October 20 2026

Verlon Johnson, Chair
Medicaid and CHIP Payment and Access Commission (MACPAC)
1800 M Street NW, Suite 650 South
Washington, DC 20036

Dear Ms. Johnson:

Doctors Hospital at Renaissance (DHR Health) appreciates that the Medicaid and CHIP Payment and Access Commission (MACPAC) is focusing attention on the Center for Medicare & Medicaid Services' (CMS) proposed rules to implement the statutory State Directed Payment (SDP) and provider tax hold harmless provisions of Public Law 119-21. In its September 2026 meeting, MACPAC not only clearly articulated critical concerns of DHR Health and our patients but also signaled an openness to hearing from providers to better understand the challenges we are facing in providing care within the Medicaid landscape. We respectfully submit these comments to share our experiences as a safety net provider.

DHR Health fully supports strong program integrity and financial stewardship to ensure Medicaid's long-term sustainability. However, the proposed rules exceed statutory intent and would cause devastating reductions in federal Medicaid spending and payment to providers, dramatically reduce state flexibility, limit care access to those who are most in need, and create significant and unnecessary burden on states, providers, and beneficiaries.

About DHR Health

DHR Health is proud to be one of the nation's largest physician-owned hospitals, serving more than 1.3 million residents of the Rio Grande Valley of deep South Texas along the U.S.-Mexico border.[1] We serve as a safety-net hospital system for our community, with 25% of our patients covered by Medicaid and more than $130 million provided annually in charity care.

Over the past two decades, DHR Health's physician-led investments have transformed regional healthcare delivery in South Texas. DHR Health established the Rio Grande Valley's first Level I Trauma Center, a certified Comprehensive Stroke Center, transplant programs, and an accredited teaching hospital supporting critical workforce needs in a medically underserved region. These investments have expanded access to complex, high-acuity, and specialty care that historically was not available locally to many residents of the Rio Grande Valley.

[1] The Rio Grande Valley is made up of the four southernmost counties in Texas: Cameron, Hidalgo, Starr and Willacy.

Key Concerns

In communities like the Rio Grande Valley, Medicaid is a core source of healthcare coverage. As such, our comments reflect the perspective of a frontline safety-net provider and vital community anchor institution serving a high-Medicaid, high-need region. Medicaid financing and payment policies directly impact our continued ability to maintain access to essential services, recruit and retain clinicians, sustain graduate medical education and specialty care capacity, and make investments in serving our community and expanding access to vital healthcare services.

State Directed Payments and Certain Fee-For-Service Payments[2]

Texas uses a variety of SDPs, which are essential in maintaining access to care for the state's 4 million Medicaid beneficiaries, to augment low Medicaid base rates which reimburse providers well below the cost of providing care. If the provisions of the rule are finalized, it may be impossible for safety-net providers, particularly those in rural and underserved areas, to continue providing services such as trauma care, specialty care, behavioral health services, substance use disorder care, maternal care, and other essential services. The health and wellbeing of Texans simply cannot withstand the loss of such services.

As highlighted in our comment letter to CMS on this rule (Appendix I), DHR Health has serious concerns regarding the severity and impact of the proposed application of the SDP cuts and payment limits as incorporated into the proposed rule. Given that the statutory overreach would undermine the state/federal government partnership essential to the Medicaid program, DHR Health asks MACPAC to support the preservation of state flexibility within permissible payment policy and operations to prevent care disruption. DHR Health urges MACPAC to continue to monitor, evaluate, and provide recommendations to Congress and CMS regarding the impact on access to care, the effect of the proposed SDP phase-down methodology, the burden created by the Medicare-equivalent payment limit calculation, the elimination of uniform increase SDPs, and the constraints placed on service delivery stemming from the limits to certain targeted fee-for-service payments.

Provider Taxes Hold Harmless Limits[3]

For many states, including Texas, provider taxes are interwoven into a longstanding and complex financing system that allows hospitals and clinicians, particularly those serving rural and high-need communities, to operate a state-wide, robust, high-quality care system to meet the care needs of those they serve. Abruptly changing these foundational financing methodologies will destabilize access to essential medical services.

[2] Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments, 91 Fed. Reg. 30400.
[3] Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes, 91 Fed Reg. 46562.

Given the significant risk to safety-net providers, DHR urges MACPAC to further assess the impact to access to care stemming from the hold harmless proposed rule provisions. As highlighted in our attached comments to CMS on the provider tax hold harmless rule (Appendix II), we recommend the assessments specifically focus on the impact of CMS's currently proposed definition of net patient revenue, its elimination of the 75/75 test, the rule's strict application of "enacted," the lack of a mechanism to pause when implementation leads to system disruption, and the inability of states to incorporate as needed good cause or CMS-required amendments to permissible provider taxes that have been operating in good faith. Based on findings from these analyses, MACPAC should recommend data-informed policies to implement the requirements of Public Law 119-21 without causing undue harm to the healthcare system, particularly the nation's safety net providers.

Impact Analysis

Providers in Texas are bracing for significant financial and service loss related to CMS's overreaching SDP and hold harmless interpretations. As highlighted by MACPAC Commissioners, CMS's impact analysis of both rules significantly exceeds that of the associated statutory provision. This gap cannot clearly and transparently be accounted for without taking into consideration CMS's addition of policies that exceed Congressional intent. Removing over $1.5 trillion from the healthcare system across the two rules will have significant consequences, the brunt of which will be felt by lower income and rural communities.

DHR Health cannot understate the importance of SDPs in Texas in ensuring access to care for Medicaid beneficiaries. SDPs are one of the principal mechanisms by which Texas mitigates the gap between Medicaid base payments and the cost of providing care. Abrupt changes to these payment mechanisms will significantly impact the resources dedicated to care. As proposed, the SDP rule alone would reduce payments to hospitals by more than $4.3 billion in Texas per year once the phase-down is complete. CMS itself projects that the proposed rule would reduce total computable Medicaid spending nationally by $774.8 billion over the next decade. Texas administers five SDP programs, including several focused on preserving access in underserved rural communities and for behavioral health services. Reductions of the magnitude are likely to signal the end of accessible and critical services such as these.

CMS estimates the provider tax hold harmless rule would reduce total computable Medicaid spending by $384 billion over the next ten years. This estimate, likely significantly underestimates the true impact, demonstrates the staggering magnitude of funding expected to be removed from the healthcare system overall, particularly when paired with the expected loss of SDP funding. Safety-net hospitals will be hit hardest of all. Many are likely not to survive.

Taken together, these cuts are likely to cause irreparable damage to the safety-net care system as well as to beneficiary health and wellbeing. We urge MACPAC to continue its work in monitoring impact and providing recommended actions to Congress and CMS to mitigate or prevent the loss of funding that directly supports care to the communities in Texas, and across the country, that are the most in need.

Conclusion

DHR Health is encouraged by MACPAC's focus on CMS's implementation of the SDP and hold harmless statutory provisions of Public Law 119-21. We ask MACPAC to remain vigilant and engaged in recommending common sense policy changes while monitoring the impact on beneficiary access, particularly in rural and underserved areas.

As a safety-net provider that Texans in the Rio Grande Vally rely upon for health and wellbeing, we are greatly concerned by the crisis we see looming if the proposals within the two rules become finalized.

DHR Health would be happy to share additional insights as well as to support MACPAC as it reviews and advises Congress and CMS on these issues. If you have any questions, please do not hesitate to contact us through Roberto Haddad, Vice President, Counsel for Government Affairs & Policy, by phone at (956) 362-7138 or by email at r.haddad@dhrhealth.com.

Sincerely,

Roberto Haddad, J.D.
Vice President, Counsel for Government Affairs & Policy
DHR Health

July 21, 2026

The Honorable Dr. Mehmet Oz
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Re: [CMS-2449-P] Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Dear Administrator Oz:

Doctors Hospital at Renaissance (DHR Health) appreciates the opportunity to comment on the Medicaid Managed Care State Directed Payments (SDPs) and Medicaid Fee-for-Service (FFS) Targeted Medicaid Practitioner Payments proposed rule (CMS-2449-P).

