The Hospital + Healthsystem Association of Pennsylvania

July 21, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2449-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2449-P, Medicaid Managed Care State-Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments.

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 235 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicaid Managed Care State-Directed Payments (SDP) and Medicaid Fee-for-Service (FFS) Targeted Medicaid Practitioner Payments. This regulation implements key provisions of the Working Families Tax Cut Act (WFTCA).

The rule was anticipated to limit SDPs for four core services (inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center) to Medicare (or 110% of Medicare for non-expansion states) as required under section 71116 of WFTCA. However, this proposed rule goes far beyond the statutory requirements outlined in WFTCA by:

- Applying the Medicaid payment limits to Medicare in WFTCA beyond the four core services to all services under Medicaid SDPs.
- Ignoring the application of Medicare payment limits in the aggregate elsewhere in the Medicaid program and instead implementing Medicare limits on Medicaid SDPs on a per service and per provider basis.
- Removing the current flexibility to structure SDPs as a percent or amount in addition to negotiated rates.
- Extending the Medicaid managed care SDP limitations to some FSS programs that today can make payments in excess of Medicare.

As outlined, CMS projects significantly greater federal savings, driven by broader restrictions on SDPs and supplemental payments ($510 billion vs. $149 billion). This is a remarkable escalation from the changes to SDPs that Congress authorized in WFTCA. Specifically, CMS is proposing to cut 3–4 times more in federal funding for the health care system nationally than Congress intended.

Health care-related taxes and Medicaid supplemental payment programs are longstanding tools used to address chronically inadequate base Medicaid payment rates. Changes to these financing systems and related provider payments will have significant and tangible negative consequences for access to care. In Pennsylvania, SDPs support access to care, delivery, and quality improvements for Medicaid beneficiaries.

The Medicaid program provides coverage for nearly a quarter of all Pennsylvanians—children, seniors, people with disabilities, and hardworking individuals who lack access to affordable coverage. HAP and our members share CMS' goal of ensuring the fiscal integrity of the Medicaid program so that it can remain strong and sustainable for those who depend on it.

SDPs are used to address chronic underpayments in Medicaid by Medicaid managed care organizations (MCO) providing benefits to their beneficiaries. They also provide predictability, especially in light of ever-changing policies implemented by the MCOs, many of which result in payment delays or denials. In Pennsylvania, Medicaid reimburses hospitals at only 87 cents for every dollar spent. When Medicaid professional services reimbursement and uninsured care are included, hospitals recover only 71 cents for every dollar of care provided. The provisions in this rule are projected to further reduce reimbursement to 64 cents on the dollar.

Cuts of this magnitude jeopardize hospital financial sustainability and increase the risk of closures or cuts to essential services such as maternal health. More than 40 percent of the commonwealth's acute care hospitals are currently operating with insufficient margins for long-term stability; nearly 30 percent are operating in the red. Over the past decade, 26 hospitals have closed statewide and as many as an additional 12–14 hospitals are projected to close by 2030 due to declining reimbursement and rising costs.[1] Hospital closures and service losses impact everyone in the community, not just those individuals who are served by the Medicaid program.

In summary, the proposed provisions amplify and accelerate a loss in reimbursement that Pennsylvania hospitals and communities simply cannot weather. **CMS can mitigate some of the worst consequences of these policy changes, and we urge the agency to rescind or reconsider proposals that extend beyond the statutory framework established by Congress.** Specifically, we urge the agency to remove or scale back the following provisions:

- Application of Medicare payment limits on a per service per provider basis.
- Extension of the Medicare payment limit to all types of SDP services and to SDPs in U.S. territories.
- Application of the Medicare payment limit to certain targeted practitioner payments under the Medicaid FFS program.
- Elimination of uniform increase SDPs, a common type of SDP in which a state directs a managed care plan to apply a uniform dollar or percentage increase to a class of providers.
- New reporting and compliance requirements, which may result in undue administrative burden for states and providers.

[1] Report: Time to Act: What The Future Holds for Pennsylvania's Hospitals, Patients, and Communities

Thank you for your consideration of HAP's comments regarding this proposed rule and its impact on SDP payments to hospitals and the patients they serve in Pennsylvania. Additional detail on our concerns is attached.

If you require any additional information, please contact me at jcalla@haponline.org or (717) 561-5308.

