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The Honorable Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8013

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

Dear Administrator Oz:

I am writing on behalf of the Alliance of Safety-Net Hospitals (ASH), a coalition of private community safety-net hospitals serving low-income patients in hard-working but medically underserved communities, to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed Medicaid state directed payment and fee-for-service (FFS) rule published in the *Federal Register* on May 22, 2026.

ASH appreciates CMS's interest in program integrity, transparency, and appropriate oversight of Medicaid financing. At the same time, we are deeply concerned that several aspects of this proposed rule would go well beyond the statutory direction Congress gave the agency and would significantly restrict states' ability to sustain access to care for Medicaid beneficiaries and the hospitals that serve them.

ASH supports responsible guardrails for state directed payments (SDPs), which should be transparent, tied to Medicaid program goals, and subject to meaningful federal oversight. But SDPs have become a vital tool for states in helping community safety-net hospitals fulfill their missions of service to their communities, and the hospitals that play the greatest role in caring for Medicaid patients are often the hospitals that rely most heavily on these payments. The proposed rule would narrow that tool at precisely the time when states and providers are absorbing historic Medicaid policy changes, rising costs, increased uncompensated care pressures, and continued instability in coverage.

ASH urges CMS to:

- limit Medicare-based caps to the four service categories Congress identified
- preserve state flexibility to use uniform rate increases;
- reconsider its proposed hospital-specific Medicare payment limit methodology; and
- maintain grandfathered status for statutorily grandfathered payments even when they reach the Medicare cap.

We offer specific feedback on each of these recommendations below.

State Directed Payments Are Critical Supports

The Working Families Tax Cut legislation (WFTC) directs CMS to implement limits on SDPs for specified categories of services; however, the proposed rule goes beyond the statute in several important respects. CMS proposes to apply Medicare-based limits beyond the four categories identified in the statute; eliminate SDPs that take the form of uniform rate increases outside grandfathered payments; calculate the Medicare payment cap at a hospital-specific level rather than as an aggregate cap; and add new requirements for payments to obtain grandfathered status. ASH believes these proposals, taken together, would materially reduce states' ability to respond to Medicaid access needs and would place additional pressure on safety-net hospitals already operating under significant financial strain. Understanding that several aspects are required in the law, we believe Congress granted CMS the flexibility to continue supporting state Medicaid programs and essential providers who rely on this funding to care for low-income families.

State Power is Crippled Without SDPs

After the growth of Medicaid managed care programs across the country, wherein states have relinquished most of the levers they can pull to reach providers or services that are overburdened by costs and underpaid by Medicaid's schedule rates, SDPs have become a vital tool to implement provider initiatives and delivery system reform. ASH continues to believe that these payment programs can be designed and implemented with fiscal integrity and can truly improve quality of care for Medicaid managed care recipients. States are charged in the Social Security Act to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Directed payments have become one of only a few avenues for states to uphold their obligations. In 2024, 41 states submitted over 350 preprints looking for authorization to start or continue SDPs in their Medicaid programs because this mechanism is simply embedded in the reimbursement framework.

Medicare is Not a Measure of Adequacy

Congressional leaders and President Trump determined in the WFTC legislation that Medicare would be the payment limit for certain SDP totals, but that does not change the fact that Medicare rates are not an adequate benchmark for the Medicaid safety net. Medicare itself does not cover the full cost of care, and Medicare payment methodologies were not designed to account for the Medicaid access obligations and uncompensated care burdens borne by safety-net hospitals.

Safety-net hospitals maintain services that communities need regardless of payer mix, reimbursement adequacy, or the administrative structure of a state's Medicaid program. These hospitals cannot rely on commercial payment or large reserves to offset Medicaid shortfalls in the same way some other providers may be able to do. That is precisely the time when the state Medicaid program comes in with SDPs to pay high-volume Medicaid providers higher to solve for their lower ability to cost shift and negotiate favorable commercial rates. CMS must do all that it can to work within the legislation and maintain protections for safety-net hospitals and the working families they serve.

Other Aspects of the Rule

ASH member hospitals offer feedback in this letter on aspects of the proposed rule on which we disagree, but here we would like to share our gratitude to CMS on other proposals in the rule:

- We thank CMS for its clear and concise calculation of the 10-percentage-point reduction that will apply to grandfathered payments that need to be reduced to meet the threshold under the law.

Using the data from the preprint offers states and providers a plain and familiar point of reference to predict changes in later years.