DHR Health supports CMS's goals of strengthening Medicaid program integrity, promoting fiscal accountability, and encouraging value-based care. These goals are important to the long-term sustainability of the Medicaid program. At the same time, we are deeply concerned that the proposed changes would dramatically reduce state flexibility in designing their Medicaid payment systems, create administratively burdensome tracking and reporting requirements for States, and cause significant reductions in payments to providers that CMS itself estimates will reduce federal Medicaid spending by $510.1 billion from 2026 through 2035.[1] This is greater than three times the Congressional Budget Office (CBO) estimate of a $149.5 billion reduction in federal Medicaid spending for the statutory impact of Section 71116 of Public Law 119-21, providing clear evidence that CMS is attempting to implement sweeping policy changes that extend far beyond Congressional intent.[2]

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Over the past two decades, DHR Health's physician-led investments have transformed regional healthcare delivery in South Texas. DHR Health established the Rio Grande Valley's first Level I Trauma Center, a certified Comprehensive Stroke Center, transplant programs, and an accredited teaching hospital supporting critical workforce needs in a medically underserved region. These investments have expanded access to complex, high-acuity, and specialty care that historically was not available locally to many residents of the Rio Grande Valley.

[1] 91 Fed. Reg. at 30451.
[2] CBO, *Supplemental Cost Estimate, Public Law 119-21*, Page 5 (Oct. 28, 2025), available at https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf.

Summary of Key Concerns

Our comments reflect the perspective of a frontline safety-net provider and vital community anchor institution serving a high-Medicaid, high-need region. Medicaid financing policies directly affect our ability to maintain access to essential services, recruit and retain clinicians, sustain graduate medical education and specialty care capacity, and continue investing in infrastructure needed to serve and expand access to vital healthcare services in our community.

In communities like the Rio Grande Valley, Medicaid is not a marginal payer; it is a core source of coverage. Texas uses a variety of SDP and supplemental payment methodologies to augment low Medicaid base rates which reimburse below the cost of care, and as a means of ensuring access to high-quality inpatient and outpatient services. SDPs are essential in maintaining access to care for 4 million Medicaid enrollees, 98 percent of whom receive care through managed care. Substantial reductions or abrupt redesigns in Medicaid payment structures could directly affect whether safety-net providers can continue furnishing advanced and a comprehensive level of services such as trauma care, specialty care, behavioral health services, substance use disorder care, maternal care, and other essential services.

Given the importance of adequate Medicaid payment rates, DHR Health has serious concerns regarding CMS's interpretation of Sec. 71116 of Public Law 119-21, including:

- ***Detrimental proposed cuts and payment limits*** that would disproportionately impact Texas's safety-net, imperiling Medicaid beneficiary access to essential healthcare services.
- ***CMS's overreaching interpretations*** that exceed statutory authority and undermine the state/federal government partnership.
- ***Disregard for preserving state flexibility*** in the design and implementation of Medicaid payment policy and operations, with potentially devastating consequences for the healthcare system across Texas.

If finalized, CMS's proposals would lead to the disruption of the healthcare safety net in Texas. The most problematic are CMS's proposals concerning (1) the SDP phase-down methodology, (2) the Medicare-equivalent payment limit calculation, (3) elimination of uniform increase SDPs, and (4) constraining certain targeted fee-for-service payments. ***DHR Health urges CMS to substantially revise the proposed payment limit methodology, phase-down schedule, and scope of limitations before finalizing this rule.***

Providers in Texas are bracing for significant impact, including the reduction of annual payments to hospitals by more than $4.3 billion once the phase-down is complete. CMS itself recognizes that SDPs can be an important tool for states to advance Medicaid program priorities and goals. SDPs are one of the principal mechanisms by which Texas mitigates the gap between Medicaid base payments and the cost of care. Texas was an early adopter of SDPs and currently administers five SDPs, including programs targeting underserved rural communities and behavioral health services. In Texas, these payments drive many quality-based initiatives and help preserve services that otherwise would be financially unsustainable. ***DHR Health urges CMS to implement the Medicaid SDP provisions of Public Law 119-21 using a commonsense approach that preserves a healthy and viable healthcare system by addressing the following issues within the proposed rule.***

Disproportionate Impact of the Payment Limits *(§ 438.6(a), (c)(2)(ii)(I), and (c)(8)).*

In Section 71116 of Public Law 119-21 Congress established new payment limits for four specific SDP service categories: inpatient hospital services, outpatient hospital services, nursing facility services, and

qualified practitioner services at academic medical centers. In non-expansion states like Texas, limits applicable to these four services correspond to 110 percent of what Medicare would pay for those services. For services not reimbursed by Medicare, CMS proposes to limit the total SDP payment to 100 percent of the state plan approved rate.

CMS states that the proposed rule would implement these new statutory requirements, but in doing so would eliminate all opportunity for states to use average commercial rates. This occurs despite CMS's interpretation within its 2024 final rule, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-F) of the appropriateness of the average commercial rate as an acceptable Medicaid upper payment limit. In that rule, CMS emphasized that the use of average commercial rates were consistent with section 1902(a)(30)(A) of the Social Security Act which requires payments to be "consistent with efficiency, economy, and quality of care, and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population." In the 2024 final rule, CMS recognized that an average commercial rate is a comparable and appropriate benchmark for enhancing payment for the care of Medicaid enrollees, who differ substantively from a Medicare population. Additionally, the 2024 final rule noted that the non-Medicaid general population counterparts of Texas Medicaid enrollees are likely to be insured commercially, not by Medicare. However, in the current proposed rule, CMS reverses its own arguments and established policy in a manner that will likely prove devastating to the Medicaid program, its providers, and most importantly, the beneficiaries who rely on it for healthcare coverage.

CMS projects substantial reductions in Medicaid spending within the proposed rule itself. However, it makes no attempt to contemplate or assess how such large payment reductions could be implemented without undermining the statutory access standard codified in section 1902(a)(30)(A). This omission is particularly concerning in Texas, where providers rely upon SDPs and supplemental payment programs to offset the gap between Medicaid reimbursement and the cost of delivering care. Significant reductions to these funding streams will affect provider participation decisions, access to specialty services, care coordination efforts, and investments intended to improve healthcare quality and outcomes.

Additionally, CMS's assumptions about the payment levels providers actually retain are also incomplete. DHR Health recommends CMS draw upon public analyses which clearly demonstrate that net SDP payments lag significantly behind average commercial rates. The Medicaid and CHIP Access and Payment Commission (MACPAC), informed in part by Texas data, has clearly demonstrated that net SDP payments to providers only begin to approach, but do not fully attain, Medicare-equivalent rates when the benchmark for gross payment is set at an average commercial rate.[3] Only a fraction of any SDP

[3] Medicaid & CHIP Payment & Access Commission (June 2024). Report to Congress on Medicaid and CHIP. https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-WEB-508.pdf
*"The [Texas] private hospital that we examined was projected to receive managed care base payments that were 65 percent of what Medicare would have paid and managed care directed payments that were 87 percent of what Medicare would have paid, resulting in total gross payments of 152 percent of what Medicare would have paid (Figure 1-4) According to Texas's provider-level financing report, this provider paid taxes that were equivalent to 63 percent of what Medicare would have paid, which were used to help finance the managed care directed payment... **total net payments are... 89 percent of Medicare if the full amount of the tax is subtracted."***

*"The [Texas] public hospital we examined was projected to receive managed care base payments that were 42 percent of what Medicare would have paid and managed care pass through and directed payments equal to 86 percent of what Medicare would have paid, resulting in a total gross payment of 128 percent of what Medicare would have paid (Figure 1-5). However, after subtracting the costs of the IGTs to finance this directed payment, **the net managed care payments to this hospital were 82 percent of what Medicare would have paid."***

payment offsets nonfederal share financing that originated with providers. In Texas SDPs are locally financed nearly 100 percent by intergovernmental transfers (IGTs) and provider assessments as a reaction to stagnant state general revenue funding base rates. Accordingly, gross SDP do not equate to providers retaining payments equal to 110 percent of Medicare, much less commercial-equivalent net reimbursement for Medicaid services.

