AMERICA'S ESSENTIAL HOSPITALS

July 21, 2026

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Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: CMS-2449-P Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Dear Administrator Oz:

Thank you for the opportunity to comment on the proposed rule on state directed payments (SDPs) and fee-for-service (FFS) targeted practitioner payments. These payments provide critical funding for essential hospitals, supporting their efforts to improve high-quality, accessible, and affordable care for rural and other hard-to-reach populations. **We are concerned that CMS is proposing to cut this critical funding by more than what Congress intended and to impose new restrictions that will limit states' ability to target payments where they are needed most. We look forward to continuing to work with CMS to identify simpler solutions to better align Medicaid payments with the value of care provided and ensure scarce Medicaid dollars are targeted to the safety net the program is intended to serve.**

America's Essential Hospitals is the leading association and champion for hospitals that fill a safety net role in their communities and are dedicated to high-quality care for all, including those who face social and financial barriers to care. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health, and other services.

Essential hospitals serve a disproportionate share of Medicaid patients and provide access to essential care that few other hospitals provide. More than three-quarters of the patients essential hospitals serve are uninsured or covered by Medicare and Medicaid.[1] In addition, nearly two-thirds of essential hospitals provided services to rural patients and communities in 2022.[2] To meet the needs of these populations, members of America's Essential Hospitals

[1] Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. essentialdata.info. Accessed June 5, 2026.
[2] America's Essential Hospitals. Policy Brief: Essential Hospitals Ensure Access to Care in Rural Areas. March 2025. https://essentialhospitals.org/wp-content/uploads/2025/03/2025-Access-to-Care-in-Rural-Areas-Brief.pdf. Accessed June 5, 2026.

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provide access to the full continuum of inpatient and outpatient care and engage in robust quality improvement initiatives to meet patients where they are. Although essential hospitals accounted for only 6% of acute-care hospitals nationwide, they provided 16% of neonatal intensive care unit beds, 21% of psychiatric beds, and 43% of burn care beds in 2023.[3]

Unfortunately, essential hospitals' ability to continue providing these services is threatened by payers that undervalue the care that essential hospitals provide. Essential hospitals care for more Medicare and Medicaid patients than other hospitals. Since payment rates for those programs are lower than those of other payers, essential hospitals have lower operating margins. In addition, essential hospitals also receive lower commercial payment rates than most other hospitals because they have less market power to negotiate higher rates.

Low Medicaid payment rates have been a persistent problem since Medicaid payments were de-linked from Medicare cost principles in 1981. To address these challenges, **Congress required states to consider the needs of hospitals that serve a disproportionate share of Medicaid and low-income patients when setting Medicaid payment policies.**[4] In FFS Medicaid, CMS has long supported this policy goal by allowing states to target funding to safety net providers as long as aggregate Medicaid payments were below a reasonable estimate of what Medicare would have paid, referred to as the upper payment limit (UPL). However, **as states moved from FFS to managed care delivery systems, states needed new tools to support safety net providers and ensure that funding provided to managed care organizations (MCOs) was being used to advance state quality and access goals.** At first, many states used Section 1115 demonstration waivers to preserve UPL supplemental payments in managed care. In 2016, CMS codified an option for SDPs in managed care without a waiver. Although SDP spending has grown in recent years, it is important to recognize that many SDPs for essential hospitals are intended to preserve funding that has long been needed to preserve access to safety net care.

SDPs have helped essential hospitals offset low Medicaid payment rates and improve access to essential services, such as maternity, trauma, and behavioral health care, for the most vulnerable Medicaid beneficiaries. Evaluations of many of the targeted SDP investments in essential hospitals approved during the first Trump administration have found substantial improvement in key quality measures for reducing infant mortality, treating for patients with opioid use disorder, and reducing avoidable hospital use in ways that make the overall health system more efficient. In addition, SDPs have been a lifeline for sustaining essential hospitals' work to preserve access to care in rural areas.[5]

The proposed cuts to SDPs and FFS targeted practitioner payments will undermine this progress and substantially increase hospital uncompensated care (UC) costs. In addition, the proposed rule's overly prescriptive application of Medicare-based limits is unworkable and will interfere with state efforts to support essential hospitals and advance value-based payment (VBP) models tailored to Medicare beneficiaries' unique needs.

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[3] Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. essentialdata.info. Accessed June 5, 2026.
[4] 42 U.S.C. 1396(a)(30)(A).
[5] Kozminski J. State Directed Payments: Closing Medicaid Payment Gaps for Essential Hospitals. *America's Essential Hospitals*. September 2024. https://essentialhospitals.org/wp-content/uploads/2024/09/Policy-Brief-Directed-Payments-September-2024.pdf. Accessed June 5, 2026.

Below, we share more specifics on how CMS' proposed cuts would affect essential hospitals, and legal analysis to support a different reading, as well as recommendations on how CMS can reduce administrative burden and better support the most vulnerable Medicaid patients.

Specifically, we urge CMS to:

- Not cut SDPs and supplemental payments that support safety net providers by more than what Congress required
- Allow states who are closer to their Medicaid populations to determine how to target payments that advance Medicaid statutory goals
- Align the calculation of Medicare-based payment limits with the simpler process used in Medicaid FFS
- Withdraw new SDP cuts for types of SDPs and services not included in the Working Families Tax Cut legislation (WFTCL)
- Withdraw new restrictions on targeted FFS practitioner payments
- Adopt a more gradual phase-down methodology for grandfathered SDPs
- Improve transparency and accountability by preserving separate payment terms and reducing redundant reporting

1. CMS should not cut SDPs and supplemental payments that support safety net providers by more than what Congress required.

Prior to enactment of the WFTCL, our members already faced an exceedingly challenging financial outlook. **In 2023, essential hospitals reported $22.4 billion in unpaid costs of care, including $11 billion in UC for uninsured individuals and $11.4 billion in under-reimbursed care from government payers, such as Medicaid, even after accounting for SDPs.**[6]

As passed by Congress, the WFTCL will substantially increase hospital UC by increasing the number of uninsured individuals and by reducing payments for care provided to eligible Medicaid beneficiaries. Congress' recent failure to extend enhanced premium tax credits has further increased the number of uninsured individuals. **Using data from the Congressional Budget Office (CBO), we estimate that the legislation will increase hospital uncompensated care costs by $466 billion over 10 years and that these cuts will disproportionately harm essential hospitals.** Although essential hospitals account for just 6% of acute-care hospitals nationwide, they will bear approximately 25% of the UC costs.[7]

Given the financial challenges that essential hospitals face under existing law, **we are deeply concerned about CMS' proposals to cut SDPs and FFS supplemental payments by more than what Congress required.** As discussed below, we are particularly concerned about the following new restrictions that are not required by statute:

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[6] Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. essentialdata.info. Accessed June 5, 2026.

[7] America's Essential Hospitals. Policy Brief: Projected Increases in Hospital Uncompensated Care After Recent Legislation. June 2026. https://essentialhospitals.org/wp-content/uploads/2026/06/Projected-Increases-in-Hospital-Uncompensated-Care-fromRecent-Legislation.pdf. Accessed June 15, 2026.

- A narrow definition and application of Medicare-based limits at the service code or discharge level, which will make it impossible for states to target payments to essential providers and limit states' ability to reward providers for high-value care, even when total payments are less than what Medicare would have paid
- The expansion of SDP limits to types of SDPs and services not included in the WFTCL
- The addition of cuts to targeted FFS payments
- A phase-down of grandfathered SDPs that is faster than what is required by statute

CMS' proposed cuts to SDPs and FFS supplemental payments do not limit states' ability to increase payments to providers through other, less targeted Medicaid payment authorities. However, CMS' own projections confirm that states are unlikely to substantially increase managed care capitation rates without assurances that the funding is being used to advance state quality and access goals. Moreover, even if states did increase managed care capitation rates, essential hospitals would still struggle to negotiate higher payment rates with health plans because they do not have as much market leverage as other hospitals.

