CHILDREN'S HOSPITAL ASSOCIATION

November 18, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Oz,

As the nation's leading advocate for children's health, the Children's Hospital Association (CHA) provides these comments regarding the Centers for Medicare & Medicaid Services (CMS) implementation of H.R. 1 to mitigate the impact on children. The 200+ children's hospital members of the CHA play a unique role as centers for pediatric care for nearly half of all children admitted to hospitals nationwide and most children with chronic conditions, serious illnesses, complex conditions, or those who need major surgical services. Specifically, we are concerned with imposing Medicare limits on state directed payments (SDPs), because Medicare payment frameworks do not adequately account for pediatric care. We know your goal is to protect children enrolled in the Medicaid program, so we ask you to allow state flexibility to mitigate unintended consequences of these changes on all children's access to care.

As major Medicaid providers, children's hospitals rely on SDPs to ensure access to care for children. Children's hospitals represent less than 5% of the nation's hospitals and account for nearly half of states' hospital days for Medicaid-enrolled children[1], while base payments cover less than 70% of children's hospitals' costs of providing care on average.[2] Since their inception in 2016, SDPs have represented an increasing and now predominant share of Medicaid supplemental payments to providers nationwide and are an essential lifeline for children's hospitals in particular. These payments play a significant role in giving children's hospitals the ability to provide access to critical and timely pediatric services, keeping all our nation's children healthy.

Impact of H.R. 1's New SDP Limits on Children's Access to Care

Effective July 4, 2025, H.R. 1 limits the scope of any new SDPs to 100% of Medicare rates for expansion states and 110% of Medicare rates for non-expansion states. A survey modeling the impact of these changes on 64 children's hospitals across 27 states showed that SDPs make up 38% of total Medicaid funding and 13% of all overall operating resources.[3] Children's hospitals in states pursuing a new SDP arrangement after enactment of the legislation would receive SDPs that are 57% below total Medicaid reimbursement (base payments and SDP) levels in place today. This analysis demonstrates the major impact these new SDP limits will have on children's hospitals and their ability to provide care for all of our nation's children, especially if any potential harm is not mitigated prior to implementation. We understand that Congress and CMS want to ensure the changes in HR 1 do not negatively impact the pediatric population. Therefore, we urge CMS to consider our recommendations to safeguard access to care for millions of Medicaid-covered children and avoid unintended harm. If hospitals have to reduce services due to these funding decreases, those reductions will impact all children who need these services.

[1] Children's Hospital Association's Analysis of Kids' Inpatient Database (KID), Healthcare Cost and Utilization (HCUP), Agency for Healthcare Research and Quality, 2019.
[2] Annual Benchmark Report Fiscal Year 2023, Freestanding and Children's Hospital in Hospital Cohort, Children's Hospital Association. 2025
[3] Children's Hospital Association. Implications of Budget Reconciliation Legislation on Children's Hospitals. August 2025.

CHILDREN'S HOSPITAL ASSOCIATION

Medicare is Not an Appropriate Payment Benchmark for Pediatric Care

Medicare is not an appropriate benchmark for pediatric care because it does not adequately account for the unique resource intensity, complexity, and family-centered nature of children's health care. As you know, Medicare only covers a very small number of children and does not include pediatric services for the most part.

Generally, Medicare payment rates are based on standardized methodologies that utilize Medicare Severity Diagnosis-Related Groups (MS-DRGs) for inpatient hospital services and a Resource-Based Relative Value Scale (RBRVS) for physician and outpatient services. However, given these methodologies are designed for individuals age 65 and older and individuals with disabilities, they do not reflect the services—and resource intensity—provided to children. Pediatric services and procedures require more face-to-face time with patients and families, more patient and family education and counseling, and more emotional support and communication, which can all increase the amount of time a physician and other clinical staff spend with each pediatric patient. The cost of pediatric services can be higher than for adult care due to the need for more direct hands-on time by clinical staff, more case management, higher telephone call volume, and other factors (e.g., cost of supplies in multiple sizes for inpatient pediatric units).[4]

Current Medicaid base rates do not cover the cost of pediatric care and supplemental payments such as SDPs are necessary to ensure that access to care for children is maintained. Therefore, it is imperative that these differences are taken into consideration during the implementation of the new SDP limits, which are likely to lead to pediatric care not being reimbursed adequately. This funding discrepancy will lead to diminished access to care for all children if not mitigated ahead of implementation.

