American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

July 21, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding Medicaid managed care state-directed payments (SDPs) and Medicaid fee-for-service targeted practitioner payments.

The proposed rule would make substantial changes to Medicaid payment policies. The rule implements changes required under Section 71116 of Public Law 119-21, which reduces SDP limits from the average commercial rate to Medicare-based payments and establishes criteria for certain SDPs to be grandfathered and phased down from their current limit to the new limits. The rule also proposes changes beyond what the statute requires, including new requirements and limitations on SDP design.

Given the totality of the proposed changes, CMS' own scoring of the proposed rule projects a reduction of $510.1 billion over 10 years, which well exceeds the Congressional Budget Office's estimate for the underlying statute ($149.4 billion over 10 years).[1] The cumulative effect of the proposed changes, if enacted, would greatly reduce patient access to care, exacerbate workforce challenges, and impact hospital and health system financial viability.

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[1] https://www.cbo.gov/publication/61570

SDPs provide vital funding for essential healthcare services for some of the nation's most medically complex and vulnerable populations. Medicaid covers a unique population that is composed disproportionately of children, pregnant women, people with disabilities, and those facing greater clinical and social complexity.[2] Hospitals provide a substantial share of care to Medicaid beneficiaries, and payments typically do not cover the cost of care because Medicaid base payments are below the costs hospitals incur in delivering those services. This has resulted in decades of chronic underpayments to providers.[3]

CMS has recognized that supplemental payments, when appropriately designed, can help advance access to care and delivery system improvements for Medicaid beneficiaries. SDPs have been used to help bridge the gap between base payment rates and the cost of delivering care, which ultimately supports access and quality goals in Medicaid managed care. Put simply, hospitals cannot maintain or expand access or invest in quality improvements for patients if they are chronically operating at a loss.

The amount states reimburse hospitals through SDPs has changed over time as more states have used managed care organizations (MCOs) as the primary delivery system for beneficiaries. In other words, SDPs, which are the mechanism to provide supplemental payments in the managed care environment, have grown while enrollment in fee-for-service Medicaid and states' use of supplemental payment types available in the fee-for-service program — or upper payment limit payments — have decreased. Specifically, state Medicaid programs now provide services to over 78% of beneficiaries through managed care.[4]

As these payments have become an increasingly vital provider payment mechanism under Medicaid, resource cuts of this magnitude will likely force affected institutions to reduce services and staffing, both of which directly limit access to care. These cuts would have an impact on all patients in the communities hospitals serve, not just Medicaid patients, because a service that is closed would no longer be available to any patients. Both the loss of financial resources and the reduction in services make it harder to recruit and retain clinical staff, deepening existing workforce shortages. The result is a cascading effect: a payment policy change simultaneously becomes a patient access crisis, a workforce crisis, and a significant financial headwind for hospitals and health systems. We ask that CMS carefully weigh the potential implications of this rule for service availability, provider participation under Medicaid managed care, and overall access to care for Medicaid beneficiaries and entire communities, so that it is consistent with the requirement that payment policies ensure sufficient provider participation and

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[2] https://www.macpac.gov/publication/medicaid-enrollment-by-state-eligibility-group-and-dually-eligible-status/
[3] https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid
[4] https://www.kff.org/medicaid/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

access. **As such, we urge CMS, within its authority, to rescind proposed policies that exceed what is required by P.L. 119-21 and lessen the financial impact of the reduction of SDP limits to Medicare levels.**

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions, or feel free to have a member of your team contact Ben Finder, AHA vice president of coverage policy, at bfinder@aha.org, or Krista Geier, AHA senior associate director of Medicaid policy, at kgeier@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

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MEDICARE PAYMENT LIMIT

Medicare Payment Inadequacy

The proposed rule would implement the statutory requirement to limit SDPs for inpatient and outpatient hospital services, nursing facility services and services provided at academic medical centers to either 100% or 110% of the total published Medicare rate (based on whether or not a state expanded its Medicaid program). Yet, CMS proposes to extend the same limits to additional payment types for which no federal Medicare-benchmarked limit previously applied. **Benchmarking Medicaid payments to Medicare rates would jeopardize patient access and provider financial viability, and we urge CMS not to extend these limits beyond those expressly required by statute.**