- ASH appreciates the proposal to interpret the grandfathering criterion that the SDP is for a "rating period occurring within 180 days of the date of enactment" to refer to 180 business days.

Apply Medicare Limit Only to Four Service Categories Identified by Congress

The WFTC legislation identified just four types of provider payments that should be subject to the statute's SDP limit: inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center. Congress chose to identify specific service categories after careful consideration and debate. However, CMS has proposed to expand the payment restriction beyond the intent of Congress to include all provider types and the effective date for the limit on the other providers would be January 1, 2029 with time for no phase in or an opportunity for grandfathering.

This rulemaking should not be seen as an opportunity for CMS to expand the WFTC restrictions to additional services and provider types in a way that would reduce state flexibility beyond the statutory text. Congress continues to have a keen eye on reducing and preventing Medicaid fraud with grants of new or expanded CMS authority in this context, and CMS should trust that the legislative body will act if and when it is appropriate for states to accommodate more changes. Such an expansion would create avoidable instability for state Medicaid programs and provider networks, particularly where states have used SDPs to respond to access needs that do not fit neatly within the four enumerated categories.

ASH urges CMS to limit the final rule to the categories expressly identified by Congress. If CMS believes additional provider payment limits are warranted, it should work with Congress to address them.

Applicability Must Extend to SDPs that Include Any of the Four Service Categories

In narrowing its proposal to apply only to the four services identified in the WFTC legislation, CMS also must include any SDP program that includes at least one of these service types for purposes of applying the aggregate limit and any grandfathering protection. This distinction has not been made clear in the proposed rule but it matters. In one state, for example, an SDP that increases payments for physician services includes services furnished by physicians at or affiliated with academic medical centers – one of the four statutory services. Under CMS's proposed interpretation, that SDP could be treated as ineligible for grandfathering even if it otherwise satisfies the statutory criteria. ASH does not believe Congress intended that result. CMS should instead recognize grandfathered status for any otherwise qualifying SDP that includes one or more of the four statutory service categories, even if the payment arrangement also reaches related providers or services outside that specific cohort.

Preserve State Flexibility to Use Uniform Rate Increases

ASH is concerned by CMS's proposal to prohibit SDPs that take the form of uniform rate increases, whether structured as a percentage or dollar amount, outside of payments that are considered grandfathered. Uniform rate increases are one of the most practical and accountable tools states can use to strengthen Medicaid provider networks, address local access challenges, and ensure that taxpayer-supported Medicaid dollars are directed to providers that are actually delivering care.

States use uniform increases because they are administrable with managed care contracting, transparent, and capable of supporting broad provider participation in Medicaid managed care while still being tied to utilization and delivery of services.

ASH urges CMS not to finalize this proposal, especially since the remaining SDP options – minimum fee schedules and value-based programs – are not strong enough mechanisms to continue the support that providers need from the state.

Fee-For-Service Schedule Increases Cannot Have Meaningful Impact

In many states, Medicaid managed care has become the dominant delivery system, while base Medicaid payment rates often remain below the cost of providing care. Safety-net hospitals and other high-volume Medicaid providers therefore depend on SDPs to help sustain access, support essential services, and recognize the substantial role they play in serving low-income and medically underserved communities.

Across mature managed care programs, uniform percentage increases to negotiated rates are among the SDP tools most directly connected to Medicaid program goals. They preserve the negotiated rate structure between managed care plans and providers while directing additional support to providers that are actually delivering Medicaid services. By contrast, minimum fee schedules can override those negotiations and may distribute limited resources to providers without regard to whether they are meaningfully serving Medicaid beneficiaries. ASH agrees that directed payments should be evaluated based on their contribution to Medicaid program objectives rather than their ability to generate additional funding. Uniform percentage increases further those objectives by supporting provider participation, preserving network adequacy, and directing resources toward providers that have demonstrated a sustained commitment to serving Medicaid beneficiaries.

For many safety-net hospitals, these payments help maintain access to care in communities where alternative sources of funding are limited. For example, a state seeking to improve access to behavioral health services, obstetric care, or other hard-to-access Medicaid services may seek to bolster the financial stability of those providers with a uniform percentage increase. A minimum fee schedule in this instance would spread limited dollars across a broad universe of providers, including many that furnish relatively little Medicaid behavioral health or obstetric care, while a uniform increase can better align funding with providers that have negotiated rates reflecting their substantial Medicaid participation.