We would like to work with you to develop a more appropriate pediatric payment benchmark that accounts for these differences and best supports children's access to care. Specifically, we ask that you allow states to use the Medicare Upper Payment Limit (UPL) methodology, allowing them the flexibility to calculate the Medicare cap on SDPs to better account for pediatric services and maintain access to care for all children.

Recommendations Regarding H.R. 1 SDP Policy Implementation

Link SDP Limit to Medicare Upper Payment Limit, Rather than the Medicare Fee Schedule

We urge CMS to align the regulatory definition of the total published Medicare rate stated in H.R. 1 with the Medicaid fee-for-service (FFS) policies that govern UPL supplemental payments. Medicaid currently requires that states cap their FFS payments at what would be paid using Medicare payment principles, referred to as the Medicare UPL. The Medicare UPL methodology requires that states pay no more than Medicare but affords states flexibility in how they calculate what Medicare would have paid. That flexibility enables them to tailor the calculations to account for the unique mix of services and populations covered by their Medicaid programs. Given that the Medicare fee schedule is not an appropriate benchmark for pediatric services, this methodology would allow states to establish the difference between a Medicaid and Medicare-equivalent payment for pediatric services. This flexibility can help account for the service delivery, resource intensity, and additional cost required to provide pediatric care. Allowing states to use this methodology can mitigate significant financial shortfalls for children's hospitals who rely on Medicaid SDPs to provide access to care for millions of children across the country.

[4] National Academies of Sciences, Engineering, and Medicine. The Future Pediatric Subspecialty Physician Workforce: Meeting the Needs of Infants, Children, and Adolescents. September 2023.

CHILDREN'S HOSPITAL ASSOCIATION

Adopting a Net-of-Tax Methodology for SDP Limits

In addition to supplemental payments such as SDPs, provider taxes also play a significant role in financing the Medicaid program. This mechanism is widely used by states to finance the non-federal share of Medicaid, with every state except Alaska having at least one provider tax in place.[5]

Provider taxes are often used to fund the supplemental payments that support Medicaid providers, including children's hospitals. Providers pay into these tax arrangements, making them a cost to providers that reduce gross Medicaid payments. According to the Medicaid and CHIP Payment and Access Commission, provider taxes reduce the net Medicaid payments that are intended for providers to cover the cost of care provided to Medicaid patients.[6] Although gross Medicaid payments to providers may seem to meet statutory limits, the actual Medicaid funding that hospitals receive after deducting their contributions to these provider taxes is much lower.

H.R.1 established maximum SDP payment limits based on Medicare rates, which is funded only by the federal government and not by states. On the other hand, Medicaid is funded partially by states and in most, relies on contributions from providers through these provider taxes. Without taking these key differences into account, implementation of these new SDP Medicare payment limits is likely to lead to faster and more significant cuts to Medicaid provider payments, especially those who serve a higher volume of Medicaid patients such as children's hospitals. This issue will be particularly impactful during the 10% annual phase-down for SDPs that will be temporarily grandfathered at higher rates, further augmenting funding reductions beyond what is intended by the statute. These exacerbated funding cuts will negatively impact access to care for children, many of whom rely on children's hospitals.

We recommend that CMS adopt a net-of-tax methodology when implementing the SDP caps at Medicare rates, to prevent an unintended significant reduction in SDP funding beyond the statutory requirements. Implementing the new SDP caps using gross payment amounts will lead to excessive reductions in SDP funding and will cause devastating financial harm to children's hospitals. Any reductions in SDP funding that go beyond what has been outlined in the statute will ultimately lead to significant reductions in children's access to care.

We appreciate the opportunity to provide initial input as you consider implementation of the SDP policies within H.R. 1. and can provide more detailed information in response to future proposed policies. We are reviewing your recent guidance on provider taxes and will follow up with any feedback. We look forward to working with you on these issues to ensure that children's access to care is not compromised amidst these changes to the Medicaid program. If you have any questions or need additional information, please contact Aimee Ossman at aimee.ossman@childrenshospitals.org or (202) 753-5333.

Sincerely,

Matthew Cook
CEO
Children's Hospital Association

[5] Medicaid Provider Taxes," Congressional Research Service. December 2024.
[6] "Improving the Transparency of Medicaid and CHIP Financing," Medicaid and CHIP Payment and Access Commission. June 2024.