Furthermore, CMS should take into consideration the distinct populations and healthcare needs served by Medicare and Medicaid, and that Medicare's rate-setting methodology is not directly comparable to Medicaid. Medicare rates were never intended to be a universal benchmark for appropriate hospital payment policy across all populations and services, much less Medicaid populations such as pregnant women and children, which Medicare rarely serves. Many Medicaid services are neither covered nor paid for by Medicare, or have weak Medicare correlates, such as births and Neonatal Intensive Care Unit (NICU) admissions.

As explored further below, DHR Health urges CMS to implement the new payment limits in a manner that preserves state flexibility, reflects the distinct needs of Medicaid populations, and promotes quality and access for Medicaid beneficiaries.

Payment Limit Methodology

CMS should implement a Medicare Upper Payment Limit (UPL) methodology to calculate the statutorily required SDP limits rather than the proposed per-service, per-provider methodology. The proposed rule would require that the Medicare payment limit be calculated on a per-service, per-provider basis, and would reject an aggregate Medicare UPL, which has long been the standard in Medicaid FFS supplemental payments and with which both states and CMS have ample experience. ***The UPL methodology is far better suited to SDPs for the following reasons:***

- ***Reasonable.*** Texas's Comprehensive Hospital Increase Reimbursement Program (CHIRP) and its predecessor programs have used an aggregate UPL methodology to estimate Medicare-equivalent payments since 2018. Through its longstanding policy and approvals, CMS has recognized the reasonableness of the UPL standard and approved associated payments. In the proposed rule, CMS proposed an untested methodology without explaining or demonstrating that Medicare UPL, a methodology that permeates throughout the Medicaid FFS payment rate requirements, produces an unreasonable Medicare equivalent rate within the managed care context.

  DHR Health is concerned that by declining to permit Medicare UPL in SDPs, CMS risks creating a double standard in which it would implement unreasonably inconsistent methodologies across managed care and FFS. States may re-evaluate whether managed care delivery models are best suited to advancing their program objectives. Taken together, the proposed policies could encourage states to reconsider managed care and return to traditional FFS payment to preserve greater methodological flexibility.

- ***Compatible with statute and Congressional intent.*** The statutory language requires aggregate total payment rates for four specific classes of services to equate to a certain percentage of

Medicare. UPL is a published methodology that CMS has long accepted and codified within regulations as the appropriate standard for determining a total Medicare equivalent rate.[4]

It is unlikely that Congress intended CMS to implement the statutory requirements in such a way as to undermine Medicaid access by incorrectly treating children and pregnant women as identical to older adults and individuals with disabilities in the services they use or the resources their care consumes. Medicare's prospective payment systems (PPS), Medicare-severity diagnosis related groups (MS-DRGs), and ambulatory payment classifications (APCs) are updated annually based exclusively upon the experience of Medicare enrollees. CMS is aware that many states including Texas do not use MS-DRGs or APCs in Medicaid prospective payments for this precise reason – Medicare's methodology cannot be transposed onto Medicaid populations.

Additionally, CMS is overreading and misconstruing Congress's use of the term "service" in Sec. 71116(b) by determining that it must refer to and limit total payments for each individual service. The appropriate meaning of "service" is the meaning CMS historically used elsewhere in its regulations as a reference to a service category such as inpatient hospital or outpatient hospital. It is unprecedented in Title XIX of the Social Security Act to interpret that "service" refers to a specified item on the Medicare fee schedule. It is unreasonable to assume that Congress intended CMS to use the term that way for purposes of this provision such that the SDP reimbursement on individual Medicaid services would be limited in such a way.

- ***Conducive to minimizing unnecessary burden and cost.*** States and CMS have longstanding experience using aggregate UPLs as the appropriate standard by which to judge alignment to Medicare rates. The aggregate level UPL is a simpler and easier approach that maintains program integrity objectives without imposing undue burden. This approach also aligns with CMS's efforts to prevent avoidable and unnecessary administrative burden and waste.

  Demonstrating compliance with this limit applied at the level of the individual service will be overly burdensome to states, providers, and CMS. As proposed, CMS would require additional fiscal projections for all applicable SDPs to demonstrate that the Medicare-based limits are not exceeded. This proposal would create extensive new requirements including new MCO contract provisions for encounter data stewardship, repricing of every single claim against the applicable Medicare rate, and annual comparisons of actual payments to Medicare limits at the level of every procedure and diagnosis code.

  In administratively lean states like Texas, resources to fulfill this new compliance obligation could force Medicaid agencies to sacrifice other priorities. We believe that is unnecessary. Given that states would be required to determine what would have been paid under Medicare fee schedules for every claim for service projected to be included in estimating a preprint value for the rating period, states will essentially need to run all underlying claims through a Medicare pricer effectively becoming a shadow Medicare Administrative Contractor. A new and completely separate process would need to be established for all non-Medicare equivalent claims services, creating even more burden on states.

[4] For example, see 42 CFR Part 447 Subpart C - Upper Limits

Texas is also one of two states that currently incorporate SDP amounts in per-member per-month capitation. It is unclear whether this demonstration would be feasible without redevelopment of programs to institute new and cumbersome separate payment terms.

- ***Flexible and well-established*.** CMS should implement flexible and well-established definitions of the Medicare payment rate aligned with its current UPL experience. CMS should build upon existing guidance regarding calculation of payments using Medicare payment principles for all four services posted on the CMS website in the context of Medicare UPL calculations. These UPL calculations are already designed to limit Medicaid payments to an aggregate group of providers to a reasonable estimate of what would be paid under Medicare payment principles. There is no reason or need to create a new approach for Medicaid agencies to adopt.

  DHR Health urges CMS to revise this burdensome proposal which would essentially require Medicaid agencies to become shadow MACs and instead apply existing guidance on estimating what would be paid under Medicare payment principles within a UPL context. CMS should also provide a commercial rate alternative where no Medicare payments are available or adequate.

DHR Health is also concerned that the proposed total published Medicare payment rate methodology will have a differential impact on prospective payment system (PPS) and non-PPS providers. The rule proposes to calculate the total published Medicare payment rate as the fee schedule or web pricer payment for PPS hospitals and a cost-based reimbursement equivalent for non-PPS hospitals. In principle, all relevant Medicare rate components should be included in establishing a per-service Medicare-equivalent payment for PPS hospitals. However, the web pricer incorporates key adjustments such as Medicare DSH, outlier payments, and indirect medical education (IME) while excluding others. Any final per-service limit must include all applicable Medicare rate components and address the treatment of components not included in the web pricers such as direct GME and bad debt.

The proposed rule also unduly limits state Medicaid flexibility in enhancing reimbursement to certain classes of hospitals based on whether Medicare reimburses it retrospectively (on cost), or prospectively. Cost-based service-specific payment limits in SDPs will have different and potentially detrimental effects on each category of cost-based hospital. A uniform cost-based service-specific limit proposal simply cannot equitably treat non-PPS hospital types such as children's hospitals and cancer hospitals. Each would lose SDP benefits for achieving cost efficiency in a way prospectively paid hospitals would not.

Medicare Payment Limits Net-of-Tax Perspective

If finalized, a per-service, per-provider Medicare payment limit calculation methodology for SDPs should use a net-of-tax perspective which better reflects providers' costs to finance safety net care. Using a net-of-tax analysis, CMS can more fairly evaluate payment rate reasonableness, distance from Medicare benchmarks, and fiscal integrity of SDPs.