Because of these new restrictions that go beyond what is required by statute, the proposed rule will cut 3.4 times more federal funding from the health system than Congress intended. CBO estimated that SDP cuts in the WFTCL would reduce federal spending by $149.4 billion over 10 years, but CMS' proposed rule is estimated to decrease federal investment in the health care system by $510 billion over 10 years. **Cuts of this magnitude will devastate essential hospitals' ability to provide high-quality care to the patients and communities they serve.**

2. CMS should not interfere with states' ability to use legal funding sources to finance targeted payments that advance Medicaid statutory goals.

We continue to urge CMS to draw a clear and principled distinction between program integrity enforcement—which targets fraud, waste, and abuse—and legitimate Medicaid payment and financing policies that states long have used to support safety net providers and the patients they serve.[8] IGTs have been a permissible source of Medicaid financing since Medicaid's inception, and their use as a share of Medicaid spending has declined in recent years, according to the Government Accountability Office.[9] Provider taxes are already highly regulated and are subject to additional reductions in the WFTCL.

Throughout the proposed rule, CMS inappropriately justifies its very significant new restrictions on SDPs and FFS targeted practitioner payments by noting that states often use intergovernmental transfers (IGTs) and provider taxes to finance these payments. CMS claims that its proposed changes will reduce waste, fraud, and abuse. However, **there is no statutory basis for CMS to cut Medicaid payments more than Congress intended because states use these legitimate Medicaid financing sources.**

CMS' determination whether a payment level is consistent with the requirements of Section 1902(a)(30)(A) of the Social Security Act should not and cannot vary based on the permissible sources of nonfederal share funding used to finance a related payment. Per statutory

[8] DeCubellis, J. Letter to Mehmet Oz on March 27, 2026. https://essentialhospitals.org/wp-content/uploads/2026/03/CRUSH-RFI-2026.pdf. Accessed July 8, 2026.
[9] America's Essential Hospitals. Our View: Public Funds Sustain Essential Services. February 2026. https://essentialhospitals.org/wp-content/uploads/2026/02/Our-View-IGTs-Feb-2026.pdf. Accessed July 8, 2026.

requirements, CMS should focus on how a payment rate affects providers' ability to serve Medicaid beneficiaries consistent with the statutory goals of economy, efficiency, quality, and access. **It is arbitrary and capricious to suggest that a payment threshold is appropriate when funded by one permissible source of nonfederal share financing but not another, or when paid to all providers of a given type in a state but not a subset.** Indeed, targeting scarce state and federal resources to incentivize provision of care to low-access services arguably is *more* consistent with the statute.

Moreover, **CMS' proposal provides no reasonable basis to distinguish between payments it deems appropriate and those it deems of concern**, while producing internally inconsistent results. On the managed care side, CMS justifies restricting SDPs beyond congressional intent with the sharp rise in overall federal spending driven by use of IGTs and provider taxes, which necessitates across-the-board federal policy restrictions (e.g., eliminating uniform payment increases) that will limit states' SDP use. Yet, in FFS, CMS indicates that increased payments to *all* providers statewide, rather than a targeted subset, are preferred and permissible, while targeted payments, which allow tailoring to achieve specific policy goals while lowering overall spending, are necessarily problematic. Although CMS has not identified any abuse concerns associated with the use of state general revenues, its proposal would effectively prevent states from using those funds to support FFS physician payments unless they are sufficient to increase payments for every practitioner in the state—regardless of providers' commitment to Medicaid patients or their role in addressing specific access needs.

Until now, CMS has separated its approval of SDPs under payment rules from its approval of underlying financing, noting in its approval letters that, "This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions." **If CMS has concerns about nonfederal share financing, including its relationship with Medicaid payments, it should identify and address the issue through existing financing authorities.** Moreover, Congress recently addressed nonfederal share financing concerns by imposing new provider tax hold harmless limit restrictions while preserving existing statutory protections, including for IGTs.

The proposed rule requests comments on how states define provider classes and expresses concern about targeted payments to public hospitals, which are legally permitted to provide IGTs to finance Medicaid payments. Meanwhile, **the rule ignores the many other legitimate reasons states might target payments to public hospitals because of their unique role in providing access to essential services.** The Medicaid statute requires states to "take into account the situation of hospitals which serve a disproportionate number of low income patients…."[10] Because essential hospitals serve a disproportionate share of Medicaid and low-income patients, it is therefore wholly appropriate for states to consider their unique needs in Medicaid payment policy.

America's Essential Hospitals supports efforts to add a federal designation of essential health systems to provide an additional tool for policymakers to use to target payments to hospitals who need it most.[11] However, **we oppose efforts to limit state flexibility and undermine states' ability to use permissible Medicaid financing sources**.

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[10] 42 U.S.C. 1396(a)(30)(A).
[11] Reinforcing Essential Health Systems for Communities Act, H.R. 7145, 119th Cong. (2026) https://essentialhospitals.org/wp-content/uploads/2026/01/Reinforcing-Essential-Health-Systems-for-Communities-Act-Text.pdf. Accessed July 8, 2026.

3. CMS can and should implement the Medicare-based payment limits in a manner that respects the state-federal partnership and is consistent with longstanding Medicaid payment principles.

CMS has proposed to apply an overly narrow definition of Medicare-based limits at the service code or discharge level, essentially requiring each state to replace the Medicaid payment methodologies and systems they have carefully developed for their programs with a Medicare system. The proposed rule directly counters the approach Congress directed the agency to take more than 40 years ago when it eliminated the application of strict Medicare limits to Medicaid payments.

This approach is unworkable because it fails to acknowledge the unique needs of the Medicaid population and how states have modified Medicaid payment policies to account for the differences between Medicaid and Medicare. **The proposal will also undermine states' ability to reward providers for high-value care, even when total payments are less than what Medicare would have paid.**

The Medicaid program is a joint state and federal program that is implemented and administered by the states, so state variation is expected. The Medicaid statute grants states the authority to define the amount, duration, and scope of covered services. States can develop payment methodologies that meet local needs and are tailored to the unique characteristics of Medicaid patients in their state. In contrast, the Medicare program is solely implemented and administered by the federal government, with payment methodologies developed through annual federal rulemaking that does not involve the states or consider their needs or circumstances.

A better approach would be for CMS to align its Medicare-based limit calculation with the more flexible, covered service–level approach used for the FFS UPL. This approach is more consistent with the WFTCL and underlying Medicaid statute and easier for states to implement. Importantly, it also honors the federal-state partnership at the core of the Medicaid program.

Below, we summarize important differences between Medicare and Medicaid populations that should be considered when comparing Medicaid and Medicare payment rates, highlight concerns with CMS' proposed approach, and describe our proposed approach to maintaining federal fiscal guardrails while aligning Medicaid payments with value.

a. Medicare and Medicaid currently use different payment systems because of differences in the populations and services they cover.

Medicare and Medicaid are fundamentally different programs designed for different beneficiary populations. For example, newborn, obstetrics, and pediatric services account for 42.9% of Medicaid stays nationally, compared with just 0.2% of Medicare stays.[12] Medicaid also finances a larger share of behavioral health and substance use disorder services, as well as services not covered by Medicare, such as long-term and dental care.

CMS has routinely cautioned non-Medicare payers from applying Medicare service codes and clinical weights to non-Medicare populations without appropriate adjustments. For example,

[12] America's Essential Hospitals Analysis of 2023 National Inpatient Sample.

