Trinity Health

July 14, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule

Submitted electronically via http://www.regulations.gov

Dear Administrator Oz,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-2448-P. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 127,000 colleagues and more than 29,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 93 hospitals, 107 continuing care locations, the second largest PACE program in the country (a total cost of care program), 142 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 8,200 medical group physicians and providers. Based in Livonia, Michigan, its annual operating revenue is $23.9 billion with $1.3 billion returned to its communities in the form of charity care and other community benefit programs.

Trinity Health has 12 Clinically Integrated Networks (CINs) that are accountable for 2 million lives across the country through alternative payment models. Our health care system participates in 12 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 10 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participated in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). Two of the 12 markets also participate in the Comprehensive Primary Care Plus Model. In addition, we participated for many years in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

In addition, Trinity Health owns a non-profit, mission-focused Medicare Advantage plan—MediGold—that plays a vital role in our integrated delivery network and provides care coordination for patients while using fair practices. Serving 56,000 beneficiaries across 6 states, MediGold is a highly-effective best practice plan model. In order to place a better emphasis on care and outcomes rather than profit, MediGold has a lower profit margin and lower administrative costs compared to commercial for-profit plans because they say “yes” more to providers and

beneficiaries. In addition, MediGold utilizes standard and transparent guidelines for decisions on precertification and other authorization approval processes, removing ambiguity of guidelines for providers.

At Trinity Health, we care for all. 78% of the patients we care for in our hospitals are covered by Medicare or Medicaid and another 1% are uninsured. Caring for this population is our mission work; but it results in an operating margin of less than 1% (prior to the Medicaid cuts recently passed by Congress) as Medicaid and Medicare historically underpay.

In our comments below, **Trinity Health urges CMS to not finalize the proposed rule due to the significant impact it will have on patient access to care and state budgets. Should CMS finalize policies that require changes to the underlying structure of health care-related taxes, a transition timeline of three years for *all* states affected by the rule is critical to minimize disruptions to the health care delivery system.**

Proposed Provider Tax Policies

In the proposed rule, CMS expresses concern that some states have been utilizing provider tax structures that are not sufficiently redistributive, even though they pass the current statistical methods used to assess whether a tax meets requirements and CMS asserts that certain states impose higher taxes on certain groups of providers.

To address agency concerns, CMS proposes to:

- Modify how CMS assesses whether a state's provider tax is "generally redistributive" in approving waivers of the "broad-based" and "uniformity" requirements in federal statute.
- Prohibit health care-related taxes that tax Medicaid business at a higher rate than non-Medicaid business, or tax high-volume Medicaid plans or providers at a different rate than low-volume Medicaid plans or providers.
- Apply to all types of health care-related taxes used to finance elements of state Medicaid programs.

Provider taxes are a longstanding and widely used mechanism to finance Medicaid payments that provide critical funding streams to support access and patient care. Moreover, these taxes and waivers are heavily regulated—CMS has closely reviewed and approved each existing provider tax and waiver, which implies all existing arrangements meet statutory and regulatory requirements.

Medicaid is an important program and provider reimbursement has lagged well-behind inflation and the cost of treating patients. Provider taxes help to offset low Medicaid base rates and achieve federal and state policy goals, including offsetting uncompensated care costs. Modifications to states' ability to levy provider taxes may prevent them from adequately reimbursing health care providers for their services and jeopardize sustainability and access to the program.

The proposed rule undercuts Congressional intent to explicitly allow for some degree of non-uniformity in health-care related taxes. In addition, at the time of drafting this letter, there are also significant changes to Medicaid eligiblity finalized by Congress in the reconciliation bill that will have far reaching and significant impacts on states and patients. As such, we urge CMS to not finalize the proposed rule. Should CMS finalize the rule, we urge the agency to do so with inclusion of the recommendations detailed below.

Transition Period

Based on how recently a state's provider tax waiver was last approved, the rule would immediately end taxes in several states while only providing a one-year transition period to others. More specifically, CMS proposes a transition period for states that obtained a waiver more than two years before the effective date of the rule and these states would need to submit a new waiver proposal for a tax that meets the requirements outlined in the proposed rule, with an effective date no later than the start of the first state fiscal year beginning at least one year from the effective date of the final regulations.

However, states with tax waivers approved less than two years before the effective date of the final rule will not have such an opportunity to modify or resubmit their provider tax waivers and any tax collections made under the applicable waiver after the effective date of the final regulations would not count toward the federal match. Trinity Health is concerned that in such cases, the federal government could deduct the value of non-compliant tax revenue from the state's federal Medicaid funding thereby increasing states' financial responsibility and decreasing the sustainability of the program and access to care.

While CMS explains that states with more recently approved waivers are not entitled to a transition period because they were on notice regarding CMS' concerns about specific provider tax waivers and therefore assumed the risk that CMS would issue corrective regulations, we reiterate the CMS reviewed and approved each existing provider tax waiver. **States should not be punished retroactively based on prior decisions made in good faith regarding the duration/terms of their tax program(s) and should be provided a reasonable opportunity to modify the structure of their provider tax.** Further, the proposed transition period is arbitrary, permitting some states to have a transition period and other similarly situated states to have none.

As outlined, the proposed timeframe is not operationally reasonable as it does not take into account the time necessary for states to run the process necessary to modify and submit preprints to CMS for approval. **If proposals that require changes to the underlying structure of health care-related taxes are finalized, a delay in implementation is critical to minimize disruptions to the health care delivery system and state budgets.** These longstanding mechanisms to fund health care services cannot be unwound overnight and *all* affected states should be afforded a realistic and operationally feasible timeframe of transition to allow them to design adjustments to their provider tax programs that would meet the proposed requirements. **Trinity Health strongly recommends a transition timeline of at least three years for all states affected by the proposed rule.**

CONCLUSION

We welcome the opportunity to inform Medicaid policy and are happy to partner with CMS. If you have any questions on our comments, please feel free to contact me at jennifer.nading@trinity-health.org.

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health