Comment on CMS-2448-P – Medicaid Program: Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole

Submitted via www.regulations.gov
Date: July 14, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2448-P
P.O. Box 8016
Baltimore, MD 21244-8016

Introduction

LeadingAge Kansas represents 150 nonprofit and mission-driven aging services providers who deliver care across the continuum—including skilled nursing, assisted living, affordable housing, and home and community-based services. We support CMS's intent to strengthen the integrity of Medicaid financing, and we appreciate the opportunity to comment on the proposed rule. As CMS finalizes this policy, we urge careful consideration of how it may affect access to long-term care in rural and underserved areas, particularly for older adults who rely heavily on Medicaid-funded services.

Why Flexibility Matters

Many states use tiered provider assessment structures as a tool to sustain long-term services and supports—especially in rural communities and among providers with high Medicaid volumes. These assessment models are designed not to exploit federal matching funds, but to equitably share responsibility among providers with varying size, payer mix, and financial capacity.

For example, some states assess providers by licensed bed count rather than revenue or utilization, and reduce rates for small, standalone, or Medicaid-heavy organizations to ensure continued access to care. These models comply with existing CMS guidelines and are essential to maintaining fragile long-term care networks that cannot absorb a uniform tax structure without risking closure or service reduction.

One-size-fits-all assessment rules could have unintended consequences, particularly in states where access to care is already limited by geography, workforce shortages, or thin margins. States must retain the flexibility to tailor provider assessments in ways that reflect

their unique provider landscapes, especially when those approaches demonstrably protect access and meet federal re-distributivity standards.

Recommendations to Support Access Through State Innovation
We urge CMS to adopt the following approaches in the final rule:

1. **Explicitly Allow Tiered Assessment Models**
   Clearly permit state-designed assessment structures that include lower rates for small or high-Medicaid providers when the model supports access and complies with federal requirements.
2. **Create a Rural Access Exception Pathway**
   Establish an application process allowing states to demonstrate that a non-uniform provider tax structure supports access, continuity of care, and Medicaid-heavy providers in underserved areas.
3. **Provide Offsetting Federal Support if Tiered Flexibility Is Removed**
   If CMS prohibits tiered models, consider adjusting the FMAP for affected states to preserve Medicaid-funded long-term care infrastructure and avoid unintended funding losses.
4. **Exclude Nursing Homes from the Proposed Uniformity Requirements**
   Nursing homes serve a predominantly Medicaid-funded population, making uniformity compliance inherently difficult. CMS should exempt them from these new requirements or apply a more tailored compliance standard recognizing their unique payer mix.

Conclusion
State-designed provider assessment models, such as the ones in Kansas, are not loopholes—they are essential tools for sustaining Medicaid access in real-world environments. Preserving flexibility is critical to ensuring the long-term viability of services for older adults, especially in rural and underserved communities.

Thank you for considering our perspective. We welcome further dialogue and remain committed to advancing policies that uphold Medicaid's promise to vulnerable populations.

Sincerely,
Kylee Childs
Director of Government Affairs
LeadingAge Kansas