Medicare's payment rates are an inappropriate benchmark for Medicaid reimbursement. Indeed, Medicare rates are widely recognized as inadequate and below the cost of providing care, and hospitals face continued and worsening Medicare underpayment. On average, Medicare only pays 83 cents for each dollar hospitals spend providing care to Medicare beneficiaries.[5] The Medicare Payment Advisory Commission projects that hospital 2026 Medicare margins will be negative 10%, which reflects more than 20 straight years of Medicare paying below hospitals' costs.[6] The AHA's own analysis showed that Medicare underpayments reached over $100 billion in 2024.[7] Capping or aligning Medicaid provider payments at Medicare levels would extend Medicare's payment inadequacy to the Medicaid program.

In addition, Medicare rates are not designed to reflect the cost of caring for the Medicaid population. Medicare and Medicaid serve fundamentally different populations and provide fundamentally different benefits. Medicare is designed primarily for adults aged 65 and older, with benefits and payment rates calibrated to the needs of a primarily older population, and for whom there is widespread provider participation. Medicaid, by contrast, serves a more heterogeneous population that includes children, people with lifelong intellectual and developmental disabilities, individuals with serious mental illness, and low-income adults with complex chronic conditions; in other words, people whose care is often more complex and resource-intensive than what Medicare rates were designed to support. Medicaid also covers a substantially broader array of benefits than Medicare, including long-term services and supports, non-emergency medical transportation, Early and Periodic Screening, Diagnostic, and Treatment services for children, and comprehensive behavioral health services, many of which have no Medicare equivalent and therefore no existing Medicare rate. Against this backdrop, Medicaid beneficiaries already face significant access barriers, with physicians far less

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[5] https://www.aha.org/guides-and-reports/2026-03-09-2025-cost-caring-report
[6] https://www.medpac.gov/wpcontent/uploads/2026/03/Mar26_Ch3_MedPAC_Report_To_Congress_SEC
[7] https://www.aha.org/costsofcaring

likely to accept Medicaid than Medicare, and unmet need driven not by cost but by provider availability.[8,9] Given the inherent differences between these programs, the implementation approach should balance the new statutory requirements against the potential for these policies to further erode provider participation in Medicaid and deepen existing access barriers for beneficiaries.

In addition, there is no simple way to compensate for or "get around" this challenge, because the unique characteristics and needs of the Medicare population are included in the methodology of calculating Medicare rates. For example, Medicare calculates weights for both inpatient and outpatient claims under the inpatient and outpatient prospective payment systems (PPS). These weights are derived from Medicare cost reports and Medicare claims data. As such, they reflect the resource intensity, length of stay, and service utilization patterns of the Medicare population — a population that is elderly and predominantly non-disabled, not a population that includes the children, individuals with disabilities, and low-income adults who make up the Medicaid population.

Even the adjustments built into Medicare payments to account for the additional costs of certain provider types and populations — such as the graduate medical education (GME) payments, new technology add-on payments (NTAP), the disproportionate share hospital (DSH) adjustment, and uncompensated care payments — are calculated using Medicare and hospital cost report data that does not capture the distinct cost drivers associated with serving Medicaid beneficiaries. For example, GME payments are determined partially based on the "Medicare patient load;" NTAPs are partially based on the standard Medicare-severity Diagnosis-related Group (MS-DRG) payment; and DSH payments are determined by formulas set in statute for the Medicare population. Using that system as the ceiling for Medicaid payments does not represent a neutral or evidence-based benchmark; instead, it applies a payment methodology that was never designed, tested or validated for the Medicaid population to institutions that serve a fundamentally different mix of patients with fundamentally different needs.

