CHILDREN'S HOSPITAL ASSOCIATION

July 21, 2026

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

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

The Children's Hospital Association (CHA) is the nation's leading advocate for children's health, uniting children's hospitals to improve care and amplify impact. On behalf of the more than 200 children's hospitals and the millions of children and families we serve, we appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS') proposed rule regarding Medicaid state directed payments (SDPs) and fee-for-service (FFS) targeted practitioner payments. Medicaid is vital to ensuring that every child—whether covered by Medicaid or not—has access to timely, comprehensive health care. We continue to be concerned about the changes to state directed payments and impact on all children's access to care. We expect these changes to reduce children's hospitals' SDP payments by over 40% by 2036. For some individual hospitals, the reduction would be much higher. As CMS implements H.R. 1, we want to partner with CMS to ensure the negative impact on children is mitigated as much as possible.

We appreciate CMS' acknowledgment of the distinct financing and care delivery needs of children's hospitals through its proposed approach for IPPS-exempt providers. We also appreciate CMS' recognition that Medicare does not include consideration of populations, like children, who generally are not covered under the program. We welcome the opportunity to work with CMS to strengthen this proposal and other provisions in the rule to better support access to pediatric care. However, several policies in this proposed rule could ultimately undermine that objective by reducing critical resources and limiting the flexibility children's hospitals rely on to care for vulnerable patients. **We strongly urge CMS to reconsider the proposed changes to Medicaid payment policy and preserve the funding and flexibility necessary to ensure children across the country continue to have access to high-quality, specialized care.**

Medicaid and the Children's Health Insurance Program (CHIP) provide essential health care coverage to approximately 35 million children in the United States.[1] This includes coverage for 42% of all U.S. children with special health care needs[2] and approximately 37% of children with cancer[3]. In 2023, 40.6% of children in small towns and rural areas were enrolled in Medicaid and CHIP.[4] Medicaid is also an essential source of coverage for nearly 3 million Medicaid-eligible children in military-connected families.[5]

[1] "February 2026: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot," U.S. Centers for Medicare and Medicaid Services, May 2026.
[2] "5 Key Facts About Children with Special Health Care Needs and Medicaid," KFF, April 2025.
[3] Ji, Xu, et al., "Narrowing Insurance Disparities Among Children and Adolescents With Cancer Following the Affordable Care Act," JNCI Cancer Spectrum: Vol. 6, No. 1, 2022.
[4] "Medicaid's Role in Small Towns and Rural Areas," Georgetown University McCourt School of Public Policy Center for Children and Families, January 2025.
[5] "Medicaid: A Vital Resource for Nearly 3 Million Military-Connected Children," FTI Consulting, 2023.

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Children's hospitals are dedicated to the health and well-being of our nation's children. Children's hospitals include both freestanding children's hospitals, which operate as independent pediatric institutions, and children's hospitals embedded within larger health systems, which also provide specialized pediatric services and expertise while operating within integrated hospital networks. They play vital roles in their communities by providing specialized clinical care for infants, children, and adolescents, including treatment for complex and rare conditions. Children's hospitals act as major referral centers at the state and regional levels, supporting smaller providers and ensuring access to high-level care across broad geographic areas. They are also hubs for training the next generation of pediatric clinicians and advancing research that drives innovation in child health. Children's hospitals are often the only source of specialized care for children, and without them and the Medicaid support they rely on, there would be no other options for children to receive needed care.

Beyond clinical care, children's hospitals lead community health programs that focus on prevention, early intervention, and identifying and addressing community conditions that contribute to otherwise preventable childhood illnesses and increased health care costs, often partnering with schools, local organizations, and public health agencies. These hospitals provide critical mental and behavioral health services and outreach to underserved and vulnerable populations, helping ensure children have the opportunity to grow, learn, and thrive. By supporting children's health and well-being from an early age, children's hospitals help lay the foundation for healthier adults who can fully participate in their communities and contribute to the nation's future workforce. Through these efforts, children's hospitals play many roles in their communities, strengthening health systems, improving outcomes, and promoting healthier lives for children and families.

Medicaid is essential to children's hospitals' ability to provide care to millions of children. Medicaid, on average, provides health insurance coverage for over 50% of children's hospitals' patients, and for some children's hospitals' patient mix, closer to 80%. SDPs are not merely helpful; they are foundational to the financial viability of children's hospitals. These payments help children's hospitals carry out their core missions: prioritizing children's health, training future pediatricians and pediatric subspecialists, and partnering across their communities, states, and the nation to improve child health. When states can strategically direct Medicaid funds, they create a lifeline that allows children's hospitals to preserve specialized service lines and continue providing access to comprehensive, high-quality care for millions of children nationwide. Any policy changes that impair states' flexibility to provide SDPs to children's hospitals would place the stability of children's hospitals, and the pediatric care infrastructure they sustain, at serious risk.

