Safety-Net Association of Pennsylvania

July 21, 2026

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 Safety-Net Association of Pennsylvania (SNAP), a group of private safety-net hospitals that care for especially large numbers of Pennsylvania's Medicaid patients, 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.

Executive Summary. SNAP respectfully asks CMS to preserve uniform percentage increase State Directed Payments, apply SDP payment limits in the aggregate by service rather than at the hospital or class level, and permit states to use a simpler Medicare cost-report-based methodology for estimating what Medicare would have paid for Medicaid services. SNAP supports CMS's goals of strengthening fiscal integrity, ensuring that Medicaid payments are connected to beneficiary access and quality, and establishing clear safeguards to prevent the inappropriate use of provider-tax-financed payments. We believe the recommendations in this letter advance those objectives while preserving states' ability to target resources to the providers most critical to maintaining access to care for Medicaid beneficiaries.

Background

Congress has, through the Social Security Act, mandated that states assure their Medicaid payments are consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available at least to the extent they are available to the general population. Congress also explicitly permits states to use funds derived from provider-related taxes to meet that obligation.

In the Working Families Tax Cut Legislation (Public Law 119-21) enacted on July 4, 2025, Congress placed additional limits on states' use of provider-related taxes and on the amount of State Directed Payments (SDP) that states may make to four types of providers that are frequently funded with provider-related taxes. These new limits reflect Congress's judgment that additional safeguards are needed to ensure provider-related taxes and State Directed Payments remain closely tied to Medicaid payment adequacy, access, efficiency, economy, and quality.

SNAP is grateful for CMS's deliberative and explicit approach to implementing these provisions and for the opportunity to comment on the agency's proposal prior to implementation. Our comments are guided by the following positions:

- SNAP agrees that funds generated through provider-related taxes should be used exclusively to further Medicaid program goals, including payment adequacy, beneficiary access, quality improvement, and delivery system stability. We support reasonable safeguards that ensure these arrangements remain focused on those objectives and do not serve as mechanisms for generating federal funding divorced from Medicaid program needs.

- SNAP also believes that uniform percentage increase SDPs serve a critical role that Congress intended to preserve and that can and should continue.

- Finally, SNAP believes that the provisions of the WFTC legislation and Presidential Memorandum, like all effective regulations, should be implemented with the minimum amount of additional administrative burden necessary to achieve the provisions' goals.

Our comments below explain how we suggest that all of these goals can be achieved. In addition, we offer our perspective on why a Medicare payment cap on Medicaid value-based arrangements limits their utility.

Ensuring Payments are Related to Medicaid Program Goals

CMS should preserve the ability of states to target Medicaid resources to high-Medicaid safety-net hospitals while maintaining appropriate aggregate fiscal guardrails. Medicaid has long-standing policies that work in concert to ensure that provider-related taxes are used in accordance with program goals when used to finance Medicaid Fee-For-Service payments for inpatient and outpatient hospital services. Taxes are subject to a variety of requirements, including that they be either broad-based and uniform or generally redistributive and not related to Medicaid payments, while related payments are capped at the amount Medicare would pay for the same services.

Congress saw fit to reduce the overall amount of taxes states may levy and to refine the definition of uniformity in the WFTC legislation, but it conspicuously made no changes to the existing payment caps for FFS hospital payments. Instead, it used those caps as a model for a limit on State Directed Payments made to hospitals under managed care program.

We believe Congress' decision to model the SDP payment limits on previously existing FFS payment limits expresses a vote of confidence in those limits' efficacy and provides a framework for implementation of the new SDP limit. The FFS upper payment limit is applied in the aggregate for each service (inpatient hospital and outpatient hospital) for all hospitals in the state that share certain characteristics (i.e. public vs. private ownership or control). This contrasts with the proposal in this rule to apply the SDP limit on a hospital and service level, which is much more restrictive. This more restrictive application of the limit would run counter to the

underlying guardrail that taxes should be generally redistributive by not permitting states to pay hospitals with a greater Medicaid share a higher proportion of their costs.