Nonetheless, to avoid even greater payment inadequacy, it is critical that the total published Medicare rate encompasses all components included in such rates. Importantly, CMS acknowledges that the total published Medicare rate may include applicable Medicare payment adjustments, including, but not limited to, geographic and quality adjustments. **As CMS implements the statutory requirement to limit SDPs to the total published Medicare rate, we urge it to explicitly state that all add-ons and adjustments are treated as components of the rate.** Absent clear direction, states could construct the limit from a rate that omits these components, producing a ceiling that falls below total Medicare payment and understates even what Medicare itself pays for a service. **We therefore ask CMS to confirm that the total published Medicare**

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[8] https://www.macpac.gov/publication/ch-2-medicaid-primary-care-physician-payment-increase/
[9] https://www.healthsystemtracker.org/chart-collection/beyond-cost-what-barriers-to-health-care-do-consumers-face/

rate is calculated to include all applicable add-ons and adjustments, and to provide a clear, replicable methodology so that the limit reflects total Medicare payment as the statute contemplates.

Additionally, Medicare payment rates incorporate a geographic adjustment based on local labor market conditions, known as the area wage index (AWI). Extending Medicare-based methodologies into Medicaid may carry forward payment inequities from the Medicare program into Medicaid. The AWI is designed to reflect differences in hospital wage levels across labor markets relative to the national average. However, in practice, it often produces unintended and uneven effects. **In implementing the Medicare-based SDP limit, CMS should be mindful of these dynamics.** For example, CMS could allow states to use an AWI of 1.0 for low-wage index hospitals solely for purposes of computing the Medicare-based SDP cap. This would help prevent Medicaid limits from being anchored to the lowest wage indices. Importantly, any policy that states adopt for the purpose of determining their Medicare-based SDP limit would not alter the AWI as applied under Medicare's inpatient or outpatient prospective payment systems.

Further, given the inadequacy of the total published Medicare rate and the limitations of the rate in adequately capturing the costs to care for the Medicaid population, **we urge CMS to refrain from using Medicare as a regulatory benchmark for Medicaid provider payments beyond what is required by statute.**

Per-service or Discharge Medicare Limit

Historically, the SDP payment ceiling has been applied at the aggregate level for each class of providers eligible for payment. CMS proposes to instead apply the Medicare payment limit at the individual service or discharge level. **We are concerned that the service or discharge level approach would be nearly impossible for states to implement.**

Medicare's inpatient and outpatient PPS payment systems use coding and grouping methodologies built for the Medicare population, which differs significantly from how many state Medicaid agencies classify the same services. As each state operates its own Medicaid program to meet its population's needs and the state's policy goals, provider payment policies and methodologies vary by state. Many Medicaid agencies use the All Patient Refined DRG (APR DRG) grouper, which incorporates severity of illness and risk of mortality subclasses, along with pediatric and neonatal detail, that better reflect the ages, services, and clinical complexity of the Medicaid population than the Medicare-focused MS-DRG. Similarly, for outpatient services, many states instead use Enhanced Ambulatory Patient Groups, which are built around the full range of ambulatory care across all ages rather than the Medicare population for which Medicare's Ambulatory Payment Classifications (APCs) were designed. Because these grouping systems use different classification logic and severity adjustments, converting a Medicaid claim into its Medicare equivalent requires translating between different

clinical systems built for different populations, introducing technical complexity and ultimately risking inaccurate pricing.

Medicaid claims, including encounter claims adjudicated by a Medicaid MCO, are structured differently from Medicare claims and may lack the diagnosis codes, procedure codes and clinical detail necessary to run through a Medicare grouper or pricer to determine an accurate Medicare equivalent rate. For example, Medicaid uses coding structures (e.g., T, H, S HCPCS codes) not recognized in Medicare systems. Converting Medicaid services to MS-DRGs or APCs is not a straightforward technical exercise; because Medicare inpatient and outpatient PPS payments vary based on principal diagnosis, comorbidities and procedure codes, a single service type could generate dozens or hundreds of potential Medicare prices depending on how the claim is coded, creating enormous administrative complexity and significant opportunities for inconsistency across states, plans and providers. Further complicating matters, Medicare claims can include modifiers to establish the appropriate payment level for a service, while Medicaid claims either use state- or MCO-specific modifiers or do not feature modifiers at all. These technical issues raise questions about whether it is even possible to accurately price a Medicaid claim against a Medicare benchmark without introducing variability that would be difficult to audit or enforce consistently.

