EMORY UNIVERSITY

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Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

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Re: CMS Proposed Rule (CMS-2449-P): Medicaid Managed Care State Directed Payments (SDP) and Medicaid Fee-For-Service (FFS) Targeted Medicaid Practitioner Payments

Emory Healthcare, part of Emory University, is an integrated academic health care system committed to providing the best care for our patients; educating health professionals and leaders for the future; pursuing discovery in all of its forms, including basic, clinical and population-based research; and serving our community. As the clinical enterprise of the Robert W. Woodruff Health Sciences Center of Emory University, Emory Healthcare remains the most comprehensive health care system in Georgia, providing extensive inpatient and outpatient services to a diverse patient population.

On behalf of Emory Healthcare, we appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services' proposed rule.

While H.R. 1 was designed to address concerns in states that more aggressively expanded or structured their Medicaid programs, Georgia is now being unintentionally included in these more restrictive efforts despite having taken a more disciplined approach.

Supplemental Medicaid payments are essential to hospitals and health systems that serve large numbers of Medicaid beneficiaries and support access to complex, specialized, and safety-net services. These payments help sustain provider participation, support critical infrastructure, and ensure that vulnerable patients can obtain timely care. For academic health systems like Emory Healthcare, supplemental payment programs are especially important because they help support high-acuity and highly specialized care, maternal and neonatal services, specialty access, medical education, clinical training, and other services that are vital to Georgia communities.

Overall Position

Emory Healthcare supports CMS's goal of promoting program integrity, transparency, and appropriate fiscal oversight in Medicaid. We also champion efforts to eliminate fraud, waste, and abuse. However, we have significant concerns that certain provisions of the proposed rule, as drafted, would exceed the statutory framework established by H.R. 1, impose substantial operational burden, and destabilize supplemental payment arrangements that support access to care for Georgia Medicaid beneficiaries.

Accordingly, we support CMS's proposal to delay the prohibition on separate payment terms for grandfathered directed payment programs until the applicable Medicare-based payment limit is reached. At the same time, we urge CMS to reconsider the proposed changes related to payment limits for targeted fee-for-service payments and the proposed Medicare-equivalent rate methodology.

Comments on Specific Provisions

- **Separate Payment Terms**

    - Emory Healthcare strongly supports CMS's proposal to delay the prohibition of separate payment terms for grandfathered directed payment programs (DPPs) until the Medicare-based payment limit is reached. This delay will support operational stability and allow hospitals time to adjust budgets, contracts, and payment operations without disrupting existing supplemental funding programs. A delayed transition will also help avoid sudden reductions in resources that hospitals rely on to support Medicaid access, workforce capacity, and high-acuity services.
    - **Recommendation:** We encourage CMS to preserve this flexibility in the final rule and to provide clear implementation guidance so that states and providers can plan responsibly.

We urge CMS to reconsider the proposed changes to the Payment Limit of Select Fee-for-Service (FFS) Payments and Medicare Equivalent provisions, as detailed below.

- **Payment Limits on Targeted Fee-for-Service Payments**
    - H.R. 1 did not impose caps on FFS payments, as it was focused exclusively on Medicaid managed care. The proposed rule departs from this framework by introducing targeted limits on FFS payments, including an abrupt "payment cliff" without a phased transition to Medicare-equivalent rates, unlike the approach afforded to grandfathered SDPs.
    - Moreover, targeting Medicaid FFS payments have a greater impact on high-risk FFS populations compared to those in managed care. This extends beyond the intent of H.R. 1.
    - This lack of a step-down mechanism would create significant disruption for providers and healthcare delivery systems that depend on predictable FFS funding streams, potentially undermining access to care.
    - **Recommendation**: We respectively urge the agency to exclude targeted FFS payment limits from the final rule. Doing so would better align the regulation with statutory intent and avoid unnecessary destabilization of the healthcare delivery system.
- **The Medicare Equivalent Rate on a Per-Service Per-Provider Basis**
    - Emory Healthcare supports CMS's efforts to eliminate fraud, waste, and abuse; however, we are concerned that the proposed Medicare-equivalent rate methodology on a per-service, per-provider basis would impose substantial administrative burden and go beyond the limits established by H.R. 1. Moreover, the per service per provider limit is more restrictive than the current Medicare FFS methodology which applies the UPL at an aggregate level.
    - By tying supplemental payments to the service level, this undermines CMS's goal of moving to a value-based system that is focused on quality and outcomes rather than volume driven reimbursement.

- From an operational perspective, this approach would introduce substantial administrative burden for both states and providers, requiring the application of potentially hundreds of thousands of individual payment benchmarks and caps. There is no clear precedent for payment benchmark policy that is both broadly applied and structured at this level of specificity and rigidity.
- Medicare is often not an appropriate benchmark for ensuring access for certain Medicaid services, Additionally, Medicaid payment systems often use APR-DRGs, while Medicare uses MS-DRGs, requiring complex crosswalks that may not accurately reflect Medicaid utilization, acuity, or program goals.
- **Recommendation**: CMS should define Medicare equivalency on an aggregate, statewide basis rather than service-by-service and provider-by-provider. This approach would advance fiscal discipline and program integrity while reducing unnecessary administrative burden, preserving state accountability, and allowing states to direct limited Medicaid resources to safety-net providers that serve the highest-need patients.

The Proposed Rule Exceeds the Cuts Established in H.R. 1

The proposed rule represents a significant reduction in Medicaid supplemental payment support beyond the cuts established in H.R. 1. By extending limits to targeted FFS payments and by applying a highly specific Medicare-equivalent rate methodology, the proposal would compound financial pressure on hospitals and health systems that serve Medicaid beneficiaries.

Medicaid supplemental payment programs support the financial stability of rural hospitals, helping ensure access to care in local communities and preserving capacity across the broader delivery system. It is critical that these programs continue to strengthen rural hospitals, so patients can remain close to home whenever appropriate—allowing our specialized beds and resources to be reserved for high-acuity cases. This is of particular importance to Georgia Medicaid, as Emory provides one of the highest levels of NICU care in the state. The funding afforded by supplemental payment programs ensure mothers and babies are able to access NICU services they would otherwise not be able to access in their local communities.

For Emory Healthcare, the combined impact of H.R. 1 and CMS-2449-P could result in substantial funding reduction. Such a reduction would have a significant impact on Emory Healthcare's ability to maintain access to care for Georgia Medicaid beneficiaries, including patients who rely on Emory for specialized, high-acuity, maternal, neonatal, and safety-net services.

Conclusion

Thank you for considering our comments. Emory Healthcare appreciates CMS's commitment to program integrity and the opportunity to contribute to this rulemaking process. We respectfully urge CMS to finalize the proposed delay related to separate payment terms for grandfathered directed payment programs, exclude targeted FFS payment limits from the final rule, and adopt an aggregate statewide approach to Medicare equivalency.

We welcome the opportunity to discuss these comments further and to provide additional information regarding the potential impact of the proposed rule on Emory Healthcare and the Georgia Medicaid beneficiaries we serve. If you have any questions regarding our comments, please feel free to contact our Assistant Vice President for Federal Affairs, Jessica Davis, at jessica.ann.davis@emory.edu.

Respectfully submitted,

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