To fully protect children's access to care and shield pediatric providers from unintended harm moving forward, we urge CMS to exempt pediatric services from the proposed changes. This is the only way to truly protect all children's access to care. If CMS proceeds with inclusion of pediatric services, we offer the comments below to help inform implementation of these provisions in a manner that minimizes adverse impacts on children and the hospitals that serve them. We would appreciate CMS' commitment to working with us as it develops further guidance to mitigate the impact on children.

We strongly encourage CMS to:

- Preserve state flexibility wherever possible, consistent with the discretion afforded under H.R. 1 and longstanding Medicaid financing principles.
- Allow states to use a Medicare Upper Payment Limit (UPL) methodology when determining "Medicare-based" payment limits for children's hospitals.
- Delay finalization of the proposed cost-based methodology for IPPS-exempt providers and work with children's hospitals to develop an appropriate methodology.

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- Work with children's hospitals and pediatric experts to develop a pediatric adjustor for services provided by IPPS children's hospitals.
- Withdraw changes that further threaten children's access to care, including the proposal to establish a new Medicare-based limit for targeted Medicaid FFS payments.

Importance of SDPs for Children's Hospitals

As major Medicaid providers, children's hospitals rely on SDPs to ensure access to care for children. Children's hospitals represent less than 5% of the nation's hospitals and account for nearly half of states' hospital days for Medicaid-enrolled children[6], while Medicaid covers less than 80% of children's hospitals' costs of providing care on average, including base and supplemental payments.[7] Since their inception in 2016, SDPs have represented an increasing and now predominant share of Medicaid supplemental payments to providers nationwide and are an essential lifeline for children's hospitals in particular. These payments play a significant role in giving children's hospitals the ability to provide access to critical and timely care.

H.R. 1 imposes sweeping new limits on the use of SDPs. A recent analysis of 64 children's hospitals across 27 states found that SDPs account for 38% of their total Medicaid funding and 13% of their overall operating resources, underscoring how central these payments are to their financial stability.[8] Under H.R. 1, children's hospitals in states pursuing a new SDP arrangement would receive SDP funding that is 44% lower than today's combined Medicaid base and SDP payment levels, a reduction that would significantly weaken their ability to sustain essential pediatric services.[9] This analysis makes clear that the new SDP limits implemented through H.R. 1 pose a substantial threat to children's hospitals and, ultimately, to all children's access to the specialized, high-quality care nationwide that only children's hospitals provide.

Children's hospitals are committed to working with CMS to implement these changes in a manner that mitigates unintended consequences and safeguards access to high-quality care for children. Simultaneously, any modifications to SDP policies should be undertaken carefully and accompanied by long glide paths, wherever possible, to avoid destabilizing the pediatric health care system. Because SDPs have become deeply embedded in states' Medicaid financing structures and are critical to sustaining access to specialized pediatric services, abrupt reductions or disruptions could jeopardize care for children and undermine hospitals' ability to maintain essential programs, workforce investments, and regional referral capacity. A measured transition is necessary to give states and providers the time needed to adapt, while preserving access to high-quality care for the children and families who depend on Medicaid.

Medicare is Not an Appropriate Payment Benchmark for Pediatric Care

Medicare is not an appropriate benchmark for pediatric care because it fails to adequately reflect the unique complexity, resource intensity, and family-centered nature of services provided to children. Medicare covers only a very limited pediatric population, and its service definitions and payment

[6] Children's Hospital Association's Analysis of Kids' Inpatient Database (KID), Healthcare Cost and Utilization (HCUP), Agency for Healthcare Research and Quality, 2019.
[7] Annual Benchmark Report Fiscal Year 2023, Freestanding and Children's Hospital in Hospital Cohort, Children's Hospital Association. 2025.
[8] Children's Hospital Association. Implications of Budget Reconciliation Legislation on Children's Hospitals. August 2025.
[9] *Ibid.*

methodologies were not designed to account for the clinical needs of children. In the proposed rule, CMS recognizes that certain services are not covered under Medicare and allows states to rely on Medicaid fee-for-service rates in those instances. However, the broader concern is that while Medicare rates may exist for pediatric services, those rates often do not capture the additional time and resources required to deliver pediatric care, as demonstrated in this **analysis of current literature**. As a result, reliance on Medicare rates as a benchmark risks systematically undervaluing pediatric services and undermining critical support for access to care for children.

