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 the Arizona Hospital and Healthcare Association (AzHHA), representing more than 70 hospitals, healthcare systems, and affiliated members, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding Medicaid managed care state-directed payments (SDPs) and targeted Medicaid fee-for-service (FFS) practitioner payments. The proposed rule implements provisions of Public Law (P.L.) 119-21.

Medicaid is foundational to Arizona's hospitals and the communities we serve. It covers approximately 1.8 million Arizonans, including children, pregnant women, individuals with disabilities, and low-income adults. Medicaid beneficiaries account for a substantial share of inpatient and outpatient services across the state, and Medicaid is the largest payer for many hospitals. These patients depend on hospitals for emergency care, labor and delivery, behavioral health, specialty care, and treatment for chronic and complex conditions.

SDPs are essential to the stability of Arizona's Medicaid delivery system. They help address longstanding gaps between Medicaid payments and the cost of providing care; support workforce recruitment and retention; and sustain services that often operate at a financial loss. They also provide needed predictability in a managed care environment in which payment delays, denials, and administrative burdens can interfere with providers' ability to serve Medicaid beneficiaries.

AzHHA is deeply concerned that the proposed rule goes well beyond the changes Congress enacted in P.L. 119-21. It adds restrictions on payment methodologies, financing structures, and provider reimbursement mechanisms that are not required by the statute. The resulting reductions would be

substantially greater than Congress contemplated and would make it more difficult for states to protect access, sustain providers, and design payment systems that respond to local healthcare needs.

Arizona hospitals are already confronting workforce shortages, rising labor and supply costs, higher patient acuity, and growing demand for essential services. Additional Medicaid reductions of this magnitude would place rural hospitals, safety-net providers, and hospitals serving a high proportion of Medicaid beneficiaries at particular risk.

AzHHA therefore urges CMS to withdraw or substantially revise the proposed rule. At a minimum, CMS should limit the final rule to the changes expressly required by P.L. 119-21 and preserve the flexibility states need to maintain access, promote quality, and support the financial stability of the healthcare delivery system.

AzHHA's concerns fall into six areas: the rule exceeds CMS's statutory authority and expands the reductions enacted by Congress; undermines the state-federal partnership and Arizona's ability to innovate; relies on an inappropriate Medicare benchmark; threatens access to care; creates unworkable administrative and compliance requirements; and disrupts financing structures developed in reliance on prior CMS policy.

1. CMS imposes payment constraints not authorized by statute and expands Medicaid reductions beyond Congress's intent

P.L. 119-21 established new limitations on certain Medicaid SDPs. Although Arizona hospitals have serious concerns with those statutory reductions, Congress made specific choices about their scope, application, and phase-down. CMS's role is to implement those choices, not to use the rulemaking process to establish additional payment restrictions that Congress did not enact.

Section 1902(a)(30)(A) of the Social Security Act requires Medicaid payments to be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers to ensure beneficiary access. Congress created a balanced standard that requires states to consider each of those objectives. The statute does not prescribe a single payment methodology, require states to benchmark Medicaid payments to Medicare, or establish universal federal payment ceilings. The proposed Medicare-based limits ignore access and quality considerations, distorting rather than implementing the statutory standard.

The proposed rule is also inconsistent with Section 1115 demonstration authority. Congress created Section 1115 to permit states to test state-driven approaches to Medicaid delivery and financing. Uniform national payment limits and prescriptive methodologies do not test a state hypothesis or advance a limited demonstration; they establish a permanent national payment framework that constrains the experimentation Section 1115 was intended to support.

CMS similarly stretches its authority under Section 1903, which governs federal financial participation in Medicaid expenditures. Section 1903 does not condition federal matching funds on whether a state payment falls below a Medicare-based ceiling. The proposed rule would effectively add that condition by treating payments above the new limits as impermissible for federal matching purposes. That approach uses CMS's authority over federal financial participation to impose de facto payment caps that Congress did not authorize.

The rule also extends beyond the managed care SDPs addressed in P.L. 119-21. Congress imposed guardrails on managed care payment arrangements; it did not direct CMS to apply comparable restrictions to FFS supplemental payments or other targeted Medicaid payment arrangements outside the SDP framework. CMS further proposes provider-level and service-level caps, per-service and per-discharge limits, and compliance calculations that combine base and supplemental payments. These are consequential policy choices absent from the statute.

The financial impact confirms that the proposed rule is not limited to implementing Congress's directive. CMS estimates that the new rule would reduce federal Medicaid expenditures by approximately $510 billion over ten years, which is more than three times the Congressional Budget Office's estimate of about $149.4 billion reduction related to the statutory SDP provisions. That difference results from CMS's decisions to broaden the providers, services, and payment arrangements subject to the limits; apply the limits at a more granular level; phase out previously permissible methodologies; and impose additional financing and compliance restrictions.

