National Rural Health Association

September 21, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

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

Comment submitted electronically via regulations.gov

Dear Administrator Oz,

The National Rural Health Association (NRHA) is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule, "Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes". NRHA appreciates CMS's effort to provide regulatory clarity regarding the implementation of these statutory changes; however, we have significant concerns about aspects of this proposed rule that would disproportionately harm rural hospitals and jeopardize Medicaid enrollee access to care in rural communities.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals (CAH), long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Provider taxes have long served as a critical mechanism for financing the non-federal share of state Medicaid programs. All states except Alaska rely on at least one health care-related tax to help fund Medicaid, and these taxes generate revenue that supports payments to hospitals and other providers, particularly rural hospitals that depend heavily on Medicaid reimbursement.

Rural hospitals serve a disproportionately high share of Medicaid and uninsured patients,[2][3] operate with thin or negative operating margins, and often provide services at a loss because they are the only available provider of essential care in their communities.[4, 5, 6] Nearly 50 percent of rural hospitals are currently operating with negative margins, and the median operating margin for rural hospitals is approximately 1%.[7] More than 200 rural hospitals have closed or ceased inpatient services since 2010, and an additional 432 hospitals are currently at risk of closure.[8] The financial pressures created by inadequate reimbursement rates are a central driver of this crisis. Provider tax revenue has played a

[4] Kaiser Family Foundation. *Health Care in Rural America*. KFF; 2023. Accessed July 17, 2026. https://www.kff.org
[5] Medicaid and CHIP Payment and Access Commission. *Medicaid in Rural America*. MACPAC; 2021. Accessed July 17, 2026. https://www.macpac.gov/publication/medicaid-in-rural-america/
[6] Thomas SR, Holmes GM, Pink GH. Financial distress and closure of rural hospitals. *J Rural Health*. 2020;36(1):22-32. doi:10.1111/jrh.12385
[7] Chartis Center for Rural Health, Rural Hospital Closures & Care-Access Crisis: 2025 State of the State (Feb. 2025), https://www.chartis.com/insights/2025-rural-health-state-state.
[8] Id.

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meaningful role in mitigating those pressures in states that rely on it to fund adequate Medicaid payment rates.

While NRHA recognizes that Congress directed CMS to impose new limits on health care-related taxes under section 71115, we are concerned that this proposed rule exceeds the statutory text, imposes new compliance burdens without commensurate benefit, and does not fully account for the rule's effects on rural patients and the providers who serve them.

II. Provisions of the Proposed Regulations

A. General Definitions

CMS proposes to define "net patient revenue" to include all revenue attributable to a permissible class of health care items or services, regardless of payer source, and regardless of whether the provider generating that revenue is itself subject to the tax. CMS states it considered, but rejected, an alternative definition limited to revenue only from taxed providers, in part because it could present a gaming risk and CMS invites comments on this decision.[9]

NRHA strongly supports CMS's proposed approach and urges CMS to finalize the net patient revenue definition as proposed, without narrowing it to exclude untaxed providers. Many rural providers are commonly exempted from a state's provider tax on inpatient or outpatient hospital services, even though their net patient revenue remains part of the taxed class. Narrowing the denominator to include only taxed providers' revenue, as CMS considered and rightly rejected, would shrink that denominator and mechanically push many states over their new, lower thresholds for reasons unrelated to any change in tax policy.

NRHA further urges CMS to ensure that any net patient revenue methodology remains consistent with established hospital financial reporting and Medicare cost-reporting principles, so that hospitals are not required to develop a separate set of financial calculations solely for purposes of the indirect hold harmless test. Because net patient revenue will be used both to establish grandfathered thresholds and to measure ongoing compliance, CMS should also make clear that any newly specified interpretation of this definition will apply prospectively only, and that states and providers will not face adverse consequences for having reasonably relied in good faith on previously accepted methodologies. Finally, because hospitals and health systems often furnish services falling within multiple permissible classes, CMS should provide clear, nationally consistent instructions for allocating revenue among classes where existing financial reporting systems do not naturally separate that revenue. NRHA urges CMS to adopt these clarifications to ensure the net patient revenue definition remains workable and administrable.