Moreover, this approach would stifle state innovation and efforts to implement value-based payment (VBP) approaches. VBP models, including population-based and per-member per-month arrangements, are designed to move away from individual service-level pricing in favor of prospective payments tied to an attributed population and a defined set of outcomes. CMS' own preamble acknowledges this tension, noting that a per-service payment limit poses operational and logistical complexities for population- and condition-based SDP arrangements, and that states implementing these models would be required to reconcile prospective payments against actual utilization just to demonstrate that the payment limit was not exceeded on a per-service basis. Requiring states to deconstruct VBPs into service-level equivalents undermines the very features that make these models effective, including their ability to reward outcomes and efficiency rather than volume. Moreover, it discourages states and providers from making the investments in care coordination and population health management that value-based payment is intended to support.

We urge the agency to instead allow states to calculate the Medicare payment limit in the aggregate, as is consistent with how states calculate upper payment limit payments in fee-for-service Medicaid. CMS has decades of operational experience implementing aggregate, facility-class-based Medicare benchmarks for these same service types under the existing fee-for-service framework. This established methodology avoids the substantial operational burden of converting individual Medicaid claims into Medicare-equivalent prices on a per-service or per-discharge basis, including the coding, grouper and modifier challenges we have outlined elsewhere in this letter, while still ensuring that aggregate SDP spending remains within the Medicare-based limits. We do not believe the statute requires CMS to abandon this

proven approach in favor of a service-level methodology, and we encourage CMS to adopt an aggregate methodology, consistent with the existing fee-for-service framework, for purposes of implementing the SDP payment limit.

Providers Reimbursed Under a Cost Basis

For providers paid by Medicare on a cost basis, CMS proposes to treat the cost-based payment approach as the total published Medicare payment rate for purposes of the SDP payment limit. Specifically, CMS proposes to use the most recent and complete Medicare cost report to establish the prospective payment limit on a per-service or per-discharge basis, including through cost allocation methodologies, to derive service-level payment amounts. However, CMS states it would need to publish specific instructions on allowable cost-reporting and cost allocation methodologies specific to Medicaid managed care and notes it could modify existing Medicaid fee-for-service cost reporting instructions based on Medicare cost reporting principles for this purpose.

Medicare cost-based reimbursement works through a two-step process: providers receive interim payments during the cost reporting period based on estimated costs, then those payments are reconciled against actual allowable costs after the cost reporting period closes, which can sometimes be a year or more later. The final Medicare payment for a cost-based hospital is only known retrospectively, once the cost report is settled.

CMS' proposed approach is to use the most recent and complete Medicare cost report submitted to validate the prospective SDP payment limit for the rating period. But the "most recent and complete" cost report data is, by definition, old data relative to the rating period for which the SDP payment limit is being set. In fact, it is typically two to three years old. This creates a significant structural lag between the data used to set the limit and the actual cost the hospital faces during the rating period.

The result is that the SDP payment limit for cost-based hospitals would almost assuredly understate the actual amount Medicare would pay these hospitals if they were in fact serving Medicare patients during the current rating period. Said another way, this approach would almost certainly result in Medicaid SDPs being capped *below* the true Medicare-equivalent rate for cost-based providers, simply due to the timing mismatch between when costs are incurred and when they are reported and reconciled.

The hospitals reimbursed on a cost basis are the facility types Congress has identified as needing a different payment methodology because prospective payment systems do not work well for them, typically due to low patient volume, high fixed costs relative to volume, and/or specialized, resource-intensive patient populations. If the SDP methodology systematically understates its Medicare-equivalent rate, the rule would impose its most significant unintended financial harm precisely on the hospitals for which the law provides special accommodation, because standard payment methodologies are not appropriate for them.