Generally, Medicare payment rates are based on standardized methodologies that utilize Medicare Severity Diagnosis-Related Groups (MS-DRGs) for inpatient hospital services and a Resource-Based Relative Value Scale (RBRVS) for physician and outpatient services. However, these methodologies are designed for individuals age 65 and older and individuals with disabilities and do not reflect the services—and resource intensity—provided to children. Pediatric services and procedures require more face-to-face time with patients and families, more patient and family education and counseling, and more emotional support and communication, which can all increase the amount of time a physician and other clinical staff spend with each pediatric patient. The cost of pediatric services can be higher than for adult care due to the need for more direct hands-on time by clinical staff, more case management, higher telephone call volume, and other factors (e.g., cost of supplies in multiple sizes for inpatient pediatric units.[10]

Current Medicaid base rates do not cover the cost of providing pediatric care, making supplemental payments such as SDPs essential to maintaining children's access to needed services. As CMS implements the new SDP limits, it is critical that these longstanding funding shortfalls and the unique economics of pediatric care are taken into account. Without such consideration, pediatric providers may face inadequate reimbursement, which could ultimately lead to diminished access to care for children. We therefore appreciate CMS's recognition of the unique aspects of pediatric care and the proposed policies in this rule that reflect those considerations.

Proposed New Medicare Limits on SDPs

Link SDP Limit to Medicare UPL

Recommendation: We strongly recommend CMS allow states to apply Medicare UPL methodology.

We continue to strongly recommend that CMS allow states to use the UPL methodology in the aggregate. Medicaid currently requires that states cap their FFS payments at what would be paid using Medicare payment principles, referred to as the Medicare UPL. The Medicare UPL methodology requires that states pay no more than Medicare but affords states flexibility in how they calculate what Medicare would have paid. That flexibility enables them to tailor the calculations to account for the unique mix of services and populations covered by their Medicaid programs. Given that the Medicare fee schedule is not an appropriate benchmark for pediatric services, this methodology would allow states to establish the difference between a Medicaid and Medicare-equivalent payment for pediatric services. This flexibility can help account for the service delivery, resource intensity, and additional cost required to provide pediatric

[10] National Academies of Sciences, Engineering, and Medicine. The Future Pediatric Subspecialty Physician Workforce: Meeting the Needs of Infants, Children, and Adolescents. September 2023.

care. Allowing states to use this methodology can mitigate significant financial shortfalls for children's hospitals who rely on Medicaid SDPs to provide access to care for millions of children across the country. Through many conversations with children's hospitals, we have determined that this is the best and strongest way to mitigate the impact on children.

H.R. 1 established a Medicare-based payment limit for SDPs but did not prescribe the provider-specific methodology CMS must use to calculate that limit. Accordingly, CMS retains discretion to preserve longstanding state flexibility in determining Medicare-equivalent payment limits. Allowing states to use the existing Medicare UPL methodology is consistent with both the statute and decades of Medicaid payment policy, is administratively feasible, and preserves greater parity between Medicaid managed care and fee-for-service payment principles. Most importantly, it avoids creating a new framework for children's hospitals that could result in unintended reductions in Medicaid funding and threaten access to care for vulnerable populations, including children.

Proposed Methodology for IPPS-exempt Providers

CMS proposes implementing a cost-based, per-service limit for IPPS-exempt hospitals, acknowledging that the Medicare payment methodology for some provider types is based on retrospective cost reimbursement rather than prospectively established service code-specific payment rates.

If CMS proceeds with this service-specific framework, rather than the current aggregate UPL model, we ask that CMS work hand-in-hand with children's hospitals to develop this new system to best support all children's access to needed care. **We urge CMS to develop this approach in collaboration with children's hospitals and ensure it is codified through the rulemaking process along with any other policies intended to mitigate adverse impacts on children.**

In response to CMS' request for comments regarding development of payment limits for providers paid outside of published Medicare payment rates, we provide the recommendations below.

Recommendation: We recommend CMS delay finalization of any cost-based payment proxy and collaborate with children's hospitals on an appropriate methodology with opportunities for comment.

Children's hospitals are actively evaluating potential methodologies and conducting analyses to better understand their operational and financial implications. Importantly, CMS acknowledges in the proposed rule's preamble that it would need to develop and publish specific instructions regarding allowable cost-reporting and cost-allocation methodologies to operationalize any cost-based payment proxy. This acknowledgement underscores a fundamental concern: the core methodology necessary to implement the proposed proxy has not yet been fully developed, tested, or subjected to public notice-and-comment review.

