Illinois Health and Hospital Association

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

RE: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)

Dear Administrator Oz:

On behalf of the Illinois Health and Hospital Association and the more than 200 hospitals and nearly 40 health systems we represent, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule on Medicaid managed care state directed payments (SDPs) and targeted Medicaid fee-for-service (FFS) practitioner payments. This regulation implements key provisions of Public Law (P.L.) No. 119-21.

Since 1965, Medicaid has been a cornerstone of Illinois' healthcare system, ensuring that residents have access to quality healthcare while providing hospitals and health systems with the resources needed to care for the communities they serve. Over the last decade, Illinois has made tremendous strides in strengthening its Medicaid program, particularly through the expanded use of SDPs. The implementation of SDPs has improved access to care by increasing providers' willingness to serve Medicaid beneficiaries, enhanced transparency in Medicaid payments methodologies, and ensured that payments are more closely aligned with the volume of Medicaid services providers actually deliver.

In 2025, nearly 25% of the population of Illinois was covered under the Medicaid program, but over one-third of inpatient days were for individuals that had Medicaid as their primary or secondary coverage. Over 45,000 deliveries were covered by Medicaid, representing nearly half of all births in the State of Illinois. Nearly half of inpatient hospitalizations resulting from a mental health crisis were covered by Medicaid. In addition, nearly 750,000 hospital visits were for children under the age of 18 who were covered under Medicaid, representing over half of all pediatric hospital visits in the state.

SDPs are primarily used to ensure access to care for individuals enrolled in the Medicaid program. Their function is to both mitigate losses that would otherwise occur for providing services to Medicaid customers and to provide financial stability to providers that are located in lower income communities and are often not able to receive increased reimbursement from commercial payors. These payments also allow for a greater level of certainty in payment, especially in light of ever-changing policies implemented by Medicaid managed care organizations (MCOs), many of which result in payment delays or denials. SDPs also improve the quality of care by encouraging more providers to participate in Medicaid, expanding access to care for Medicaid beneficiaries.

We are deeply concerned that several provisions in the proposed rule will curtail the ability of hospitals to care for some of the most vulnerable members of our community by reducing the financial resources needed to maintain essential services. Notably, the proposed rule would dramatically decrease the federal investment in the healthcare system nationally by an estimated $510 billion over 10 years. This is a remarkable escalation from the changes to SDPs Congress authorized in P.L. 119-21, which were estimated to result in approximately $149.4 billion less in federal funding over 10 years. Specifically, CMS is proposing to cut 3.4 times more in federal funding for the healthcare system nationally than Congress intended.

Resource reductions of this magnitude will undoubtedly lead to hospital closures, reduced access to care for all Illinois residents (not just those that are enrolled in Medicaid), and significant service line reductions. The significant loss of Medicaid funding facing Illinois hospitals will also result in the loss of thousands of jobs. Those impacts will extend beyond Illinois, affecting individuals who commute to Illinois hospitals from neighboring states, including Indiana, Iowa, Missouri, and Wisconsin

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.

Calculation of the Medicare Payment Limit

CMS proposes to apply the Medicare payment limit at the individual service or discharge level rather than in the aggregate. This represents a significant departure from longstanding Medicaid financing approaches. Applying the limit at the service level would be tremendously destabilizing to the healthcare system. Many hospital systems currently experience losses on their Medicaid and Medicare lines of business. SDPs help offset a portion of those losses in some cases. For safety net providers with little commercial payer revenue, however, SDPs are often the only thing keeping their doors open. Limiting SDPs to the Medicare payment level on a service-by-service basis would be devastating. For a number of hospitals across Illinois, it would effectively amount to a foreclosure notice, leaving them unable to sustain operations at that level of reimbursement.

