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Advancing High Performance Health

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The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
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:

On behalf of AMGA, I appreciate the opportunity to comment on the Medicaid Program; Medicaid Managed Care State Directed Payments (SDPs) and Medicaid Fee-for-Service (FFS) Targeted Medicaid Practitioner Payments proposed rule.

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in high-value care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

AMGA recognizes CMS' responsibility to ensure that Medicaid payments are consistent with statutory requirements and to promote the long-term sustainability of the Medicaid program. We support efforts to ensure that payment policies advance value and accountability. However, we are concerned the proposed rule would impose sweeping changes to Medicaid financing and supplemental payment structures without sufficient consideration of the potential impact on provider participation and beneficiary access to care.

Given the scale of the proposed changes and the projected reductions in Medicaid spending, AMGA believes CMS should proceed cautiously and ensure that any final

policy appropriately balances the statutory goals of efficiency, economy, and quality, with the interrelated beneficiary access to care issues which would likely stem from decreasing provider payment limits. We are particularly concerned the proposal does not sufficiently evaluate potential effects on provider participation, network adequacy, workforce stability, and access to medically necessary services. Without assessing the impact of payment limitations on access to care, CMS runs the very real risk of creating outcomes that are contrary to foundational statutory requirements.

Accordingly, AMGA is pleased to offer the following recommendations:

- **Incorporate Access to Care Analyses:** AMGA urges CMS to more fully evaluate and address the potential impact of these policies on beneficiary access to care, provider participation, and network adequacy before finalizing payment limitations that could significantly alter Medicaid financing and care delivery. A prospective analysis should be completed prior to the finalization of the rules to ensure informed decision making. Additionally, CMS should incorporate ongoing monitoring of the impact of any payment limit rules finalized upon Medicaid beneficiary access.

- **Protect Program Integrity While Enhancing High-Value Care:** AMGA recommends CMS pursue the upfront actuarial certification of value-based payment (VBP) within an SDP alternative discussed in the rule preamble rather than requiring after-the-fact reconciliation against the Medicare-based limit.

- **Elongate Implementation Timeline and Transitions:** AMGA recommends that CMS adopt a substantially longer and more deliberate implementation timeline, including additional transition periods and formal impact assessments, to mitigate unintended disruptions to Medicaid beneficiary access and provider participation.

Our detailed comments follow.

Access to Care Considerations

AMGA is concerned the proposed rule places disproportionate emphasis on the "efficiency" and "economy" components of section 1902(a)(30)(A) of the Social Security Act while providing comparatively little discussion of the statute's equally important requirement that Medicaid payments be sufficient to ensure beneficiary access to care. The statute expressly requires payments be "*consistent with efficiency, economy, and quality of care"* while also being "*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 geographic area."* These requirements must be considered together and balanced against one another.

Medicaid payment policy is not merely a budgetary matter. Payment adequacy directly

affects whether providers can participate in Medicaid, whether managed care plans can maintain adequate networks, and whether beneficiaries can access medically necessary services. In communities with high Medicaid enrollment, reductions in supplemental payment arrangements can affect access to emergency care, obstetrics, behavioral health, primary care, specialty physician services, and other essential services. CMS should therefore evaluate Medicaid payment limitations not only through the lens of federal savings or payment-limit compliance, but also through the statutory requirement that payment rates be sufficient to preserve meaningful access to care.

A recent AMGA member survey underscores these are not hypothetical concerns. Nearly four in ten responding medical groups and health systems (38%) report they have already eliminated patient services because of Medicaid-related funding pressures, and 68% expect to eliminate additional services in the future absent mitigation. The services most frequently cited for elimination or reduction include primary and specialty medical care (67% of affected groups), pediatric services (41%), maternity services (30%), behavioral health/psychiatric services (23%, rising to 41% looking forward), and surgical services (30%). These are precisely the categories of "medically necessary services" section 1902(a)(30)(A) is designed to protect.

Throughout the proposed rule, CMS cites concerns regarding financing arrangements, provider taxes, intergovernmental transfers, and increasing Medicaid expenditures as justification for limiting SDPs and targeted FFS supplemental payments. However, while CMS projects substantial reductions in Medicaid spending, the proposed rule does not include a corresponding analysis of how these payment limitations may affect provider participation, network adequacy, service availability, or beneficiary access to care. Nor does CMS cite evidence demonstrating that these reductions can be implemented without undermining the access requirements of section 1902(a)(30)(A). The rule also does not incorporate a provision for ongoing monitoring and assessment of the impact of these payment limitations on the Medicaid program.