CMS noted in its final rule establishing the Medicare Severity Diagnosis Related Group (MS-DRG) system:

> As we have stated many times in the past, our primary focus in maintaining the CMS DRGs is to serve the Medicare population. We do not have the data or the expertise to maintain the DRGs in clinical areas that are not relevant to the Medicare population. We continue to encourage users of the CMS DRGs (or MS-DRGs…) to make relevant adaptations if they are being used for a non-Medicare population.[13]

We highlight inpatient hospital payments, but similar examples are available for outpatient hospital services and other services.[14]

Medicare rates are particularly ill-suited for services Medicare beneficiaries rarely use, such as births, maternal health services, and pediatric hospital admissions, because they are based on limited and outdated data. In the fiscal year (FY) 2026 Inpatient Prospective Payment System (IPPS) rule, CMS required a minimum of 10 cases to calculate a reliable MS-DRG payment weight. CMS identified nine DRGs with fewer than 10 cases, seven of which were for neonates, prematurity, and normal newborns—hospital stays that account for a significant share of total Medicaid hospital stays.[15] The original weights for the low-volume DRGs were calculated based on data from two states (Maryland and Michigan), obtained in the late 1970s, and never updated. See 57 Fed. Reg. 39758 (Sept. 1, 1992) (citing 48 Fed. Reg. 39768 (Sept. 1, 1983)). Applying the Medicare payment rates for these services without adjustments to reflect Medicaid's broader population, evolving care standards, and technological advances, is wholly inappropriate.

The Medicaid statute grants states the authority to define the amount, duration, and scope of covered services and to develop innovative payment methodologies tailored to local needs and the state's Medicaid populations. For example, most states have adopted All Patient Refined Diagnosis Related Groups (APR-DRGs) for inpatient hospital services, which are an expansion of Medicare DRGs that include Medicaid patients and incorporate severity of illness and risk of mortality.[16] These refinements allow for more nuanced clinical complexity and, therefore, more appropriate payment methodologies. Mississippi has adopted APR-DRGs, noting that they are "more suitable for use with a Medicaid population, especially with regard to neonatal, pediatric, and obstetric care" than MS-DRGs, which "were designed for a Medicare population using Medicare claims."[17] In Mississippi, these categories of inpatient hospital stays represent almost 70% of FFS stays.[18]

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[13] 72 Fed. Reg. 47130, 47155 (Aug. 22, 2007).
[14] For example, states have adopted Enhanced Ambulatory Patient Groups (EAPGs) instead of Medicare Ambulatory Payment Classifications (APCs) to represent outpatient services provided to all patient groups. *See, e.g.,* Implementing the 3M™ Enhanced Ambulatory Patient Grouping System, September 2018. https://multimedia.3m.com/mws/media/576454O/3m-eapgs-frequently-asked-questions.pdf. Accessed July 15, 2026.
[15] 42 C.F.R. Parts 412, 495, and 512 (2025). https://public-inspection.federalregister.gov/2025-14681.pdf
[16] Medicaid and CHIP Payment and Access Commission. *Medicaid Inpatient Hospital Services Fee-for-Service Payment Policy*. December 2018. https://www.macpac.gov/publication/medicaid-inpatient-hospital-services-payment-policy/. Accessed July 8, 2026.
[17] Mississippi Division of Medicaid. *Mississippi Medicaid DRG Payment Method Frequently Asked Questions for FY2018*. July 1, 2017. https://medicaid.ms.gov/wp-content/uploads/2017/05/APR-DRG-frequently-asked-questions.pdf. Accessed July 8, 2026.
[18] Ibid.

b. CMS' proposal to apply the Medicare limit at the service-code and provider-specific level involves excessive administrative complexity, would lead to inaccuracy, and undermines value-based care.

Because the service codes used to classify Medicare and Medicaid services differ, it is incredibly complex to accurately compare Medicaid payments to Medicare at a service-code and provider-specific level, as CMS has proposed. The enormous administrative burden of calculating limits at the service code– and provider-specific level also makes this policy unworkable. For example, instead of setting one payment limit for inpatient hospital services, the rule would require more than 700 diagnosis-related group (DRG) rates for thousands of hospitals, which would require states and MCOs to retrofit Medicaid payment methodologies to millions of Medicare service code-specific limits. This also would negate any Medicaid-specific adjustments that states and health plans make to account for the care needs, service mix, or costs associated with Medicaid patients.

The complexity of attempting to precisely align Medicaid service rates with Medicare likely would lead to inadvertent miscalculations and inaccuracies. Unless a state adopts the exact methodology used by Medicare, differences in reimbursement levels for specific hospitals, services, or discharges will inevitably remain. For example, Medicare only has seven MS-DRGs for newborns, but most state Medicaid programs use more than 100 APR-DRGs for newborn DRGs, which help states pay accurately for vulnerable patients. More than half of the newborn APR DRGs have case weights above the highest Medicare newborn DRG. Thus, if CMS forces states to retrofit their payment systems to Medicare, payments for these children with complex needs will be severely reduced.[19] The changes will be particularly harmful for essential hospitals, which are twice as likely as other hospitals to have obstetric units that are equipped to respond to the most severe newborn illnesses and abnormalities.[20]

These challenges are further compounded in cases where no comparable Medicare rate exists and a substitution is used, as well as when longstanding Medicaid bundled payments would need to be de-bundled to align with Medicare's payment structure. Moreover, Medicare payments and adjustments are constantly changing, so it would be difficult to establish the payment limit for each service even if every single claim could be reduced to its Medicare equivalent.

Under the proposed policy, both states and MCOs will have to overhaul their payment systems and become akin to Medicare contractors. MCOs also will be responsible for recouping payments to providers that exceed the payment limits. Beneficiaries will face the brunt of this policy, as MCOs and states will have to reallocate their scarce human and financial resources away from supporting care for Medicaid patients and toward meeting burdensome administrative policies. The increased administrative costs to states also would increase federal spending, as Medicaid provides administrative matching funds, offsetting the benefit of imposing the Medicare-based limit in the first place.

i. The Medicare web pricer does not include all Medicare adjustments on which essential hospitals rely.

[19] Analysis of 2023 National Inpatient Sample.
[20] Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. essentialdata.info. Accessed June 5, 2026.

In the proposed rule, CMS completely ignores these complexities by falsely claiming that states can use existing Medicare tools, such as the Medicare web pricer, to calculate the payment limit at a service or discharge specific level. The web pricer was designed for use by Medicare Advantage (MA) plans, not Medicaid, and does not solve the complex problem of crosswalking Medicaid payments to Medicare in states that use different payment methodologies.

The Medicare web pricer can be a helpful starting point for some states and some services, and we appreciate that the tool does include some Medicare adjustments that are important for essential hospitals, such as Medicare disproportionate share hospital (DSH) and UC payments. **These safety net provider payment adjustments should continue to be considered in any comparisons between Medicare and Medicaid.**

However, some other critical payment adjustments for essential hospitals, such as Medicare outlier payments, are not fully accounted for in the web pricer because they are hospital-specific and vary based on data that are later reported on Medicare cost reports. According to our analysis of the Medicare IPPS impact file, 8% of Medicare payments to essential hospitals were outlier payments, compared to 4% for other hospitals, and so essential hospitals will be uniquely harmed by the exclusion of outlier payment adjustments. **CMS must ensure that its proposed payment limits adequately account for high severity cases so states can continue to support essential hospitals' ability to provide access to care for the most vulnerable patients.**

ii. CMS' proposed options for services that lack a Medicare payment equivalent and providers for which Medicare does not publish payment rates are inadequate.

When a published Medicare rate is not available for a service, CMS proposes that the Medicaid state plan rate (or rate under a waiver of the state plan)—defined to exclude supplemental payments—becomes the *de facto* payment limit.

First, CMS should revise its definition of state plan rates to include supplemental payments. State plan rates are typically very low and often well below Medicare rates, which is why states provide supplemental payments to ensure sufficient access to care. Neither the WFTCL nor existing Medicaid statute defines "state plan rate." Supplemental payments are, in fact, defined in a state plan (or in terms and conditions under a waiver of such plan), so their inclusion is a more accurate interpretation of the state plan rate.

Moreover, while the WFTCL directs states to make state plan rates an alternative, this language does not preclude initial flexibility in CMS' implementation of the Medicare rate limit, before defaulting to the state plan rate (as CMS must acknowledge in permitting cost-based approaches for IPPS-exempt hospitals). In fact, in some circumstances, state plan rates might not be any more viable an alternative. State plans are the means for establishing FFS program rates; to the extent a state has transitioned to a full managed care program, state plan rates might no longer be available or not have been updated in many years.

