Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

July 21, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

REF: CMS-2449-P

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

Dear Dr. Oz:

I am writing on behalf of the Catholic Health Association of the United States (CHA), the national leadership organization representing more than 2,200 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations. Our ministry is present in all 50 states and the District of Columbia, with one in every seven patients in the United States cared for in a Catholic hospital each year. CHA appreciates the opportunity to comment on the referenced proposed regulation implementing portions of Public Law No. 119-21 (the "One Big Beautiful Bill Act" or H.R. 1). We are deeply concerned about the potential negative impact the new requirements could have on access to care for Medicaid beneficiaries and the heath care facilities that serve them.

Medicaid is a crucial element of our nation's safety net and provides essential health care services to working families, children, the elderly and the disabled, many of whom would be uninsured and without access to health care in the absence of a strong and vital Medicaid program. Medicaid provides health coverage for nearly 80 million individuals – including half of children with special health care needs, more than 40% of children living in rural areas and small towns, pregnant women, adults, seniors, and individuals with disabilities. The program is also a major source of financing for long-term care and a primary funding source for America's safety net institutions. That includes the many Catholic hospitals and nursing homes that serve a disproportionate share of the low-income, uninsured and underinsured in their communities every day. It is imperative that people who rely on Medicaid have timely access to the care they

need, which is why it is so important that state and federal financing for Medicaid be sufficient to provide adequate payment to Medicaid providers.

State directed payments (SDPs) are an important Medicaid funding mechanism, used by states with Medicaid Managed Care organizations (MCOs) to address chronic underpayments to providers and physicians. SDPs allow states to set specific payment rates or reimbursement methods for MCOs. They can be used, for example, to require participation in value-based payment programs. SDPs help preserve access to care for missions of people who rely on Medicaid for health care by providing adequate payment for including hospitals, physician practices, behavioral health providers, home and community-based service providers, dental providers, nursing facilities, and other safety net organizations.

H.R. 1 amended the law on SDPs to establish new limits to state payments in four specific service categories – inpatient hospital services, outpatient hospital services, nursing facility services and qualified physician services at medical centers. Under prior law, state payments were capped by the average commercial rate in each category. Now SDPs for those services are capped at 100% of the total published Medicare payment rate in Medicaid expansion states and 110% of the total published Medicare payment rate in non-expansion states. If no total published Medicare payment rate exists for a covered service, the applicable limit is the payment rate under the Medicaid state plan (or a waiver of such plan). The proposed rule implements the provisions of H.R. 1, and goes beyond what the law requires, in ways that will undermine access to care for the most vulnerable among us. We have serious concerns about several specific proposals.

- **Overbroad Application of SDP Payment Limits**

Service Types: Congress imposed new SDP payment limits on four specific service types. CMS would go beyond congressional intent and apply the limits to all types of SDPs, regardless of service category or provider type. This will impose the new payment limits on populations and for types of care for which Medicare rates were not designed and may not be appropriate. For example, Medicare rates and methodologies may not reflect the higher acuity and social needs of behavioral health patients in Medicaid or the unique health care needs of children and infants, and maternal health utilization is limited in Medicare. Applying Medicare-based SDP limits to all MCOs could sharply reduce access to needed care for these and other vulnerable populations. We would also point out that CMS' own analysis has shown that most SDPs at average commercial rate are concentrated in the four provider classes Congress intended to address, calling into question the policy need for expanding the limit.[1]

Application to Fee-For-Service: CMS also proposes to go beyond H.R. 1 by replacing the ACR with the Medicare-based payment limits to certain targeted Medicaid fee-for-service (FFS)

[1] 89 Fed. Reg. 41059 (May 10, 2024).

supplemental payment arrangements. The limit would apply when enhanced payments are available only to a subset of providers furnishing a service, not to all providers of the service.

Targeted supplemental practitioner payments remain an important and longstanding mechanism for supporting access to specialized services within Medicaid. Medicaid payment rates alone are often insufficient to ensure adequate provider participation and beneficiary access to care. As a result, supplemental payment programs have become an essential component of Medicaid, especially for providers that furnish a disproportionate share of care to Medicaid enrollees, including practitioners affiliated with academic medical centers, safety-net providers, and other specialized provider groups that often serve as critical access points for complex care. Replacing the ACR with the SDP Medicare-based rate could have a significant negative impact on behavioral health, maternal health, and pediatric service providers, as well as the beneficiaries who need those services. as Medicare rates do not accurately reflect the costs and care needs associated with these services.

H.R. 1 was intended to address Medicaid managed care directed payments. The proposal to establish new Medicare-based limits for FFS would undermine the ability of states to direct additional resources to providers serving large numbers of Medicaid beneficiaries, despite no clear statutory requirement in H.R. 1 to do so.