B. Classes of Health Care Services and Providers Defined

CMS proposes to add a new permissible tax class for "services of health insurers," distinct from the existing managed care organization class. The agency notes this would include health insurers offering qualified health plan coverage through the Health Insurance Exchange under section 1115 premium assistance demonstrations.[10]

NRHA is concerned this proposal exceeds CMS's statutory authority as nothing in section 71115 directs CMS to create a new permissible class. The statute amends the indirect hold harmless threshold applicable to existing classes, not the scope of what may be taxed in the first place. States frequently use health insurer taxes to fund state-based Marketplace operations, under user fees, and other public health initiatives entirely unrelated to Medicaid financing, not only the Medicaid premium-assistance context

[9] 91 Fed. Reg. 46562, 46566 (July 23, 2026); Proposed 42 C.F.R. § 433.52 (definition of "Net Patient Revenue").
[10] 91 Fed. Reg. 46562, 46566-67 (July 23, 2026); Proposed 42 C.F.R. § 433.56(a)(19).

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CMS specifically identifies. NRHA is concerned that extending section 71115's threshold and expansion-state phase-down requirements to this broader, non-Medicaid use of insurer tax revenue was not contemplated by Congress and could disrupt state health insurance Marketplace financing well beyond the Medicaid program. NRHA urges CMS to withdraw this provision or, at minimum, to narrow it to apply only to health insurer taxes that finance state Medicaid programs, consistent with the statutory purpose of section 71115.

C. Permissible Health Care-Related Taxes

2.a. Enacted and Imposes

CMS proposes to determine whether a health care-related tax was "enacted and imposed" as of July 4, 2025, the threshold question for grandfathering, without requiring that a required broad-based or uniformity waiver be formally approved by that date itself, so long as the waiver's effective date is retroactive to July 4, 2025 or earlier, and without requiring active collection of the tax as of that date. This proposal is meaningfully more flexible than CMS's November 14, 2025 preliminary guidance, which would have required both.[11]

NRHA supports finalizing this more flexible reading of enacted and imposed as it will help preserve provider tax revenue, and the payments it supports, for a meaningfully larger number of states, including several with significant rural populations that enacted or updated provider tax structures in the months leading up to H.R. 1's passage.

CMS should also clarify that ordinary ministerial or administrative steps occurring after July 4, 2025, such as routine billing system updates, notice publication, or administrative sign-off following a substantively completed legislative process, do not defeat grandfathered treatment where a tax otherwise satisfies the "enacted" and "imposed" definitions as of that date. NRHA urges CMS to adopt this clarification in the final rule to provide states additional certainty without expanding grandfathering beyond the statutory requirement.

3. a. Timing

CMS proposes to calculate the indirect hold harmless threshold using each state's own state fiscal year (SFY) that contains July 4, 2025. However, the agency proposed to apply that threshold for ongoing monitoring and enforcement purposes on a federal fiscal year (FFY) basis beginning October 1, 2026, reasoning that FFY application promotes consistency across states and aligns with other federal Medicaid oversight processes.[12]

NRHA respectfully disagrees that FFY application is the most operationally appropriate choice, notwithstanding CMS's general practice. As CMS itself acknowledges elsewhere in this proposed rule, it has departed from a default FFY interpretation where doing so "made the most operational sense," including in the 2008 Medicaid DSH final rule, which aligned with the Medicaid State plan rate year specifically because of "varying fiscal periods between hospitals and States." The same rationale applies here as states' tax collection cycles, Medicaid state plan years, managed care rating years, and legislative budget calendars are all built around the SFY, the same SFY CMS proposes to use for the threshold calculation itself. Requiring states to separately track, prorate, and attribute tax revenue across split portions of their SFY to match FFY reporting periods introduces avoidable complexity and increases the risk of compliance errors, particularly for state Medicaid agencies with limited administrative staff.

