Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

VIA ELECTRONIC SUBMISSION

July 21, 2026

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2449-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments to CMS-2449-P
Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

The Center for Children and Families (CCF), part of the McCourt School of Public Policy at Georgetown University, is an independent, nonpartisan policy and research center that conducts research, develops strategies, and offers policy solutions to support access to high-quality, comprehensive, and affordable health coverage for the nation's children and families, particularly those with low- and moderate-incomes. Thank you for the opportunity to make the following comments to this Centers for Medicare & Medicaid Services (CMS) proposed rule, which are based on our deep expertise in health policy and in the Medicaid program.

In H.R. 1 (Public Law 119–21), under section 71116, Congress set new limits on the use of State Directed Payments (SDPs) in Medicaid. SDPs are a legal authority that states can use to improve provider payment rates in Medicaid managed care and have been critical to improving access for Medicaid-enrolled individuals by ensuring they can access the providers they need.[1] The limitations set out in H.R. 1 will lead to harmful funding losses for states — an estimated $149 billion over ten years in reduced federal spending according to the Congressional Budget Office (CBO).[2] On May 22, 2026, the Center for Medicare & Medicaid Services (CMS) published a Notice of Proposed Rulemaking on Medicaid Managed

[1] Anne Karl et al., "How Medicaid State-Directed Payments Support Critical Health Care Providers," Commonwealth Fund (July 3, 2025), available at https://www.commonwealthfund.org/blog/2025/how-medicaid-state-directed-payments-support-critical-health-care-providers

[2] Congressional Budget Office, "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline," (July 21, 2025) available at https://www.cbo.gov/publication/61570

Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments ("SDP NPRM").

The SDP NPRM goes far beyond the limitations established by H.R. 1 with no adequate legal justification, and will lead to far greater funding losses which will harm access to care for low-income individuals enrolled in Medicaid. CMS has estimated that this proposed rule will reduce federal funding for states by $515 billion over ten years — well over three times the CBO estimate based on the actual letter of the law.[3] **We recommend that CMS not finalize numerous provisions of the SDP NPRM that have no basis in law and will harm individuals with Medicaid, as described further below**.[4] Instead, CMS should finalize only the provisions of the rule that are actually required by H.R. 1, consistent with the statute and in consideration of access to care for all Medicaid-enrolled individuals.

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Applicability of SDP Payment Limits (§438.6(c)(8)(iii), §438.6(c)(1)(iii)(B))

H.R. 1 sets new limits on SDP payments, but those limits are precise and bounded. The SDP NPRM ignores the targeted limits set out by Congress, and includes numerous, additional constraints on SDP payments that go far beyond the standards in H.R. 1. We recommend that CMS not finalize any of these provisions, described below, as they are inconsistent with the law and harmful for individuals enrolled in Medicaid.

Services, Types of SDPs, and States Subject to SDP Payment Limits – §438.6(c)(8)(iii)

The new limits set on SDP payments under H.R. 1 (at section 71116(a)) apply only to payments for four types of services described in *current* regulations at § 438.6(c)(2)(iii): inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center. However, § 438.6(c)(8)(iii) of the SDP NPRM would apply the new SDP payment limits to *all* services beginning the first rating period beginning on or after January 1, 2029.

For example, payments to many or most mental health providers should not be subject to the SDP payment limits under H.R. 1, but could be impacted by the policy implemented in the SDP NPRM. A wide range of providers could be impacted by this overbroad policy. The Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that 19% of SDPs enhance payments for Mental Health/Substance Use Disorder providers, 10% for Home and Community Based Services (HCBS) providers, 11% for physicians, and 3% for

[3] This figure of $515 billion over 10 years includes $510.1 billion from the major SDP rule elements plus $5.05 billion of impacts on "other policy," including the extension of SDP limits to additional services and limits on supplemental fee-for-service payments proposed in the rule.

[4] Center for Medicare & Medicaid Services, "Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments," (May 22, 2026), available at https://www.federalregister.gov/documents/2026/05/22/2026-10292/medicaid-program-medicaid-managed-care-state-directed-payments-and-medicaid-fee-for-service-targeted.

dental providers.[5] Many of these types of providers that Congress intended to exclude from the H.R. 1 SDP limits would be harmed by the SDP NPRM — along with their patients. **CMS should finalize the SDP NPRM to only apply to the four types of services specified in H.R. 1.**