This concern is particularly significant for children's hospitals because many are excluded from the IPPS and primarily serve non-Medicare populations. As a result, some children's hospitals may have historically been exempt from filing full Medicare cost reports or may have been permitted to omit certain worksheets due to their limited Medicare utilization. If Medicare cost reports are expected to serve as the primary data source for determining payment levels under H.R. 1, substantial operational and reporting changes may be required for many children's hospitals. Additional time will therefore be essential to allow for

appropriate coordination between Medicare Administrative Contractors and children's hospitals to ensure that all required information is collected, reported, and interpreted accurately. Absent sufficient implementation time and clear guidance, changes to cost-reporting requirements could inadvertently disadvantage children's hospitals and undermine access to care for children.

Because these critical operational details remain unresolved, we believe it would be premature for CMS to finalize a cost-report methodology at this time. **Instead, we urge CMS to bifurcate this issue and undertake a separate rulemaking focused specifically on IPPS-exempt and other providers, including children's hospitals.** A dedicated rulemaking process is necessary to fully develop the underlying cost-allocation methodologies, provide transparency regarding their implementation, and afford stakeholders a meaningful opportunity to evaluate and comment on their impact before they are finalized. CMS should not establish these foundational policies through subsequent sub-regulatory guidance.

In addition, we request that CMS establish a dedicated workgroup to develop and evaluate payment methodologies for IPPS-exempt institutions and include CHA and affected hospitals. Given the unique patient populations, payment structures, and cost-reporting challenges facing these providers, a collaborative stakeholder process is essential. This workgroup should explicitly include representatives from children's hospitals and other IPPS-exempt institutions in an advisory capacity, alongside CHA and other relevant stakeholders, to ensure any future methodology appropriately reflects the operational realities, reporting challenges, and costs associated with providing specialized pediatric care.

We are currently evaluating different approaches such as cost-to-charge ratio applied to actual Medicaid charges, an adjusted Disproportionate Share Hospital (DSH) audit methodology, and other alternatives, with children's hospitals. Preliminary discussions suggest these approaches can have varying impact across hospitals and states.

While these approaches provide useful starting points for discussion, additional analysis is needed to evaluate their effectiveness and determine whether modifications or alternative methodologies may better meet the needs of children's hospitals and children. We will be undertaking a major analytics project to fully vet approaches to inform CMS on what approach would best work for children. Given the significant implications of this policy, CMS should partner with CHA, children's hospitals, and other stakeholders through a transparent rulemaking process—and through a dedicated workgroup for IPPS-exempt institutions—to develop a methodology that accurately reflects the costs of providing specialized pediatric care, is administratively feasible, and protects access to essential services for children across the country.

To ensure any future methodology accurately captures the costs of providing specialized pediatric care and reflects the unique role children's hospitals play serving Medicaid beneficiaries, we recommend CMS work with us to design the methodology around the following core principles:

1. **Recognize the Unique Role of Children's Hospitals and the Medicaid Population They Serve.**
   Children's hospitals primarily serve pediatric populations that are generally not covered by Medicare and, as a result, have limited Medicare patient volume and experience with Medicare

cost-reporting systems. Any methodology should recognize these unique circumstances and provide adequate time for implementation to ensure children's hospitals can accurately capture costs and adapt to new requirements without disrupting access to pediatric care.

2. **Recognize the Full Cost of Serving Children on Medicaid.**
   The methodology should reflect the full range of costs associated with furnishing services to Medicaid beneficiaries and should not be limited to Medicare-allowable costs. Because Medicare is not designed to cover pediatric populations and represents only a small portion of most children's hospitals' payer mix, Medicare costs alone do not adequately capture the costs of providing pediatric care under Medicaid. At a minimum, the methodology should include recognition of pediatric uniqueness in the areas of:
   - Physician and faculty practice plan costs that support hospital-based services;
   - Graduate Medical Education (GME) costs;
   - High-cost specialty pharmaceuticals, gene therapies, and other advanced treatments;
   - Outlier and catastrophic cases, including organ transplants and other exceptionally high-cost services;
   - Pediatric-specific clinical services, care coordination, and support services necessary to provide comprehensive care;
   - Non-reimbursable cost centers currently excluded under Medicare cost-reporting methodologies, including costs identified in Worksheet B;
   - Provider taxes paid by children's hospitals; and
   - Other costs necessary to furnish pediatric services that are not recognized under traditional Medicare cost-reporting rules.

3. **Capture the Full Scope of Medicaid Services.**
   The methodology should account for costs associated with services delivered through both FFS and Medicaid managed care delivery systems. Limiting the methodology to managed care costs alone would underestimate the true cost of serving Medicaid beneficiaries and fail to account for the full range of services and populations supported by children's hospitals.

4. **Reflect Changes in Costs Over Time.**
   The methodology should include an appropriate inflationary or trend factor to recognize ongoing growth in health care costs and ensure payment levels remain aligned with the actual cost of furnishing services over time.

