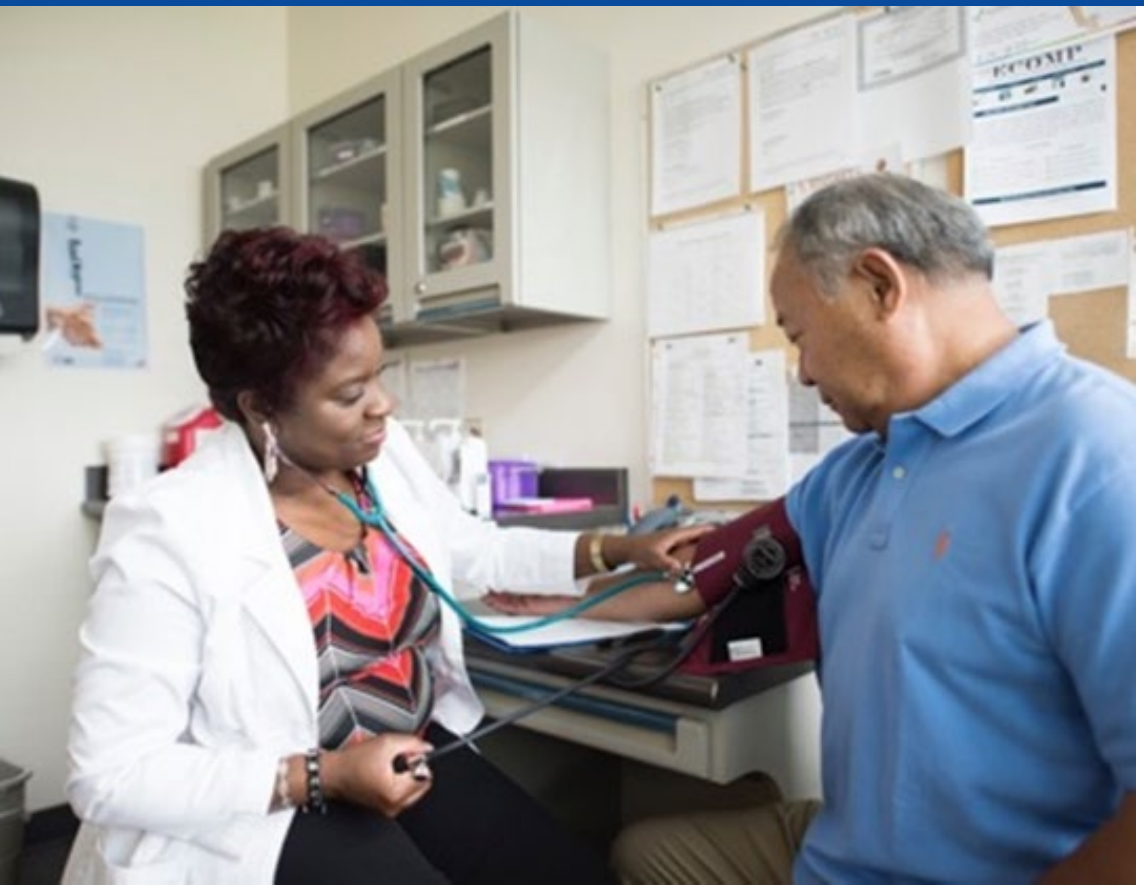
# All-State Medicaid and CHIP Call
# July 28, 2026

# Agenda

- Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes Proposed Rule (CMS-2452-P)
- Medicaid Beneficiary Fraud and Abuse: Sanctions and Penalties
- Q&A

# Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes Proposed Rule (CMS-2452-P)



## CMCS All State Call

July 28, 2026

# Topic Agenda

- Background
- Key Proposed Changes
- Timeline & Next Steps

# Background (1/2)

- On July 4, 2025, Public Law 119-21 was enacted (which CMS refers to as the “Working Families Tax Cut” (WFTC) legislation).
- Section 71115 of the WFTC legislation amended the indirect hold harmless threshold for health care-related taxes.
- On July 23, 2026, CMS published the Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes Proposed Rule (91 FR 46562) to implement this section.
  - The public comment period closes on September 21, 2026.

# Background (2/2)

- Currently, the threshold for a state's collection of tax revenues generally is no more than six percent of net patient revenue attributable to the assessed permissible class of health care items or services.
  - This limits how much tax states and localities may collect without penalty

- Section 71115 generally sets the threshold equal to the applicable percent of net patient revenue attributable to taxes enacted and imposed as of July 4, 2025.

- It also includes a phase-down of those thresholds in most permissible classes for expansion States.