Historically, CMS has established overall limits on Medicaid spending while allowing states flexibility to design provider payment methodologies that reflect the unique needs of their Medicaid populations and help ensure access to care for vulnerable communities. The proposed rule would effectively eliminate that longstanding flexibility, preventing states from tailoring payment systems to meet local needs and significantly undermining access to care for the very individuals the Medicaid program is intended to serve.

Moreover, the proposed approach stifles state innovation and efforts to implement value-based payment (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.

CMS' proposed approach would apply the Medicare payment limit at the service or discharge level to freestanding children's 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. CMS itself noted that states would need extensive guidance to attempt to accomplish what is proposed under this rule.

We urge CMS 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 FFS Medicaid.

Phase-down of Grandfathered SDPs

Through P.L. 119-21, Congress limited the value of SDPs when combined with claims-based payments to the Medicare level of payment and required SDPS that were determined to be grandfathered to be reduced by 10 percentage points annually until the specified Medicare limits are reached. Through this regulation, CMS interprets this as applying an annual 10% reduction to the original grandfathered total dollar amount approved by CMS, using that amount as a fixed reduction, until payments reach the statutory Medicare-based limits. **This approach results in more rapid and severe reductions than Congress required and intended.** Specifically, by linking the reduction only to the original grandfathered dollar value rather than the gap between that specific limit and the new Medicare-based target limit, the proposal will both accelerate and magnify payment cuts for all hospitals in Illinois. All hospitals that are currently serving Medicaid patients and receive SDPs as part of the overall reimbursement structure will face abrupt revenue reductions, with limited time to adjust operations.

We urge CMS to adopt an alternative phase-down methodology that would provide less disruption as states reduce SDP rates to Medicare levels by applying the required 10-percentage point annual reduction to the difference between a state's current SDP rate and the applicable Medicare payment rate. This approach is fully consistent with the statutory language enacted by Congress and more closely reflects congressional intent regarding the gradual phase-down of SDPs. It would also create a more equitable transition by ensuring all states progress toward the Medicare payment limit at the same pace and reach the new limit within the same timeframe, while minimizing unnecessary disruption for Medicaid providers and the patients they serve.

CMS Is Applying Broader Cuts Than Congress Directed

As previously noted, we are deeply concerned that the proposed rule applies payment limitations and policy changes more broadly than contemplated by Congress. CMS proposes to apply Medicare-based payment limits beyond the specific categories identified in statute and to a wider range of payment arrangements. These expansions result in deeper and more widespread reductions in provider payments than Congress intended. In Illinois, these changes threaten access to specialty care, particularly in rural

and other underserved communities, where Medicaid supplemental payments play a critical role in maintaining provider participation and ensuring beneficiaries have timely access to care.

We encourage CMS to realign the proposed policies with the statutory framework and limit their application to the areas explicitly identified by Congress. Specifically, we urge CMS to:

- Refrain from extending the Medicare payment limit beyond the categories expressly identified in statute.
- Preserve states' flexibility to utilize uniform increases for SDPs and other payment methodologies that support access to care.
- Reconsider applying the Medicare payment limit to targeted practitioner payments under the Medicaid FFS program.
- Eliminate or substantially streamline the proposed reporting and compliance requirements to minimize unnecessary administrative burden on states and providers.

We recognize that the Medicaid program is already undergoing significant changes that will place considerable strain on states, providers, and the patients they serve. The additional payment restrictions proposed in this rule will only compound those challenges and further undermine states' ability to design Medicaid payment systems that respond to local healthcare needs. We respectfully request that CMS revise the proposed rule to more closely align with the statutory framework enacted by Congress and preserve the flexibility states need to ensure continued access to care for Medicaid beneficiaries.

The changes outlined above would help lessen the detrimental impact these proposals would have on Illinois hospitals' ability to continue providing essential services and ensure Medicaid beneficiaries throughout the state retain access to the care they need. We appreciate your consideration of these comments and look forward to continued engagement with CMS on these important issues.

Sincerely,

A.J. Wilhelmi
President and CEO
Illinois Health and Hospital Association