The AHA encourages CMS to address this vulnerability in the final rule. CMS could consider incorporating an adjustment to the proposed approach that would account for the timing mismatch between the retrospective nature of Medicare cost-based reimbursement and the prospective nature of Medicaid managed care rate-setting, such as applying an appropriate trend or inflation factor to the most recent available cost report, or establishing a retrospective reconciliation process once final cost report data becomes available. Absent such a mechanism, the proposed methodology risks producing SDP payment limits for cost-based providers that fall below the total published Medicare payment rate those providers would actually receive, which would be inconsistent with the rule's stated rationale that Medicare payment rates represent a reasonable, appropriate and attainable benchmark.

Net of Tax Methodology for SDP Limits

Provider taxes play an integral role in Medicaid financing. According to a 2020 Government Accountability Office (GAO) report, healthcare provider taxes comprised 17% of the nonfederal share of Medicaid spending.[10] However, they also incur an additional cost to hospitals that effectively reduces gross Medicaid payments. The Medicaid and CHIP Payment and Access Commission found that provider taxes reduce the net payment that providers can use to cover the cost of care provided to Medicaid patients and has expressed interest in exploring how this affects quality and access to care.[11]

The same dynamic applies to intergovernmental transfers (IGTs), wherein hospitals or other providers owned or operated by local governments transfer funds to states that may be used to finance the non-federal share of their Medicaid program. According to the GAO, IGTs comprised 10% of the nonfederal share of Medicaid spending. Whether the non-federal share is funded through provider taxes or IGTs, the challenge remains the same: the funds hospitals can actually use to cover the cost of care are meaningfully lower than the gross payment amount suggests.

This distinction is critical when considering how the SDP payment limits set at the Medicare rate are applied. In addition to the concerns already identified above, another limitation of comparing Medicare and Medicaid rates is that Medicare rates are funded entirely by the federal government, whereas Medicaid financing relies on provider contributions. Ignoring this structural difference when applying the SDP limits could lead to faster and deeper cuts in Medicaid payments to providers, disproportionately harming hospitals that serve a high volume of Medicaid patients.

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[10] https://www.gao.gov/assets/gao-21-98.pdf
[11] https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-Chapter-1-Improving-the-Transparency-of-Medicaid-and-CHIP-Financing-1.pdf

Establishing SDP limits using gross payment amounts risks unintended consequences for patient access. Accelerated funding reductions would impose greater financial strain on providers and thus put access to care at greater risk. **To prevent these outcomes, the AHA urges CMS to adopt a net-of-tax methodology when implementing the P.L. 119-21 provision limiting SDPs to Medicare rates.** This would prevent an excessive reduction of SDP funding beyond what the statute requires. Additionally, we urge CMS to provide clear guidance on the calculation methodology to promote transparency and compliance.

GRANDFATHERED SDPs

Phase Down of SDP Limit

The statute requires that, beginning Jan. 1, 2028, the total SDP amount for a grandfathered SDP will be reduced by 10 percentage points annually until it reaches the applicable Medicare rate. The statute does not prescribe a specific timeframe for achieving that benchmark. In the proposed rule, CMS would implement this requirement by applying an annual 10% reduction to the original grandfathered total dollar amount approved by CMS for a grandfathered SDP, using that amount as a fixed baseline, until payments reach 100% of Medicare in expansion states and 110% of Medicare in non-expansion states. **The AHA is concerned that CMS' proposed approach of using the original grandfathered total dollar amount as a fixed baseline may result in reductions that are more rapid and steeper than was anticipated for many SDPs.**

Under CMS' proposed approach, each annual reduction is set at a constant 10% of the original grandfathered total dollar amount, rather than the remaining SDP amount. Consequently, the dollar value of the reductions remains fixed over time, irrespective of how close an SDP is to the applicable Medicare limit. This appears to be a more aggressive interpretation of the statutory language, which required a 10 percentage point reduction annually. There are two alternatives described below that could extend the glidepath to reduce a grandfathered SDP, although the magnitude of the effect varies across states and SDPs.

Reducing SDPs to Medicare levels on a more rapid timeline would impose real and lasting harm to both the hospitals that depend on these payments as well as the patients they serve. When reductions of this magnitude are concentrated over a short period, hospitals have little ability to prepare for or absorb the loss in funding, and the exacerbated financial pressure can force difficult decisions such as to terminate service lines or close a facility entirely, which threatens access to care for entire communities. A more gradual glidepath would not deviate from the statutory requirement to limit SDPs to Medicare levels but could allow for a more measured transition, giving hospitals additional time to adapt to the reductions and helping to preserve access to care.