# Key Provisions in the Indirect Hold Harmless Proposed Rule

# When a Tax is Enacted and Imposed

- Enacted: The state/locality has completed the legislative process necessary to authorize the specific tax structure in effect as of July 4, 2025.
  - Note: Later legislative or administrative adjustments, including revenue increases, would not be treated as part of the tax structure enacted as of July 4, 2025, even if made retroactively effective.

- Imposed: The tax was in effect as of that date, meaning taxpayers were subject to a legally enforceable obligation to pay the tax as of July 4, 2025. If a tax requires a broad-based and/or uniformity tax waiver, the waiver must have an effective date of July 4, 2025, or prior.

# Application of New Thresholds

- We propose an interim threshold process until actual data are available to calculate the final threshold, where we will also determine which taxes are enacted and imposed
  - This interim process will provide states insights into their situation while also providing a metric to use for waiver and financing approvals
- We also propose to apply the new threshold and any applicable statutory phase-down on a Federal fiscal year basis.
- We propose to allow states two years to correct tax data prior to evaluating threshold compliance

# New Reporting Requirements – One Time

- Interim: States must report the following:
  - Best available tax and net patient revenue data
  - Documentation to support which taxes were enacted and imposed such as enacting legislation, applicable waiver approvals, notices to taxpayers
- Final: States must report final, actual tax and net patient revenue data for the applicable time period (generally, the state fiscal year that contains July 4, 2025) to calculate the final thresholds for each state and permissible class

# New Reporting Requirements - Ongoing

- Currently, states report aggregated tax revenue data annually on the CMS-64.
- We propose that states must report additional data on taxes quarterly by tax, along with new patient revenue data at the permissible class level.
- States would also be required to report what the taxes are used to finance
- We are updating the CMS 64.11 to facilitate this reporting

# Rescission of 75/75 Test

- Currently, if a state's health care-related taxes exceed 6 percent of net patient revenue for the permissible class may nevertheless remain permissible under the second prong of the test:
- If 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs backs, the tax fails the second prong.
  - This prong has been in place a long time with almost no utilization
- As such, it is possible that new or increased health care-related taxes could be imposed without resulting in an impermissible indirect hold harmless finding.
- Therefore, we propose discontinuing the 75/75 test to prevent states from exceeding the class specific indirect hold harmless thresholds established under section 71115 of the WFTC legislation.

# New Permissible Class: Health Insurers

- Currently, taxes on health insurers generally are health care-related taxes, but services of health insurers are not recognized as a permissible class under current regulations.

- CMS proposes to add services of health insurers as a permissible class to provide clarity regarding the treatment of these taxes

- We also propose to apply the same indirect hold harmless threshold requirements that would apply to other permissible classes under section 71115.

# Additional Proposals

- Definitions: Propose to define:
  - Expansion state
  - Non-expansion state
  - Net patient revenue
- Reorganization of existing regulations
- Update to regulations pertaining to penalties to ensure clarity of how they are applied

# Timeline and Next Steps

# Timeline and Key Dates

- Comment period closes September 21, 2026
- Section 71115 is effective October 1, 2026.
- The proposed rule contains dates and example timelines that may need to shift depending on the timing of a final rule.
- The threshold phase-down begins October 1, 2027

# Next Steps for States

- Begin gathering tax data and documentation
  - Refer back to CMS's CMS-64 tax data collection exercise that began in fall 2025, and any instructions CMS provided to address data issues
  - Facilitate information exchange with local governments imposing health care-related taxes
- Consider how you will address instances where a tax exceeds the threshold and whether remedial steps will require an update to your state plan, or collaboration with your state legislatures

# Conclusion

**Please submit questions or comments on the proposed rule via the Federal Register.**

**The comment period closes on September 21, 2026.**

# Medicaid Beneficiary Fraud and Abuse: Sanctions and Penalties

*Center for Medicaid and CHIP Services*

*July 2026*

# Definitions (42 CFR 455.2)

- **Fraud**: “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.”
- **Abuse**: “beneficiary practices that result in unnecessary cost to the Medicaid program”

# State Practices

- States must have:
  - Methods and criteria to identify suspected fraud cases;
  - Methods to investigate these cases that do not infringe on the legal rights of persons involved and afford them due process of law; and
  - Procedures to refer suspected fraud to law enforcement.
- After conducting a preliminary investigation of alleged fraud/abuse, the state Medicaid agency must:
  - Refer alleged **fraud** to law enforcement.
  - Conduct a full investigation of alleged **abuse**, which must continue until resolution (either a warning letter to the beneficiary or another sanction provided under the state plan).