Each of those regulatory choices independently reduces Medicaid funding beyond what Congress enacted. Collectively, they convert a targeted statutory change into a comprehensive restructuring of Medicaid financing. CMS should remove provisions that are not expressly required by P.L. 119-21 and implement the statute without expanding either its scope or its financial impact.

2. The proposed rule undermines Medicaid's state-federal partnership and Arizona's ability to innovate

Medicaid has always operated as a state-federal partnership. Congress establishes federal requirements, while states retain substantial authority to design payment systems, delivery models, and program innovations that reflect their healthcare markets and beneficiary needs. That flexibility is not incidental to Medicaid; it is essential to a program serving populations and communities that differ markedly across states.

Arizona illustrates why state flexibility matters. The state must support care in major urban centers, tribal nations, border communities, and rural and frontier regions separated by significant distances. Provider availability, workforce shortages, hospital mix, transportation barriers, and the cost of delivering care vary substantially across those settings. A payment policy that may appear workable in a dense metropolitan market may fail to preserve even basic access in a remote Arizona community.

Arizona has operated under the Section 1115 demonstration authority for decades and has used that authority to become a national Medicaid innovator. The state developed one of the nation's earliest statewide Medicaid managed care programs and has advanced the Arizona Long Term Care System's emphasis on home- and community-based services, integrated physical and behavioral healthcare, housing supports for individuals with serious mental illness, a statewide behavioral health crisis system, and expanded telehealth capacity. These approaches were possible because Arizona could tailor Medicaid financing and delivery to the needs of its beneficiaries.

The proposed rule moves in the opposite direction. By prescribing Medicare-based limits, narrowing permissible payment designs, and centralizing decisions at the federal level, CMS would reduce states' ability to target resources, respond to emerging access problems, and sustain services that are critical locally but financially vulnerable. The result would be a Medicaid program that is less flexible, less innovative, and less responsive to the communities it serves.

3. Medicare is not an appropriate benchmark for Medicaid

The proposed rule assumes that Medicare payment rates provide an appropriate upper limit for Medicaid reimbursement. That assumption is flawed. Medicare and Medicaid serve different populations, cover different services, and rely on different payment structures. A benchmark designed primarily around older adults cannot reliably measure the resources required to care for children, pregnant women, newborns, individuals with developmental disabilities, and beneficiaries with significant behavioral health and social needs.

Those differences affect staffing, care coordination, service intensity, and payment design. Medicaid finances services that may have no direct Medicare equivalent and supports patient populations that are not adequately reflected in Medicare's classifications or utilization patterns. Arizona and other states therefore have developed payment methodologies that more accurately account for Medicaid beneficiaries rather than simply replicating Medicare.

Medicare rates are also an inappropriate ceiling because they frequently do not cover hospitals' cost of providing care. Applying those rates as a maximum for Medicaid payments would institutionalize underpayment in both public programs and restrict one of the few tools states can use to address the resulting gap. CMS should not treat Medicare as a presumptively sufficient or universally applicable measure of Medicaid payment adequacy.

4. Medicare-based payment caps threaten access to care

States use SDPs and other supplemental payment mechanisms to address provider shortages, support workforce capacity, and preserve services that would otherwise be vulnerable to reduction or closure. Restricting those tools and tying total reimbursement to Medicare-based caps would reduce Arizona's ability to respond when access deteriorates or when a hospital or service line becomes financially unsustainable.

Many essential hospital services already operate at a loss but remain available because they are indispensable community resources. Labor and delivery, inpatient behavioral health, emergency and trauma care, burn and wound care, infectious disease services, nephrology, pulmonary and respiratory care, and long-term acute care are among the services most vulnerable to payment reductions. Supplemental Medicaid funding helps hospitals maintain the workforce, infrastructure, and around-the-clock readiness these services require.

When that funding is reduced, hospitals have limited options. They may defer workforce and capital investments, reduce capacity, consolidate or eliminate service lines, or, in the most severe circumstances, close facilities. The consequences extend beyond Medicaid beneficiaries. Emergency departments, maternity units, behavioral health beds, trauma programs, and other hospital services are community assets used by patients of every payor.

Rural Arizona is particularly vulnerable. Rural and Critical Access Hospitals often operate with narrow or negative margins, limited workforce depth, and few nearby alternatives. A service reduction in an urban area may require a patient to travel across town; a similar reduction in a rural or frontier community may require hours of travel or leave no realistic alternative. Once a hospital service disappears from a rural community, rebuilding it is at best difficult but often impossible.

Payment reductions can also create a damaging cycle: constrained payments lead to reduced capacity; reduced capacity delays care; delayed care allows conditions to worsen; and patients ultimately require more intensive and expensive treatment. CMS should preserve states' ability to use payment tools proactively to protect access rather than waiting for a measurable access crisis after services have already been lost.