In the proposed rule, CMS outlines two potential alternatives it considered:

1. **Apply the 10% phase down as an annual, compounding reduction.** Rather than applying a constant 10% reduction of the original dollar amount each year, CMS could reduce each program by 10% of its remaining dollar amount annually. Unlike a fixed reduction applied to the original baseline, this approach gradually diminishes reductions over time, smoothing the transition and avoiding disproportionately steep reductions. This more measured glidepath would better support hospital financial planning and help maintain access to care during the transition.
2. **Apply the 10 percentage point phase down to the total payment rate (as a percentage of the total published Medicare payment rate).** Alternatively, CMS could reduce the approved percentage-of-Medicare benchmark by 10 percentage points each year until it reaches the 100% or 110% limit, rather than applying the reduction directly to a dollar amount. Unlike a dollar-based approach, this method ties the duration of the glidepath to the degree to which a program exceeds the benchmark. This approach would slow the transition for SDPs further from the new statutory limits, giving states and providers much-needed time to prepare and helping to reduce the potential for destabilizing reductions.

For many states, an alternative approach would better balance the statutory requirement to transition SDPs to Medicare-based limits with the need to maintain stable and predictable funding for hospitals and the patients they serve. **We urge CMS to allow states to choose between CMS' proposed approach and alternatives discussed in the rule preamble; doing so will provide states the flexibility to choose which option is best and thus help them mitigate the risks associated with rapid financing losses.**

Separate Payment Terms

Separate payment terms allow states to direct a fixed pool of Medicaid funding to providers outside the base capitation rate, preserving transparency and certainty that the dollars a state intends for hospitals serving Medicaid patients will reach those hospitals. When structured through separate payment terms, the SDP funding pool is reserved and reconciled to actual utilization, and MCOs pay hospitals in alignment with the amounts the state proposed and CMS approved in the preprint. This creates an important layer of transparency for providers, MCOs and CMS regarding approved SDPs and the payments providers receive. Under the 2024 managed care rule, separate payment terms will be prohibited as of the first rating period beginning on or after July 9, 2027, which is anticipated to cause undue administrative burden for states, providers and MCOs and create new risks for longstanding SDPs.

The AHA appreciates that CMS has proposed to delay the prohibition on separate payment terms for grandfathered SDPs, recognizing the disruption an immediate transition would cause. That temporary measure, however, does not go far

enough. It is a temporary delay rather than a solution, and it extends only to grandfathered arrangements, meaning non-grandfathered SDPs will be subject to the prohibition.

Most SDPs, including uniform rate increase and VBP arrangements, currently rely on separate payment terms.[12] Requiring states, MCOs and providers to transition these arrangements into capitation rate adjustments would impose substantial administrative burden on already constrained Medicaid programs and introduce uncertainty and greater risk into payment predictability for hospitals. A delayed implementation does not mitigate these challenges; instead, it defers them to a later date.

The challenges are further exacerbated for states that operate multiple grandfathered SDPs. The proposed approach could result in simultaneously operating some SDPs as separate payment terms because they have not yet reached the Medicare-based payment limit, while being required to incorporate others directly into capitation rates because they have already met the payment limit. This creates a bifurcated administrative environment within a single managed care program that does not exist today, and a situation the rule does not fully address. An administratively simpler alternative would be to extend the separate payment term flexibility to all grandfathered SDPs within a state until the last grandfathered SDP in that state meets the payment limit.

Further, when the SDP is incorporated into the base capitation rate, plans may have a financial incentive to steer utilization toward providers not eligible for the SDP that are viewed as less expensive from the plan's perspective. Separate payment terms eliminate this incentive by reserving a defined pool and reconciling payments to services the eligible providers deliver.