Sincerely,

Jolene H. Calla, Esq.
Vice President, Finance & Legal Affairs

Attachment

HAP Comments—Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Medicare-based Payment Limits for SDPs

Consistent with the WFTCA, for rating periods beginning on or after July 4, 2025, the rule would reduce the maximum payment rate for SDPs for inpatient and outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center to:

- 100 percent of the total published Medicare payment rate in Medicaid expansion states.
- 110 percent of the total published Medicare payment rate in non-expansion states.

During 2024, Medicare reimbursed hospitals at just 83 cents on the dollar.[2] **HAP opposes limiting SDPs to Medicare payment rates, as Medicare does not fully cover the cost of care. Restricting payments from Medicaid—the second largest payor for hospitals—to rates that fall below cost jeopardizes hospital financial sustainability.**

CMS proposes calculating the "total published Medicare payment rate" at the service or discharge level rather than as an aggregate payment limit. The published Medicare payment rate is defined as the amounts calculated as payment by service that have been developed under title XVIII Part A and Part B of the Social Security Act, including all reimbursement components in the rate developed by CMS for Medicare, such as disproportionate share hospital adjustments and adjustments related to medical education, geography, and quality. The proposed rule does not address how payments for items reimbursable on a reasonable cost basis that are reimbursed on an interim basis with retrospective adjustment such as capital-related costs and direct medical education costs will be incorporated into the "total published Medicare payment rate." Not incorporating all reimbursement components will result in Medicaid payment at less than 100 percent of the total Medicare payment rate.

CMS' proposed approach would apply the Medicare payment limit at the service or discharge level to freestanding children's hospitals, certain cancer hospitals, and critical access hospitals, which are reimbursed by Medicare on a cost basis with payment reconciled retrospectively and in the aggregate, using Medicare cost report data. Requiring these hospitals to derive a per-service or per-discharge limit from the most recent complete cost report is particularly burdensome for these hospitals and would risk codifying a limit below Medicare rates for such hospital services which seems to run counter to other efforts by this administration to support those hospitals. CMS itself noted that states would need extensive guidance to attempt to accomplish what is proposed under this rule.

For decades, CMS has accepted an aggregate statewide upper payment limit (UPL) calculation based upon a reasonable estimate of what the same service would have paid under Medicare for FFS payments. This includes the option to define the Medicare limit as the cost of services. **This service level interpretation deviates from the payment limit for the same services**

[2] Costs of Caring | AHA

under Medicaid FFS, is significantly more restrictive, and exceeds statutory requirements outlined in WFTCA. We recommend that CMS apply the same methodologies as under Medicaid FFS to determine the aggregate Medicare UPL.

SDPs were designed to provide critical funding to hospitals based upon Medicaid utilization. They help to ensure the hospitals with the highest Medicaid population will receive reimbursement that helps close the gap between reimbursement and the actual cost of care. Under the proposed rule, hospitals will only be eligible to receive SDPs for services for which their contracted rate does not exceed Medicare. This service-based Medicare cap eliminates hospitals' ability to negotiate rates with health plans that cover the costs of providing care for the services needed in their communities.

Limiting all services to Medicare at the service or discharge level results in setting rates at a national level and removes the flexibility and autonomy of states to address the needs of the population of their state. State Medicaid reimbursement design often significantly deviates from Medicare as it covers a different population. Only 11 percent of Pennsylvania Medicaid enrollees are Medicare age, and 42 percent are under age 21.[3] Currently, states can set higher payments for services critical to the needs of their residents. Limiting all services to Medicare rates takes away this flexibility, and services that are critical under Medicaid but not as prevalent under Medicare (e.g., maternal health) could see decreases in reimbursement.

Applying the limit at the service level introduces substantial operational challenges, as Medicaid claims do not align directly with Medicare payment methodologies. Repricing claims would require complex system changes and impose a significant administrative burden on states and MCOs. This approach also reduces state flexibility to target payments to critical service areas and risks underpayment for services provided to Medicaid populations.

HAP is concerned that CMS has significantly underestimated the cumulative administrative burden associated with the proposed monitoring, reporting, validation, and compliance requirements. Much of this burden results directly from CMS' proposal to impose service-by-service and provider-specific payment limit calculations. States, MCOs, hospitals, actuaries, consultants, and technology vendors would all be required to redesign systems and methodologies that currently operate successfully under provider class-level approaches.