MACPAC has used provider- and program-specific SDP financing data collected by Texas to convey more detailed information on how self-financed SDP payments compare to Medicare rates. In recent reports to Congress, MACPAC has provided a roadmap for CMS and states to replicate the data elements needed to analyze what providers *retain* from SDPs, which is not the same as what states are paying. *For example: if a hospital paid a tax of $40 to earn a directed payment of $100 on a Medicaid service performed, the net payment retained was $60. When added to a $200 state-financed base payment for the service, the hospital would have earned $300 in gross Medicaid payments, but only $260 in net*

payments after subtracting the $40 expense of the tax. If the hospital's equivalent Medicare payment for the same service was $300, the Medicaid SDP payment received would be equivalent to 100% of the total Medicare payment rate. From a net-of-tax perspective, the hospital's Medicaid SDP payment would be equivalent to $260/$300 or 87% of the total Medicare payment rate. Therefore, DHR Health proposes that CMS apply the SDP limit only to the extent that the net-of-tax SDP payment exceeds 100% of the total Medicare payment rate (110% if non-expansion state).

Provider-specific, program-specific financing data is not available in all states. In these circumstances, CMS could use Texas as a model for establishing uniform data collection and reporting requirements. Following MACPAC's recommendations, CMS should consider actions within its authority to collect comprehensive data from states on their Medicaid financing methods and the amounts of the non-federal share of Medicaid spending derived from specific providers per program. Combining these data with provider-specific payment data for each SDP would produce a reasonable net-of-tax estimate.

Grandfathered Phase-Down Methodology *(§ 438.6(c)(2)(iii))*

Beginning with rating periods on or after January 1, 2028, the proposed rule would phase down grandfathered SDPs by removing 10 percent of the total grandfathered dollar amount each year until the program reaches a floor of 110 percent of the total published Medicare payment rate. CMS's proposed rule undermines Congress's intended glidepath in the grandfathering transition period. Congress established this as a means of thoughtfully preventing destabilization of the healthcare system. CMS's interpretation undermines the stability Congress intended to provide with grandfathering. Programs benchmarked to average commercial rates were meant to transition incrementally, balancing maintenance of access and quality with new fiscal limits.

Commensurate with the state's size, population, size of the Medicaid program, and Medicaid managed care enrollment, Texas SDP programs are large and involve a significant amount of funding. Applied to large programs such as those in Texas, CMS's phase-down method results in the most abrupt loss of funds CMS could have selected. These recurring reductions phased in over a compressed period are likely unworkable for hospitals currently reliant upon SDPs to provide comprehensive access to Medicaid patients. A rapid phase-down may not give states sufficient planning time to transition to alternate reimbursement strategies while also preserving the safety net. This includes any required transition of uniform increase SDPs into value-based SDPs or fee-schedule SDPs upon the elimination of uniform increase SDPs - a proposal CMS should abandon.

If the current proposal is finalized, the cuts that would be absorbed by Texas hospitals will be severe – approximately 2% of gross expenditures in the entire Texas Medicaid program removed in multiple consecutive years. This loss of funding represents reduced services to low-income newborns, children, pregnant and postpartum women, and Texans with disabilities in long-term care. If not for enhanced SDP reimbursement, certain services could not be maintained at current levels – or at all. While this loss would immediately impact Medicaid beneficiaries, the impact would quickly have consequences across the entire continuum of care.

Grandfathered Payment Limit Calculations

CMS is not required to phase down grandfathered programs through a single, inflexible methodology. DHR Health urges CMS to not only modify the 10 percent reduction methodology but also to provide

alternative phase down approaches from among which states would choose the one best suited to their state needs.

10 Percentage Point Reduction for Grandfathered SDPs

Public Law 119-21 provides that, for grandfathered SDPs, "the total amount of such payment shall be reduced by 10 percentage points each year" until the applicable payment limit is reached. CMS should interpret "the total amount of such payment" to refer to the payment amount in effect for the relevant year of the phase-down. Under this approach, each year's 10 percentage point reduction would be applied to the annual SDP total dollar amount.

This interpretation more closely reflects the plain meaning of the statutory language. The statute does not state that the annual reduction must be calculated based on the original grandfathered payment amount. Instead, it refers to reducing "the total amount of such payment" each year. Reading that phrase to refer to the annual payment amount gives effect to the annual nature of the phase-down and avoids converting the statutory transition into a fixed-dollar reduction based on a static historical amount.

Applying the reduction to the annual SDP amount would still move grandfathered SDPs toward the applicable payment limits. However, it would do so in a more measured way that better protects access, network stability, and state Medicaid program administration. Therefore, DHR Health recommends that CMS revise proposed 438.6(c)(2)(iii)(B) to clarify that the annual 10 percentage point reduction for grandfathered SDPs will be calculated based on the annual SDP total dollar amount for the applicable rating period, rather than the original grandfathered SDP amount. CMS should also allow states to request temporary pauses, modifications, or hardship relief where continued reductions would create significant access concerns, destabilize Medicaid provider participation, or threaten the availability of essential services.

CMS explains that it opted against this approach due to anticipated administrative burdens in computing the phase-down separately for each provider class, service, and program. We expect that states would prefer to be given the option to preserve resources and transition their programs incrementally in exchange for a modest increase in burdens. Additionally, any burden attributable to this option would be insignificant within the context of currently estimated burden from the entirety of the rule.

Alternate Phase-Down Approaches

(1) Alternative Phase-Down 10 Percentage Point Calculation

CMS notes it considered an alternative approach under which the phase-down would occur as a ten percentage point reduction to the total payment rate, expressed as a percentage of the total published Medicare payment rate, rather than to the total dollar amount of the SDP. For programs with larger total grandfathered dollar amounts, this phase-down is likely more workable.

(2) Alternate Approach: Phase-Down Applied to Dollars in Excess of Payment Limit

DHR Health urges CMS to modify the phase-down approach to allow for an optional calculation that applies to only the dollar amounts in excess of the applicable Medicare payment limit in that state*. In this example, if a non-expansion state had a $10 billion SDP and 110% of the aggregate total published*

Medicare payment rate was equal to $4 billion, the 10 percentage point phase-down would apply only to amounts in excess of $4 billion. This means that the phase-down would remove $600 million (10% of $6 billion) annually from the program, and the glidepath to the end of the grandfathering period would last ten years. This would also carry the benefit of aligning the timing of the phase-down with CBO's original projections, which measured savings over ten years.

Uniform Increase SDPs *(§ 438.6(c)(1)(iii), (c)(2)(i), and (c)(2)(iii)(E))*

CMS proposes that, beginning with the first rating period on or after January 1, 2028, new uniform increase SDPs and renewals of non-grandfathered uniform increase SDPs would no longer be permitted. For grandfathered SDPs, CMS proposes to allow uniform increase SDPs only until the first rating period in which the applicable payment limit is reached. Once the payment limit is met, the state would be required to redesign the SDP to comply with the remaining permissible SDP categories. DHR Health opposes this proposal.

DHR Health is concerned that a categorical prohibition on uniform increase SDPs would not only sweep too broadly, it would also encroach upon the legitimate role of the state in the Medicaid federal/state partnership. The scope of this proposal extends far beyond Sec. 71116, which clearly only sets an aggregate limit on SDPs while remaining silent on the methodologies through which states pay such SDPs

Uniform increase methodologies serve legitimate purposes, including improving Medicaid payment adequacy, supporting provider participation, and addressing access challenges across a class of providers. In some cases, a uniform increase may be administratively simpler and more transparent than more complex alternative methodologies.

CMS should not seek to further restrict use of permissible sources of funds beyond the limitations already prescribed by federal law. Financing derived from local intergovernmental transfers rather than state general revenue is permissible under Section 1903(w)(4) of the Social Security Act. Prescribing limitations on SDPs to curtail a state's flexibility in its legitimate and time-honored role of administering Medicaid beyond what Congress has authorized CMS to do is unlawful. Payment restrictions should not be proposed as a proxy for unsupported objections to financing.