[11] 91 Fed. Reg. 46562, 46570 (July 23, 2026).
[12] 91 Fed. Reg. 46562, 46575 (July 23,2026), citing Medicaid Program; Disproportionate Share Hospital Payments, 73 Red. Reg. 77904 (Dec. 19, 2008).

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NRHA urges CMS to apply the threshold for monitoring and enforcement purposes on a state fiscal year basis, consistent with the SFY already used to calculate the threshold itself.

If CMS nonetheless concludes that the statute requires monitoring and enforcement on an FFY basis, the final rule should at minimum establish a safe harbor allowing a state to use a reasonable, consistently applied allocation methodology, such as proportionate allocation of annual or cost-report-based net patient revenue across the relevant federal fiscal years, without reconstructing actual quarterly data, and should protect states from adverse findings based solely on reasonable differences between allocated and subsequently finalized data. NRHA urges CMS to adopt such a safe harbor if it retains FFY-based monitoring, so that states are not required to solve, on a recurring annual basis, an allocation problem CMS itself has not yet fully specified.

3.b.Phase Down for Expansion States

For Medicaid expansion states, CMS proposes to phase down the applicable threshold beginning in FFY 2028, stepping down in 0.5 percentage point increments from 5.5 percent to 3.5 percent by FFY 2032, consistent with section 71115.[13] NRHA appreciates that CMS has proposed to exempt taxes on nursing facility and intermediate care facility for individuals with intellectual disabilities services from the phase-down, consistent with the statute.

NRHA urges requests CMS conduct a rural-specific impact assessment of the proposed indirect hold harmless threshold phase down. We ask CMS to closely monitor and publicly report the phase-down's impact on rural hospitals specifically as it is implemented, given that expansion-state provider taxes frequently finance state directed payments and supplemental payment pools on which rural hospitals disproportionately rely. We urge the agency to use all available discretion under the statute to minimize disruption to rural provider payment streams as thresholds decline.

3.c-d. Interim Indirect Hold Harmless Threshold Process and Data Remediation

CMS proposes a two-year remediation window between the close of a federal fiscal year and final compliance determination, modeled on the timely-filing and Medicaid DSH reconciliation frameworks. Under this structure, a state would not receive a final threshold determination for the July 4, 2025 baseline period until as late as September 30, 2028, and would not face final compliance determinations for FFY 2027 collections until well after providers have already been paid using that revenue.[14]

NRHA appreciates CMS's effort to build a workable interim process but remains concerned about the underlying shift away from the prospective compliance approach states have relied on since CMS first established the indirect hold harmless threshold in 1992. Net patient revenue is not a stable figure, rather it fluctuates with patient volume, payer mix, and broader market conditions, and can move sharply during unforeseen events such as a public health emergency. Because rural facilities serve relatively small patient populations, fluctuations in service volume that are outside the control of the hospital can have a disproportionate effect on financial stability and per-patient costs.[15] If actual net patient revenue for a class comes in lower than projected, even modestly, a state could be found to have exceeded its threshold and be required to refund tax collections and recoup provider payments tied to services rendered years earlier. Rural providers, many of which operate with only a few weeks of cash on hand, are particularly ill-positioned to absorb an unplanned repayment obligation of this kind. We further note that net patient revenue is likely to become less predictable, not more, in the years ahead as other H.R. 1 legislation provisions, including new community engagement requirements and the state

[13] 91 Fed. Reg. 46562, 46576 (July 23, 2026).
[14] 91 Fed. Reg. 46562, 46577-79 (July 23, 2026); Proposed 42 C.F.R. § 433.74(b)(2).
[15] Karim SA, Thompson KW, Pink GH, Holmes GM. Fixed-to-total cost ratio is predictive of rural hospital financial distress and closures. *J Rural Health*. 2026; 42:e70123. https://doi.org/10.1111/jrh.70123

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directed payment reductions discussed in section V.C.3 below, affect hospital revenue simultaneously. **NRHA urges CMS to consider a true prospective compliance option, or at minimum to commit to using its stated discretion under the interim threshold process to avoid retroactive penalties for states that relied in good faith on CMS-provided interim thresholds and data.**

