WISCONSIN HOSPITAL ASSOCIATION

ADVOCATE. ADVANCE. LEAD.

5510 Research Park Drive
Fitchburg, WI 53711
608.274.1820 | FAX 608.274.8554
www.wha.org

July 21, 2026

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 our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments 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, which CMS refers to as the ''Working Families Tax Cut'' (WFTC) legislation in the proposed rule.

WHA was established in 1920 and is a voluntary membership association. We are proud to represent over 150 Wisconsin hospitals, including small Critical Access Hospitals, mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

Enacted in state statute in 2009, Wisconsin's Medicaid hospital SDP program was designed and has been consistently implemented with fiscal and program integrity, under Republican and Democratic state administrations alike. As CMS notes in its proposed rule, the original purpose of SDP arrangements "is to permit states to direct certain managed care plan expenditures within specified parameters to improve access and ultimately, quality of beneficiary care."[1] Wisconsin's hospital SDP has consistently achieved CMS' intended objectives for state directed payment arrangements while operating with a high degree of transparency. The program is subject to statutory reporting requirements, with annual implementation reports submitted to the Wisconsin Legislature's Joint Committee on Finance and made publicly available through the nonpartisan Wisconsin Legislative Fiscal Bureau's webpage.

SDPs are a critical financing mechanism and an essential component of Medicaid provider reimbursement. In Wisconsin, as in many states, base Medicaid payment rates have not kept pace with the cost of delivering care. According to data from the state-mandated hospital fiscal survey, Wisconsin hospitals received only 63 cents for every dollar spent caring for Medicaid patients in 2024, even after accounting for supplemental payments.

SDPs remain an important source of state Medicaid financing, and CMS should preserve states' flexibility to structure payment arrangements that advance access to care while avoiding unnecessary administrative barriers to their use. Below we provide detailed comments on a number of provisions proposed in CMS-2449-P.

Definition of a Grandfathered SDP

Section 71116(b) of the WFTC legislation provides "grandfathered" SDPs a temporary period of time during which they are eligible for delayed full compliance with the total payment limit for SDPs established by Section 71116(a) of the Act. This means starting in 2028, a non-expansion state, like Wisconsin, with a grandfathered SDP for inpatient hospital services and outpatient hospital services, for example, will need to reduce its SDP by ten percentage points each year until the total payment rate equals 110% of published Medicare rates or the payment rate under its Medicaid State Plan when no Medicare rate exists.

WHA agrees with CMS' decision to propose a definition of ''Grandfathered State directed payment'' in § 438.6 that aligns with Congressional intent and provides clarity to states on the criteria an SDP must meet for grandfathering status. However, while WHA appreciates the runway Congress has given states to move toward the new payment limits for grandfathered SDPs under Section 71116(b) of the WFTC legislation, we remain deeply concerned about the implementation of the annual ten percentage point phase down of SDPs during the temporary grandfathering period.

As we will discuss further below, WHA is concerned that the approach CMS proposes for implementing the ten-percentage point phase down starting in 2028 will result in more rapid and severe reductions than Congress intended. To help lessen any unintended negative financial consequences of implementing Section 71116(b) of the WFTC legislation, WHA urges CMS to offer states maximum flexibility to choose a phase-down approach that could make reducing SDP programs to Medicare based levels less disruptive to hospitals and other providers.

Phase Down of Grandfathered SDPs

Section 71116(b) of the WFTC legislation requires states to reduce all grandfathered SDPs by ten percentage points annually until the "total payment rate" reaches 110% of Medicare for a non-expansion state like Wisconsin, beginning with the first rating period on or after January 1, 2028. As described in section IV.D.1. of the proposed rule, CMS considered two interpretations of the ten percent annual phase down provided under Section 71116(b) of the WFTC legislation.

Under the interpretation CMS proposes, 100 percent of the grandfathered total SDP dollar amount (shown in Item 4 of the current SDP preprint) would be reduced by ten percentage points each year until reaching the limit. Under the alternative interpretation CMS considered, the total payment rate (Medicaid base payment + SDP), measured as a percentage of the total published Medicare payment rate, would be reduced by ten percentage points annually.