Finally, while we agree that CMS should allow states to take a cost-based approach to determining the limit for services provided by Prospective Payment System–exempt hospitals, CMS must revise its proposed approach to permit more flexibility. As with FFS UPL calculations, CMS should allow states to make reasonable adjustments for inflation and other factors. CMS also should set limits at an aggregate level rather than a provider-specific level.

iii. The service-code specific limit will undermine efforts to tie payments to value.

CMS' proposed limits also would undermine the shared federal and state priority to incentivize value-based care in Medicaid. Although CMS has historically encouraged states to move away from FFS payment methods that reward the volume of care over value, the proposed rule would require states to retrofit VBP models into FFS at the service code level without accounting for shifts to more cost-effective settings that lower health system costs. As a result, the rule will limit states' ability to reward high-value care, even when total payments are below Medicare levels.

CMS' proposed retrospective enforcement of the new payment limits will add administrative burdens that will make VBP models unworkable. Since VBP payments are often paid after the end of the year in a lump sum, CMS will require states to develop a "detailed validation methodology" to ensure that the service-specific limits are not breached, including accounting for the specific base payment rates that providers have negotiated with each managed care plan. The administrative challenges of developing a validation methodology could make VBP payments impractical for states to implement.
CMS' proposal will also limit states' ability to make up-front investments to support new delivery system reforms that can result in long-term savings for the health system. If payment is capped at the Medicare rate at the service and provider level, there likely will be no opportunity for shared savings and, therefore, little incentive for providers to invest in quality improvement. **CMS should exclude VBP and delivery system reform SDPs from the proposed rule's strict Medicare payment limits and explore other ways for states to demonstrate the value of these investments.**

c. CMS' proposed retrospective enforcement of service code–specific limits is unnecessary for DSH hospitals.

The proposed rule notes that hospitals receiving Medicaid DSH payments are already subject to a detailed audit process to ensure that total Medicaid payments do not exceed hospital costs for Medicaid and uninsured patients. Considering this, we ask that CMS consider whether DSH hospitals also must be subject to retrospective enforcement of service-specific SDP limits. Because Medicare-based payments to hospitals are often below hospitals' costs of care, hospitals will be eligible for DSH payments to help cover this Medicaid shortfall. Any recouped SDP payments during the retrospective review process will only add to the DSH payments for which a hospital is eligible, and so this additional administrative burden will not affect federal spending. However, delayed retrospective SDP reviews will interfere with states' ability to make vital DSH payments and delay the DSH audit process. As a result, America's Essential Hospitals suggests that **CMS exempt DSH hospitals from the proposed retrospective review of SDP limits.**

d. The proposed limits are at odds with the statutory and regulatory framework of the Medicaid program and the WFTCL.

In enacting Medicare-based limits on SDPs in the WFTCL, Congress was focused on slowing the growth of SDPs for the four specified services by capping the "total payment" rate for these covered services at 100% or 110% of the total published Medicare payment rate. Neither the statutory text nor the legislative history suggests that Congress intended or requires CMS to limit SDPs to the exact rate that a specific provider would receive from Medicare for a specific service code. In fact, such an approach is at odds with the WFTCL text and its legislative history, as well as CMS' approach to applying Medicare-based limits to the Medicaid program for over 40 years.

i. State flexibility within federal limits is a hallmark of the Medicaid program that the WFTCL did not change.

Medicaid statute has long provided states with significant flexibility to design and operate their programs, subject to broad federal requirements and oversight. Within these requirements, *states* have responsibility for designing and administering their programs. This responsibility includes establishing payment policies and rates, provided they are "consistent with efficiency, economy, and quality of care," are sufficient to ensure access to care and services, and "take into account the situation of hospitals which serve a disproportionate number of low income patients….".[21] To meet this standard, states' approaches to payment methodologies and amounts for a particular service and/or provider will necessarily vary, just as Medicaid populations, the availability of providers and practitioners, and policy priorities all vary considerably. Indeed, states have adopted an array of service delivery and payment system models, financial incentives for quality and access improvement, and managed care contracting requirements, all tailored to serving their states' Medicaid population and achieving state policy goals.

This flexibility has coexisted alongside Medicare-based payment limits for institutional services since the adoption of the FFS UPL regulations in the early 1980s, when Congress repealed the reasonable cost payment standard and adopted the existing economy, efficiency, and access standard. *See* Omnibus Budget Reconciliation Act of 1981. In implementing the new standard, the Health Care Financing Administration (HCFA), CMS' predecessor, applied the limit 1) in the aggregate at the Medicaid statutory covered service level, rather than the discharge level, and 2) based not on the exact amount Medicare would pay a particular provider for a specific service but rather on a "reasonable estimate of the amount that would be paid for the services … under Medicare payment principles."[22] Indeed, in the legislative history for the Omnibus Budget Reconciliation Act (OBRA) of 1981, Congress emphasized that "states should have flexibility in developing methods of payment for their Medicaid programs" and that "the Secretary would only be expected to compare the aggregate amounts paid to hospitals by Medicaid" in applying a Medicare payment limit.[23] Consistent with this direction, HCFA explained that it sought to strike a balance between ensuring that the Medicare upper limit would not be exceeded, while ensuring that states have some flexibility to design their payment systems and to establish a federal review process that is less administratively burdensome.[24]

Nothing in the text of the WFTCL suggests Congress intended to strip states of the flexibility to establish appropriate payment rates at the service and provider level—flexibility that is necessary for states to ensure that payments are sufficient to ensure access to care under section 1902(a)(30)(A). CMS should not implement an interpretation that undermines this longstanding principle.

ii. Actuarially sound rates require states to make reasonable and appropriate adjustments that account for the costs of care for the population covered.

In prior rules, CMS has taken the position that section 1902(a)(30)(A) does not apply to managed care and that SDPs are instead governed by the actuarial soundness and network access provisions at 1902(m)(1)(A)(i) and (2)(A)(iii). However, these actuarial soundness

[21] 42 U.S.C. 1396(a)(30)(A).
[22] 42 C.F.R. § 447.272.
[23] See S.Rep. No. 97-139, at 477 (1981), reprinted in 1981 U.S.C.C.A.N. 396, 744.
[24] See generally 48 Fed. Reg. 56046, 56052 (Dec. 19, 1983).

standards parallel the requirements of 1902(a)(30)(A) for states to make reasonable adjustments to account for the unique needs of Medicaid patients.

For example, the definition of actuarial soundness in 42 C.F.R. 438.4(a) requires rates to account for "all reasonable, appropriate, and attainable costs … for the time period and the population covered under the terms of the contract." Further, in 42 C.F.R. 438.4(b)(3), CMS notes that rates must "be adequate to meet the requirements … in §§ 438.206 [Availability of services], 438.207 [Assurances of adequate capacity and services], and 438.208 [Coordination and continuity of care.]"

CMS' proposed, overly restrictive standard for enforcing Medicare-specific rates will limit the ability of states and health plans to make reasonable adjustments to ensure access to services, even when total payments are less than what Medicare would have paid. As a result, the proposed policy is not consistent with the actuarial soundness standard.

iii. Applying the Medicare limits on a granular per-service, per-provider level is inconsistent with the WFTCL.

Section 71116 directs CMS to amend the current commercial limit on the "total payment rate" for certain SDPs to establish a limit based on the "total published Medicare rate." While replacing the applicable limit, nothing in Section 71116 otherwise alters the current SDP framework referenced by Congress.

CMS' existing regulations define the "total payment rate" as a calculation not on a provider-specific basis, but as an "aggregate" calculated on an "average" basis across the providers of a covered service by class (if any).[25] The comparison of the total payment rate to the currently commercial limit is then performed on a covered service ("each service included in the SDP") and class basis. For purposes of each of these provisions, CMS SDP regulations clearly define the concept of "service" to include "inpatient hospital services," "outpatient hospital services," etc.—that is, a category of Medicaid covered services as defined in Section 1905(a) of the Social Security Act.[26]

The WFTCL does not direct CMS to change this structure; rather, Congress chose to keep the existing concept of the total payment rate and simply replace the commercial limit with a percentage of Medicare.