In Pennsylvania, there are no public hospitals and Medicaid rates for hospital services are often at levels that are lower than the cost of providing care. For safety-net hospitals with high rates of Medicaid utilization, supplemental payments are a critical a lifeline to financial solvency. An aggregate cap enables hospitals that are disproportionately reliant on Medicaid to receive payments in excess of the cap, while ensuring that overall payments remain within the cap. The ability to do this is important because just last March, MedPAC stated in its report to Congress that "Hospitals' FFS Medicare margin improved slightly to –12.1 percent and to –1 percent for the median relatively efficient hospital." In other words, receiving 100% of Medicare payments is not sufficient to keep a relatively efficient hospital operating in the black, let alone maintain or invest in capital or quality improvement initiatives. And this analysis doesn't even account for the financial subsidies that safety-net hospitals must pay to physicians to assure access to their services for Medicaid enrollees. The very hospitals that rely most on Medicaid will be those most seriously harmed by a hospital-specific cap on SDPs.

We believe that the application of the cap at the class level similarly limits states' ability to identify and direct funding to those hospitals with the strongest commitment to and reliance on Medicaid.

Importantly, allowing states to apply SDP limits in the aggregate does not diminish fiscal accountability. Aggregate limits continue to ensure that total payments remain within a defined Medicare-based ceiling while preserving the flexibility needed to direct resources toward providers that disproportionately serve Medicaid beneficiaries. In this respect, aggregate application advances CMS's objective of preventing provider-specific payment arrangements while remaining consistent with longstanding Medicaid supplemental payment policies.

For these reasons, we request that CMS permit states to calculate and apply the cap on approved SDPs in the aggregate for each service rather than separately for each hospital (or class) and service.

The Value of States Directing Uniform Percentage Increases to Rates

Because Pennsylvania has no public hospitals, the state has historically relied on Medicaid payment rates that are below the cost of providing care, with commercial payment helping to offset the resulting shortfall. That approach is increasingly difficult to sustain for hospitals that provide a high portion of Medicaid care, so the state also has a long history of directing additional, supplemental funding to hospitals and other providers that have a significant relationship with the program either because of particularly high volumes or percentages of Medicaid care.

Even today in Pennsylvania's mature managed Medicaid environment, hospitals and other providers rely on directed payments to help offset low Medicaid reimbursement. Of the directed payments that states can make, uniform percentage increases to negotiated rates are most directly linked to Medicaid program goals. Eliminating them because they are frequently financed with provider-related taxes would remove a targeted and effective tool rather than addressing the

specific financing concerns CMS has identified. Uniform percentage increases preserve the market dynamics reflected in negotiated contracts, while minimum fee schedules undermine those negotiations by directing funds only to those providers for whom an administrative fee schedule calculation has determined a higher rate than the MCO deemed necessary to pay for the service.

SNAP 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 providers, these payments help maintain access to care in communities where alternative sources of funding are limited.

For example, Pennsylvania recently submitted a preprint for a directed payment for specific dental services, which was designed to promote access to those services for the pediatric population. The state considered directing payments as a minimum fee schedule, but chose instead to implement a uniform percentage increase after determining that a minimum fee schedule methodology would direct much of the funding to a large number of dentists who provide relatively little care to Medicaid patients. Put simply, fee schedule increases can spread limited resources too broadly to change provider behavior meaningfully.

A minimum fee schedule approach would have diluted the impact of the funding by distributing small amounts across many providers without materially changing incentives. As a uniform percentage increase, the funds are generally targeted to the limited number of dentists that are truly committed to caring for Medicaid enrolled children and whose outsized partnership with the program is reflected in the rates they have negotiated with the MCOs. This directed payment has enabled these providers to maintain or grow the amount of care those children receive.

Pennsylvania's uniform percentage increase for hospital inpatient services follows the same model. Many of the hospitals who are the Medicaid program's greatest partners have the greatest need to negotiate rates that exceed a minimum fee schedule and a minimum fee schedule does nothing to support those partners. We have been almost entirely in managed care in Pennsylvania for over a decade, and there is no reasonable Medicaid fee schedule because it has not been maintained for at least as long. As discussed above, Medicare rates are also insufficient to sustain an efficiently run hospital.