Texas's programs currently operate in part as uniform increases. Any remaining flexibility Texas would have in transitioning its program to a fee schedule is flexibility in name only, because the underlying Medicare per-service limit still constrains how much a state can direct through a fee schedule. While Texas's existing value-based components could in principle continue, requiring an increasing share of a rapidly shrinking pool of funds to be placed at risk on a performance basis is imprudent after several consecutive years of high-dollar cuts. DHR Health urges CMS not to force significant program redesign onto the same compressed phase-down timeline as the dollar-value reductions themselves.

Expansion to All SDPs

While CMS's proposed rule would implement the specific requirements of Section 71116 of the Public Law 119-21, it also seeks to greatly expand upon the statutory changes to impose limits on services beyond the four services identified in law. The proposed rule also appears to impose limits in a manner that exceeds Congress' explicit direction.

CMS's claims of deriving the legislative authority for these expanded changes not from Public Law 119-21 but from Section 1902(a)(4) and 1903(m)(2)(A)(iii) of the Social Security Act are misplaced and unpersuasive. Section 1902(a)(4) is general language regarding administration and Section 1903(m)(2)(A)(iii) is a provision requiring that managed care contracts are actuarially sound and approved by CMS. None of the language CMS claims as authority has changed since 1997, notwithstanding multiple Congressional opportunities to address and revise this authority, including within Public Law 119-21 itself. This reinterpretation of existing statutory language brings into question whether CMS has authority to regulate and impose new restrictions on programs without explicit new direction from Congress.

The Supreme Court held in *Loper Bright Enterprises v. Raimondo,* that administrative agencies use the best interpretation of Congress's direction when implementing legislation through regulation. It is therefore necessary to address whether CMS's proposals are the best interpretation of Congress's direction. CMS appears to have interpreted Congress's direction in Section 71116 as a mandate for applying additional harsher changes to SDPs, far beyond that actually provided in the legislative record or the statutory text. Additionally, CMS seeks to interpret a very clear and specific limitation far beyond what the law states to all other services and in other contexts. It seems inconceivable that this is the best interpretation of the plain language of the statute.

An alternative interpretation would be that Congress was fully aware of existing Medicaid law and regulations regarding payment, and that it addressed clearly and specifically the exact limits it wanted implemented. This appears by far the most compelling understanding of Congressional intent. If Congress wanted to authorize CMS to apply additional limits, it would have directed the Agency to do so within the legislation. Courts applying *Loper Bright* have been skeptical about agency interpretations of statutes that revise longstanding interpretations of statutes undisturbed by Congress. This is a very clear example of just the type of situation contemplated under *Loper Bright*.

For this reason, ***DHR Health urges CMS to withdraw the proposed rule and issue a rule limited to implementing Congress's clearly articulated direction in Section 71116.***

Targeted FFS Medicaid Payment Limits *(§ 447.381)*

CMS again overreaches in its proposal to establish new non-statutory limits on targeted FFS practitioner payments. This CMS-invented proposed requirement does not correspond to the direction and intent of Congress in Public Law 119-21. Furthermore, this proposal would establish a dangerous precedent – creating the potential of a broader federal intrusion into Medicaid state plans, operations, and financial management including the establishment of base rates outside of the managed care environment. CMS should not adopt this proposal.

In accordance with longstanding CMS policy, states routinely adopt FFS reimbursement strategies that target payment strategies that can exceed Medicare rates even when not explicitly benchmarked to average commercial rates. This helps preserve statutorily required beneficiary access to a particular service or provider type when lower rates are insufficient for access.[5]

[5] Section 1902(a)(30)(A) of the Social Security Act requires Medicaid payments to be consistent with efficiency, economy, and quality of care while also being sufficient to enlist enough providers so that services are available to Medicaid beneficiaries at least to the extent such services are available to the general population in the geographic area

CMS has not adequately justified this departure or reconciled it has against its own longstanding policy. Furthermore, the proposal lacks sufficient clarity on the types of payments, services, or providers it means to constrain to a Medicare limit. CMS also has not provided sufficient detail on safeguards with respect to such limits regarding FFS base and supplemental payment enhancements for those services also subject to UPL demonstrations. This is troubling given that UPL demonstrations can be legitimately targeted to subsets of providers furnishing the same applicable Medicaid services.

Actuarial Certification Alternative for Value-Based Payment SDPs:

DHR Health appreciates CMS's recognition that value-based payment arrangements present unique operational considerations and urges CMS to adopt the actuarial alternative described in the preamble. Under this approach, a state would work with its actuaries to develop a population-based or condition-based SDP using actuarial principles and obtain actuarial certification that the payment methodology, including performance-based payments or shared savings, is designed not to exceed the applicable payment limit under proposed 42 CFR 438.6(c)(8)(ii)(B).

This prospective actuarial approach is preferable to an after-the-fact, per-service reconciliation requirement. Value-based models are commonly structured around populations, conditions, episodes, outcomes, or performance measures rather than individual units of service. Requiring states and providers to later allocate those payments back to discrete services would create significant administrative complexity and could undermine the very shift away from volume-based payment that value-based arrangements are intended to advance.

A rigid per-service reconciliation process could also discourage states from developing more sophisticated value-based models, particularly if prospective payments may later be treated as exceeding payment limits based on retrospective utilization. That uncertainty would be inconsistent with CMS's broader goals of promoting accountability, improving outcomes, and supporting more efficient Medicaid payment models.

Prospective actuarial certification would better balance program integrity with innovation. It would give CMS upfront assurance that the methodology is actuarially sound while avoiding retroactive reconciliation processes that could deter participation. CMS could support accountability through appropriate monitoring, reporting, and evaluation requirements.

This flexibility is especially important for providers serving communities with high rates of chronic disease and barriers to preventive and specialty care. Population- and condition-based models can support investments in care coordination, chronic disease management, quality improvement, and population health infrastructure. DHR Health therefore urges CMS to adopt the preamble alternative and permit prospective actuarial certification that the payment methodology is designed not to exceed the applicable payment limit.

Transition Periods, Hardship Exceptions, and Formal Offramps

DHR Health urges CMS to adopt a substantially longer and more deliberate implementation timeline. The proposed rule would require states, managed care plans, actuaries, providers, and state legislatures to make significant operational, contractual, financing, and payment system changes. These changes

cannot be implemented responsibly on an accelerated timeline without risking disruption to provider payments and Medicaid access.

States will need sufficient time to evaluate existing payment arrangements, assess payment adequacy, model the impact of Medicare-based limits, identify alternative methodologies, update managed care contracts, revise rate certifications, obtain CMS approval, and, where necessary, secure legislative or budgetary changes. Providers will need time to assess the effects on service lines, workforce planning, capital investments, graduate medical education, and access strategies.

A longer transition is particularly important for high-Medicaid providers and regions with limited alternatives. Abrupt payment reductions delay investments, reduce services, limit Medicaid participation, and constrain expansion of high-need programs—consequences that may not be captured in federal budget estimates but are significant for beneficiaries and communities.

CMS should also establish hardship exceptions and formal mechanisms to slow or pause implementation when states or providers demonstrate significant negative impacts. Relevant triggers could include material reductions in Medicaid or provider participation, managed care network adequacy concerns, closure or reduction of essential service lines, significant increases in beneficiary access complaints or grievances, or evidence that payment reductions are impairing access in high-Medicaid or medically underserved communities.

These mechanisms should be designed to provide a meaningful pause during which the state would work with CMS, managed care plans, and providers to develop a plan that balances access to care with CMS's goals of fiscal accountability, program integrity, and appropriate Medicaid stewardship.

Grey Area Payment Policy

CMS proposes to revise 438.6(c)(2)(ii)(A) to specify that SDPs must be based only on the utilization and delivery of services furnished by a provider. In addition, CMS directs that states may not direct managed care plans and/or providers to pay a portion of SDP expenditures to entities for activities that are not based on the utilization and delivery of services to Medicaid managed care beneficiaries, and that it is impermissible for states to direct the distribution of SDP funds to a third-party entity. CMS further characterizes that this constitutes a clarification of longstanding SDP requirements, rather than a change in policy.