CMS should publish more detailed burden estimates and evaluate whether existing provider-class methodologies can achieve the same program integrity objectives with significantly lower compliance costs. At a minimum, CMS should delay implementation until states and providers have sufficient time to modify systems and operational processes.

Medicaid serves a population that differs substantially from Medicare beneficiaries, including pregnant women and children. In Pennsylvania, Medicaid covers more than 34 percent of births and 39 percent of children.[4] Medicaid payment methodologies for these populations are

[3] Data Dashboards & Reports | Department of Human Services | Commonwealth of Pennsylvania
[4] Data Dashboards & Reports | Department of Human Services | Commonwealth of Pennsylvania

specifically designed to cover the cost of care and do not align readily with Medicare rate structures.

On the inpatient side, Medicare Severity Diagnosis-Related Groups (MS-DRG) were designed for a Medicare population using only Medicare claims while All-Patient Refined Diagnosis Related Groups (APR-DRG) utilized in Medicaid reimbursement incorporate sophisticated clinical knowledge to capture the differences in comorbidities and complications that can significantly affect hospital resources used. In Medicare, less than one percent of stays are for obstetrics, pediatrics, and newborn care.

On the outpatient side where Medicare pays based on bundles of services, repricing each individual service at Medicare rates will require a complex crosswalk. Currently, the state actuary, Mercer, has only been able to price 53.8 percent of outpatient encounters or 65.7 percent of outpatient dollars due to the differences in Medicare and Medicaid pricing methodologies.

State Medicaid agencies will be impacted by greater administrative complexity in re-pricing all Medicaid claims to Medicare. This will lead to increased health care costs but not in any way that benefits Medicaid enrollees. These agencies are not well versed in the complexities and nuances of the Medicare program. In addition, to use the web pricer for inpatient claims, an MS-DRG is needed which does not account for the initial crosswalk from APR-DRG.

HAP urges CMS to apply the Medicare rate at the aggregate level instead of a claim-based level. This interpretation of the Medicare rate is significantly more restrictive than the statutory requirements outlined in WFTCA. Utilizing the aggregate level will allow state Medicaid agencies to maintain the autonomy and flexibility in designing programs that meet the needs of the population of their state.

CMS clarifies that when no Medicare rate exists for the covered service, the total payment limit is set at 100 percent of the Medicaid state plan-approved rate. Pennsylvania is primarily a managed care state, and FFS rates have not increased in decades. Instead, FFS supplemental and disproportionate share hospital (DSH) payments are used to close the gap between reimbursement and cost, providing critical funding to rural and sole community hospitals, birthing hospitals, trauma centers, and burn units. These supplemental payments would not be accounted for in the state plan-approved rate resulting in hospitals being paid below the cost of care. **HAP opposes limiting the reimbursement for services not covered by Medicare to the state plan-approved amounts which may not cover the cost of care. If payments are limited to state plan-approved amounts, they must be inclusive of supplemental payments.**

Value-based payment (VBP) SDPs, even those designed as prospective population-based payments, would be expected to be added to base payments and reconciled to the total Medicare ceiling based on actual utilization to ensure a provider does not receive payments in excess of the total Medicare ceiling for any given service. The proposed approach could effectively stifle

state innovation and efforts to implement VBP approaches. By tying payment limits to individual Medicare service rates, the proposed rule would undermine state and health system efforts to move toward VBP models that bundle multiple services together or invest in care coordination and wraparound services that Medicare does not cover, which are the kinds of innovations that have shown the most promise in improving outcomes and reducing costs for Medicaid's most complex populations. **We urge CMS to exclude VBP arrangements from the Medicare cap.**

Extension of Limits to All SDP Services and U.S. Territories

CMS proposes extending Medicare-based payment limitations to all SDP service types beginning January 1, 2029, beyond those specified by Congress in WFTCA. **HAP opposes this expansion, as it exceeds statutory requirements making it more difficult to provide comprehensive health care.**

Grandfathering Period for Existing SDPs

In alignment with the statute, CMS proposes grandfathering provisions for SDPs if a completed preprint was submitted prior to July 4, 2025, and the rating period falls within 180 business days before or after that date. CMS also proposes limiting grandfathering to SDPs that exceed the new payment limits.