If CMS nevertheless requires retrospective reconciliation to final actual data, that process should operate symmetrically where final net patient revenue shows that a state's collections fell below the applicable threshold, the state should be permitted to make a corresponding adjustment up to, but not above, that threshold, rather than facing only downside risk. NRHA is also concerned that hospital Medicare cost-report periods do not uniformly align with the federal fiscal year, and that the cost-report information needed to establish actual net patient revenue for a given FFY may not be finalized until near, or even after, the end of CMS's proposed two-year remediation period, particularly where a hospital's fiscal year spans two separate cost reports. At minimum, CMS should consider a framework comparable to the Medicaid DSH audit process, which separates the period for collecting and analyzing final cost data from the subsequent period available to remediate identified overpayments. NRHA urges CMS to adopt a symmetric reconciliation approach and a remediation timeline that reasonably accounts for the actual availability of final cost-report data.

4. Revision of the Second Prong of the Indirect Hold Harmless Test (the 75/75 Test)

CMS proposes to discontinue the 75/75 test, an alternative compliance pathway that has existed in regulation since 1993, for FYs beginning on or after October 1, 2026, citing concern that states could use it to circumvent the new statutory thresholds. CMS's own preamble acknowledges that only one tax nationally has ever relied on this test to date.[16]

NRHA is concerned that this change is not required by section 71115, which does not address the 75/75 test at all and removes flexibility that states might otherwise use to support provider classes with extraordinary access needs. Removing a decades-old regulatory safety valve that Congress did not direct CMS to eliminate, forecloses a compliance option that some states, including states with significant rural populations, may need as they adjust to the new, lower class-specific thresholds. We recognize CMS's concern that the incentive to rely on this test may grow as thresholds tighten, particularly for expansion states facing the phase-down. However, we believe that concern can be addressed through continued CMS oversight and scrutiny of individual 75/75 determinations rather than wholesale elimination of the pathway. **NRHA urges CMS to retain the 75/75 test as an available compliance option.**

D. Limitation on Level of FFP for Revenues from Health Care-Related Taxes

CMS proposes to clarify that where a state's aggregate tax revenue for a permissible class exceeds the applicable threshold, CMS will deduct all revenue from all taxes in that class from the state's claimed expenditures, not only the portion above the threshold. CMS states this reflects existing practice rather than a new policy.[17]

NRHA is concerned about the magnitude of this exposure given the additional changes underway in this rule. Under the retrospective compliance and data remediation framework described above, a state could be found years after the fact to have exceeded its threshold by a small margin and face disallowance of an entire tax's revenue, not merely the excess. NRHA urges CMS to consider a proportional remedy, limited to the amount by which a tax exceeds its threshold, at least for states that can demonstrate a good-faith compliance effort consistent with CMS's own interim threshold guidance.

[16] 91 Fed. Reg. 46562, 46581 (July 23, 2026); Proposed 42 C.F.R. § 433.68(f)(3)(i)(B) (current 75/75 test).
[17] 91 Fed. Reg. 46562, 46582 (July 23, 2026); Proposed 42 C.F.R. § 433.70(b).

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NRHA is also concerned that CMS proposes to calculate state- and class-specific thresholds to a highly precise decimal standard and to measure compliance against that standard without a corresponding materiality or de minimis rule. Provider-tax collections and net patient revenue fluctuate with collection timing, changes in patient volume and payer mix, cost-report adjustments, and other ordinary events that cannot be predicted with mathematical certainty when a state establishes its assessment. An immaterial variance should not place an entire class of provider tax revenue at risk. NRHA urges CMS to establish a reasonable materiality or de minimis standard under which minor, inadvertent variances may be corrected without rendering the entire tax impermissible, distinguishing good-faith estimation or data-revision issues from intentional efforts to collect above the applicable threshold.

