Trinity Health

July 17, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Submitted electronically via http://www.regulations.gov

Dear Administrator Oz,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-2449-P. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 133,000 colleagues and 30,000 physicians and clinicians caring for diverse communities across 23 states. Nationally recognized for care excellence and patient experience, the Trinity Health system includes 91 hospitals, 101 continuing care locations, and the second largest PACE program in the country (a total cost of care program). Trinity Health has 15 medical groups with 8,900 medical group physicians and providers. With headquarters based in Livonia, Michigan, its annual operating revenue is $25.4 billion with $2.9 billion returned to its communities in the form of charity care and other community benefit and community impact programs.

Trinity Health has 12 Clinically Integrated Networks (CINs) that are accountable for 1.8 million lives across the country through alternative payment models. Our health care system participates in 10 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 8 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participated in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). In addition, we participated for many years in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts. In addition, Trinity Health owns a non-profit, mission-focused Medicare Advantage plan—MediGold—that plays a vital role in our integrated delivery network and provides care coordination for patients while using fair practices.

We are eager to work with Congress and HHS on alternative payment models that enable providers to move away from fee-for-service and assume responsibility for total cost of care and outcomes for populations served by public programs. Our participation in Medicare demonstration projects, our MediGold MA plans and our PACE programs demonstrate our ability to effectively manage cost and outcomes.

In our detailed comments below, we urge CMS to:

- Evaluate and address the potential impact of the proposed policies on beneficiary access to care, provider participation, and network adequacy before finalizing payment limitations that could significantly alter Medicaid financing and care delivery.
- Extend the implementation timeline such that the proposed SDP policies will not go into effect until the first rating period beginning on or after January 1, 2032.
- Allow states to calculate the Medicare payment limit in the aggregate, as is consistent with how states calculate upper payment limit payments in fee-for-service Medicaid.
- Offer states alternative phase-down approaches for grandfathered SPDs that could provide less disruption in reducing SDP programs to Medicare levels.
- Remove or scale back the following proposed provisions:
    - Extension of the Medicare payment limit to all types of SDP services.
    - Application of the Medicare payment limit to certain targeted practitioner payments under the Medicaid FFS program.
    - Elimination of uniform increase SDPs, a common type of SDP in which a state directs a managed care plan to apply a uniform dollar or percentage increase to a class of providers.
    - New reporting and compliance requirements, which may result in undue administrative burden for states and providers.

<u>Importance of State Directed Payments</u>

Medicaid plays a critical role in our ability to care for the communities we serve with 17% of our patients being covered by the program.

SDPs are used to address chronic underpayments in Medicaid by those states that have Medicaid Managed Care organizations (MCOs) providing benefits to their residents. They also provide predictability, especially in light of ever-changing policies implemented by the MCOs, many of which result in payment delays or denials. SDPs often support access to care, delivery and quality improvements for Medicaid beneficiaries, as well as help to sustain the healthcare workforce.

We are deeply concerned that several provisions in the proposed rule will curtail our ability to care for some of the most vulnerable members of our community by reducing the financial resources needed to maintain essential services. Notably, the proposed rule would dramatically decrease the federal investment in the healthcare system by an estimated $510 billion nationally over 10 years. This is a remarkable escalation from the changes to SDPs Congress authorized in P.L. 119-21, which were estimated to result in approximately $149.4 billion less in federal funding over 10 years. Specifically, CMS is proposing to cut 3.4 times more in federal funding for the healthcare system nationally than Congress intended. Resource reductions of this magnitude could lead to service losses and hospital closures, which would impact everyone in our community, not just those individuals who are served by the Medicaid program.

Prior to finalizing the rule, we urge CMS to evaluate and address the potential impact of the proposed policies on beneficiary access to care, provider participation, and network adequacy before finalizing payment limitations that could significantly alter Medicaid financing and care delivery. Additionally, CMS should incorporate ongoing monitoring of the impact of any payment limit rules finalized upon Medicaid beneficiary access.

CMS can mitigate some of the worst consequences of these policy changes, and we urge the agency to rescind or reconsider proposals that extend beyond the statutory framework established by Congress as outlined below.

Implementation Timeline

Though CMS acknowledges the unprecedented scale of the anticipated spending reductions, the proposed implementation timelines do not reflect the magnitude and complexity of the proposed 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.

Trinity Health urges CMS to extend the implementation timeline such that the proposed SDP policies will not go into effect until the first rating period beginning on or after January 1, 2032. This longer transition 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.