HAP supports these grandfathering provisions and appreciates CMS allowing current SDP structures to remain in place during the grandfathering period.

Phase-down of Existing SDPs

In alignment with the statute, grandfathered SDPs are subject to a 10-percentage-point annual phase-down of the SDP, beginning with the first rating period on or after January 1, 2028, until the payments reach the new statutory limits. CMS proposes that the annual phase-down will be applied to the approved estimated total amount for the rating period in which the SDP qualified for grandfathering status. For preprint submissions of the same SDP for different rating periods, CMS would consider the highest total dollar amount it approved to be the grandfathered amount.

We acknowledge the authority of CMS to require the proposed phase-down based upon a 10-percentage-point annual reduction of the total payment amount; however, we also encourage CMS to reconsider this approach and instead allow flexibility in how this provision is implemented by states.

Time-limited Exemption to the Prohibition on Separate Payment Terms

CMS proposes a time-limited exemption to the prohibition on separate payment terms for a grandfathered SDP until the first rating period in which the payment limit is met.

While we support the time-limited exemption as it allows for a more accurate and administratively feasible transition to Medicare rates, we urge CMS to permit their continued use beyond the transition period. Separate payment terms are the least

administratively burdensome method for MCOs to process payments and provide hospitals with clear and predictable reimbursement.

Proposed Prohibition of "Uniform Increase" SDPs

Beginning January 1, 2028, CMS proposes eliminating uniform increase SDPs, with a limited exception for grandfathered arrangements. No prohibition on uniform increase SDPs was required in WFTCA.

While we support allowing grandfathered uniform increase SDPs to temporarily continue, we strongly urge CMS to permit their continued use beyond the transition period. Uniform increases are the least administratively burdensome method for MCOs to process payments and provide hospitals with clear and predictable reimbursement.

Limitations on Types of SDPs

Current regulations state that SDPs may be structured as VBP models, delivery system reform, or performance improvement initiatives, minimum fee schedule (defined as the state plan approved rates, 100 percent of Medicare rates in effect no more than three years prior, or something else), maximum fee schedule, or uniform dollar or percentage increases.

The proposed rule calls for revising the language related to minimum and maximum fee schedule SDPs and removing uniform dollar or percentage increases as an allowable structure.

Starting with rating periods beginning on or after January 1, 2028, CMS proposes to remove states' ability to create uniform dollar or percentage increase SDPs. This will result in significant structural changes to increases that are now tied to days, discharges, or claim counts. States will have the option to increase payments for services under a minimum fee schedule, allowing SDPs to pay at the gap between Medicaid base payments and the full Medicare rate for each service. While this may have a similar aggregate payment impact as a uniform add-on, requiring states to limit payments at the service level could alter distribution shares by provider and would likely prohibit a uniform increase across all services.

HAP urges CMS to permit uniform add-on SDPs to continue after the grandfathering period which creates less administrative burden on MCOs and allows for more predictability for providers.

Currently, regulations allow flexibility in defining the class(es) or providers to which SDPs apply. CMS requested feedback on defining provider classes going forward. **HAP urges CMS to maintain flexibility to accommodate state-specific needs. Narrow definitions, particularly those tied strictly to state plan classifications, would limit the ability to target critical groups of providers, such as rural hospitals, which may not be separately identified in the state plan.**

Medicare-based Payment Limits for Targeted Medicaid Practitioner Payments in FFS

CMS is proposing to better align the limitations on practitioner payments under FFS with the new limitations on SDPs. If a state makes payments to a subset of targeted practitioners, the new proposed limit would be actual Medicare payment rates applicable to the practitioner or provider for the same time period as the Medicaid state plan rate year.

The proposed limit applies to both base and supplemental payments. States would be unable to raise base rates above Medicare levels for a targeted group of practitioners. Pennsylvania is primarily a managed care state and has not increased FFS rates in over a decade. Currently, Medicaid reimburses physician practices 40 cents on the dollar for providing care.

HAP opposes the proposal to cap targeted FFS payments at Medicare rates. Targeted payments allow enhanced payments to providers to maintain network adequacy and access to care. Not only does this restriction to FFS payments exceed the statutory authority in WFTCA, but it will limit states' ability to incentivize certain service types that may need enhanced reimbursement to preserve access to care (e.g., primary care, neonatal, etc.).