E. Reporting Requirements

1.2. One Time and Ongoing Reporting Requirements

The proposed rule's new one-time interim and final threshold data submissions, together with new quarterly CMS-64 reporting beginning October 1, 2026, and new notification requirements whenever a state exempts a government-owned provider from a tax, represent a significant new administrative workload for state Medicaid agencies.[18] Many states, particularly smaller and rural states, already operate Medicaid financing offices with limited staff capacity. CMS should consider the downstream administrative burden on small rural providers that may be required to support expanded state reporting and compliance efforts. **NRHA urges CMS to provide technical assistance and adequate lead time to help states build the systems necessary to comply, and to consider a phased or good-faith implementation period for states that demonstrate a documented, good-faith effort to comply but require additional time due to legitimate systems or operational limitations.**

NRHA is also concerned that the proposed rule indicates CMS may delay or withhold approval of unrelated state Medicaid payment proposals, including supplemental and state directed payments, based on incomplete or disputed provider-tax reporting. Rural hospitals should not lose timely access to otherwise lawful Medicaid payments because of a separate reporting dispute that does not itself establish that a tax exceeds its applicable threshold. NRHA urges CMS to ensure that any consequence for incomplete provider-tax reporting is proportionate and tied to the specific missing information or tax at issue, rather than used as leverage over unrelated Medicaid payment approvals.

V. Regulatory Impact Analysis

C. Detailed Economic Analysis

2. Impact on Medicaid Spending

CMS states in this section that it estimates the proposed rule will have "no effect on enrollment" and that all resulting reductions in spending will be absorbed through reduced provider payments and benefits, reasoning that states "would be more likely to prioritize covering enrollees above maintaining provider payment rates and benefits."[19] Further, the agency acknowledges reductions could result in "lower prices paid for services and/or few services provided to Medicaid beneficiaries." While CMS acknowledges that fewer services may be provided as a result of reduced Medicaid financing, the agency does not evaluate the unique consequences for rural communities where a single provider organization frequently serves as the only local source of emergency, inpatient, obstetric, and behavioral health services. In rural areas, service reductions often lead to complete loss of local access rather than redistribution of care among competing providers.

[18] 91 Fed. Reg. 46562, 46583-84 (July 23, 2026); Proposed 42 C.F.R. § 433.74.
[19] 91 Fed. Reg. 46562, 46590 (July 23, 2026).

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NRHA does not believe these assumptions are adequately supported, including by the evidence CMS itself cites elsewhere in this section. CMS's assertion draws in part on a 2021 MACPAC issue brief for the proposition that states generally use provider taxes to increase or maintain provider payments. However, that same brief goes on to describe how Colorado used a portion of its hospital provider fee specifically to expand Medicaid eligibility to adults up to 133 percent of the federal poverty level and to children and pregnant women up to 250 percent FPL.[20] Other research reaches the same conclusion. A Mercatus Center case study documents how Arizona's hospital provider tax was created specifically to fund the state's share of ACA Medicaid expansion costs,[21] and the National Association of Medicaid Directors identifies financing coverage expansions and new eligibility groups as a documented use of provider tax revenue nationally.[22] The Congressional Budget Office has separately estimated that section 71115 alone would increase the number of uninsured individuals by 1.1 million by 2034.[23] **NRHA urges CMS to revisit this assumption and to analyze, rather than assume away, the rule's potential enrollment effects before finalizing the rule.**

NRHA is particularly concerned with any regulatory impact assumption that states will replace a substantial share of lost provider-tax financing with other state revenue. States are simultaneously facing additional fiscal pressures and increased funding responsibilities, including greater state responsibility for SNAP administrative costs, making it less realistic to assume that unrestricted general-fund resources will be available to backfill Medicaid financing losses at the rate CMS assumes. Such an assumption may materially understate the rule's effects on Medicaid spending, provider payments, benefits, and beneficiary access. **NRHA urges CMS to clearly identify the empirical basis for its state-replacement assumption and to provide sensitivity analyses showing the effects of materially different replacement rates, including no replacement, separately identifying impacts on state general-fund obligations, total Medicaid spending, provider payments, benefits and services, and beneficiary access.**

3. Offsets

CMS analyzes this rule's interaction with section 71117 and with the state directed payment (SDP) limits proposed in the companion rule (CMS-2249-P), projecting that SDPs will decline by $774.8 billion in real 2026 dollars from 2026 through 2035, of which CMS estimates 55 to 75 percent is currently financed through provider taxes.[24] NRHA appreciates this analysis, which confirms what rural hospitals already understand which is provider tax revenue and state directed payments are often two legs of the same financing structure, and both are being reduced simultaneously.