The AHA therefore urges CMS to rescind the prohibition on separate payment terms in its entirety, rather than providing a temporary delay for grandfathered SDPs. Doing so would decrease administrative burden, improve transparency, and ensure funds go to patient care, not MCOs. At a minimum, if CMS declines to rescind the prohibition, it should extend the delay to all SDPs that would be subject to Medicare limits under the final rule.

PROPOSALS BEYOND WHAT IS REQUIRED UNDER P.L. 119-21

Elimination of Uniform Increase SDPs

CMS proposes that, beginning with rating periods on or after Jan. 1, 2028, states could no longer establish new uniform increase SDPs, in which a state directs an MCO to

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[12] https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf

apply a uniform dollar or percentage increase to a class of providers, or renew non-grandfathered uniform increase SDPs. This limits states to only three permissible SDP methodologies: minimum fee schedule, maximum fee schedule and VBP SDPs.[13] **This prohibition is not required under P.L. 119-21, and the AHA is deeply concerned that it will undermine state flexibility to design payments to meet program needs. In addition, this proposal would further decrease financial resources for providers who rely on such SDP payments.**

Uniform increases are the most common SDP structure, accounting for at least two-thirds of all SDP spending.[14] By eliminating the methodology behind the majority of SDP dollars, the proposal threatens to destabilize the primary vehicle through which states support providers caring for Medicaid patients. Additionally, when combined with the proposed per-service or discharge limit, this proposal could significantly alter the distribution of payments across providers, potentially undermining certain providers' ability to rely on SDP funding at historically consistent levels.

Further, the proposal would cause an undue administrative burden by requiring states to translate uniform increase arrangements into fee schedule SDPs. To restructure a percentage or dollar increase into a fee schedule, states would face significant administrative burden, including translating aggregate payment increases into service-level fee schedule changes, renegotiating managed care contracts, and submitting new preprints to CMS, among other requirements. For many states and providers, this is not merely burdensome but technically infeasible, which may leave essential SDP funding streams at risk.

Finally, CMS offers a limited exception that only delays the administrative burden to later years. Uniform increase SDPs would be permitted only for grandfathered arrangements, and only until the applicable Medicare payment limit is reached.

The AHA urges CMS to rescind the proposed elimination of uniform increase SDPs and to retain that methodology as a permissible option, subject to the payment limits established by P.L. 119-21.

Limits for all SDP Service Types and SDPs in U.S. Territories

CMS proposes to extend the Medicare payment limit to all service types covered under SDPs, effective for rating periods beginning on or after Jan.1, 2029. This proposal applies cuts to critical service areas, including behavioral health, substance use disorder treatment (SUD), dental, home- and community-based services (HCBS), as well as personal care, primary care and specialty physician services. For services with

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[13] While VBP SDPs continue to be permissible, they are subject to new structural limitations under the rule. See Value-based Payment Considerations on page 16.

[14] https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf

no comparable Medicare rate, including many HCBS, behavioral health and SUD services, CMS would require the limit to be set at the Medicaid state plan base rate. Additionally, CMS proposes to subject SDPs in the U.S. territories to these same limits. The territories already operate under distinct Medicaid financing constraints, and applying the Medicare-based limit would compound those challenges.

We are particularly concerned about the impact on behavioral health and SUD services when those services are critical for so many Medicaid beneficiaries. Many states have used SDPs to strengthen payments for mental health providers, SUD treatment programs and crisis services precisely because base Medicaid rates have long failed to sustain access. Capping these payments at Medicare levels, or the state plan rate, risks destabilizing access to behavioral health care.

Compounding this situation, SDPs subject to the new limits would be required to comply beginning Jan. 1, 2029. However, unlike SDPs for inpatient and outpatient hospital services, nursing facility services and services provided at academic medical centers, they would not be eligible for any phase-down or transition period. The result would be an abrupt payment reduction rather than a glidepath, causing significant disruption to providers who depend on these payments and raising serious access concerns for the patients and communities that rely on these services.

We urge CMS to rescind this extension of payment reductions to all SDP service types and SDPs in U.S. territories, which exceeds what is required under P.L. 119-21. Should the agency proceed, we urge CMS at a minimum to extend a meaningful phase-down period to all SDPs so that providers and states have a reasonable pathway to adapt to these changes.