> [T]he Secretary…shall revise section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations (or a successor regulation) such that, with respect to a payment described in such section made for a service … the total payment rate for such service is limited to…[100 or 110] percent of the specified total published Medicare payment rate (or, in the absence of a specified total published Medicare payment rate, the payment rate under a Medicaid State plan (or under a waiver of such plan)…

In the proposed rule, CMS claims it must apply the payment limit to each individual service, rather than at the covered service level, because the law refers to "the payment rate for such service" in establishing the payment limit.[27] But the WFTCL does not say "the payment rate for

[25] See 42 C.F.R. 438.6(a).
[26] See 42 C.F.R. 438.6(a).
[27] 91 Fed. Reg. at 30413.

such service;" it says "the **total payment rate** for such service." In the regulations Congress referenced, the total payment rate is an aggregate one, so CMS cannot rely on its misquoted language to support the opposite.

The legislative history of Section 71116 also indicates that Congress specifically decided against applying the limit at the individual service level. The initial Senate version of Sec. 71116 provided:

> The term 'total published Medicare payment rate' means amounts calculated as payment **for specific services** that have been developed under part A or part B of title XVIII of the Social Security Act (42 USC 1395 et seq.). (emphasis added)

After further deliberation, however, Congress submitted an amendment in the nature of a substitute to revise the language before passage to read:

> The term "total published Medicare rate" *has the meaning given to such term in section 438.6(a) of title 42, Code of Federal Regulations (or a successor regulation).*" Section 71116(d)(4) (emphasis added).[28]

This change removed the reference to "specific services" and replaced it with a reference to the existing regulatory framework.

Thus, nothing in the WFTCL suggests that Congress sought to upend the aggregate nature of the limit calculation. Without clear language directing such a monumental change to a per-service-per-provider limit, the reasonable interpretation is the one rooted in the Medicaid statute's definition of "service," consistent with the WFTCL's legislative history, and adopted in the pre-existing regulatory structure on which Congress' amendments are built.

iv. The WFTCL also does not direct the overly strict and narrow concept of a Medicare payment rate proposed by CMS.

The WFTCL does not require the strict concept of the term "total published Medicare rate" that CMS now proposes. Yes, Section 71116 refers to the "specified total published Medicare payment rate." This term is defined under existing SDP regulations for purposes of allowing states to adopt minimum fee schedules based on the Medicare rate without obtaining prior CMS approval (per Section 438.6(c)(1)(iii)).[29]. However, Congress clearly expected CMS would need to revise the term through rulemaking to implement the law's provisions. In incorporating the regulatory term "total published Medicare payment rate," Section 71116(d)(4) specified that that the term would have "the meaning given to such term in section 438.6(a) of title 42, Code of Federal Regulations *(or a successor regulation)*" (emphasis added). Furthermore, CMS must acknowledge this (or some other) source of flexibility, as the current proposal assumes flexibility to deviate from a published rate for reasonable purposes, such as for non-IPPS providers. Section 71116 thus does not bar CMS from using such flexibility to better align payment rates with Medicaid and its statutory payment principles.

[28] See July 1, 2025, Senate amendment in the nature of a substitute.
[29] See 42 C.F.R. § 438.6(a)

e. Recommendation: CMS should define the total Medicare payment rate as a reasonable estimate of what Medicare would pay for the service and apply the limit at the statutorily covered service level that Congress intended.

The language of the WFTCL and the policy justifications outlined above support retaining the current flexible structure for setting SDP limits at the statutorily covered service level and for allowing reasonable flexibility when estimating what Medicare would pay for the service.

First, the payment limit should continue to be applied at the statutorily covered service level and not at the individual service level. CMS should maintain the current approach, on which Congress built Sec. 71116, and simply substitute for the average commercial rate (ACR) an estimate of the published Medicare rate. Calculating the limit in this manner would ensure that Medicaid SDPs do not exceed Medicare rates across the covered services covered by the preprint consistent with Section 71116 while avoiding the significant and unnecessary complexities of CMS' current service-code-specific proposal.

Second, CMS should allow states reasonable flexibility when determining the published Medicare rate limit to ensure accuracy and appropriateness for Medicaid and avoid unreasonable burden without a corresponding compliance benefit. Rather than trying to force a Medicare structure onto the Medicaid managed care structure already in place, CMS should permit states to develop prospective, aggregate approaches at a covered service level that are reasonable estimates of the published Medicare rate as adjusted to reflect the range and relative cost of services provided to the Medicaid population. CMS has extensive experience in evaluating state demonstrations and using them to create template options for UPL calculations under FFS; a similar process could apply here. States would have more flexibility to adopt tailored payment methodologies that might exceed the specific published Medicare rate for a specific service by a specific provider or for a subset of providers, as long as payments across the covered service do not exceed the limit.

As part of the flexibility of the recommended approach, we urge CMS to permit states the option to implement the following approaches to address specific concerns:

- CMS should extend the option of a cost-based demonstration beyond IPPS-exempt hospitals. This would be similar to the cost-based UPL demonstrations currently permitted under FFS. Consistent with the challenges of an appropriate cost-based rate for certain providers, CMS should allow demonstrations that are consistent with Medicare cost principles but not so strictly tied to the Medicare cost report where it is inapplicable.

- CMS should define state plan rates to include supplemental payments. States have enacted targeted adjustments to support providers of specialized services (e.g., reflecting the higher costs of specialized pediatric services) or in underserved locations (e.g., rural hospital rate increases). Where Medicare rates do not exist and state plan rates might apply, CMS should not unnecessarily limit providers serving managed care beneficiaries to an insufficient rate.

- CMS should also allow reasonable substitutes where a Medicare rate does not exist. For example, CMS could allow states to develop rate increases based on the difference between Medicare and Medicaid rates for those services that do have a Medicare rate and exclude those that do not from the initial rate increase calculation. States would

then apply this increase to all services (including those without a Medicare rate). This option requires maintaining uniform rate increases, which we also strongly urge.

Our proposed approach has the benefit of aligning with methodologies that CMS has already developed to calculate the UPL in FFS. Congress has recently taken action to improve the transparency and accountability of this process, and we support efforts to apply similar transparency to the calculation of Medicare-based limits for SDPs.[30] In the proposed rule, CMS notes that it chose not to pursue a UPL approach because current regulations provides "States with broader flexibility than what is required for FFS UPLs in defining the provider class for which States can implement SDPs. This flexibility has proven important for States to target their efforts to achieve their stated policy goals tied to their managed care quality strategy." We agree that states should not be required to use similar ownership categories as FFS when defining provider classes for SDPs, but the issue of how provider classes are defined in FFS is not a sufficient reason to propose a much more stringent standard that reduces state flexibility to align SDPs to state policy goals.

4. CMS should not prohibit allowable SDP types left untouched by the WFTCL, specifically uniform payment increases or minimum fee schedules based on state plan rates.

CMS also has proposed enormous administrative changes to the way in which states can make SDPs. The agency would eliminate states' ability to make uniform rate SDPs—the most common type of SDPs—and no longer permit states to make SDPs based on Medicaid state plan rates. In doing so, CMS asserts that these types of SDPs are merely designed to reward providers who can assist with financing the payments, whether through provider taxes or IGTs, and do not serve to advance Medicaid quality goals. As explained above, CMS cannot determine the permissibility of a payment limit under the Medicaid statute based on a different permissible form of nonfederal share funding, and states should not be prohibited from using legitimate and helpful policy tools on this basis.

In discussing the rationale for eliminating states' ability to make SDPs based on state plan approved rates, CMS acknowledges that state plan approved rates require agency approval. CMS does not acknowledge that inpatient and outpatient hospital services are already subject to a UPL based on Medicare. Yet, CMS notes, it is concerned that these rates could exceed its much more restrictive application of the Medicare limit to SDPs. It is unclear why CMS would create a new approach to Medicare-based payment limits for SDPs when the existing approach has governed FFS hospital and nursing facility services for more than 40 years and remains intact for hospital services in the rule. Nothing in the WFTCL suggests Congress intended to completely reinvent these limits, much less in a way that threatens states' ability to use SDPs to ensure sufficient payment rates to ensure access to quality care for Medicaid beneficiaries.

