July 21, 2026

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

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Reference: CMS-2449-P

Re: Medicaid Program; Medicaid Managed Care State Directed Payments & Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2026-1916; 91 Fed. Reg. 30,400, May 22, 2026)

Dear Administrator Oz:

We appreciate the opportunity to comment on CMS's proposed rule limiting state directed payments (SDPs) and fee-for-service supplemental payments in Medicaid managed care.

Americans for Prosperity's grassroots activists in all 50 states advocate for policies that expand opportunity, protect taxpayers, and hold government accountable for how it spends their money. AFP's goal is to reignite the American Dream through broad-based grassroots outreach that drives long-term solutions to the country's biggest problems.

When it comes to health care, we work to give every American a Personal Option — reliable, hassle-free health care you can afford – by removing barriers between patients and doctors and by empowering consumers to shop for value in a free and competitive marketplace. And when it comes to public safety nets like Medicaid, we believe they should be narrowly tailored to help the truly vulnerable – and prudently managed to protect taxpayers.

Our position. AFP strongly supports the proposed rule. We urge CMS to finalize it promptly after strengthening it in the ways suggested below. Congress enacted this reform in the Working Families Tax Cut because a handful of states had turned Medicaid managed care into a mechanism for funneling federal money to favored hospitals and nursing homes at rates far above what Medicare pays for the same care. The proposed rule carries out this mandate faithfully, and in a few places goes wisely further, a positive reflection on the Trump administration's determination to root out waste, fraud, and abuse across government. By finalizing and strengthening this proposed rule, the agency will take an important step toward ensuring Medicaid benefits vulnerable patients, not special interests.

Our Medicaid reform principles. Our support for this rule rests on principles we bring to every Medicaid debate. Medicaid dollars should buy care for patients, not pad reimbursement for politically connected hospital systems or deliver undeserved windfalls for state budgets. Although fundamental structural reform of Medicaid is much needed and long overdue, even a modestly reformed Medicaid's first obligation must be to the people for whom it was originally established: vulnerable low-income seniors, people with disabilities, and families with children. It should not disadvantage those vulnerable populations in favor of able-bodied adults, who, as a result of Medicaid Expansion, now make up a significant share of the Medicaid population in many states. State financing schemes that exist mainly to draw extra federal matching dollars,

whether through provider taxes or intergovernmental transfers, amount to self-dealing that taxpayers should not have to underwrite. Every Medicaid dollar that is wasted, including every dollar wasted on excessive state-directed payments, is a dollar that cannot benefit a patient. And every dollar that adds to the national debt creates a burden for every current and future taxpayer – the people who will ultimately have to pay that dollar in the form of higher taxes, higher prices, slower economic growth, or a reduced standard of living.

The problem. Historically, Medicaid has paid providers less than Medicare, but Medicaid managed care plans have long been allowed to pay some providers, through SDPs, at even higher rates, namely, up to 100 percent of commercial insurance rates, which are typically two or three times what Medicare pays for identical services. Higher than average payment rates may be necessary in some areas to ensure access for patients, but for most items and services, in most geographic areas, Medicare rates are generally adequate. Unfortunately, states have developed problematic ways to finance these higher payments: provider taxes and intergovernmental transfers (IGTs) that flow back to the same hospitals and nursing homes that receive the payments and thus generate federal matching funds at little real cost to the state. Over the past decade, states have aggressively used SDPs to push Medicaid's rates above Medicare's. Providers have predictably responded by prioritizing patients who bring the highest reimbursement. And this has hurt vulnerable patients. Since Medicaid's expansion population is large and, on average, younger and healthier than the population that Medicare serves, this change in providers' incentives has crowded out services for seniors and people with disabilities who often need more time and more complex care.

The proposed solution. Section 71116 of the Working Families Tax Cut addresses this problem by capping SDPs for hospital, nursing facility, and academic medical center physician services at 100 percent of the Medicare rate (110 percent in states that have not expanded Medicaid). The proposed rule implements this statutory provision as Congress intended. In place of the current 100-percent-of-commercial-rate ceiling, it caps nearly all Medicaid managed care SDPs at the Medicare rate, and to prevent gaming, it wisely applies the cap beyond the four service types named in the statute, and to every state, the District of Columbia, and the territories. And it reasonably gives existing arrangements a generous but temporary phase-down period. Finally, it caps fee-for-service (FFS) supplemental payments, thus closing a loophole that has let states achieve, outside managed care, what the new SDP limits are meant to prevent.