Furthermore, the payment limits in H.R. 1 only apply to a subset of the SDPs (for the four services) for which states are required to get written prior approval (again, because that is what is described in *current* regulations at § 438.(c)(2)(iii)). SDPs that do not require written prior approval, such as SDPs requiring managed care plans to pay providers using a minimum fee schedule based on state Medicaid rates, are not limited under the terms of H.R. 1. However, at §438.6(c)(8)(iii), the SDP NPRM contravenes the statutory limit set by H.R. 1 and sets limits on *all* types of SDPs. This policy has no basis in law and is not even consistent with CMS's own logic. CMS claims it is concerned with SDP spending and financing, but fee schedule SDPs, for example, are only 15% of spending, largely target the providers Congress did not target in H.R. 1, and use fewer of the financing methods CMS is ostensibly concerned with.[6] **CMS should finalize the SDP NPRM to only apply to the subset of SDPs for which prior written approval is required, as Congress specified in H.R. 1**.

In §438.6(c)(8)(iii), the SDP NPRM also applies the new payment limits to Puerto Rico and the other U.S. territories, contrary to the requirements of Congress's statute. H.R. 1 (at section 71116(d)(3)) specifically limits the scope of the new SDP payment limit provisions to "1 of the 50 States or the District of Columbia". However, the SDP NPRM implements an inconsistent policy, part of which violates the H.R. 1 limits. Although the SDP NPRM does exempt the territories from the SDP payment limits during a transition period created at proposed §438.6(c)(8)(ii), the territories are unlawfully and permanently subject to SDP payments limits starting January 1, 2029 under proposed §438.6(c)(8)(iii). This inconsistent policy is also rooted in the definition of "State" at proposed §438.6(a), which *temporarily* applies the proper definition of State (i.e. consistent with H.R. 1), as used in proposed §438.6(c)(8)(ii), but then starting 2029 reverts to the definition in §438.2, which is used in proposed §438.6(c)(8)(iii) and conflicts with H.R. 1. **CMS should finalize the new payment limits in the SDP NPRM to only apply to the 50 states and D.C., as Congress specified, by amending the definition of "State" at §438.6(a) to exclude the territories from the SDP payment limit definition at all times, and make conforming amendments to §438.6(c)(8)(iii) (including removing reference to §438.2).**

<u>Elimination of Uniform Payment Increase SDPs – §438.6(c)(1)(iii)(B)</u>

In H.R. 1 (at section 71116(a)), Congress set clear *limits* on how high uniform payment rate SDPs can be, in the form of caps based on Medicare payment rates. However, at §438.6(c)(1)(iii)(B), the SDP NPRM entirely *eliminates* all uniform payment SDPs as an SDP

[5] Medicaid and CHIP Payment and Access Commission, "Directed Payments in Medicaid Managed Care" (October 2024). available at https://www.macpac.gov/publication/directed-payments-in-medicaid-managed-care.

[6] *Id*.

option starting with rating periods beginning on or after January 1, 2028, irrespective of whether they comply with the Medicare-based caps. Uniform payment SDPs are a critical type of SDP, accounting for approximately 70% of SDP spending, under which payments to providers are increased (above negotiated payment rates) by a certain dollar amount or percentage.[7] The SDP NPRM thus radically transforms the statutory design to eventually prohibit most SDPs and therefore eliminate a large majority of current SDP spending, regardless of whether the SDP is compliant with the new payment limits Congress established.

It is virtually certain that states will not be able to restructure all of these SDPs to preserve the current payments levels, and will face an incredibly heavy administrative burden to replace any of it. For example, under a uniform rate increase SDP, the state simply layers additional payments on top of existing managed care payment levels; to convert the same funding to a fee schedule SDP, the state would need to obtain proprietary information about prospective plan rates for every applicable service and provider, then design per-service payment levels above the current plan rates, but below Medicare levels, to distribute the additional SDP funding. States would then need to submit new preprints to CMS (which would likely have backlogs due to a flood of new preprints), amend managed care contracts (which might trigger re-procurement processes in some states), and might even need to restructure some provider classes to help ensure the funding is distributed in a consistent manner. Managed care plans, for their part, would likely need to redesign their claims systems to implement the new fee schedules. States will be unable to do this on time for much or most of current uniform payment increase SDP spending. This will represent a massive loss of financing for state health care systems, including safety net and rural hospitals, and will have harmful impacts on access to care, well beyond the negative impact of the SDP limits included in H.R. 1.