In addition to preserving the ability of states to establish the limit at the covered service level, states should maintain the ability to make SDPs based on the Medicaid state plan rate. Particularly for providers in rural states that have a much lower Medicare wage index, Medicaid FFS rates may exceed the Medicare rate.

5. CMS should not extend SDP cuts to services not required by Congress.

[30] Section 202, Consolidated Appropriations Act, 2021 (P.L. 116-260).

Congress made it very clear in Section 71116 that it was only restricting SDPs to Medicare-based limits for four service categories: inpatient hospital services, outpatient hospital services, nursing facility services, and professional services affiliated with an academic medical center. **Cuts to other SDPs for other services not mandated by the WFTCL go beyond congressional intent and threaten access to care.**

Some of the additional Medicaid services that would receive payment cuts under CMS' proposal include primary care, behavioral health, home- and community-based services (HCBS), and dental care. These cuts are shortsighted because Medicaid beneficiaries already face challenges accessing these services and lack of access to this care in communities is likely to increase avoidable hospital use and other costs to the health system in the long term.

If CMS extends SDP cuts to services outside of those required by Congress, CMS should provide the same phase-down schedule that it has provided to grandfathered SDPs. A phase-down will minimize the disruption of SDP cuts on providers, particularly those that rely on these payments. Though new Medicare payment limits are delayed until the rating period beginning on or after Jan. 1, 2029, providers will need more time to adjust their care model to accommodate lower reimbursements. As mentioned above, lower reimbursement for these services will likely lead to more providers dropping out of the Medicaid program or further limit the number of Medicaid patients they see, so providers will have to adjust their practices accordingly. A sharp drop in payments will be very disruptive to both providers and Medicaid beneficiaries, leading to fewer providers and longer wait times.

6. CMS should not implement cuts to targeted FFS payments, which will interfere with the ability of states to ensure access to quality care for Medicaid beneficiaries.

Targeted FFS practitioner payments have long been a critical, appropriate tool to deploy limited state and federal resources to high-value providers who help ensure access to quality care for Medicaid beneficiaries. As CMS itself acknowledges in the proposed rule, states have most commonly targeted ACR-based payments in FFS "to practitioners affiliated with and furnishing services in AMCs and safety net hospitals."[31] And for good reason. These are provider types that are critical to the health and access of Medicaid beneficiaries and yet, due to unique financial pressures, cannot sustain access without supplemental Medicaid reimbursements.

As described below, there have been longstanding concerns about Medicare rates for professional services, as well as Medicaid base rates. Yet where Medicaid programs have targeted support and where professionals are affiliated with systems that invest in access for low-income patients, professionals have been more willing to accept Medicaid patients.

a. CMS' proposal to restrict targeted FFS practitioner payments is inconsistent with Congressional intent and the Medicaid statute and program structure as a whole and should be withdrawn in its entirety.

i. Congress did not include it in the WFTCL.

[31] Bessent S, Sonderling K, Kennedy R, et al. Letter to Mike Johnson and JD Vance on June 9, 2026. https://www.cms.gov/oact/tr/2026. Accessed July 8, 2026.

Congress could have chosen to change the limit on payment rates to professionals under the FFS program but did not. These payments represent a much smaller share of total spending, both because of the nature of the services and because states have shifted so much to managed care. Moreover, they are a longstanding tool that did not merit disruption, particularly because of their outsized role in supporting patient access.

ii. The Medicaid statute has a long history of allowing states to target limited funding to support vulnerable populations, consistent with the statutory goals of efficiency, economy, quality, and care commensurate with the general population.

As CMS itself acknowledges in the proposed rule, the agency has been approving ACR-based supplemental payments for physician and professional services in FFS for over two decades. To support such approvals, CMS itself had to determine that payment at the ACR level for these services was consistent with efficiency, economy, and quality of care, and sufficient to enlist enough providers to serve the Medicaid population. Apparently, all those past approvals were wrong in the eyes of the current agency.

CMS now expresses concern that these payments are not economic and efficient on several grounds. First, CMS asserts that because ACR-based FFS practitioner payments are based on proprietary commercial payment data, they create oversight risk and are not readily verifiable or auditable. But commercial data has always been proprietary. This rationale does not support an upheaval of longstanding policy.

Next, CMS points to increases in state ACR calculations as a percentage of Medicare over time. But the fact of an increase does not necessarily correlate to a lack of economy or efficiency. Has Medicare reimbursement for practitioners kept pace with practice costs, increased enrollment, commercial payment rates, and the like? Or has Medicare become an increasingly poorer payer over time, justifying increases in the Medicaid percent? This administration's own leadership, through the Board of Trustees of the Federal Hospital Insurance Trust Fund, seems to suggest the latter. In evaluating the financial status of the Medicare trust funds, the Board (which includes the Secretary of HHS) concluded that the current Medicare physician payment system:

> raises important long-range concerns that will almost certainly need to be addressed by future legislation. The law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term.[32]

If Medicare rates are inadequate to secure long-term access for Medicare beneficiaries, they surely are inadequate to ensure long-term access (a statutory requisite) for Medicaid beneficiaries, who are significantly less likely to have access to physician services. The Medicaid and CHIP Payment and Access Commission reported in 2021 that "physicians were significantly

[32] Ibid.

less likely to accept new patients insured by Medicaid (74.3 percent) than those with Medicare (87.8 percent)."[33] Notably, though, physicians affiliated with faculty practice plans have accepted Medicaid patients at above-average rates.[34] Given that FFS supplemental payments have largely been directed to professionals affiliated with safety net hospitals and AMCs, these higher acceptance rates could be driven at least in part by the higher Medicaid payment rates that have been available to these practitioners.

Rather than providing any meaningful analysis of this type, CMS simply points to outlier programs that far exceed Medicare in an attempt to paint ACR-based payments as excessive. But CMS already has a robust subregulatory process, including annual UPL demonstrations, developed over years, to validate and audit FFS supplemental payments to practitioners. If CMS has concerns that any particular program results in payments that are not economic or efficient, it has authority through the existing process to require reductions or alter its approvals. A one-size-fits-all change in policy is not needed; the existing process is working well to limit federal spending and curb abuse. The fact that CMS has approved programs that it now identifies as concerning at most reflects the failure of CMS to use its own approval and auditing processes effectively and at worst conveys that this data point is simply pretext for addressing other concerns, namely nonfederal share financing.

Most troubling, after expressing concerns that would seemingly apply to all FFS supplemental practitioner payments, the proposed rule suggests that only targeted payments are the problem. It defies reason that it would be economic and efficient for states to pay all physicians above Medicare (resulting in vastly higher total Medicaid spending), but the mere fact of targeting to a subset of providers—even those that provide high-value care and play a unique or critical role in serving the Medicaid population—results in payments that are not economic or efficient. But that is what CMS' policy would codify—inexplicably precluding states from determining that more targeted payments and more limited spending is a more efficient use of state and local taxpayer dollars.

Finally, CMS proposes to limit these payments at the individual service level, similar to its proposal to apply the Medicare limit to SDPs. This proposal is directly at odds with Congress' elimination of the service-specific Medicare limits that applied prior to the enactment of OBRA 1981. In the Senate report accompanying OBRA 1981 Congress specifically provided that the Secretary "would only be expected to compare the aggregate amounts paid to hospitals by Medicaid" and that "[a] similar aggregate test of reasonableness of Medicaid reimbursement would be applicable to physicians." See S.Rep. No. 97-139, at 477 (1981), reprinted in 1981 U.S.C.C.A.N. 396, 744.

7. CMS should align the 10% annual reduction with the statutory text by applying the reduction to the immediately preceding year's limit.