These omissions are particularly concerning because many SDPs were developed specifically to address longstanding inadequacies in Medicaid payment rates and to preserve provider participation in the program. In many states, supplemental payment programs help narrow significant payment disparities between Medicaid and other payers, support access to hospital-based services, sustain physician participation, and maintain critical safety-net infrastructure. Reductions of this magnitude could alter provider participation decisions, particularly in underserved communities, rural areas, and regions facing existing workforce shortages.

This pattern is already visible at the facility level. In the same survey, 21% of responding organizations report they have already closed or restructured facilities due to Medicaid funding pressures, and 57% anticipate further closures or restructuring. Rural hospitals and clinics, specialty clinics, and urgent care centers were among the facility types most commonly identified, and several respondents specifically described closures or service

reductions affecting rural obstetric and maternity units, critical access hospitals, and behavioral health programs. These findings are consistent with AMGA's concern that further payment reductions imposed through the SDP rule would compound an access crisis that is already unfolding in the communities section 1902(a)(30)(A) is meant to protect.

AMGA is also concerned the proposed rule does not appear to include a sufficiently detailed assessment of how payment reductions would affect access in communities with high Medicaid enrollment, high uncompensated care burdens, workforce shortages, and limited access to alternative providers. These communities may experience disproportionate effects from abrupt payment reductions, particularly where Medicaid managed care organizations rely on safety-net hospitals, physician groups, and other providers to meet network adequacy standards.

The real-world stakes of these access concerns are reflected in member feedback AMGA has collected. One rural hospital respondent explained it is "the most rural hospital in [its state]," serving "the sickest, oldest, and most isolated population," with the nearest tertiary hospital two hours away, and warned that further funding reductions "will close our hospital" and that "people in our area will ... suffer." Other respondents described eliminating rural obstetric units, downgrading NICU capacity, and closing maternity service lines entirely due to Medicaid reimbursement pressure. These accounts illustrate why CMS cannot rely solely on aggregate savings projections without assessing the localized, and sometimes irreversible, access consequences of payment reductions.

In 2015, the United States Supreme Court held in *Armstrong et al v. Exceptional Child Center, Inc*.[1] that CMS has sole responsibility for enforcing Section 30(A) as Medicaid statute. Because there is no private right to action under section 30(1), and therefore no alternative enforcement mechanism to ensure that Medicaid payment rates are sufficient to meet the statutory access standard, it is imperative that CMS, in the final rule or any future action, incorporate requirements that monitor and protect beneficiary access to care.

Accordingly, AMGA urges CMS to conduct additional analysis regarding the access implications of the proposed policies before finalizing them. Such analysis should include evaluations of provider participation trends, network adequacy impacts, beneficiary access measures, and potential effects on vulnerable populations, including Medicaid beneficiaries residing in rural and underserved communities. ***CMS should also establish a framework for ongoing monitoring of access indicators before and after implementation to ensure that payment reductions do not inadvertently undermine beneficiary access to medically necessary services.***

Protect Program Integrity While Enhancing High-Value Care

[1] Armstrong v. Exceptional Child Ctr., Inc., No. 14-15, 2015 WL 1419423 (U.S. Mar. 31, 2015).

The current proposal at § 438.6(c)(8)(ii)(B) to require States to provide a detailed validation methodology to ensure that payments from VBP SDPs do not exceed the payment limit on a per service basis would create significant burden and act as a deterrent in Medicaid to pursuit of high-value care.

By expecting states to reconcile prospectively certified population-based payments to actual utilization occurring during the rating period to verify that the payment limit was not exceeded on a per service basis, the rule creates substantial disincentives for states in creating value-based economic and efficient care. The costs of such validation on all VBP SDPs would inevitably exceed any benefit from identifying a small number of VBP SDPs that might inadvertently exceed the payment limit. The operational and logistical complexities of such a validation methodology would significantly hamper high-value care in Medicaid

Value-based payment arrangements 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 prospective actuarial certification approach would better balance program integrity with innovation by giving CMS upfront assurance that the methodology is actuarily sound while avoiding retroactive reconciliation processes that could deter participation.

Actuarial science is well designed to incorporate and adjust for these types of payment mechanisms while alleviating all stakeholders from additional validation. Additionally, CMS actuaries review and approve the state-submitted actuarially certified rates, inclusive of SDP adjustments. ***Given that actuarial science is specifically designed to incorporate VBP and CMS' well-established actuarial oversight role, AMGA strongly urges CMS to adopt the actuarial approach to validating VBP SDPs.***

Elongate Timeline and Transition Periods

AMGA is also concerned that the implementation timelines proposed by CMS do not adequately reflect the magnitude and complexity of these policy changes. States, managed care plans, providers, and healthcare systems have structured delivery systems, financing arrangements, contractual relationships, and long-term investments based on existing Medicaid payment policies. Abrupt implementation of substantial payment limitations could create significant disruption across the healthcare delivery system before policymakers fully understand the consequences for patient access and care delivery.