The same principle applies to hospital services. In many states, the hospitals that are the Medicaid program's strongest partners are also the hospitals most likely to need payment support beyond a minimum fee schedule. Where Medicaid programs have operated predominantly through managed care for many years, FFS schedules may no longer reflect current market conditions, provider costs, or the realities of sustaining safety-net capacity. Medicare rates, as discussed above, are also insufficient to serve as a reliable measure of what is needed to maintain access for Medicaid beneficiaries.

If CMS remains concerned that states could use narrowly defined provider classes to target payments inappropriately, CMS should address that issue directly through provider-class standards rather than eliminating uniform increases altogether. A narrower approach would preserve states' ability to direct payments to providers with demonstrably different Medicaid responsibilities, patient populations, or service obligations.

For these reasons, ASH requests that CMS maintain states' ability to direct payments as a uniform increase to negotiated payment rates. If CMS does not agree, ASH requests that any prohibition on uniform increases apply only to new directed payments and that grandfathered SDPs be permitted to continue after payments have been reduced to or below their Congressionally mandated funding caps.

Value-Based Payments Will be Weakened by Medicare Limit

CMS in the rule stated that they would continue to permit value-based SDPs if the proposal to end uniform increases is finalized. The Medicare payment limit, however, significantly weakens the power of value-based programs (VBP) to make meaningful change for Medicaid providers or patients. Provider organizations often make large investments in the innovations needed to reach MCO value-based goals, with new administrative processes, care coordination pathways, or new patient service offerings to improve quality outcomes. Without meaningful upside rewards on the line, providers – and especially financial fraught safety-net or rural providers – are loathe to make those investments and innovation moves slowly or not at all. If these providers are held to the Medicare payment limit regardless of their VBP performance, that reward will be less enticing than ever.

If states are limited to value-based payment arrangements and minimum fee schedules, they will have far less room to create meaningful Medicaid quality incentives. Medicare value-based payment models often rely on relatively small withholds, such as two or three percent of payment, that providers can earn back by meeting performance targets. Translating that model into Medicaid would require states and MCOs to identify where they can withhold a comparable share of already constrained Medicaid funding and then use those dollars as the quality incentive. That structure is unlikely to create the kind of upside opportunity needed to support major provider investments in care coordination, new patient services, or other delivery system improvements. By contrast, current uniform increase SDPs can include quality and measurement criteria while still providing meaningful payment support tied to Medicaid utilization. Medicare-based caps would therefore make stand-alone VBP SDPs a much weaker tool for changing MCO and provider behavior than uniform increases are today.

Calculate the Limit using the Total Payment Rate Only

The WFTC legislation requires any new SDPs to stay below the Medicare payment limit and any grandfathered SDPs to reduce to the limit over time, considering whether the SDP's "total payment rate" has reached that amount. CMS proposes states will annually monitor and report to CMS whether the total payment rate has met the Medicare limit in the same manner that states perform this comparison currently as part of the SDP preprint submission. States current report in Table 2 of the preprint the SDP amount for each service included in the program (inpatient, outpatient, etc.) and the total amount's comparison to the average commercial or Medicare payment rate. ASH agrees that this is the appropriate measure of the state's comparison to the WFTC's Medicare payment limit.

We do not agree with the extra-statutory requirement CMS would place on states to monitor each individual provider's SDP amount, which would be subject to recoupment if it goes beyond the state's total payment rate limit. Congress did not intend for CMS to closely monitor each provider's payments for compliance with the Medicare limit, nor did it intend to place such greater administrative burden on the states to collect and monitor this data at the provider level. The WFTC legislation took aim at the payment mechanism, not the amount of payment each provider receives from their state Medicaid program. For instance, the House Committee on the Budget stated in its report on HR 1 that it was concerned about the growth of spending on SDPs. The bill's summary described this provision as a measure to "limit state-directed payments for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center under Medicaid managed care contracts to the payment rate for services under Medicare." When Congress seeks to limit payments that certain providers receive, they say so directly in legislative text. Here, the assembly was concerned that state spending through SDPs for these particular four services was growing uncontrolled, not that individual providers were being unfairly compensated.

Nevertheless, CMS advised states and MCOs in the proposed rule to have in place policies and procedures to address SDP-related overpayments. CMS also will expect states to report NPI-specific payment amounts that providers receive under the SDPs described in a state's preprint, which may be used for reconciliation against the provider's actual claims. This level of monitoring revises the WFTC's Medicare payment limit into a provider payment limit. ASH is not convinced that this is what Congress wanted and we know it is not what will benefit the Medicaid program or CMS's pursuit of program integrity.