DHR Health urges CMS not to finalize the proposal which would remove valuable tools states use to effectively administer the Medicaid program and to ensure access to care. Arrangements incorporating directed payments to third party entities have been and should continue to be a viable option to ensure access to high-quality care in Medicaid while supporting provider participation. DHR Health recommends that CMS avoid an overbroad interpretation of the proposed "grey area payment" policy. CMS should preserve state and provider flexibility to conduct reasonable, documented activities that support SDP implementation, quality improvement, access monitoring, care coordination, compliance, and evaluation.

Leverage Hospital and Health Plan Transparency Data

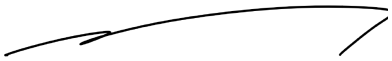
CMS should stop relying solely on Medicare data to inform Medicaid payment limit methodologies. CMS itself has been the steward of enormous advances in the availability and accuracy of commercial healthcare data in the last few years through its hospital and health plan price transparency initiatives. Leveraging this data could provide exceptional new insights for use in Medicaid payment limits, including more appropriate service equivalent payment rate data.

DHR Health urges CMS to evaluate the usefulness of newly available commercial data. Recent advances, including CMS's own authority over such data, have created entirely new opportunities to refine and improve analyses based on publicly available data. These data could be a viable proxy for appropriate prices, particularly for those services that lack an appropriate Medicare-equivalent payment rate.

Conclusion

DHR Health looks forward to working with CMS to strengthen Medicaid program integrity while preserving access to high-quality care for Medicaid beneficiaries in South Texas and across the country. If you have any questions, please do not hesitate to contact Mr. Roberto Haddad, Vice President, Counsel for Government Affairs & Policy by phone at (956) 362-7138 or by email at r.haddad@dhrhealth.com.

Sincerely,



Roberto Haddad, J.D.
Vice President, Counsel for Government Affairs & Policy
DHR Health

DHR Health

September 21, 2026

The Honorable Dr. Mehmet Oz
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Re: [CMS-2452-P] Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes

Dear Administrator Oz:

Doctors Hospital at Renaissance, Ltd. (DHR Health) appreciates the opportunity to comment on the Medicaid Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes proposed rule [CMS-2452-P]. Our comments reflect the perspective of a frontline safety-net provider and vital community anchor institution serving a high-Medicaid, high-need region.

DHR Health supports the Center for Medicare & Medicaid Services' (CMS) goals of strengthening Medicaid program integrity, promoting fiscal accountability, and enhancing financial stewardship. These goals are important to the long-term sustainability of the Medicaid program. At the same time, we are deeply concerned that the proposed changes would reduce state flexibility in designing Medicaid financing systems, hamstring states in funding their Medicaid programs, and cause significant disruptions within the healthcare system.

About DHR Health

DHR Health is proud to be one of the nation's largest physician-owned hospitals, serving more than 1.5 million residents of the Rio Grande Valley in South Texas. We serve as the primary safety-net hospital system for our community, with 25 percent of our patients covered by Medicaid and more than $130 million provided annually in charity care.

Over the past two decades, DHR Health's physician-led investments have transformed regional healthcare delivery in South Texas. DHR Health established the Rio Grande Valley's first Level I Trauma Center, a certified Comprehensive Stroke Center, transplant programs, and an accredited teaching hospital supporting critical workforce needs in a medically underserved region. These investments have expanded access to complex, high-acuity, and specialty care that historically was not available locally to many residents of the Rio Grande Valley.

Summary of Key Concerns

Medicaid financing policy is a significant factor in our ability to maintain access to essential services, recruit and retain clinicians, sustain graduate medical education and specialty care capacity, and invest in infrastructure to serve and expand access to vital healthcare services in

our community. In communities like the Rio Grande Valley of deep South Texas, Medicaid is an essential source of coverage. Texas uses a variety of Medicaid financing methodologies to enable it to augment low Medicaid base rates, which reimburse providers below the cost of care, as a way of securing access to high-quality inpatient and outpatient services. CMS estimates the rule would reduce total computable Medicaid spending by $384 billion over the next ten years. While this likely substantially underestimates the true impact, it illustrates the staggering magnitude of funding expected to be removed from the healthcare system overall, with safety-net hospitals hit hardest of all.

Medicaid financing structures, including provider taxes, are foundational to a complex system that ensures our communities with complex care needs have access to the care they need. Significant and abrupt changes to the underlying financing methodologies could directly impact whether safety-net providers can continue furnishing advanced and comprehensive levels of services such as trauma care, specialty care, behavioral health services, substance use disorder care, maternal care, and other essential services.

Given the importance of sufficient non-federal sources of Medicaid funding, DHR Health has concerns regarding the proposed provisions to implement the hold harmless restrictions of Section 71115 of Public Law 119-21. If finalized, CMS's proposals would disrupt the healthcare safety net in Texas, including provisions related to the:

- Application of CMS's proposed definition of "net patient revenue,"
- Permissibility of CMS-required amendments to provider taxes predating the statutory deadline and operating in good faith,
- Strict application of "enacted,"
- Elimination of the 75/75 test, and
- Lack of a mechanism to slow implementation in states or geographic areas where healthcare systems are imperiled by these proposals.

DHR Health urges CMS to modify these proposed provisions to maintain state flexibility while effectuating a balanced and thoughtful implementation that would prevent potentially catastrophic impact for safety-net providers and the communities they serve. In Texas, the existing and longstanding provider taxes are foundational to preserving services that otherwise would be financially unsustainable. DHR Health urges CMS to implement the Medicaid provider tax hold harmless provisions of Public Law 119-21 using a commonsense approach that preserves a healthy and viable healthcare system.

Application of CMS's proposed definition of "net patient revenue" *(§ 433.52)*

DHR Health urges CMS not to finalize its proposed definition in § 433.52 of "net patient revenue" (NPR). The current proposed meaning of "revenues received by the taxpayer, which are revenues attributable to the assessed permissible class of health care items or services, regardless of payer source" is insufficient in describing what and how patient revenues should be counted.

This definition simply does not reflect the operating reality and practices of hospitals and hospital systems. CMS should revert to the existing "imposed on at least all health care items or services in the class or providers of such items or services" which has historically been interpreted to allow additional flexibility in the inclusion of revenues of classes of providers.

CMS proposes to define NPR as revenues received by the taxpayer that are attributable to the assessed permissible class of health care items or services, regardless of payer source. While this formulation may appear straightforward, hospital financial and regulatory reporting systems do not necessarily categorize revenue according to the precise permissible classes used in the Medicaid provider-tax regulations. Determining which revenues are "attributable" to a particular permissible class may therefore require significant allocation, reconciliation, and judgment.

As an alternative, CMS should eliminate the proposed definition under § 433.52 and instead defer to states to operationally define "net patient revenue". Deference to the states to define "net patient revenue" would respect the joint state-federal structure of the Medicaid program and would allow States to craft a definition that fits within the context and landscape of the state's unique Medicaid program and healthcare system.

CMS Should Apply New NPR Methodologies Prospectively

DHR Health is particularly concerned about the application of newly articulated NPR standards to historical periods. Prior CMS guidance regarding the precise calculation and allocation of NPR for purposes of the indirect hold harmless test has been limited. States and localities have therefore developed and administered health care-related taxes using available financial data and reasonable interpretations of federal requirements.

To the extent the final rule establishes new requirements regarding the separation of inpatient and outpatient revenue, exclusion of particular categories of revenue, selection of particular data sources, or allocation of revenue among permissible classes, CMS should expressly provide that those requirements apply prospectively.

CMS should not impose retroactive disallowances based upon NPR methodologies that were not clearly articulated when the applicable taxes were assessed and collected. States and localities that reasonably relied upon existing reporting systems and methodologies should be provided an adequate transition period to modify their calculations and reporting practices.