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 also need time to assess the effects on service lines, workforce planning, capital investments, care delivery strategies, and access initiatives.

These implementation concerns are reinforced by current workforce trends. In AMGA's 2026 member survey, half of responding organizations report they have already had to furlough or layoff staff, renegotiate contracts, or make other administrative changes in response to proposed Medicaid funding reductions, and 62% expect to take such actions in the future. The most common actions include layoffs of administrative and non-clinical staff (72% currently, 75% anticipated), front-office staff (64% currently, 71% anticipated), and clinical support staff such as RNs, LPNs, and medical assistants (56% currently, 61% anticipated). Superimposing the SDP rule's payment limitations on top of these existing workforce disruptions—without a longer transition period—risks compounding harm to an already-strained provider workforce before its effects can be fully understood.

The proposed rule itself acknowledges the unprecedented scale of the anticipated spending reductions. Yet CMS has not sufficiently evaluated how quickly providers and states can adapt to these changes without disrupting Medicaid and the overall healthcare system. In the absence of such evidence, AMGA believes a more gradual implementation approach is warranted.

AMGA therefore recommends that CMS support a streamlined implementation pathway with feasible timelines associated with both the SDP and targeted Medicaid FFS payment limitations. At a minimum, CMS should provide additional transition years beyond those proposed and establish formal evaluation checkpoints before subsequent phases of implementation take effect. This would allow CMS, states, providers, and beneficiaries to better assess real-world impacts, identify unintended consequences, and make necessary adjustments before additional payment reductions are imposed.

Within the final rule, CMS should effectuate a longer and less disruptive transition through a series of interrelated policy decisions, including:

- ***Implementing a longer overall timeline*** for the SDPs and SDP policies not specifically included within Public Law 119-21 such that they ***would not go into effect until the first rating period beginning on or after January 1, 2032***, at the earliest.

- ***Creating a hardship exception for all SDP policies*** so that states have the flexibility to work with CMS to address urgent and emerging issues, such as loss of sufficient participation in Medicaid by hospitals, hospital systems, physician groups, or other practitioners due to lower provider payments.

- ***Implementing a new methodology for the phasing down*** of grandfathered SDPs

to ***reduce the SDP by 10 percentage points of the then-current SDP total dollar amount*** (rather than the original grandfathered total amount) and thereby accurately reflecting the plain meaning of the statutory phrase "the total amount of such payment shall be reduced by 10 percentage points each year" until the applicable payment limit is reached. (438.6(c)(2)(iii)(B)).

- ***Creating offramps to slow or pause implementation when a state or providers encounter significant negative impact from rule policies.*** AMGA encourages CMS to add trigger points at which states or providers could pause implementation upon experiencing significant disruption. Relevant triggers could include material reductions in Medicaid 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. This would allow a cooling period of relief in which the state could work with CMS and its provider community to develop and implement a plan balancing the need for continued access with financial stewardship.

A phased implementation strategy incorporating these policy decisions would better balance CMS' fiscal objectives with the statutory obligation to preserve beneficiary access to care. It would also provide policymakers with the opportunity to evaluate whether projected savings are achieved without compromising provider participation, network adequacy, or access to medically necessary services. Given the substantial uncertainty surrounding the operational and access-related effects of these policies, a slower and more deliberate implementation timeline is both prudent and consistent with CMS' responsibility to ensure that Medicaid beneficiaries maintain meaningful access to care.

Conclusion

AMGA appreciates CMS' efforts to ensure the fiscal integrity and long-term sustainability of the Medicaid program. However, because the proposed rule would significantly alter longstanding Medicaid financing mechanisms and result in substantial reductions in Medicaid payments, we urge CMS to more carefully evaluate the potential consequences for beneficiary access to care before finalizing these policies.

AMGA believes that preserving access to care is not only a policy objective but a statutory obligation that must be weighed alongside considerations of efficiency and economy. Before finalizing these policies, CMS should conduct additional analysis regarding potential impacts on provider participation and beneficiary access and adopt a more gradual implementation approach that allows for meaningful evaluation of real-world effects.

We thank CMS for the opportunity to submit these comments. Should you have questions, please contact Darryl M. Drevna, AMGA's Senior Director of Regulatory Affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

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