We believe that the new payment limit - in concert with other CMS SDP policies (including defining the percent increase rather than a total payment pool, prohibiting retroactive adjustments, and eliminating separate payment terms) - effectively address CMS's concerns about SDPs being linked to tax contributions rather than policy priorities. If, however, CMS continues to believe that states are using uniform increases to target payments to certain providers through the use of narrowly defined classes, a narrower provider-class definition would directly address CMS's concern that states may construct overly specific classes for payment purposes, while preserving the ability of states to target payments to providers with demonstrably different Medicaid responsibilities, patient populations, or service obligations.

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

Improving Oversight Without Undue Regulatory Burden

CMS can strengthen oversight without requiring states to run Medicaid claims through Medicare payment systems that were not designed for Medicaid data. A simpler and more comprehensive approach would estimate what Medicare would have paid by applying Medicare cost-report-derived payment-to-charge ratios to Medicaid managed care encounter charges. "What would Medicare have paid for hospital services provided to a Medicaid enrollee?" is a complicated question for a number of reasons:

- Medicare enrollees' health care needs are different from Medicaid enrollees',
- Medicare often uses different billing information than Medicaid, and
- Medicare and Medicaid have different scopes of coverage.

Although running Medicaid claims data through Medicare payment groupers may appear to produce the most precise estimate, Pennsylvania's experience suggests that the result may not be the most reliable basis for Medicaid policy.

In Pennsylvania, we have a directed payment for outpatient hospital services under which hospitals are sorted into classes according to the difference between what they are actually paid under their Medicaid MCO contracts and what they would have been paid by Medicare. This differential is calculated by a major national accounting and actuarial services company by running outpatient Medicaid claims data through the Medicare OPPS PRICER. The result is that only around 54% of the Medicaid claims actually "group" appropriately in the Medicare PRICER and those are used to perform the calculation: 46% of the services hospitals provide are ignored in the calculation.

We believe giving states the option to use an approved Medicare cost-report based approach would strengthen, rather than weaken, CMS oversight because it would produce calculations based on a more complete set of services, reduce reliance on assumptions required when adapting Medicaid data to Medicare payment systems that were not designed for that purpose, and eliminate the need to develop Medicaid-specific cost accounting principles for cost-reimbursed providers that file Medicare cost reports.

One example of a permissible calculation could use the following Medicare cost-report payment-to-charge ratios:

> *Medicare Inpatient Payment-to-Charge Ratio*
> Medicare Inpatient Payments Hospital: Worksheet E Part A, Line 71, Column 1 minus Line 29.01 minus Line 53 / (Medicare Inpatient Routine Charges Hospital:

> D-3, Column 2, sum of lines 30-43 + Medicare Inpatient Ancillary Charges Hospital: D-3, Column 2, Line 202)
>
> *Medicare Outpatient Payment-to-Charge Ratio*
> Medicare Outpatient Payments Hospital: Worksheet E Part B, Line 40, Column 1 / Medicare Outpatient Charges Hospital: Worksheet D, Part V, Columns 2, 3, 4, Line 202 Title XVIII Hospital.

The calculation could likely be refined to recognize limitations in what is or is not included in the specific lines we identified for this example.

> **For these reasons, we request that CMS permit states to calculate the SDP limit through the application of a payment-to-charge ratio derived from Medicare cost reports to Medicaid charges extracted from Managed Care encounter data.**

Avoiding Cliffs and Preserving Congressional Intent

Congress capped the federal commitment to state directed payments and provided a temporary grandfathering period to help states transition to those new limits. The statute did not, however, change the underlying permissibility of existing directed payment methodologies. As a result, the grandfathering framework protects hospitals from an abrupt reduction in payment authority, but it does not protect them from separate policy changes that CMS proposes to implement at the same time, including the elimination of uniform percentage increases and the application of the payment limit on a hospital-specific basis.

The elected representatives who voted for HR1 understood that states would need to scale back spending. They could not have known that CMS would propose concurrent changes that would make existing state programs impermissible regardless of size.

