July 14, 2026

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

Submitted electronically to www.regulations.gov

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

Dear Administrator Oz,

The American Nurses Association (ANA) appreciates the opportunity to provide comment to the Centers for Medicare and Medicaid Services (CMS) on the proposed changes to Medicaid State Directed Payments (SDPs) and other provider payments. ANA is concerned that the proposed changes in the rule will further limit states' ability to ensure patients' access to trusted practitioners who provide needed care. While we understand the Administration's broader concerns about waste, fraud, and abuse in the Medicaid program, severely restricting state flexibility in determining payment arrangements only serves to hinder states' ability to target and address public health and other health access challenges in their communities. Moreover, ANA is concerned that the proposed rule would codify Medicare payment differentials to non-physician providers, a policy ANA has long advocated against. These payment differentials reinforce an outdated provider hierarchy that does not reflect the way care is delivered today. While we appreciate CMS' thoughtful proposals, ANA urges the agency to consider our comments and retain state flexibility to determine provider payments as it finalizes its rulemaking.

ANA represents the interests of the nation's over 5 million registered nurses (RNs) through its constituent and state member associations, organizational affiliates, and individual members. ANA advances the nursing profession by championing nurses, fostering rigorous standards of nursing practice, promoting safe and ethical work environments, bolstering nurses' health and wellness, and advocating on the healthcare issues that impact both nurses and their patients. ANA seeks to ensure that nurses' voices, interests, and perspectives are represented and heard in policymaking discussions. ANA's membership consists of both RNs and Advanced Practice Registered Nurses (APRNs)—nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs).

Nursing is a profession grounded in critical thinking, scientific rigor, and evidence-based practice. Nurses form the backbone of the American healthcare system and serve across the full spectrum

of healthcare settings in multiple direct care, care coordination, research, and administrative leadership roles. Nurses provide and coordinate patient care, educate patients and the public about self-care and various health conditions, and they offer counsel and emotional support to patients and their family members. As the most trusted profession, nurses play a critical role in treating patients and influencing health behaviors.[1]

1. **CMS must not extend Medicare-based payment limits further than what was laid out in statute.**

Under the One Big Beautiful Bill Act (or H.R. 1), Congress set limitations on SDP arrangements in an effort to reduce federal Medicaid spending and to create more uniformity across states. The limitations included in H.R. 1 target inpatient and outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers.[2] However, in the above-captioned rule, CMS proposes to extend Medicare-based payment limits beyond what Congress enacted and previous managed care rulemaking. Of particular concern, CMS proposes to apply similar restrictions to targeted fee-for-service (FFS) practitioner payment arrangements. ANA is concerned that this proposal extends Medicare-based payment limitations beyond the scope of the statutory changes enacted by Congress.

Section 71116 of H.R. 1 specifically amended the statutory framework governing Medicaid managed care SDPs. Congress carefully delineated the payment limitations that would apply to SDPs, including the applicable Medicare payment percentage, transition provisions, and grandfathering of existing arrangements. Notably, Congress did not impose comparable Medicare-based payment limits on Medicaid fee-for-service targeted practitioner payments. The proposed rule would effectively create new payment restrictions for FFS arrangements that Congress did not intend. While CMS states that these provisions are intended to prevent states from restructuring payments to avoid the statutory caps, preventing potential future circumvention does not warrant the agency to expand restrictions to payment arrangements that Congress did not include within the scope of the statute. **If Congress had intended to apply Medicare-based payment limits broadly across Medicaid payment systems, it would have done so explicitly.**

CMS also notes that provisions in the proposed rule seek to implement the directive from President Trump's Memorandum that directs the agency to align Medicaid payments with how Medicare reimburses for healthcare services to further eliminate waste, fraud, and abuse from the Medicaid program and to address imbalances between the Medicare and Medicaid programs, as allowed by applicable law.[3] While ANA understands the Administration's broader policy objectives and its

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[1] Brenan, M. (2026, January 12). Nurses continue to lead in honesty and ethics ratings. Gallup. https://news.gallup.com/poll/700736/nurses-continue-lead-honesty-ethics-ratings.aspx

[2] One Big Beautiful Bill Act, Pub. L. No. 119-21 (2025). https://www.congress.gov/bill/119th-congress/house-bill/1

[3] The White House. (2025, June 6). *Eliminating waste, fraud, and abuse in Medicaid*. https://www.whitehouse.gov/presidential-actions/2025/06/eliminating-waste-fraud-and-abuse-in-medicaid/

interest in preserving the fiscal integrity of the Medicaid program, further limiting states' ability to determine provider payment methodologies may introduce fiscal instability to state Medicaid programs. Congress amended the SDP authorities governing managed care arrangements but did not amend the underlying statutory authorities governing Medicaid FFS payments. CMS should not infer authority to impose Medicare-based payment limits on FFS arrangements where Congress chose not to do so.

States utilize the flexibility afforded to them through the use of Medicaid supplemental and targeted payments to support safety-net, rural, and other providers serving large numbers of Medicaid beneficiaries. These critical payments support quality improvement initiatives, graduate medical education, and provider capacity, helping offset chronically low Medicaid reimbursement rates.[4] Consequently, limiting states' flexibility to structure targeted fee-for-service supplemental payments may reduce resources available for workforce development and other investments intended to maintain access to care for Medicaid beneficiaries, especially in rural and underserved communities.