5. The proposed rule creates unworkable administrative and compliance requirements

The proposed rule would impose an extraordinarily complex provider- and service-level compliance framework on state Medicaid agencies, managed care organizations, and providers. It would require states to compare total Medicaid payments with Medicare amounts at the individual provider and service level, monitor compliance using multiple data sources, identify overpayments, and administer recoupments. The administrative cost and compliance risk would be substantial, while the programmatic benefit of this level of granularity is unclear.

Arizona's inpatient hospital system demonstrates the problem. AHCCCS uses the All Patient Refined Diagnosis Related Group (APR-DRG) methodology, which accounts for pediatric and obstetrical patients, neonates, severity of illness, risk of mortality, and interactions among multiple conditions. Medicare uses MS-DRGs, which were developed primarily for an adult Medicare population. There is no reliable, standardized conversion that produces a true service-level Medicare equivalent for every Arizona Medicaid claim.

The proposed rule also leaves central implementation questions unresolved:

- How should a state calculate the payment limit when Medicare does not cover an equivalent service or population?
- How should Critical Access Hospitals and other cost-based providers derive a per-service or per-discharge limit from retrospectively settled costs?
- Which Medicare add-ons and adjustments, including graduate medical education, outliers, and other supplemental amounts, must be included?
- How should quality incentives, value-based payments, and other payments that are not readily attributable to a single service be treated?
- How should states evaluate negotiated managed care rates that vary by plan and provider, are not publicly posted, and may be subject to confidentiality restrictions?
- What documentation, reconciliation period, audit standard, and recoupment process will CMS require when rates or cost settlements change retroactively?

These questions determine whether compliance is possible; they cannot be deferred to future subregulatory guidance after a final rule has already imposed the underlying obligation. Without clear and workable standards, states, plans, and providers will make reasonable but different calculations, creating significant exposure to retrospective disallowances and recoupments years after care was delivered.

For AHCCCS, implementation would require extensive claims repricing, data collection, system modifications, plan oversight, reconciliation, and audit capacity at the same time the agency is implementing other major federal Medicaid requirements. Those resources would be diverted from activities that more directly protect beneficiaries, support program integrity, and improve care.

CMS should permit states to demonstrate compliance through aggregate methodologies, including Medicare cost report or upper payment limit approaches, rather than requiring claim-level repricing. The agency should also establish clear prospective standards, reasonable transition periods, and safe harbors for states and providers that rely in good faith on CMS-approved methodologies.

6. The proposed rule disrupts existing financing structures and reverses prior CMS policy

Arizona's SDP programs were developed through extensive engagement with CMS and structured to comply with federal guidance, financing rules, and program integrity requirements. AHCCCS, health plans, hospitals, and other providers invested significant time and resources in those programs based on CMS approvals and stated policies.

The proposed rule would now eliminate or materially restrict financing and payment approaches that CMS previously permitted. Most notably, it would phase out uniform increase SDPs even though the 2024 Medicaid Managed Care Rule recognized uniform increases as a permissible and scalable SDP

model. Arizona and other states have been redesigning programs to comply with that rule, only to face another immediate and conflicting redesign requirement.

Changing the rules while states and providers are implementing recently approved requirements creates unnecessary cost, operational disruption, and uncertainty. It also undermines confidence that CMS approvals and formal guidance can be relied upon when states make multi-year program, budget, workforce, and infrastructure decisions.

The proposed rule would also constrain established provider-funded supplemental payment arrangements that have been disclosed to and approved by CMS. If CMS has program integrity concerns with a particular financing arrangement, it should address those concerns directly and consistently with the statute, rather than broadly displacing payment structures that states developed in good faith under existing federal rules.

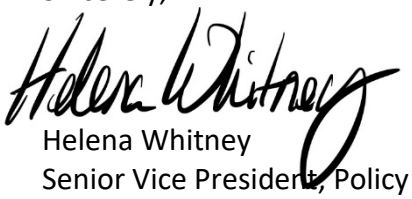
At a minimum, CMS should preserve uniform increases in SDPs to the extent allowed by P.L. 119-21, honor existing approvals during a meaningful transition period, and avoid retroactive or midstream changes that strand state and provider investments. A predictable federal framework is necessary for responsible Medicaid administration and for the continuity of services supported by these payments.

Conclusion

AzHHA urges CMS to withdraw or substantially revise the proposed rule. The final rule should implement only the changes expressly required by P.L. 119-21, preserve workable aggregate compliance methods, respect state flexibility and prior CMS approvals, and avoid reductions that threaten access to care.

Arizona hospitals appreciate CMS's consideration of these comments.

Sincerely,



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