Calculation of the Medicare Payment Limit

CMS proposes to apply the Medicare payment limit at the individual service or discharge level rather than in the aggregate. This represents a significant departure from longstanding Medicaid financing approaches. Applying the limit at the service level introduces substantial operational challenges, as Medicaid claims do not align directly with Medicare payment methodologies. Repricing claims would require complex system changes and impose a significant administrative burden on states and providers. This approach also reduces state flexibility to target payments to critical service areas and risks underpayment for services provided to Medicaid populations.

CMS' proposed approach would apply the Medicare payment limit at the service or discharge level to freestanding children's hospitals, certain cancer hospitals and critical access hospitals, which are reimbursed by Medicare on a cost basis with payment reconciled retrospectively and in the aggregate using Medicare cost report data. Requiring these hospitals to derive a per-service or per-discharge limit from the most recent complete cost report is particularly burdensome for these hospitals and would risk codifying a limit below Medicare rates for such hospital services. CMS itself noted that states would need extensive guidance to attempt to accomplish what is proposed under this rule.

In addition, the proposed rule would require States to provide a detailed validation methodology to ensure that payments from value based payment (VBP) SDPs do not exceed the payment limit on a per service basis would stifle state innovation and efforts to implement VBP approaches. By tying payment limits to individual Medicare service rates, the proposed rule would undermine state and health system efforts to move toward VBP models, which are the kinds of innovations that have shown the most promise in improving outcomes and reducing costs for Medicaid's most complex populations.

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.

VBP 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.

We urge CMS to instead allow states to calculate the Medicare payment limit in the aggregate, as is consistent with how states calculate upper payment limit payments in fee-for-service Medicaid.

Phase-down of Grandfathered SDPs

Through P.L. 119-21, Congress limited the value of SDPs to the Medicare payment rate and required all grandfathered SDPs to be reduced by 10 percentage points annually until the specified Medicare payment rate is achieved (or 100% of Medicare for expansion states and 110% of Medicare for non-expansion states). Through this regulation, CMS interprets this as applying an annual 10% reduction to the original grandfathered total dollar amount approved by CMS, using that amount as a fixed reduction, until payments reach the statutory Medicare-based limits. This approach results in more rapid and severe reductions than Congress intended. Specifically, by linking the reduction to the original dollar value rather than the gap between current payments and the target limit, the proposal could accelerate payment cuts for certain providers and markets. Hospitals that rely on these payments to support care for Medicaid beneficiaries would face abrupt funding reductions, with limited time to adjust operations.

We urge CMS to offer states alternative phase-down approaches that could provide less disruption in reducing SDP programs to Medicare levels. Specifically, CMS could allow states to choose among the following approaches: 1) applying the 10-percentage point reduction to the current SDP rate as compared to Medicare (e.g., from 200% of Medicare to 190%, 180%, etc.); 2) applying the 10% reduction to the dollar value of the SDP in the prior year (e.g., $1,000,000 to $900,000 to $810,000, etc.); or 3) applying the 10% reduction to the dollar value of the SDP in the base year of the phase down to each subsequent year, as has been proposed by the agency (e.g., $1,000,000 to $900,000 to $800,000, etc.).

CMS Is Applying Broader Cuts Than Congress Directed

As previously noted, we are deeply concerned that the proposed rule applies payment limitations and policy changes more broadly than contemplated by Congress. CMS proposes to apply Medicare-based payment limits beyond the specific categories identified in statute and to a wider range of payment arrangements. These expansions result in deeper and more widespread reductions in provider payments than intended. We encourage CMS to realign the proposed policies with the statutory framework and limit their application to areas explicitly identified by Congress. **Specifically, we urge the agency to remove or scale back the following provisions:**

- **Extension of the Medicare payment limit to all types of SDP services and to SDPs in U.S. territories.**
- **Application of the Medicare payment limit to certain targeted practitioner payments under the Medicaid FFS program.**

- **Elimination of uniform increase SDPs, a common type of SDP in which a state directs a managed care plan to apply a uniform dollar or percentage increase to a class of providers.**
- **New reporting and compliance requirements, which may result in undue administrative burden for states and providers.**

Conclusion

The changes outlined above would help lessen the detrimental impact on Trinity Health's ability to continue providing essential services to all members of our community. We appreciate your consideration of these comments and look forward to continued engagement with CMS on these important issues. If you have any questions on our comments, please feel free to contact me at jennifer.nading@trinity-health.org.

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health