Under the WFTCL, SDPs are subject to a 10–percentage point annual reduction beginning with rating periods on or after Jan. 1, 2028. The language of the statute itself—that "beginning with the rating period on or after January 1, 2028, the total amount of such payment shall be reduced by 10 percentage points each year"—indicates that Congress envisioned a very gradual

[33] Medicaid and CHIP Payment and Access Commission. *Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey*. June 2021. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-m-the-National-Electronic-Health-Records-Survey.pdf. Accessed July 8, 2026.
[34] Ibid.

phase down in SDPs. As we have urged in prior comments to CMS, in implementing the parameters of this phase-down in its upcoming rulemaking, CMS should heed the direction provided by Congress. More quickly implementing the reductions specified in the WFTCL will inflict significant additional damage on essential hospitals.

Nonetheless, **instead of adopting a methodology that would slowly shrink each SDP to disperse the negative impact as Congress intended, CMS is implementing the phase down in a manner that results in larger annual cuts and a significantly shorter transition.** In the proposed rule, CMS states that the annual reduction will equal 10 percentage points of the original grandfathered total dollar amount until the applicable limit is reached. CMS also asserts that this interpretation is *required* by the statute, despite considering an alternative methodology.

CMS' interpretation is not compelled by the WFTCL, nor is it the most reasonable interpretation of it. CMS interprets the "total amount of such payment" to mean the total dollar amount of the approved grandfathered SDP for purposes of setting the starting point for the annual reductions. However, the law only specifies that the starting point for the phase down is the total dollar amount of the approved grandfathered SDP. Nothing in the law dictates that this starting amount is the amount from which the 10% annual reduction is to be taken after the first year of the phase down.

An approach that adheres more closely to Congress' goal of gradually phasing down grandfathered SDPs to the Medicare rate and that is consistent with the plain language of the statute would be to use CMS' approach for determining the starting point for the reductions and then each year calculate the 10% reduction from the prior year's limit.[35] Under this approach, if the grandfathered total dollar amount is $1 billion, the 10% reduction in Year 1 (2028) would equal $100 million for a reduced total dollar amount of $900 million. In Year 2 (2029), the 10% reduction would be applied to the Year 1 total dollar amount of $900 million for a reduction of $90 million and a total dollar amount limit of $810 million, and so on. This alternative methodology would more gradually reduce SDPs as contemplated by Congress and soften the impact on essential hospitals. Further, this more gradual phase down is consistent with Congress's efforts to minimize the reductions for non-expansion states, for which the SDP limit is set at 110% of the total published Medicare rate rather than 100% for expansion states. CMS' aggressive phase down approach would result in expansion states reaching the 110% limit much

[35] CMS also considered an approach in which the total payment rate in the grandfathered SDP, translated into a percentage of the total published Medicare payment rate) would be reduced by 10 percentage points each year until it reaches the applicable Medicare rate. CMS does not address the statutory basis for this interpretation, but as CMS must also have concluded, this interpretation is consistent with the WFTCL. The end goal of the phase down is to reach a point where total payments for the service per the total rate comparison process are no more than 100% or 110% of Medicare, so it is reasonable to interpret the "total amount of such payment" to mean the SDP when added to the base and any other SDPs. While CMS used a different interpretation of "total amount of such payment" to justify the freeze on the grandfathered SDPs until the phase down begins, CMS noted that the guidance in the letter could be subject to change during rulemaking, and the guidance did not previously address the phase down period. CMS' reasons for not adopting this approach are related to administrative burden because it would necessitate states calculating and applying the phase down separately for each of multiple services, provider classes and programs. CMS could do the calculation for the covered service overall across classes.

Also, CMS is already proposing to require states to express the total payment rate comparison as a percent of Medicare in its monitoring of the phase down process, so states are going to have to figure out the analysis already and the incremental burden must be less significant. If a state wants to take this approach, CMS could permit this option, which could also help with the eventual transition to post-grandfathering rules.

more quickly, thereby eliminating these states' option to continue to make uniform increase SDPs and to utilize separate payment terms.

We support CMS' decision to apply the reduction from the total dollar amount limit for the preprint each year. Doing so provides states the needed flexibility to determine how best to implement the phase down within a particular program, while ensuring that spending does not exceed the limit. This approach is consistent with CMS' preliminary guidance implementing the WFTCL and states have relied upon and will continue to rely upon this guidance in designing their programs for rating periods subject to the limits. CMS did not consider any further restrictions on how states implement the phase-down in this proposal and should not finalize a policy that would newly implement such restrictions in a final rule.

We also encourage CMS to provide states with the flexibility to consider other alternatives to smooth the transition in their state. Some other options that CMS could consider include applying the 10-percentage point reduction to the current SDP rate as compared to Medicare (e.g., from 200% of Medicare to 190%, 180%, etc.) or applying the 10% reduction to the difference between the Medicare payment rate and the grandfathered payment amount. It is important to provide multiple options so states can determine which approach is best for their unique circumstances.

8. CMS should continue to allow states to implement separate payment terms to improve the transparency and accountability of SDPs.

a. We appreciate delay of the phase-out of separate payment terms for grandfathered SDPs and urge CMS to extend this policy to all SDPs.

Separate payment terms are an important tool to ensure transparency and accountability in SDP spending. We appreciate that CMS has acknowledged separate payment terms as a transparent and administratively feasible mechanism to monitor and conduct oversight of compliance for grandfathered SDPs during the phase down period. To that end, **CMS should continue the use of separate payment terms for all SDPs to avoid fraud and waste in SDP payments in the future.**

If CMS continues the course to prohibit separate payment terms**, CMS should at least employ this tool to all SDPs while they transition to Medicare payment limits.** As discussed above, CMS should allow a gradual transition period for SDPs for other services to phase down to the Medicare limit, in which separate payment terms could be leveraged to monitor compliance. If SDPs for these services are not granted a phase-down period, the agency should allow the use of separate payment terms through the rating period that begins on or after Jan. 1, 2029.

b. CMS should delay implementing the prohibition on interim payments based on historic utilization for grandfathered SDPs during the phase-down period.

In the 2024 managed care rule, CMS acknowledged that states can pair separate payment terms with post payment reconciliation processes to ensure compliance with payment terms. Interim payments based on historic utilization enable providers to be paid on a timely and accurate basis before the claims runout process is complete. In the 2024 rule, CMS noted that the claims run-out process can be as long as 16 months in some states, which means that without interim

payments based on historic utilization, a hospital might need to wait more than a year to get fully paid for services rendered to Medicaid beneficiaries.[36] Given the forthcoming changes to SDPs, timely and accurate payments will be critical to maintain access to care. **CMS should delay implementing the prohibition on interim payments based on historical utilization for grandfathered SPDs in conjunction with the delay in prohibition of separate payment terms, so SDP payments remain transparent and compliant with forthcoming payment limits.**

c. Separate payment terms are effective and efficient ways to make SDPs to essential hospitals that are consistent with the risk-based nature of managed care and prevent steerage.

In the 2024 final rule, CMS noted the widespread use of separate payment terms and the comments it received underscoring how these arrangement "provide greater transparency, ensure that payments flow to providers as intended, minimize administrative burden for states, and make it easier for states to track SDPs."[37] In our own analysis, we have found that separate payment terms are particularly helpful tools for states that target SDPs to essential hospitals because they reduce the risk that health plans would have an incentive to steer patients away from the providers the state intended to help. The American Academy of Actuaries highlighted similar findings in its comments on the rule, noting that "prohibiting these separate payment terms could result in access issues or steerage away from certain providers, including some who may be essential safety net providers."[38]

Despite the proven benefits of separate payment terms in achieving the statutory goal of efficiency, CMS noted in its preamble to the 2024 final rule that it chose to eliminate these provisions because of concerns these policies are inconsistent with "the risk-based nature of managed care." However, the agency does not explain why it prioritizes this goal over the statutory responsibilities of states to safeguard access and ensure managed care payments benefit Medicaid beneficiaries. There is no statutory reason for CMS to restrict the use of separate payment terms.