CMS-Required NPR Changes Should Not Jeopardize Grandfathered Tax Status

Finally, CMS should clarify the interaction between its NPR definition and the statutory protections applicable to health care-related taxes enacted and imposed as of July 4, 2025.
If implementation of CMS's final NPR definition requires a State or locality to modify the calculation, structure, administration, or assessment methodology of an existing health care-related tax, such a modification should not cause the tax to be considered newly enacted or

newly imposed and should not otherwise reduce or eliminate the tax's grandfathered indirect hold harmless percentage.

A contrary result would place States and localities in an untenable position: they could be required by CMS to modify an existing tax to comply with a newly articulated federal methodology while simultaneously risking the grandfathered treatment Congress provided to that tax.

CMS should therefore expressly provide that technical, administrative, or conforming amendments necessary to implement the final NPR definition will not affect the grandfathered status or applicable indirect hold harmless percentage of an otherwise qualifying pre-July 4, 2025 tax.

Permissibility of CMS-required amendments to provider taxes predating the statutory deadline operating in good faith *(§ 433.68(f)(3)(ii)(A)(1)(i) & 433.68(f)(3)(ii)(A)(1)(ii))*

DHR Health appreciates CMS's clarification that "imposed" does not depend on when the tax is collected, but rather on whether the tax is in effect and creates a legally enforceable obligation to pay. = DHR Health remains concerned, however, with CMS's suggestion that a tax may be considered enacted but not "imposed" where a state legislature or other taxing authority has established the tax but delegated to an administrative agency the authority to determine certain aspects of its implementation, including the timing of implementation.

Such an interpretation does not adequately account for the governmental structures and established practices of many states and localities. It is common for a legislature or other taxing authority to establish a tax by law while delegating responsibility for implementing that tax to an administrative agency. That delegated authority may include establishing implementation dates, calculating tax obligations, developing administrative procedures, and determining the timing and manner of assessment and collection. The existence of such delegated implementation authority should not, standing alone, mean that the underlying tax was not "imposed" for purposes of § 433.68.

DHR Health therefore urges CMS to recognize these established state and local governmental practices in the final rule. Specifically, CMS should clarify that a tax otherwise established through legally valid state or local authority is not disqualified from satisfying the "imposed" requirement merely because an administrative agency has been delegated authority over implementation details, including determining the effective date or timing of implementation. Such an approach would appropriately distinguish between the legal establishment of a tax and the administrative actions necessary to implement and collect it

CMS should clarify that the terms "enacted" and "imposes" refer to the legal existence of the tax obligation, not the date on which each administrative step associated with the tax occurred. A tax should not be considered newly enacted or newly imposed merely because the State or locality later:

- adopted implementing regulations;
- issued administrative guidance;
- established forms or reporting procedures;
- identified the entities subject to assessment;
- calculated the amount owed for a particular assessment period;
- issued invoices or notices of assessment;
- established payment deadlines; or
- modified internal collection procedures.

These actions may be necessary to administer a tax but do not necessarily create the underlying legal obligation. CMS should evaluate whether the tax obligation was legally authorized and operative as of July 4, 2025, rather than focusing on the date of each subsequent administrative action.

Strict application of "enacted" *(§ 433.68(f)(3)(ii)(A)(1)(i))*

DHR Health disagrees with CMS's currently proposed determination that, for a tax to be considered enacted, the applicable state or local government must have completed the entire legislative process necessary to authorize the tax, either initially or *through an amendment to an existing tax* in effect on or before July 4, 2025, not later than that date. Furthermore, the rule proposes a tax would not have been enacted as of July 4, 2025, if the state amends a prior existing tax and makes it retroactively effective for a period beginning on or before July 4, 2025.

DHR Health is also concerned about the treatment of amendments made after July 4, 2025 to taxes that were enacted and imposed before that date. A distinction should be drawn between a State or locality voluntarily creating a new tax and amendments that are necessary to preserve, administer, or bring an existing tax into compliance with subsequently articulated federal requirements.

This concern is especially significant where CMS itself requires or urges a State or locality to modify the methodology used to calculate or administer an existing health care-related tax. A tax should not lose its grandfathered status, or have its applicable indirect hold harmless percentage reduced, merely because the State or locality makes a good-faith amendment necessary to comply with CMS's interpretation of federal law or regulation.

Such a result would be particularly inequitable where CMS announces or clarifies an interpretation after July 4, 2025 regarding requirements that were not clearly established when the tax was originally enacted and imposed. States and localities should not be forced to choose between maintaining the precise terms of an existing tax in order to preserve grandfathered status and amending that tax to comply with a subsequently articulated CMS requirement.

Accordingly, DHR Health urges CMS to clarify that amendments made after July 4, 2025 will not cause an otherwise qualifying tax to be treated as newly enacted or newly imposed, and will not adversely affect the tax's grandfathered indirect hold harmless percentage, where the amendment:

1. is necessary to comply with a CMS or court directive, interpretation, approval condition, or other legal requirement;
2. corrects or modifies the methodology used to calculate, administer, or collect an existing tax without creating a new permissible class of tax or otherwise circumventing the statutory limitation;
3. implements authority or substantive tax provisions that were established under State or local law on or before July 4, 2025; or
4. constitutes a ministerial, technical, administrative, or conforming change that does not represent the establishment of a genuinely new health care-related tax.

CMS should further clarify that such amendments may be made prospectively without reopening the grandfathered status of the underlying tax or permitting CMS to treat the conforming amendment as evidence that the tax was not properly enacted or imposed as of July 4, 2025.

This clarification is particularly important given the significant changes CMS is now proposing to the administration and calculation of the indirect hold harmless threshold. Where States and localities have historically administered health care-related taxes based on reasonable interpretations of existing law and CMS subsequently requires changes to those methodologies, the resulting amendments should facilitate compliance—not become the basis for eliminating the very grandfathering protection Congress provided.

CMS Should Recognize Taxes That Operate Through Periodic Assessments

Many health care-related taxes are administered on a quarterly, annual, or other periodic basis. In those circumstances, the tax may have been legally in effect before July 4, 2025, even though the first assessment, invoice, or payment obligation for a particular period arose later.

CMS should clarify that a tax is not disqualified from grandfathered treatment merely because the applicable assessment period began after July 4, 2025, provided that the tax was enacted and imposed before that date and the later assessment is made pursuant to the preexisting tax structure.

Otherwise, the proposed definitions could produce arbitrary results based solely on the timing of a State's fiscal year, assessment cycle, or billing schedule. Two substantially identical taxes could receive different treatment merely because one State issued its first invoice before July 4 and another issued its invoice shortly afterward.

CMS Should Protect Taxes Subject to Contingent or Conditional Implementation Requirements

Some taxes may have been legally authorized before July 4, 2025, but subject to conditions involving federal approval, waiver approval, budget enactment, appropriations, or other governmental action. CMS should clarify that a tax may still qualify as enacted and imposed where the pre-July 4 law established the substantive tax obligation and the later condition concerned implementation, approval, or administration rather than the creation of a new tax.

At a minimum, CMS should distinguish between:

1. a condition that determines whether the tax may legally exist at all; and
2. a condition that determines when, how, or against whom an already-authorized tax will be administered.

Only the former should potentially affect whether the tax was enacted or imposed as of July 4, 2025.

CMS Should Clarify the Treatment of Amendments That Reduce or Conform an Existing Tax

The proposed rule should expressly recognize that not every post-July 4, 2025 amendment increases the risk addressed by Congress. Amendments that reduce a tax, narrow its applications, correct an administrative defect, or conform the tax to federal requirements should not be treated the same as amendments that create a new tax or materially expand the tax base.

CMS should therefore clarify that a post-July 4 amendment will not cause an existing tax to lose grandfathered status where the amendment:

- reduces the tax rate or amount;
- narrows the class of taxpayers subject to the tax;
- eliminates an impermissible feature;
- corrects a drafting or calculation error;
- conforms the tax to CMS guidance or federal law;
- changes the timing or mechanics of collection; or
- otherwise does not increase the economic burden imposed by the tax beyond the pre-July 4, 2025 structure.

This clarification would prevent States and localities from being discouraged from making corrective changes that benefit taxpayers or improve compliance.