For some states the approach proposed by CMS could result in more rapid and severe reductions than Congress intended. Specifically, by calculating the reduction from the original SDP payment amount instead of the gap between current total reimbursement levels and the target limit, the proposal could hasten payment reductions for certain hospitals and markets. As a result, hospitals that rely on these funds to support Medicaid services could experience abrupt revenue losses, with limited time to implement operational or financial adjustments. For example, based on preliminary modeling by WHA, in Wisconsin, CMS' proposed approach could result in a six-year phase down versus 11 years under the alternative approach CMS considered and outlined in the proposed rule.

It's important to note that hospitals are facing severe reimbursement challenges not only from federal underfunding of Medicaid, but also Medicare. In Wisconsin, hospitals are paid only about 74% of what it costs to provide care to Medicare patients according to an annual fiscal survey of Wisconsin hospitals done by the WHA Information Center. And because Wisconsin is an aging state, as measured by the percentage of the population eligible for Medicare, we are seeing a large shift in people moving off private insurance and onto Medicare.

From 2016 to 2024, the average payor mix for a Wisconsin hospital has experienced growth from 43% to 49%, while commercially insured patients have shrunk from 37% of the payor mix to only 32% concurrently, according to claims data analyzed by WHA's Information Center. In fact, as of 2024, Wisconsin was tied for 8th among states with the highest percentage of their population covered by Medicare, at 22%, according to research by the Kaiser Family Foundation. Due to this, annual Medicare underpayments to Wisconsin hospitals have grown from $1.77 billion in 2016 to $3.6 billion in 2024, more than doubling in eight years. This problem can be particularly challenging for rural areas which tend to have a higher percentage of their population at a Medicare eligible age. For 2024, nearly one quarter of Wisconsin hospitals operated at a loss due in part to these reimbursement challenges.

WHA worked closely with Wisconsin's governor, legislative leaders, and lawmakers on both sides of the aisle who enacted a bipartisan state budget last summer that significantly increased Medicaid reimbursement to our state's hospitals through an enhanced SDP in recognition that these losses are not sustainable, and greatly contributed to the closure of two longtime hospitals in 2024. Crucially, Wisconsin's Congressional delegation also worked closely with state legislative leaders to ensure Wisconsin would qualify for the enhanced federal funding that made this possible. Thanks to their work, Wisconsin hospitals will see an estimated $740 million annual increase in Medicaid reimbursement in the next two years, which will roughly cut in half their $1.3 billion in annual Medicaid losses compared to what it costs them to treat Medicaid patients. This funding will be a crucial lifeline to hospitals given the continued growing losses they are projecting under Medicare.

To help lessen the disruption caused by reducing SDP programs to Medicare levels, and as recommended by the American Hospital Association, WHA encourages CMS to offer states the option of selecting from at least three alternative approaches for applying the ten-percentage point reduction, including to:

1. the current SDP rate as compared to Medicare (e.g., from 200% of Medicare to 190%, 180%, etc.);
2. the dollar value of the SDP in the prior year (i.e., an annual compounding reduction) (e.g., $1,000,000 to $900,000 to $810,000, etc.); or

3. the dollar value of the SDP in the base year of the phase down to each subsequent year, as proposed by CMS (e.g., $1,000,000 to $900,000 to $800,000, etc.).

Delaying the Prohibition on Separate Payment Terms
The 2024 Managed Care Final Rule prohibited states from utilizing separate payment terms in SDP programs for rating periods on or after July 9, 2027. CMS proposes at §438.6(c)(2)(iii)(F) to delay the phase out of separate payment terms for grandfathered SDPs until the Medicare limit is met. As CMS acknowledges in its proposed rule, in the "limited context resulting from the WFTC legislation, (separate payment terms) may provide a more transparent and administratively feasible mechanism for Federal and State monitoring and oversight of compliance with the grandfathered total dollar amount and associated phase down requirements as a separate payment term can be directly targeted to the total dollar amount."