5. **Promote Administrative Simplicity and Transparency.**
   The methodology should be designed to minimize administrative burden, improve transparency, and promote consistency in its application. CMS should provide clear guidance and sufficient implementation time so that children's hospitals can accurately report costs and comply with any new requirements.

6. **Provide State Flexibility and Support Program Stability.**
   CMS should provide states flexibility in implementing an appropriate methodology for children's hospitals, allowing states to select the approach that best reflects their unique health care

delivery systems and financing structures. Such flexibility is essential to maintaining financial stability for children's hospitals and preserving access to specialized pediatric services for Medicaid beneficiaries.

Given the complexity of this issue and the unique nature of pediatric health care delivery, we strongly urge CMS to work in close partnership with children's hospitals before advancing any future methodology. A one-size-fits-all approach risks failing to account for the distinct costs and operational realities of pediatric providers, with potentially significant consequences for children's access to care. CMS must ensure any methodology is informed by children's hospitals and designed to protect access to care for all children.

Considerations for IPPS Children's Hospitals

Recommendation: We recommend CMS apply a pediatric adjustor for services provided to children under 21.

To ensure the impact on children is mitigated more broadly for children served outside of IPPS-exempt hospitals, we ask CMS to work with children's hospitals and pediatric experts to develop a pediatric adjustor that reflects the higher cost and unique care provided in IPPS children's hospitals. These IPPS children's hospitals operate within larger health systems and serve as essential pediatric providers in their regions and states. While these hospitals are reimbursed under the IPPS, Medicare-based payment methodologies were designed around adult populations and do not capture the unique clinical complexity, specialized workforce, and resource intensity required to care for children. Many pediatric services are not recognized or adequately reflected in the Medicare payment system, including routine pediatric nursing care, neonatal and pediatric intensive care, respiratory therapy, cardiac catheterization, and physical therapy. These services often require more specialized expertise, greater clinical resources, and significantly higher time and cost investments than comparable services provided to adult patients, reflecting the unique and complex needs of children.

To ensure reimbursement more accurately reflects the true cost of delivering pediatric care, states should apply a pediatric adjustment factor to services provided to individuals under age 21. A pediatric adjustor would recognize the critical differences between pediatric and adult care delivery and help preserve access to high-quality pediatric services for all children.

States such as Delaware, Missouri, Wisconsin, and the District of Columbia have already recognized the need for pediatric-specific payment adjustments and have implemented, or are pursuing, targeted policies to address the inadequacy of traditional Medicare-based reimbursement methodologies. These state initiatives demonstrate growing recognition that payment systems built on Medicare rates alone are insufficient to support the full spectrum of pediatric services. Without an appropriate pediatric adjustment factor, reimbursement will continue to underestimate the costs of caring for children, undermining providers' ability to maintain critical pediatric capacity and access to care.

We urge CMS to allow states to implement pediatric adjustment factors for services provided to individuals under age 21 outside of IPPS-exempt children's hospitals. We welcome the opportunity to work collaboratively with CMS to develop a meaningful pediatric adjustor that reflects the true costs of pediatric care, promotes payment adequacy, and helps ensure children and families have continued access to the specialized services they need regardless of where they receive care.

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Value-Based Payment (VBP) SDPs

CMS proposes states provide a "detailed validation methodology" that ensures providers do not receive more than the Medicare-based limit on a service code basis for VBP SDPs.

Recommendation: We recommend CMS withdraw its proposal to apply the Medicare-based limit to VBP SDPs.

Value-based payment approaches provide flexibility to address the underlying causes of poor health in patients and to align payment with the outcomes children's hospitals seek to achieve. They allow providers to invest in traditional medical care and innovative and preventive approaches that can prevent a health care need from arising in the first place (e.g., eliminating a trigger for asthma instead of treating a child's asthma exacerbation in the emergency department).

Aligning incentives to promote improved health outcomes, particularly for children, remains a critical policy objective. CMS has long recognized the importance of testing and advancing value-based payment models in Medicare to improve outcomes, enhance care coordination, and promote more efficient care for seniors. Given that Medicaid is the nation's largest insurer of children, it is equally important states and providers have the flexibility to pursue value-based approaches that improve child health outcomes and generate long-term value. However, the rule's proposal to require states to implement a "detailed validation methodology" ensuring that value-based SDPs do not exceed the Medicare-based limit on a service-code basis may introduce significant administrative and operational constraints. The proposed retrospective reconciliation approach would mean providers who successfully reduce utilization and improve outcomes may be required to return a portion of their payments, effectively penalizing investments in care management, care coordination, and other value-enhancing activities.