Limits on Certain Targeted Practitioner Payments

In addition to the changes to SDPs, beginning Jan. 1, 2029, CMS proposes to extend the new Medicare-based payment limit to certain targeted practitioner payments made under fee-for-service, capping total Medicaid payment at the applicable Medicare rate. This would apply to certain payments for physicians, dentists, emergency and non-emergency medical transportation providers, and certain clinics, among other providers. **In addition to expanding provider payment cuts beyond what is required under P.L. 119-21, the AHA is concerned about CMS curtailing state efforts to support the healthcare workforce and enable access to care based on the needs of their population.**

States use targeted payments to address workforce shortages and access gaps that may vary by provider type, care setting, and location. By aligning payments with these specific needs, states can support provider participation and maintain access to care. Imposing a Medicare-based limit would constrain this flexibility, limiting states' ability to direct resources where they are most warranted and undermining efforts to address workforce and access challenges.

As with the other categories of payments that would be newly subject to the limits under the rule, targeted practitioner payments would not be eligible for any phase-down or transition period, subjecting these providers to an abrupt reduction in payments. Further, state Medicaid agencies will face a significant administrative burden in applying the Medicare limit for these services, consistent with our concerns outlined above.

We urge CMS to rescind this extension of payment reductions to targeted practitioner payments, which exceeds what is required by P.L. 119-21. Should CMS proceed, we urge the agency to offer a meaningful phase-down period for payments it considers to be targeted practitioner payments.

VALUE-BASED PAYMENT CONSIDERATIONS

Taken together, the AHA is concerned that CMS' proposals undermine progress toward VBP in Medicaid. CMS has consistently identified VBP arrangements as a tool that supports its priorities, including holding providers accountable for health outcomes and reducing wasteful spending. VBP arrangements under Medicaid managed care and fee-for-service accomplish this by tying payment to performance and rewarding measurable improvements in quality and outcomes, thereby moving away from paying for volume alone.

For states implementing VBP SDPs, the proposed rule requires a detailed methodology to confirm that payments do not exceed the Medicare limit on a per-service basis. It also articulates that a provider already receiving negotiated managed care rates above the limit cannot receive additional SDP payments that would push them past the per-service cap. The result is that a provider whose negotiated rates already meet or exceed the Medicare limit on a given service could earn no value-based incentive at all, no matter how well they perform on cost and quality metrics. Applying the Medicare limit at the aggregate level would maintain the flexibility to shift SDP dollars within a VBP arrangement, for example, directing payment to services that are central to VBP approaches while paying at or below Medicare rates for more routine services. This kind of payment differentiation and flexibility is essential for designing and administering VBP arrangements. **As such, for SDPs subject to the Medicare limits under P.L. 119-21, the AHA urges CMS to apply the Medicare limit at an aggregate level, which would enable VBP structures within current statutory requirements.**

Further, the rule defines certain targeted practitioner payments to include any quality incentive or value-based payment directed to certain practitioners or providers while excluding other similar ones from participating in or receiving the payment. Well-designed VBP models may use eligibility criteria that result in variation in provider participation, and grouping these outcome-based payments would similarly undermine VBP efforts. **Again, we urge CMS to rescind the extension of Medicare limits to targeted practitioner payments, which exceeds what is required by P.L. 119-21.**

PROVIDER CLASS CONSIDERATIONS

CMS seeks comment on whether and how to define "provider class" in the context of SDP design to inform future rulemaking. The ability to define provider classes is one of the most important flexibilities states have to direct resources toward the access challenges faced by their populations. This may include addressing a lack of maternal health resources, responding to the behavioral health and SUD crisis, sustaining rural and other essential providers, or meeting other policy goals that vary considerably among states. A more prescriptive or narrowed federal definition would constrain states' ability to tailor SDPs to local conditions and would risk displacing the policy decisions that states make about where payment can be used as a means to preserve access.

Should CMS pursue future rulemaking, we urge the agency to refrain from imposing a uniform federal definition of "provider class" and to preserve the existing state flexibility that allows SDPs to function as an important tool to maintain access to care.