WHA believes the rationale above that CMS cites in the proposed rule for temporarily pausing the elimination of separate payment terms holds true beyond the time limited grandfathering period. Separate payment terms promote transparency as well as fiscal and program integrity in the expenditure of Medicaid funds by allowing states to distinguish SDP funding from other managed care payments, helping ensure that supplemental payments reach hospitals as intended. By not permanently preserving the use of separate terms in this proposed rule, CMS is missing an opportunity to preserve transparency and fidelity in how Medicaid managed care organizations pass on directed payments to health care providers.

WHA supports CMS' proposal to allow states to maintain separate payment terms during the grandfathering phase down period. However, CMS should permanently preserve separate payment terms as a lawful, allowable payment mechanism for all current and future state directed payments to ensure hospitals and other providers receive the full amount intended through these directed payment arrangements.

Service Code Specific Payment Limits
CMS proposes in § 438.6(c)(8) to apply the Medicare payment limit for SDPs, established by Section 71116(a) of the WFTC legislation, on an individual service code level rather than in aggregate for hospitals reimbursed under PPS or cost-based methodologies. For grandfathered SDPs, this new service code payment limit would apply for rating periods beginning on or after January 1, 2029.

CMS' proposal to apply the Medicare limits at the service code level, which equates to more than 20,000 HCPCS codes and 700 MS-DRG codes, would introduce significant operational challenges, as Medicaid claims are priced using different payment methodologies than Medicare. Further, CMS' proposal to require states to not exceed the Medicare payment limit at the service line level extends beyond the statutory requirement established by Congress and represents a significant departure from traditional Medicaid financing approaches which allowed states to perform SDP payment limit calculations in aggregate. For critical access hospitals and children's hospitals, in particular, which are reimbursed based on costs, deriving a service-level or discharge-level payment limit from their most recent finalized cost report would impose significant administrative burden and could effectively establish payment limits below Medicare reimbursement levels for these services.

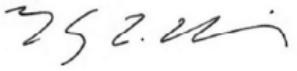
WHA urges CMS to withdraw its proposal to require states to calculate Medicare-based payment limits at the individual service code level rather than in the aggregate.

Prohibition on Uniform Rate Increases
CMS proposes to add § 438.6(c)(1)(iii) to prohibit a state from operationalizing a uniform increase SDP, which is defined at § 438.6(a) as an SDP that directs Medicaid managed care plans to pay the same amount (i.e., same dollar amount or percentage increase) per Medicaid covered service in addition to the base rate negotiated with providers eligible for the SDP. Further, the agency proposes to provide a limited exception to this prohibition for grandfathered SDPs. Specifically, CMS proposes to add § 438.6(c)(2)(iii)(E) to allow states to maintain grandfathered uniform rate increase SDPs during the grandfathering period until the Medicare limit is met.

Under Wisconsin's Medicaid hospital SDP, eligible hospitals receive a uniform fixed dollar amount paid for each Medicaid inpatient discharge and for each Medicaid outpatient service. Since 2009, Wisconsin Medicaid has operated our state's uniform increase hospital SDP with fidelity, under the watchful eye of the State Legislature and its nonpartisan Legislative Fiscal Bureau. Consistent with our recommendation above related to preserving separate payment terms, WHA supports CMS' proposal to allow states to maintain uniform rate grandfathered SDPs during the grandfathering period; however, we urge CMS to permanently eliminate the prohibition on uniform rate SDPs altogether, as it goes beyond Congressional intent. Furthermore, prohibiting uniform rate increase SDPs after a grandfathered SDP meets the Medicare limit would force a state like Wisconsin to significantly modify our longstanding hospital SDP program, which was designed and implemented with fiscal integrity and continues to improve access and ultimately, quality of beneficiary care, as CMS originally intended.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please feel free to contact Christian Moran, Senior Vice President Finance & Payment: cmoran@wha.org

Sincerely,



Kyle O'Brien
President & CEO

[1] 91 Federal Register 30401 (May 22, 2026)