However, this section does not account for other H.R. 1 legislation provisions that will independently affect Medicaid enrollment and, in turn, provider revenue, including new community engagement requirements. Beneficiaries who lose coverage under those provisions will not stop needing care. They will continue to seek it from rural hospitals, rural health clinics, and other safety-net providers,

[20] Medicaid and CHIP Payment and Access Commission, The Effect of State Approaches to Medicaid Financing on Federal Medicaid Spending, at 6 (Nov. 2021), https://www.macpac.gov/wp-content/uploads/2021/11/The-Effect-of-State-Approaches-to-Medicaid-Financing-on-Federal-Medicaid-Spending.pdf.
[21] Brian Blase, Medicaid Provider Taxes: A Gimmick That Exposes Flaws in Medicaid's Financing, Mercatus Center at George Mason University, https://www.mercatus.org/research/research-papers/medicaid-provider-taxes-gimmick-exposes-flaws-medicaids-financing.
[22] National Association of Medicaid Directors, How Medicaid Provider Taxes Work: An Explainer, https://medicaiddirectors.org/resource/how-medicaid-provider-taxes-work-an-explainer/.
[23] Congressional Budget Office, Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline, https://www.cbo.gov/publication/61570.
[24] 91 Fed. Reg. 46562, 46592 (July 23, 2026).

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increasing uncompensated care burdens at the same time providers face reduced Medicaid payments under this rule and reduced SDPs under the companion rule. NRHA urges CMS to expand this offset analysis to account for these additional, concurrent H.R. 1 legislation provisions.

C. Detailed Economic Analysis

CMS certifies that this rule will not have a significant economic impact on small entities, including that, under section 1102(b) of the Act, it will not have a significant impact on a substantial number of small rural hospitals. CMS's reasoning is that compliance costs are borne entirely by state and local governments, and that nothing in the rule prevents states from using other non-federal share financing mechanisms to offset any reduction in provider tax revenue.[25]

NRHA does not believe this certification is adequately supported. While the rule's direct compliance costs, data reporting, threshold calculations, do fall on states, the practical effect of a lower threshold is less provider tax revenue available to fund Medicaid payments to hospitals and other providers, most acutely in states that rely most heavily on provider taxes and that lack alternative non-federal share financing capacity. CMS's own accounting statement elsewhere in this rule projects a net reduction of $90.9 billion in federal transfers and $147.5 billion in net transfers to states from 2026 through 2035, even after accounting for interactions with other H.R. 1 legislation provisions,[26] and the companion SDP rule alone is projected to reduce a substantially provider-tax-financed payment stream by $774.8 billion over the same period. The premise that states can simply substitute other financing sources does not reflect the reality in many states, particularly those with constrained general fund capacity.

These pressures fall disproportionately on rural hospitals. Medicaid reimbursements account for nearly 10 percent of net revenue for the typical rural hospital,[27] and nearly half of all rural hospitals currently operate on negative margins, with more than 400 at risk of closure.[28] Because provider tax revenue disproportionately finances the SDPs on which rural hospitals rely to close the gap between Medicaid base rates and the cost of care, a reduction in available provider tax financing can be severe even in states that otherwise comply with the applicable threshold. In Kansas, for example, 87 percent of rural hospitals already operate in the red despite deceiving SDP, with 47 identified as vulnerable to closure, and a reduction of SDPs to 100 percent of Medicare rates was projected to cut Medicaid payments to those hospitals by up to 21 percent.[29]

Given the scale of revenue at stake, and small rural hospitals' disproportionate reliance on Medicaid supplemental and directed payments financed through provider taxes, NRHA urges CMS to reconsider this certification and to conduct the regulatory flexibility analysis section 603 of the RFA requires for a rule of this magnitude. Specifically, we call on CMS to analyze the following interactions of the regulation on small rural hospitals:

- conduct a rural-specific impact assessment of the proposed indirect hold harmless threshold phase down. The proposed rule includes extensive modeling of state fiscal impacts but does not assess effects on rural hospitals and providers that frequently operate with limited financial reserves and disproportionately rely on Medicaid-related supplemental payments.