By discouraging the very investments that help keep children healthy, the proposal risks undermining innovation in value-based pediatric care and creating a policy inconsistency in which CMS continues to encourage value-based approaches for Medicare beneficiaries while limiting similar opportunities in Medicaid. Rather than fostering preventive, child-focused care that can improve lifelong health outcomes and reduce future health care costs, the proposal could make it more difficult for providers to invest in the strategies that deliver better outcomes and greater value for children and families.

Grandfathered SDPs & Phase Down

Gradual Phase Down of Grandfathered SDPs

H.R. 1 specifies that for rating periods starting on or after Jan. 1, 2028, states must reduce grandfathered SDPs by 10 percentage points per year until the total payment rate equals 100% of Medicare rates for expansion states and 110% for non-expansion states. In the rule, CMS proposes reducing SDPs by 10 percentage points of the grandfathered total SDP amount each year and notes its consideration of an alternative approach that would set the annual reduction equal to 10 percentage points of the total payment rate relative to Medicare.

We agree with CMS that the phase-down of grandfathered SDPs should be applied to the aggregate grandfathered amount, with the actuary required to certify only the overall rate comparison. Congress intentionally grandfathered existing SDPs to provide states and plans with adequate time to transition while avoiding unnecessary disruptions to beneficiary access to care. Applying the phase-down at the aggregate level is consistent with that congressional intent and helps preserve continuity of care throughout the transition period.

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We urge CMS to provide states with multiple options for phasing down SDP payments to Medicare-equivalent levels, allowing each state to select the approach that best aligns with its unique programmatic and fiscal circumstances. We also believe CMS should not require states to complete these reductions within a 10-year timeframe. H.R. 1 does not prescribe a specific methodology or timeline for achieving Medicare-equivalent payment levels and therefore does not require CMS' proposed 10% annual reduction approach. Moreover, CMS' own analysis indicates that differences in aggregate spending outcomes across potential phase-down approaches are relatively minimal, underscoring the value of providing states with flexibility to choose the pathway that best fits their circumstances. Giving states sufficient flexibility and time to implement SDP payment reductions is essential to minimizing disruption to beneficiary access to care and maintaining Medicaid program stability, particularly as states work to implement the numerous Medicaid policy changes required under H.R. 1.

CMS should consider various policies, including but not limited to:

Option 1: *Alternative approach CMS considered in the proposed rule*

- Defining the annual phase down as 10 percentage points of the total payment rate (Medicaid base rates + SDPs) relative to Medicare. For example, if a state's total payment rate was 200 percent of Medicare in CY 2027, the total payment rate would be reduced to 190 percent of Medicare rates in CY 2028, 180 percent in CY 2029, and 170 percent in CY 2030, etc., until it reaches 100 percent or 110 percent of Medicare rates for expansion and non-expansion states, respectively, or the SDP itself reaches zero.

Option 2:

- Applying the annual 10% phase down to the difference between the total payment rate (base rates + SDPs) and the Medicare limit. For example, if the total payment rate is $2B and the Medicare limit is $1.9B, then the total payment rate would be reduced by $10M each year until it reaches the Medicare limit.

Option 3:

- Applying the 10% reduction to the dollar value of the SDP in the prior year. For example, an SDP of $1,000,000 would be reduced to $900,000, then $810,000, and so on.

Providing states with flexibility to select a phase down methodology is imperative to ensuring reductions in SDP payments occur in a predictable and sustainable manner that does not undermine access to care for children. States vary significantly in their provider payment structures, fiscal environments, and reliance on SDPs to support pediatric providers. A one-size-fits-all approach risks creating abrupt funding reductions that could destabilize provider networks and jeopardize access to essential pediatric services. By offering multiple phase-down pathways, CMS can better support state-specific circumstances, promote continuity of care, and help ensure that children continue to receive timely access to the high-quality care on which they depend throughout this transition period.

Separate Payment Term Phase Out

CMS proposes to allow states to continue to use separate payment terms during the temporary grandfathering period, until the first payment period the SDP falls below the Medicare-based limit, at which time the SDP would need to be incorporated into capitation.

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We support CMS' proposal to allow states to continue using separate payment terms during the temporary grandfathering period. Preserving this flexibility will enable states to continue directing resources more accurately to children's hospitals, helping ensure these providers continue to receive payments that reflect their unique patient populations and cost structures. Children's hospitals incur higher costs associated with caring for medically complex children, maintaining specialized pediatric services, and supporting highly trained pediatric subspecialists and care teams. Temporarily maintaining separate payment terms will help sustain the financial stability of children's hospitals during the grandfathering period, preserve access to critical pediatric services for Medicaid-enrolled children, and better align Medicaid funding with the essential role children's hospitals play as providers of highly specialized, comprehensive pediatric care.