CMS Should Provide a Safe Harbor for Good-Faith Conforming Amendments

To provide certainty, CMS should establish a safe harbor for amendments made in good faith to comply with CMS requirements or to correct the administration of a pre-July 4, 2025 tax. Under the safe harbor, an amendment would not affect grandfathered status if:

- the underlying tax was enacted and imposed before July 4, 2025;

- the amendment is documented as necessary to comply with federal requirements or correct administration;
- the amendment does not create a new tax or materially expand the tax base; and
- the State or locality applies the amendment prospectively.

A safe harbor would reduce unnecessary disputes and allow States and localities to make timely compliance changes without risking the loss of grandfathered treatment.

CMS Should Avoid Retroactive Application of New Interpretations

CMS should clarify that the final definitions will apply prospectively and will not be used to invalidate taxes that States and localities reasonably understood to have been enacted and imposed before July 4, 2025. Where CMS's interpretation changes or becomes more specific after that date, States and localities should have a reasonable period to conform their laws and administrative practices.

CMS should also provide that a State or locality's decision to amend an existing tax in response to a new CMS interpretation will not be treated as an admission that the tax was previously invalid, unenacted, or not imposed.

CMS should also provide clarification that it would not pursue retrospective disallowances, deferrals, penalties, or other enforcement actions based on a historical provider tax structure, which a state updates based on direction by CMS. Provider taxes, administered in good faith, should not be penalized due to new interpretations and the transition to new policies under Public Law 119-21 and related regulations. CMS should recognize prior structures as lawful and treat them as such.

Elimination of the 75/75 test *(§ 433.68(f)(3)(i)(B) & 433.68(f)(3)(ii))*

DHR Health urges CMS not to eliminate the 75/75 test, which has long provided flexibility for states in funding the non-federal share of Medicaid. The 75/75 test historically served as a compliance guardrail that provided additional flexibility for taxes that do not, in practice, hold providers harmless. This flexibility remains crucially important for states. DHR Health is concerned that, contrary to the Office of the Inspector General (OIG) recommendation, CMS's proposed elimination of this test without due consideration of alternatives would unnecessarily and impermissibly curb state flexibility.

DHR Health recommends that CMS not finalize its proposal but instead evaluate alternatives to identify tailored solutions to any identified issues, monitor state use of the 75/75 test going forward, and implement as needed in future rule-making modifications to the second prong of the hold harmless test. Given the sparse use of the test to date, and CMS's own acknowledgement that there is no identified imminent risk, CMS and states would benefit from taking additional time for a transparent review and assessment of the existing test. A thoughtful

analysis is particularly merited given the new context in which such a test would be operating due to the Medicaid financing and payment changes enacted by Public Law 119-21.

Additionally, DHR Health strongly urges CMS not to rely upon silence as Congressional direction to eliminate the 75/75 test. CMS argues that by not addressing the test, Congress intended it to be removed. On the contrary, DHR Health believes that after considering all existing statutory and regulatory requirements, Congress would have specifically acted to remove the prong within the statute in the same manner and in the same provision in which it made changes to other portions of the hold harmless requirements. However, Congress neither removed nor addressed the 75/75 test, which more plainly aligns with a Congressional intent to allow the test and resulting flexibility for states to continue.

Lack of a mechanism to slow implementation in states or geographic areas where healthcare systems are imperiled by these proposals.

DHR Health recommends that CMS adopt additional flexibility to support the transition to new requirements including guardrails to mitigate unintended disruptions to Medicaid beneficiary access and provider participation. States and hospitals have longstanding delivery systems, financing arrangements, contractual relationships, and investments based on existing Medicaid financing and payment realities. The substantial statutory and regulatory changes in Medicaid financing creates significant risk of disruption across the healthcare delivery system before federal and state policymakers fully understand the impact.

DHR Health therefore urges CMS to establish hardship exceptions or formal pathways to slow implementation when states, providers, or Medicaid beneficiary populations demonstrate significant negative impact. Triggers for states to avail themselves of such an option could include material reductions in Medicaid or provider participation, closure or reduction of essential service lines, inability of a state to continue to fund certain services within Medicaid, significant increases in beneficiary access complaints or grievances, or evidence that payment reductions are jeopardizing access in high-Medicaid or medically underserved communities.

These mechanisms should be designed to provide a meaningful pause or slowing of implementation, during which the state would work with CMS, providers, and beneficiary advocates to develop a plan that balances access to care with CMS's goals of fiscal stewardship. This would be a significant step forward in proactively mitigating unintended disruptions to Medicaid beneficiary access and provider participation.

Conclusion

DHR Health looks forward to working with CMS to strengthen the fiscal stewardship and program integrity of Medicaid while preserving access to high-quality care for Medicaid beneficiaries in South Texas and across the country. If you have any questions, please do not hesitate to contact

our Counsel for Government Affairs and Policy, Mr. Roberto Haddad, by phone at (956) 362-7138 or by email at r.haddad@dhrhealth.com.

Sincerely,

Mr. Roberto Haddad, J.D.
Vice President, Counsel for Government Affairs & Policy
DHR Health

Outlook

Repeat-run instability in automated prior authorization decisions

From Rohith Reddy <rohithreddybc@gmail.com>
Date Sun 9/27/2026 1:10 PM
To Public Comments <comments@MACPAC.gov>
Cc rbell084@fiu.edu <rbell084@fiu.edu>

You don't often get email from rohithreddybc@gmail.com. Learn why this is important

To the Commission and staff,

I read MACPAC's April 2026 recommendations on automation in Medicaid prior authorization, including human review of adverse determinations. I would like to offer one technical point that may help as the Commission considers how states and managed care plans oversee these tools.

Systems built on large language models do not always return the same decision for the same case. In our study of a multi-step clinical AI agent, re-running identical cases changed the agent's chosen action in 8.7 percent of 4,320 repeated measurements, and the rate varied about eightfold across types of action. A second model showed a similar pattern.

For oversight, this means a single test run can pass or fail a system by chance. Asking plans and vendors to report how often a decision changes on repeat runs, before deployment and after each model update, is a low-cost check. The paper and its open-source measurement tool, which uses synthetic cases so no patient data is involved, are here: https://www.google.com/url?q=https://doi.org/10.48550/arXiv.2609.03221&source=gmail&ust=1790614166065000&sa=E

I would be glad to send a short written note, or to speak during public comment at the October or December meeting.

Sincerely,
Rohith Reddy Bellibatlu
Visiting Scholar, Florida International University
ORCID 0009-0003-6083-0364

Outlook

MACPAC September 2026 comment - CE requirements

From Mike Berg <mtberg35@gmail.com>
Date Thu 9/24/2026 4:01 PM
To Caroline Broder <caroline.broder@MACPAC.gov>; Public Comments <comments@MACPAC.gov>

You don't often get email from mtberg35@gmail.com. Learn why this is important

Good afternoon,

I am submitting these comments as a private citizen and resident of Wisconsin.

With respect to commissioners' concerns regarding the acceptable threshold for procedural disenrollments from Medicaid because of CE requirements as a result of OBBBA and CMS's subsequent IFC:

It is my opinion that States will decide what is acceptable based on political, social, and economical considerations. Ultimately, this will trickle throughout the system as policy decisions that may not have medical or scientific or legal concerns top-of-mind. My recent experience with our current governmental climate has taught me that first-hand or even academic expertise has been subordinated to less objective-seeking and less universally-applicable priorities.

Because of this, it may be in MACPAC's best interest to take on the work of researching and then suggesting to Congress what an acceptable threshold for meritless procedural disenrollments should be. Perhaps recommending amendments to U.S. Code, and/or new laws or regulations, would be integral to protecting the intent of the Medicaid program, that is serving the people that capitalism has left behind. These legal recommendations, after your analysts' work, could be related to better systems requirements, reducing beneficiary burden, and minimizing bureaucratic obstacles.

Thank you for your work.

All the best,

Mike Berg