In the preamble of the proposed rule, CMS states:

> Together, the temporary grandfathering framework and the proposed applicability date are intended to provide States sufficient time to transition away from uniform increase SDPs, including redesigning SDPs, amending managed care contracts, and adjusting associated financing arrangements. We recognize that some States may have structured SDPs and associated financing arrangements in reliance on prior policy permitting uniform increase SDPs; however, we believe the proposed applicability date provides sufficient time for States to redesign SDPs, amend contracts, and adjust associated financing mechanisms as needed.

SNAP respectfully believes that although *states* may have enough time to adapt under this timeline, CMS's interpretation would not provide a meaningful transition for many affected *hospitals*. The temporary grandfathering framework was designed to transition spending to a new cap without altering the underlying methodology. Under CMS's proposed interpretation, SDPs

that were not made in excess of what Medicare would pay would receive no transition, and states that paid only modestly above Medicare would receive only limited transition protection.

As a result, states that most extensively used the practices CMS has identified would receive the longest transition periods, while states that used provider-related taxes to increase funding to reasonable levels in support of access could face a much shorter and more disruptive path to compliance. The practical effect would fall on hospitals and the patients who rely on them.

For example, a high-Medicaid hospital in a low-income Pennsylvania community may have negotiated rates with managed care entities that are higher than the rates paid to lower-Medicaid facilities, yet still insufficient to cover operations, invest in the facility's future, and provide the physician subsidies needed to secure access to care for its patients. For such a hospital to remain viable, Medicaid must pay its fair share, which may require payments modestly above what Medicare would pay. A state may reasonably recognize this need and use provider-related tax funds to support the hospital and others like it through a uniform increase to negotiated rates.

As CMS proposes, moving this hospital from a uniform percentage increase to a minimum fee schedule at the end of the existing SDP's grandfathering period could result in the sudden loss of all SDP funding. Applying the Medicare payment limit at the hospital level, rather than in the aggregate as under the fee-for-service program, would have the same destabilizing effect. As a result, states that most extensively used the practices that CMS hopes to curtail would receive the longest transition periods, while hospitals in states that used provider-related taxes more modestly to support access could face a shorter and more disruptive path to compliance. That result would not advance fiscal integrity; it would instead create instability for hospitals and for the Medicaid patients who rely on them.

> **For these reasons, we request that CMS preserve the grandfathering framework and allow existing SDPs to transition to the new payment limits without being invalidated by separate policy changes, including changes to payment methodology or the level at which the cap is applied.**

Value-Based Payments Will be Weakened by Medicare Limit

If the proposal to end uniform increase SDPs is finalized, CMS said it would continue to permit value-based SDPs but the Medicare payment limit significantly weakens the ability of value-based payments to make meaningful changes for Medicaid providers or patients. To participate in VBP, provider organizations make substantial investments in new administrative processes, care coordination pathways, and patient service offerings needed to meet MCO goals and secure payment. Without meaningful upside rewards, these providers — especially financially strained safety-net providers — are less able to make those investments. If providers are held to the Medicare payment limit regardless of their performance, that reward will be less useful as a tool to support Medicaid innovation.

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.

Conclusion

SNAP supports CMS's efforts to improve transparency, accountability, and program integrity within Medicaid managed care. We respectfully believe that the recommendations in this letter would better advance those objectives while preserving beneficiary access to care and maintaining the financial viability of providers that serve a disproportionate share of Medicaid patients.

For the reasons described above, SNAP urges CMS not to finalize the proposed elimination of uniform rate increases; to apply payment limits in the aggregate; and to permit states to use a simpler and more comprehensive method for calculating what Medicare would pay for Medicaid services.

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SNAP appreciates the opportunity to comment on the proposed rule and would welcome the opportunity to discuss these recommendations with CMS.

Sincerely,

Michael Chirieleison
Executive Director, SNAP

About SNAP

Pennsylvania's safety-net hospitals make up one-quarter of the commonwealth's hospitals but provide over half the care to the state's one million uninsured residents and its 3.2 million Medical Assistance (Medicaid) recipients. Because of the amount of care they provide that is reimbursed according to Medicaid policies, these hospitals face a significant and continuing challenge to their financial health. Our members are committed to delivering strong, reliable care that families can count on when it matters most. We play a critical role in the health care system, providing essential services to those who rely on Medicare, Medicaid, and other public programs for access to care.