Additional Proposed Medicaid Payment Limitations

Prohibition of Uniform Increase SDPs

CMS proposes to prohibit uniform increases for new and non-grandfathered SDPs, beginning the first rating period on or after Jan. 1, 2028. States with grandfathered SDPs would be permitted to use uniform increases until the SDP reaches the Medicare-based limit.

Recommendation: We recommend CMS withdraw its proposal to prohibit uniform increases for new and renewed SDPs.

H.R. 1 does not require states to limit provider-directed payments to a provider's individual Medicare payment rate or to base payments exclusively on Medicare fee schedules. Rather, the statute can be implemented in a manner that evaluates compliance at the provider-class or service-category level using an aggregate UPL-type methodology. Such an approach would recognize CMS' concern that providers have different Medicare payment rates and that a uniform payment increase cannot realistically be calibrated to each hospital's individual Medicare equivalent. Applying the payment limit in the aggregate would allow states to implement uniform or targeted payment increases while ensuring total payments remain within the statutory ceiling. Interpreting the statute to prohibit uniform rate increases or require provider-specific Medicare-based caps would impose restrictions that extend beyond the law's requirements and would unnecessarily constrain states' ability to address longstanding payment inadequacies within the Medicaid program.

For children's hospitals, preserving state flexibility is particularly critical. 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. Children's hospitals are among the providers most reliant on these mechanisms because they serve a uniquely Medicaid-dependent population and often provide highly specialized services that are unavailable elsewhere in a community or region.

Restricting SDPs to provider-specific Medicare rates would undermine states' ability to address pediatric access challenges, invest in children's health care capacity, and sustain critical pediatric specialty and subspecialty services. An aggregate UPL-style methodology would provide an appropriate safeguard against excessive payments while preserving states' ability to design payment policies that support access to care and reflect the unique needs of pediatric providers. A provider-specific approach, by contrast, would be inconsistent with one of Medicaid's core principles: state flexibility to tailor payment policies to meet the needs of vulnerable populations and ensure access to care. States must retain the ability to implement provider-class and service-level payment enhancements that recognize the substantial resources required to deliver high-quality pediatric care, as well as the unique role children's hospitals serve in providing access to care for all children.

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Medicare-Based Payment Limit for "Targeted" Services in Medicaid Fee-For-Service (FFS)

CMS proposes to establish a new provider- or practitioner-specific limit on total Medicaid FFS payments when any portion of those payments is "targeted."

Recommendation: We recommend CMS withdraw its proposal to establish a new Medicare-based limit for targeted Medicaid fee-for-service payments.

Because Medicaid reimbursement rates consistently fall below the cost of providing care, supplemental payment programs play a critical role in preserving children's access to care. These funding mechanisms help states support providers that serve a disproportionately high share of Medicaid beneficiaries and address longstanding gaps between Medicaid payments and the actual cost of delivering pediatric services. Without these payments, children's hospitals would face significant financial challenges in sustaining the specialized services, workforce, and infrastructure that children and families depend upon.

Congress has long recognized that base Medicaid payment rates alone are insufficient to ensure adequate provider participation and beneficiary access to care. Supplemental payment programs have therefore become an essential component of Medicaid financing, helping states maintain robust provider networks and ensuring children can obtain timely access to specialized services. The proposal to establish a new Medicare-based limit would undermine these longstanding investments by restricting states' ability to direct additional resources to providers that care for large numbers of Medicaid beneficiaries, despite no clear statutory requirement in H.R. 1 to do so. By further constraining Medicaid payment capacity at the same time that states and providers are adapting to other substantial Medicaid financing changes enacted through H.R. 1, the proposal would compound financial pressures throughout the pediatric health care system.

Children's hospitals are uniquely vulnerable to these changes because they serve a disproportionate share of Medicaid-covered children and rely heavily on supplemental payments to offset chronic underpayment within the Medicaid program. The proposed limits on certain FFS payments, in addition to the other limitations on Medicaid payments included in H.R. 1, would widen the gap between Medicaid reimbursement and the actual cost of providing care, further reducing access to care for all children.

By imposing restrictions that are not required under H.R. 1, the proposal would unnecessarily curtail state flexibility and jeopardize a critical funding mechanism that helps children's hospitals maintain access to specialized pediatric services for all children. Preserving state flexibility to make targeted provider payment enhancements is essential to protecting access to pediatric care. Reductions in these payments would threaten the financial viability of critical pediatric services and exacerbate existing shortages of pediatric specialists, behavioral health providers, and other clinicians who care for children. Most importantly, the proposed policy risks shifting the burden to children and families through longer wait times, reduced provider participation, and diminished access to the specialized care that only children's hospitals are equipped to provide.