[25] 91 Fed. Reg. 46562, 46596-97 (July 23, 2026).
[26] 91 Fed. Reg. 46562, 46596 (July 23, 2026) (Table 19, Accounting Statement).
[27] Chartis Center for Rural Health, *2026 Rural Health State of the State* (July 2026).
[28] Commonwealth Fund, Why Rural Hospitals Face a Funding Crisis (Feb. 2026)
[29] Commonwealth Fund, *How Medicaid State-Directed Payments Support Critical Health Care Providers* (2025). https://www.commonwealthfund.org/blog/2025/how-medicaid-state-directed-payments-support-critical-health-care-providers.

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- evaluate whether limiting future provider-tax-supported Medicaid financing may reduce states' ability to maintain targeted investments in rural hospital stabilization, obstetric services, emergency care, behavioral health services, and workforce recruitment initiatives.
- specifically evaluate whether elimination of the 75/75 test may disproportionately affect states with significant rural provider populations and limited alternative financing mechanisms.
- analyze the true consequences of service reductions on rural providers and populations. While CMS acknowledges that fewer services may be provided as a result of reduced Medicaid financing, the agency does not evaluate the unique consequences for rural communities where a single provider organization frequently serves as the only local source of emergency, inpatient, obstetric, and behavioral health services. In rural areas, service reductions often lead to complete loss of local access rather than redistribution of care among competing providers.
- examine the cumulative effect of provider tax restrictions and State Directed Payment limitations on rural hospitals and rural health systems. Rural providers frequently rely on multiple Medicaid financing mechanisms simultaneously, and the interaction among these policies may create substantially larger impacts than consideration of each policy independently.

The Administration has repeatedly highlighted recent investments in rural transformation and innovation through the Rural Health Transformation program operated out of the CMS Office for Rural Health Transformation. However, the proposed rule may reduce states' flexibility to sustain many of those investments through Medicaid financing mechanisms. CMS should assess whether the combined effect of this proposal and other Medicaid financing changes may undermine the long-term sustainability of rural transformation efforts.

In Summary

NRHA appreciates CMS's stated intent to work collaboratively with states as it implements section 71115, and we recognize that several aspects of this proposed rule, including the broader grandfathering standard in section II.C.2.a and the continued inclusion of exempt providers' revenue in the net patient revenue calculation in section II.A, reflect a genuine effort to align with statutory text and minimize disruption. However, for the reasons described above, organized by the corresponding section of the proposed rule, NRHA urges CMS to:

- narrow or withdraw the new permissible class for services of health insurers (II.B);
- retain the 75/75 test (II.C.4);
- apply the threshold on a state fiscal year basis (II.C.3.a);
- adopt a true prospective compliance option or good-faith transition relief (II.C.3.c–d);
- limit FFP deductions to the amount exceeding the threshold (II.D);
- provide technical assistance and a good-faith implementation period for new reporting requirements (II.E);
- fully analyze the rule's enrollment and access effects, including in combination with other concurrent WFTC legislation provisions (V.C.2–3); and
- complete an adequate Regulatory Flexibility Act certification as it applies to small rural hospitals (V.F).

Thank you for the opportunity to respond to this proposed rule. We look forward to working together to protect rural patients and providers across the country. If you have any questions or would like further information, please contact NRHA's Senior Government Affairs and Policy Coordinator, Marguerite Peterseim (mpeterseim@ruralheath.us).

Sincerely,

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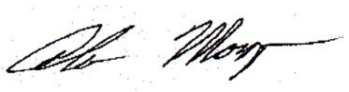

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