See 42 §§ CFR 455.12-16.

# Permissible Penalties and Sanctions

- Fraud: Individuals may be subject to criminal and civil penalties for fraud, or liable for civil damages due to fraud.
  - Individuals convicted of fraud in either state or federal court would be subject to the penalties imposed by the court.
  - Similarly, in a civil fraud proceeding, an individual may be found liable via a court judgment or may settle voluntarily.
  - States must refer suspected beneficiary fraud to law enforcement.
- Abuse: Prior to imposing administrative sanctions, states must complete a full investigation which results in a determination that the beneficiary committed abuse.
  - Administrative sanctions are:
    - A warning letter;
    - A fine, if approved in the Medicaid state plan; and
    - Other sanctions, if approved in the Medicaid state plan.
  - Sanctions for abuse cannot conflict with other federal statutory or regulatory requirements

See 42 CFR §§ 455.15(b), 455.15(c), and 455.16.

# Impermissible Administrative Sanctions

In general (see next slide for exceptions), states cannot:

- *Financially recoup funds* from beneficiaries because it effectively functions as a retroactive termination of eligibility, which would violate the Medicaid beneficiary's due process rights (advance notice of termination and fair hearing rights) under Supreme Court case law, federal statute and regulations.[1]
- *Lock-out beneficiaries from Medicaid* because this policy would violate statutory requirements. States must:
  - Allow all individuals to apply for Medicaid and
  - Furnish benefits to eligible individuals with reasonable promptness and in accordance with their state plans.[2]

[1] See section 1902(a)(3) of the Social Security Act, 42 CFR part 431, subpart E, 42 CFR § 435.930(b), and relevant Supreme Court due process jurisprudence (see Goldberg v. Kelly, 397 U.S. 254 (1970) and its progeny).
[2] See sections 1902(a)(8) and 1902(a)(10) of the Social Security Act.

# Impermissible Administrative Sanctions: Exceptions

- Permissible Exceptions for Recoupment include:
  - Liens placed on a beneficiary's property prior to death pursuant to the judgment of a court that Medicaid benefits were incorrectly paid (see section 1917(a)(1)(A) of the Act and 42 CFR § 433.36(g)(1)).
  - Estate recovery proceedings for incorrectly paid Medicaid benefits (see section 1917(b)(1) of the Act).
  - Benefits provided pending the outcome of a fair hearing (see 42 CFR § 431.230).
- Permissible Exceptions for Lock-out include:
  - Section 1128B(a) of the Act allows the state to lock out an otherwise-eligible individual for up to one year after conviction of fraud in federal court. Penalty cannot affect the Medicaid eligibility of any other person regardless of the relationship between the individuals. Section 1128B of the Act does not authorize lock-outs for state court convictions or for civil judgments.

# Impact on Eligibility

- State Medicaid agencies cannot automatically terminate the eligibility of a beneficiary suspected of committing or determined to have committed fraud or abuse.
- Instead, states must:
  - Treat the information that led the state to suspect fraud or abuse as a possible change in circumstances and conduct a redetermination of eligibility on all bases.[1]
  - If the redetermination results in a determination that the beneficiary is ineligible for Medicaid on all bases, provide advance notice (with fair hearing rights) prior to terminating eligibility.[2]
- In cases of suspected beneficiary fraud, the period of advance notice may be shortened from 10 days to 5 days if the state Medicaid agency has verified facts indicating possible fraud through independent sources.[3]
  - No reductions in the advance notice period are authorized for cases of suspected beneficiary abuse.

[1] See 42 CFR §§ 435.916 (as amended by the interim final rule with comment period titled "Medicaid Program; Community Engagement Requirement for Certain Individuals" (91 Fed. Reg. 33,343, June 3, 2026), effective July 31, 2026)) and 435.930(b).
[2] See Section 1902(a)(3) of the Act and 42 CFR part 431, subpart E.
[3] See 42 CFR § 431.214.

# SMDL #24-005

- On December 5, 2024, CMS published SMDL #24-005, *Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions.*
- CMS rescinded SMDL #24-005 on May 1, 2025.
  - The SMDL remains on Medicaid.gov with a red "stamp" on each page: "RESCINDED ON MAY 1, 2025".
- The rescission of SMDL #24-005 did not change the underlying Constitutional principles and federal laws governing sanctions and penalties for Medicaid beneficiary eligibility-related fraud and abuse.
- State Medicaid agencies should consult with their legal counsel on court orders, criminal or civil penalties, or administrative penalties that they are concerned may be inconsistent with federal Medicaid statute and regulations.

Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd24005.pdf

# Questions