Why this rule helps patients and taxpayers. SDPs are the principal channel through which provider taxes and IGTs inflate Medicaid spending. The two financing tools distort care in different ways: (1) Provider taxes let a state tax a hospital, funnel the proceeds back to that hospital as a Medicaid payment increase, and draw down federal matching funds on top, at little real cost to the state. Research shows these taxes also raise commercial hospital prices, hitting everyone with private insurance, not just Medicaid patients. (2) IGTs favor government-owned providers over comparable private ones, since public hospitals and nursing homes can send money to the state that comes back multiplied through Medicaid. A recent National Bureau of Economic Research (NBER) study found that one state's nursing home IGT program measurably shifted resources toward hospitals, degraded nursing home quality, and was associated with an estimated 50 additional resident deaths per year.

The rule will also help address the problem of insurers who profit unduly from the flawed status quo. Managed care plans are supposed to pass SDP dollars along to providers, but because the payments count as claims for purposes of a plan's medical loss ratio (MLR) threshold (the maximum amount the plan can spend that is not directly benefiting patients), the payments help the insurer meet its required spending floor without touching its own profit margin. Additionally, insurers profit from the float on the payments and from shared ownership with the providers receiving them. In fact, a meaningful share of "provider" spending under SDPs goes into insurance-company coffers rather than reaching patients.

The proposed rule's benefits for taxpayers are substantial. CMS projects it will reduce Medicaid spending by $774.8 billion from 2026 through 2035, including $510.1 billion in federal savings. An additional benefit

is that these savings will reduce the amount of taxing, borrowing, and debt service needed to finance SDPs, along with the deadweight loss and economic drag such impositions create.

CMS is on solid legal footing. Some commenters may argue that CMS lacks authority to extend the limits beyond the four services named in the Working Families Tax Cut. This is incorrect. CMS has long had broad authority to ensure Medicaid managed care rates are actuarially sound and consistent with program goals and integrity. Congress did not narrow that authority when it enacted the statute's specific SDP caps. It would be irresponsible for CMS not to use its existing authority to foreclose easily foreseen state workarounds.

Where CMS should strengthen the rule. We offer the following recommendations to close some gaps that might otherwise enable states to avoid full and prompt compliance with the proposed rule.

1. **Move faster on the phase-down.** Every year a grandfathered SDP stays above the new caps preserves the waste Congress voted to end.

2. **Count "180 days" as calendar days, not business days.** The statute says "days." Reading that as "business" days instead of "calendar" days, as CMS proposes, stretches the grandfathering window by more than six weeks and thus grandfathers more spending than Congress intended.

3. **Cap fee-for-service supplemental payments before 2029.** States should not be allowed extra years to evade the rule by shifting wasteful financing into fee-for-service.

4. **Look at total Medicaid payments, not each stream in isolation.** CMS should bar government-owned providers from collecting more than comparable private providers for the same care. Otherwise, states will simply route around the new caps by stacking payment streams.

5. **Make SDP financing public.** CMS should require states to report annually where SDP dollars actually go, publish exactly how these payments are financed, and post the Medicare payment data CMS uses for compliance so states cannot claim confusion about the cap they must meet.

6. **Counter state evasions as they appear.** CMS should review state financing annually to detect new evasion strategies as they appear and reopen any approved SDP if the underlying arrangement changes in ways that suggest evasion.

7. **Verify and publish the rule's economic benefits**. CMS should quantify the additional economic benefits of the final rule – from reduced taxing, borrowing, and economic drag – in its formal regulatory impact analysis, consistent with longstanding OMB guidance on the excess burden of taxation.

Congress enacted the Medicaid reforms in the Working Families Tax Cut to end a status quo that let states use laundered money to pay Medicaid providers at far-above-adequate rates – a status quo that is burdensome to taxpayers and unfair to vulnerable patients. CMS must finish what Congress started and close the gaps by which states can evade what Congress directed.

This rule represents one of the most significant Medicaid integrity reforms in decades. We urge CMS to finalize it, with the suggested improvements, at the earliest possible date. Thank you for the opportunity to comment.

Respectfully submitted,

Americans for Prosperity