Section 1903(m)(2)(A) of the Social Security Act does require managed care plans to be paid on a prepaid risk basis, but the statute does not specify how much risk managed care plans should take on. In managed care, states often employ a variety of strategies to help minimize the risk to managed care plans for costs outside their control. For example, because most health plans are paid on a per member per month basis, health plans are not at risk for changes in Medicaid enrollment. In addition, many states have established risk corridors and outlier payment policies for high-cost services to reduce the risk that health plans are underpaid for the services they provide.

Section 1903(m)(2)(A)(iii) of the Social Security Act further specifies that prepaid amounts to managed care plans must be actuarially sound. Federal regulations define this term to mean that the capitation rate covers all reasonable, appropriate, and attainable costs of services covered under the contract (42 C.F.R. § 438.4). Ultimately, actuarially sound rates help reduce the risk that health plans are overpaid or underpaid for the care they provide.

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[36] 89 Fed. Reg. 41,002, 41,285. (May 10, 2024).
[37] Ibid.
[38] American Academy of Actuaries. Letter to CMS regarding "Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality (CMS-2439-P)" on June 30, 2023. https://www.regulations.gov/comment/CMS-2023-0071-0104. Accessed July 8, 2026.

Although actuaries are responsible for certifying managed care rates, states are ultimately responsible for setting managed care contracts, including requirements for SDPs to advance state access and quality goals. When a state changes the managed care contract by adding SDPs, it necessarily changes the actuarially sound rate needed to cover the costs of that contract.

Separate payment terms were developed as a tool to make sure that the amount paid through SDPs is equal to the amount states intended to advance the state's quality and access goals. Separate payment terms are particularly useful for ensuring accurate rate setting for SDPs that are targeted to specific safety net providers because other types of rate adjustment (e.g., regional cost benchmarks) cannot fully account for the differences in payments for one provider versus another. Separate payment terms not only help provide more clarity to health plans and providers but also make the MCO payment process more efficient and help state policymakers better budget available resources. Moreover, actuaries have certified and endorsed the use of this practice as actuarially sound.

CMS concerns about separate payment terms appear to be based on a mistaken view that separate payment terms remove health plans' responsibility for managing utilization of services under the contract. However, SDPs remain based on actual utilization during the contract period, and plans continue to be at full risk for base payments under the contract. Separate payment terms do reduce incentives for health plans to steer patients away from essential hospitals that receive targeted SDPs, but that is consistent with the state goals to target their limited resources to hospitals that need the funding the most.

We recognize that risk is an inherent part of managed care, but CMS must ensure that any risks passed to health plans have the potential to benefit Medicaid patients. Eliminating separate payment terms only adds administrative risk that SDPs will not equal the amount targeted by the state or the amount funded through managed care capitation rates. Ultimately, actuaries will need to account for this risk by adding in new administrative costs to the rate that do not benefit patients.

To mitigate the consequences of eliminating separate payment terms, CMS has noted that states can add risk corridors to limit how much the actual SDP amount can deviate from the expected amount and recoup unspent SDP funding. However, in recent subregulatory guidance, the proposed risk corridors and other mitigation strategies that CMS has suggested are not sufficient to eliminate the risk that plans will steer patients away from essential hospitals.

d. The consequences of eliminating separate payment terms are apparent in recent MA plan decisions to exclude essential hospitals from networks.

In MA, Medicare DSH and UC add-on payments are included in MA benchmark rates without separate payment terms to make sure that they are directed to the providers that Congress intended, and plans have minimal obligations to include essential hospitals in their care networks. As a result, we have noticed in recent years that some MA plans have chosen to exclude essential hospitals from their networks so that they can avoid paying the DSH and UC payments that are part of their benchmark capitation rates.[39] The Medicare Payment Advisory Commission (MedPAC) noted this issue in its June 2026 report and has noted how separate

[39] DeCubellis J. Letter to Mehmet Oz on Jan. 26, 2026. https://essentialhospitals.org/wp-content/uploads/2026/01/Americas-Essential-Hospitals_2027-MA-Proposed-Rule_Comment-Letter.pdf. Accessed July 8, 2026.

payment terms and stronger network adequacy requirements could be better tools to help address this issue.[40]

e. Eliminating separate payment terms runs counter to CMS' goals of improving transparency and accountability.

An unintended consequence of CMS' new policies is that it will undermine the agency's stated goals of improving the transparency and accountability of SDPs. Separate payment terms make it easy for states, health plans, and providers to immediately know how much providers are paid and when.

Knowing how much providers are paid in SDPs also helps policymakers keep health plans accountable for ensuring SDPs are used for state-defined goals. In CMS' 2023 proposed managed care rule, it acknowledged the lack of accountability when SDPs are folded into the large capitation rate: "Incorporating this funding into the State's capitation rates through standard rate development would not ensure that plans did not use this funding, or portions of this funding, for other purposes."[41]

For value-based SDPs, it is particularly disruptive for providers not to know how much money they can earn for achievement of quality milestones. Ultimately, if the payments providers receive from SDPs become more uncertain, providers are less likely to make the up-front investments needed to reform their delivery systems and achieve these quality goals.

9. CMS should take other steps to minimize administrative burden for states.

The proposed changes to SDPs, as well as other Medicaid provisions in the WFTCL, will require large system changes, and new monitoring processes and reporting requirements at a time when states are experiencing staff shortages and shrinking budgets. The rule's SDP requirements will increase administrative burden on states and have negative downstream effects on providers. As CMS implements SDP provisions in the WFTCL, we look forward to working with the agency to minimize disruption for essential hospitals who are using SDPs to improve access and quality of care for the most vulnerable Medicaid patients.

a. CMS should minimize new reporting requirements for grandfathered SDPs.

CMS proposes adding reporting requirements for grandfathered SDPs to monitor payment limits through the phase-down period. Monitoring requirements for SDP preprints are already extensive and comprehensive. While reporting on the rate demonstration and total rate comparison to the applicable rate limit is appropriate, other requirements—a list of all eligible providers and a detailed description of the monitoring plan to ensure payments to each provider do not exceed the payment limit—are excessive. The same goes for the proposed reporting on VBPs.

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[40] Medicare Payment Advisory Commission. *Estimated association between Medicare Advantage enrollment and hospitals' and post-acute care providers' finances*. June 2026. https://www.medpac.gov/wp-content/uploads/2026/06/Jun26_Ch4_MedPAC_Report_To_Congress_SEC.pdf. Accessed July 8, 2026.
[41] 88 Fed. Reg. 28,092, 28,146 (May 3, 2023).

Current SDP reporting requirements are comprehensive, and the added value of the proposed additional reporting is unclear. New monitoring requirements will put further strain on states' limited workforce and resources to compile this information while states are implementing significant changes to their Medicaid programs. **CMS should limit new reporting requirements for grandfathered SDPs and ensure reporting requirements add meaningfully to monitoring compliance and are not inefficient and wasteful.**

b. CMS should take steps to expedite approval of SDPs and focus more on measuring quality.

CMS should consider ways to accelerate SDP payment application approval to advance the agency's goals of improving federal and state program administration, which are part of the Medicaid and CHIP Scorecard.[42] Recently, some states have had to wait over a year for their SDP approval, delaying payments to providers and threatening their ability to maintain access to care. By simplifying SDP administration, CMS can better focus on monitoring policies that matter to patients, such as access to maternal and behavioral health. **CMS must accelerate the SDP approval process to support providers and use its limited resources to improve health care quality.**

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Director of Policy Robert Nelb, at 202-585-0127 or rnelb@essentialhospitals.org.

Sincerely,

Jennifer DeCubellis
President and CEO

[42] Centers for Medicare & Medicaid Services (CMS). Medicaid and CHIP Scorecard. https://www.medicaid.gov/state-overviews/scorecard/measure/State-Directed-Payment-Review-Administrative-Data?pillar=6&measure=FS.12&dataset=2025&measureView=national&dataView=pointInTime&chart=bar. Accessed June 17, 2026.