insurance rates. Low Medicaid base rates are coupled with additional payments to address this underpayment, including funding from provider taxes, and are critical in allowing children's hospitals to continue providing care to millions of children across the country. Medicaid payments generated by provider taxes made to children's hospitals help ensure that they can continue to provide the life-saving care that children need to stay healthy.

Champions for Children's Health

Provider taxes, including Managed Care Organization (MCO) taxes, have been implemented by states to increase low reimbursement rates for certain services covered by Medicaid. The funds raised by these taxes are put back into the state's Medicaid program with the goal of increasing access to care and paying providers adequately for the care they provide. In one state, a MCO tax was recently enacted to help offset the low Medicaid reimbursement rate for outpatient mental health services. The funds from this tax will allow the state to pay mental health providers for the care they are providing, which will have additional positive impacts on how these providers maintain an adequate mental health workforce and reduce waitlists for patient care. Children's hospitals, who have spent the past few years facing an inpatient boarding crisis due to the ongoing youth mental health crisis, are a recipient of these funds in this state. These payments will help these children's hospitals, who care for many children covered by Medicaid in need of these mental health services, to continue providing this lifesaving care. It is critical that states can continue implementing provider taxes, not only to raise their share of funds for the program, but also to continue expanding access to care for the millions of children covered by Medicaid.

Whether or not proposed changes target certain provider taxes, any changes to provider tax regulations that aim to restrict how states generate their share of Medicaid funding will have a downstream impact on children. Reducing states' Medicaid funding by any means will negatively impact children's access to care across the country, as well as force pediatric providers to reduce the services they provide to all children, regardless of insurance status. We do not support any restrictions on how states implement provider taxes to support their Medicaid programs, or any changes to Medicaid that will negatively impact access to care for children. The proposed changes to provider taxes, combined with the other payment reductions to the Medicaid program passed in the recent reconciliation legislation, will cause significant strain on state Medicaid programs and result in reduced access to care for children. We acknowledge that the proposed rule is closely aligned with the provider tax uniformity provision in the reconciliation bill and therefore our comments below outline areas where CMS could build upon the statute or exercise discretion given to it under the statute.

In our comments, we outline considerations for CMS regarding the proposed changes within the rule. If the proposed changes move forward, we strongly encourage CMS to:

- allow more time for states to comply with the proposed requirements to mitigate the impact on children's access to care, and
- clarify the requirements for provider taxes to be considered generally redistributive.

Our detailed comments are outlined below.

Extending Deadlines for States to be Compliant with New Requirements

We urge CMS to provide all states with the full three-year transition period included in the reconciliation bill to comply with the proposed changes, regardless of when a state's provider tax arrangement was approved. CMS proposes to provide some states with transition periods while not providing one to states who have received approvals within the past two years. The proposed rule indicates that CMS will only provide at least one full state fiscal year for newly approved state's provider tax arrangements to come into compliance with their new requirements. These short timeframes for states are not sufficient to assess which provider taxes need to be altered, in addition to taking the necessary steps to become compliant.

It takes a considerable amount of time for states to implement new or alter existing provider taxes, including receiving state legislature approval, submitting applications to CMS, as well as the time needed to get CMS approval. In addition, some states only have two-year legislative cycles, which would hinder them from being able to comply with the proposed requirements

within the proposed timeframes. Every state should have the opportunity to comply with the requirements, regardless of when their provider tax arrangements were approved.

It is critical that states are given enough time to adequately navigate and assess the effects of these new provider tax requirements on their Medicaid programs, including the impact of these changes on Medicaid beneficiaries, benefits, coverage, and provider payments. Any potential reductions to Medicaid payments to children's hospitals resulting from a state's inability to comply with the proposed changes would be detrimental to their ability to continue providing pediatric care to all children.

Clarifying Requirements for Provider Taxes to be Considered Generally Redistributive

We recommend that CMS clarify the proposed language regarding the requirements for which provider taxes will be considered generally redistributive, and therefore permissible. The proposed rule states that provider taxes that either (1) imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes or (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service will be prohibited. In addition to those requirements, the rule also states that any provider tax that would have the "same effect" as these two new prohibitions would also be impermissible. This language is vague and creates significant uncertainty for states in determining which provider taxes are permissible for states to implement and which are not. We ask that CMS clarify in the final rule that the "same effect" language is not meant to apply to situations where there is a legitimate other policy purpose that is not directed at manipulating relative tax burden toward the Medicaid program, such as excluding rural providers from a provider tax to help preserve beneficiary access. While CMS makes this distinction in the preamble of the proposed rule, we ask that CMS include this in the final rule to ensure clear guidance for states on what is permissible under the new rule.

We also request clarification regarding the provision that would prohibit states seeking provider tax waivers from using a substitute definition, measure, attribute, or the like as a proxy for Medicaid in order to impose a higher tax rate on Medicaid taxable units than on non-Medicaid taxable units. The terminology and characteristics that states would be prohibited to apply in their provider taxes are unclear in the rule, causing further confusion as to what provider tax arrangements are permissible and which are not.

For states to design and implement permissible provider tax arrangements, it is necessary that provider tax regulations are clear and specific. Any ambiguity in what is considered a permissible provider tax will make it significantly difficult for states to budget and finance their Medicaid programs. This will have a negative impact on the pediatric providers who care for children covered by Medicaid, creating uncertainty in the payments they rely on to continue providing access to care for children.

We appreciate the opportunity to provide comments on this proposed rule and CMS' consideration of our recommendations. Please contact Milena Berhane at milena.berhane@childrenshospitals.org or (202) 753-5521 with any questions.

Sincerely,



Aimee C. Ossman
Vice President, Policy