Medicare payment rates were not designed to serve as a universal benchmark for the Medicaid program. The Medicare and Medicaid programs serve different populations, operate under different statutory authorities, and pursue different policy objectives. States have historically relied on targeted Medicaid payments to address unique access challenges that disproportionately affect Medicaid beneficiaries. In fact, underlying Medicaid statute directs state payment methods to be determined in a way that assures that payments are consistent with economy, efficiency, quality of care, and are sufficient to enlist enough providers.[5] Applying Medicare-based ceilings to payment arrangements outside the scope of Section 71116 risks constraining states' ability to respond to local public health and beneficiary access needs.

Moreover, extending the statutory payment caps beyond managed care SDPs may discourage innovative payment models that support interdisciplinary care teams, nursing workforce development, care coordination, and quality improvement initiatives. Additional payment limitations constrain already limited resources for Medicaid providers. These are precisely the types of investments needed to improve health outcomes for Medicaid beneficiaries.

ANA is concerned that, as proposed, CMS is effectively removing states' ability to make and direct Medicaid payments to achieve policy goals related to their Medicaid beneficiary patient populations. CMS must limit the scope of this rulemaking to codify the provisions of H.R. 1 and allow states to adjust accordingly to the new limitations in such a way that preserves flexibility and stability in their respective Medicaid programs. **As such, CMS must not extend Medicare**

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[4] Medicaid and CHIP Payment and Access Commission (MACPAC). *Report to Congress on Medicaid and CHIP*. June 2024. https://www.macpac.gov/publication/june-2024-report-to-congress-on-medicaid-and-chip/.

[5] Social Security Act § 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A).

benchmark restrictions to Medicaid payments outside of the scope of the services included in section 71116 of H.R. 1.

2. **CMS must allow states the ability to retain targeted provider payment arrangements needed to ensure patient access to vital primary and specialty healthcare services.**

CMS's proposal to base Medicaid payment limits on Medicare rates would effectively incorporate Medicare's provider-type differentials, which includes the 85 percent payment rate applicable to nurse practitioners and other statutory percentages of the physician fee schedule for many services provided by APRNs.[6] These payment differentials reflect specific Medicare statutory provisions and policies that are unique to the Medicare program. **ANA has long held that these differentials are outdated and unnecessarily limit beneficiary access to trusted APRN providers.**

Medicaid historically affords significant flexibility to states in establishing payment methodologies that reflect local workforce needs, provider shortages, and beneficiary access concerns. Many states have used this flexibility to support access to primary care, behavioral health, maternal health, and anesthesia services delivered by APRNs, particularly in rural and underserved communities. Requiring states to adopt Medicare's nonphysician payment differentials could reduce reimbursement for APRN services in states that currently recognize APRNs as independent Medicaid providers or reimburse them at rates that are structured specifically to address provider shortages, expanded access to care, and other important state-level policy challenges as states manage their respective Medicaid beneficiary populations.

Furthermore, lower reimbursement for APRN services may discourage participation in Medicaid, reduce provider capacity, and impede investments in team-based care models, care coordination, and workforce development initiatives.[7] APRNs being reimbursed at 85 percent of payment rates will force them to reconsider accepting Medicaid payments as the lower rates will make it impossible for these practitioners to cover the cost of the care they provide to Medicaid patients. These outcomes would be inconsistent with Medicaid's statutory objective of ensuring adequate access to covered services, as noted above.

Payment differentials for nonphysician providers in Medicaid payment rates runs counter to the Administration's long-standing recognition of the role APRNs play in the nation's healthcare delivery system and consequently beneficiary access. Most recently, through implementation of the Rural Health Transformation Program, CMS recognized the vital role of

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[6] 42 U.S.C. § 1395l(a)(1)(O)

[7] Medicaid and CHIP Payment and Access Commission. (2023, June). *June 2023 report to Congress on Medicaid and CHIP*. https://www.macpac.gov/publication/june-2023-report-to-congress-on-medicaid-and-chip/.

APRNs to address chronic challenges with delivering care to rural communities across the country.[8] If the proposed provisions are finalized, CMS is effectively limiting the reimbursements to APRNs at the same time they are encouraging state reliance on these practitioners to deliver care—undermining both federal and state workforce and access goals.

Accordingly, CMS should clarify that Medicare payment benchmarks applicable under Section 71116 establish aggregate payment limits only and do not require states to adopt Medicare's statutory practitioner payment differentials. **CMS must ensure that states retain the flexibility to establish reimbursement methodologies for APRNs that support beneficiary access and address local workforce needs.**

ANA appreciates the opportunity to have this discussion and looks forward to continued engagement with CMS on shared priorities. Please contact Tim Nanof, ANA's Executive Vice President, Policy & Government Affairs at (301) 628-5166 or tim.nanof@ana.org with any questions.

Sincerely,

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Chief Nursing Officer

cc: Jennifer Mensik Kennedy, PhD, RN, NEA-BC, FAAN, ANA President
Angela Beddoe, ANA Chief Executive Officer

[8] Centers for Medicare & Medicaid Services. (2025, December 29). Rural Health Transformation (RHT) Program: Overview. U.S. Department of Health & Human Services. https://www.cms.gov/initiatives/rural-health-transformation-rht-program/overview