Therefore, we recommend that CMS withdraw its proposal to establish a new Medicare-based limit for targeted Medicaid fee-for-service payments. If CMS moves forward with this proposal, states should apply a pediatric adjustment factor when determining the Medicare-based payment limit for targeted FFS payments, similar to the one described above. This would be critical to ensuring reimbursement through these payments reflects the unique costs of caring for children.

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CHILDREN'S HOSPITAL ASSOCIATION

Formal Definition of "Provider Class"

CMS is considering, but not proposing, to formalize a definition of "provider class" for SDPs. In response to CMS' request for comment on whether and how to define provider classes, we offer the comments below.

Recommendation: We do not recommend that CMS formalize a definition of "provider class."

Given the significant changes to SDPs already proposed in this rule, we urge CMS to avoid imposing additional restrictions that could undermine children's hospitals' ability to provide specialized care and preserve broad state flexibility to support pediatric providers. Implementing a formal definition of provider class risks being overly restrictive and could inadvertently limit states' ability to support the full range of pediatric providers. For example, the term "children's hospital" is often defined narrowly to include only IPPS-exempt children's hospitals, which may exclude other providers that deliver essential pediatric services, such as children's hospitals within systems. States should retain the flexibility to support the providers that best meet the needs of children in their health care systems.

Prohibition of Certain "Grey Area" Payments

In the rule, CMS proposes to prohibit various "grey area" payment arrangements, including prohibiting states from developing capitation rates that assume provider payment levels above the Medicare-based limit, even if the state does not require plans to pay a specific rate to providers (as in an SDP).

Recommendation: We recommend CMS withdraw its proposal to prohibit states from developing capitation rates that assume payment levels above the Medicare-based limit.

Limiting states' flexibility to influence rate development could have significant consequences for children's hospitals and the children and families they serve. Moreover, the proposal goes beyond what H.R. 1 requires by imposing additional constraints on state Medicaid payment policy that were not required by the statute. CMS has previously expressed concerns about "grey area" payment arrangements in which managed care contracts required plans to increase provider payments by an unspecified amount, effectively directing payments outside of established federal authorities. This proposal, however, reaches even further upstream by scrutinizing and restricting the rate-setting assumptions and methodologies that states may use when developing actuarially sound managed care rates. In doing so, it expands federal oversight beyond specific payment directives and into core state decisions regarding rate development.

For children's hospitals, this loss of flexibility is particularly concerning. Because the costs of delivering pediatric care frequently exceed standard Medicaid reimbursement rates, states have historically relied on a range of payment strategies and rate-development approaches to strengthen pediatric provider networks, support specialized services, and help ensure adequate funding for children's hospitals. Restricting states' ability to incorporate appropriate assumptions into rate development or use payment methodologies that recognize the unique costs of pediatric care would make it more difficult to address longstanding gaps between Medicaid payment rates and the cost of providing services.

As a result, children's hospitals may face limited capacity to invest in specialized services, workforce development, and innovative models of care. The proposal also risks limiting states' ability to address access challenges and respond to local health care delivery needs through managed care financing mechanisms. Preserving state flexibility in rate development is therefore essential to protecting access to pediatric care and ensuring children's hospitals can continue serving as the backbone of the pediatric health care safety net for all children.

CHILDREN'S HOSPITAL ASSOCIATION

Promoting Transparency and Predictability in the SDP Approval Process

<u>Recommendation</u>: We urge CMS to expedite SDP preprint reviews and increase transparency in the approval process to support state planning and maintain children's access to care.

Delays in the review and approval of SDP arrangements create uncertainty for states and providers and can hinder critical investments in pediatric services, workforce capacity, and care delivery infrastructure. Greater transparency and predictability in the review process would enable states and children's hospitals to better plan for and sustain essential services, helping to preserve access to the comprehensive care that children with complex and chronic health needs depend on.

Medicaid is critical to ensuring access to care for millions of children and provides a vital source of support for children's hospitals that serve the nation's most vulnerable patients. We appreciate CMS' recognition that children's hospitals have unique financing and care delivery needs and that Medicare-based reimbursement methodologies do not adequately reflect pediatric populations. We welcome the opportunity to work with CMS to strengthen these policies and ensure children continue to receive the care they need. Given the significant operational and financial implications of the proposed Medicaid payment changes, we respectfully urge CMS to delay implementation to allow for further evaluation and stakeholder engagement, while preserving the funding stability and flexibility that are essential to sustaining access to pediatric care nationwide.

We appreciate the opportunity to comment on the proposed rule and stand ready to work with CMS to develop thoughtful, flexible approaches that address the issues outlined above and maintain access to care for children across the country. Please contact Aimee Ossman at aimee.ossman@childrenshospitals.org and Milena Berhane at milena.berhane@childrenshospitals.org with any questions or for more information.

Sincerely,

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