Application to Territories: H.R. 1 defines "State" as one of the 50 states or the District of Columbia. However, CMS proposes to apply the SDP limits to all U.S territories after January 1, 2029. CHA believes this goes beyond the intent of Congress.

CHA strongly urges CMS not to finalize the proposals to expand the application of the Medicare-based payment to apply to all SDPs, to FFS payment arrangements and to all U.S. territories.

- **Phase-down of Grandfathered SDPs**

H.R. 1 provides for a phase-down period for certain grandfathered SDPs that exceed the new Medicare-based payment limits. Grandfathered SDPs would be reduced by ten percentage points annually until they reach the applicable Medicare-based limit. CMS proposes to apply the annual 10% reduction to the original grandfathered SDP amount approved by CMS, using that amount as a fixed annual reduction. This approach results in more rapid and severe reductions than Congress intended. By tying the reduction to the original dollar value rather than the gap between current payments and the target limit, the proposal could accelerate payment cuts for certain providers and markets. Hospitals that rely on these payments to support care for Medicaid beneficiaries would face abrupt funding reductions, with limited time to adjust operations.

We urge CMS to offer states alternative phase-down approaches that could provide less disruption in reducing SDP programs to Medicare levels. CMS could allow states to choose among the following approaches: 1) 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.); 2) applying the 10% reduction to the dollar value of the SDP in the prior year (e.g., $1,000,000 to $900,000 to $810,000, etc.); or 3) applying the 10% reduction to the dollar value of the SDP in the base year of the phase down to each subsequent year, as has been proposed by the agency (e.g., $1,000,000 to $900,000 to $800,000, etc.).

- **Payment Limit Methodology**

CMS proposes to move from an aggregate payment limit methodology to a provider and service level approach. Payment limits would be determined and enforced separately for each billing code and provider rather than across a provider class or service category as a whole. This would significantly constrain the flexibility that states currently have to design targeted payment strategies. Under an aggregate payment limit, states can concentrate resources where they are most needed while remaining within the applicable ceiling for the provider class as a whole. The proposed approach would severely limit that flexibility by requiring every provider and every billing code to independently satisfy the payment cap. For example, states would no longer be able to provide enhanced funding for providers in rural or underserved areas or to safety-net providers. Mandating a code-level methodology would create huge operational and administrative challenges, as states would have to create new data collection, analytic and reporting processes. **CHA urges CMS to allow states to use an aggregate payment methodology when calculating the Medicare-based payment rate.**

Tying payment limits to individual Medicare service rate would also undermine state efforts to implement Medicaid value-based purchasing (VBP) models that bundle multiple services or include care coordination and wraparound services not covered by Medicare. VBP models allow states to focus on patient outcomes and total cost of care, leading to more cost-effective and high-quality care. CMS proposes to further restrict Medicaid VBP models by retrospectively comparing payments to what would have been paid under Medicare FFS without any consideration of how shifts in care to more cost-effective settings have lowered costs for the health system. As a result, the rule will limit states' ability to reward providers for high-value care, even when total payments are less than what Medicare would have paid. To ensure that VBP SDPs can continue to promote better health outcomes for Medicaid beneficiaries, **CMS should preserve states' flexibility to design value-based payment arrangements and evaluate Medicare-based limits at the broader service category level, consistent with longstanding agency policy and the realities of value-based care delivery.**

- **Elimination of Uniform Increase SDPs**

Uniform increase SDPs remain an important tool for states to support access and advance quality goals while preserving appropriate payment differentials across providers. Under uniform dollar or percentage increase SDPs, states can require plans to pay a fixed dollar amount or percentage increase on top of base rates and direct this additional funding toward a class of providers to enhance services and access.

States have historically relied on uniform payment increases and other targeted payment strategies to strengthen their provider networks, maintain access to essential services, and support providers that care for a disproportionate share of Medicaid beneficiaries. Removing states' ability to design a uniform increase SDP to meet the specific needs of their populations would be counterintuitive to the design of the Medicaid program. **We urge CMS to not finalize this policy and to retain uniform increase SDPs to ensure states have flexibility when designing SDPs**.

- **Magnitude of Financial Implication**

The financial impact of these and other provisions in the proposed rule will be devastating for states, for providers and, most importantly, for the families, children, older adults and people with disabilities who rely on Medicaid for health care. The Congressonal Budget Office estimated that the changes to SDPs in H.R. 1 as passed would reduce federal funding by $149 billion dollars over 10 years. CMS projects that its proposals to implement H.R. 1 will cut federal Medicaid funding by $510 billion – a 300% difference. **CHA strongly opposes this dramatic reduction in Medicaid funding, far in excess of what Congress intended, and urges CMS to reconsider its proposed rule, especially the provisions outlined above.**

In closing, thank you for the opportunity to provide comments on this rule. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

Lucas Swanepoel, JD
Vice President Public Policy and Advocacy