States frequently design Medicaid financing strategies on an aggregate basis to address access, provider participation, network adequacy, and safety-net capacity. A provider-by-provider and service-by-service cap would impose a level of complexity that could significantly increase administrative burden for states, managed care plans, and providers while reducing the practical value of SDPs as a policy tool. Crucially, ASH believes this approach will fail to reflect the broader role safety-net hospitals play in serving high-acuity, medically complex, and low-income communities. Limiting SDPs to Medicare-based amounts at a provider- and service-specific level treats a payment benchmark developed for one program as a sufficient measure of need in another program with different beneficiaries, different access challenges, and different financing realities.

Calculating the Limit for Medicaid-Only Services

For a service that does not have a specific published Medicare payment rate, the WFTC legislation specifies that the payment rate for each of the four statutory service types is limited to the payment rate under the Medicaid State plan or under a waiver of such plan. CMS outlines its plan in the rule to use the existing definition of "state plan approved rates" under § 438.6(a) to find this amount, but we believe the existing definition does not share the same purpose that the legislation intended. The current regulatory definition excludes supplemental payments outlined in the state plan because the definition is employed for purposes of MCO regulation in areas such as medical loss ratio, actuarial soundness, and standard contract terms. The "state plan approved rate" needed in the context of the WFTC legislation is one that serves as a stand-in for Medicare rates.

For that reason, ASH believes this term must be inclusive of Medicaid supplemental payments that all parties – states, MCOs, providers – consider the entire Medicaid payment to which to compare SDPs. States design Medicaid supplemental payments as a way to maintain access to certain provider services that are underpaid by the state plan rate or services that experience a shortage of providers or capacity. This is a main component of reimbursement and should therefore be considered in calculating the Medicare-equivalent rate for SDP services that do not have a Medicare published rate.

Maintain Statutory Grandfathering Beyond Medicare Limit

When negotiating the final WFTC legislation, Congress crafted three criteria for SDPs to be considered grandfathered under the statute and therefore maintain their payment levels until the 10 percentage point phase down begins on January 1, 2028. These payments must be for one of the four services listed in the statute (inpatient, outpatient, nursing facility, academic medical center practitioner groups), for a rating period occurring within 180 days of enactment, and approved or nearly approved by CMS according to legislative deadlines. States and provider associations have been working under the assumption that these were the only criteria needed to have grandfathered status, but in the rule CMS proposes an additional criterion that Congress did not include: the SDP must continue to be over the Medicare payment limit to keep its grandfathering. In other words, in the first rating period that the payment limit is met, all of the requirements of the legislation and this rule as finalized will apply to that SDP. The State would be required to incorporate the SDP as an adjustment to the capitation rates, submit the preprint prospectively, and readjust the payment structure if the SDP was not previously tied to the fee schedule or VBP-based. ASH urges CMS not to finalize this additional criterion, which will bring instability for providers and unexpected burden on states that were not planning with this in mind.

ASH is concerned that the hospital-specific calculation and the abrupt end of grandfathering for payments that come under the limit will create sudden revenue disruptions for essential providers. Neither interpretation is required by the statute and we urge CMS to reconsider.

In practical terms, a payment that was previously protected as grandfathered could quickly become subject to new approval, timing, and design requirements as soon as it falls to the Medicare limit. CMS has requested comments on any operational issues it should consider and ASH predicts this will create insurmountable operational issues for both states and safety-net providers. Safety-net hospitals cannot quickly unwind services, staffing, and community commitments that have been built around lawful state payment arrangements. CMS should offer meaningful transition time for states to remove uniform increase SDPs if that provision is finalized and permit time for states to educate providers about what is at risk in future years.

Conclusion

ASH appreciates the opportunity to comment on this important proposed rule. We share CMS's commitment to transparency, oversight, and the long-term stability of the Medicaid program. But those goals should be pursued in a way that preserves states' ability to protect access to care and sustain the safety-net hospitals on which Medicaid beneficiaries and underserved communities depend.
For the reasons described above, ASH urges CMS not to finalize the proposed elimination of non-grandfathered uniform rate increases; to adopt a more administrable aggregate methodology for any payment limits; to limit Medicare-based caps to the four service categories Congress identified; to avoid fee-for-service-related restrictions that would leave states without meaningful tools to support safety-net hospitals; to preserve flexibility for cost-based providers; and to provide meaningful transition time for states and providers.

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The Alliance of Safety-Net Hospitals appreciates the opportunity to comment on the proposed rule and welcomes any questions CMS may have about the views we have expressed in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director