When viewed in its totality, CMS's regulatory approach is not a legally permissible nor plausible interpretation of the statute. Congress clearly distinguished two groups of SDPs: some SDP types subject to new payment limits (such as uniform payment increase SDPs) and other types not subject to new payment limits (such as minimum fee schedule SDPs based on state plan rates). CMS's regulatory approach eliminates some of the SDPs in the first group, while at the same time taking the payment limit Congress established only for the first group and applying it to the second group. Congress could not possibly have anticipated, much less intended, such a massive and unspoken change in SDP financing. **CMS should finalize the SDP NPRM by not including provisions narrowing the use of uniform payment rate SDPs, outside of the payment limits actually set out by Congress in H.R. 1.**

Per Service, Per Provider Compliance (§438.6(c)(8)(ii)(A)(2); §438.6(c)(8)(iii)(A)(2); §438.6(c)(8)(ii)(B))

Current SDP regulations, at §438.6(a), define "total payment rate[s]" for SDPs as an *aggregate* calculation for each managed care program. While reporting may sometimes

[7] *Id.*

require more granular information, SDP *compliance* is evaluated by that aggregate average payment level across all providers for a specified service. This means, for example, an individual provider can receive higher payments under a SDP than other providers as long as average payments to the provider type remain within permissible levels. The SDP NPRM, entirely changes the aggregate calculation methodology, instead requiring a *per-service and per-provider* compliance standard. It does so at §438.6(c)(8)(ii)(A)(2) for certain SDPs during a transitional period and at §438.6(c)(8)(iii)(A)(2) broadly for all SDPs starting in 2029. While CMS has retained the aggregate calculation definition at §438.6(a), that standard is no longer operational as the primary standard for payment limit compliance after the changes at §438.6(c)(2)(ii)(I).

There is no basis in H.R. 1 to make this change. In fact, there are numerous elements of H.R. 1 that imply that Congress could not have intended this interpretation. For example, Congress never banned uniform payment increases, which do not use per-service, per-provider rates to measure against payment limits, and doing so would require provider-specific negotiated rate information that the uniform increase design was never intended to require and that states have never needed to obtain. Congress has repeatedly legislated around Medicaid supplemental payments and the Upper Payment Limit (UPL) fee-for-service framework for over two decades, as well as SDPs, without ever requiring per-provider compliance with payment limits. Aggregate payment was the long-established context when Congress wrote H.R. 1, and Congress would have spoken if it intended that standard to change.

This change in SDP compliance policy will be very harmful for states and providers, as it will narrow the number of SDP arrangements that can comply with the SDP payment limits. Some SDPs which are compliant with Medicare payment limits under current policy would no longer be compliant. This will cause huge problems for states with current SDPs, and problematize the development of new SDPs compliant with Medicare payment limits. **CMS should not finalize provisions of the NPRM that shift from aggregate SDP compliance to per-service or per-provider compliance.**

CMS proposes a similar change, at §438.6(c)(8)(ii)(B), for SDPs based on value-based purchasing (VBP) and multi-payer models. These SDP models are by design not based on volume of services and are based on prospective population-level payments, and as such are structurally incompatible with a per-service, per-provider methodology. CMS acknowledges as much in the NPRM, noting the "operational and logistical complexities" and "unique challenges" for such SDPs, and seeks comment on an idea to have state actuaries conduct a special analysis to certify the SDP is compliant with payment limits, but no such policy is proposed in the regulatory text. As written, the regulation would create great uncertainty for states, and would, at best, have a chilling effect for states using such SDPs. The obvious solution, consistent with H.R. 1 and Congress's design for VBP and multi-payer models, is to preserve the current aggregate payment methodologies. **CMS should not finalize any provision using per-service methodologies for VBP or multi-payer models as well.**

Grandfathering Protections (§ 438.6(a), § 438.6(c)(2)(iii), § 438.6(c)(8)(iii), § 447.381(e))

Section 71116 of H.R. 1 temporarily grandfathers existing SDPs (for the four services subject to the new H.R. 1 restrictions) and exempts them from the applicable Medicare-based caps until the start of the first rating period on or after January 1, 2028. To be eligible for grandfathering, the SDP must meet *one* of the following criteria: (1) the SDP has received written prior approval before May 1, 2025 or there was a good faith effort to receive such approval as determined by the Secretary; (2) the SDP is for rural hospitals and received written prior approval before the date of enactment of H.R. 1 or there was a good faith effort to receive such approval; *or* (3) a completed preprint application was submitted to the Secretary prior to date of enactment of H.R. 1 for a rating period occurring within 180 days of date of enactment.

The SDP NPRM effectively eliminates the good faith effort exemptions by saying that only a completed preprint application will be considered a good faith effort. It also merges the three criteria together and requires grandfathered SDPs to meet *all* three requirements: written prior approval, is for an eligible rating period within 180 days of enactment, and description in a completed preprint. (It then adds a requirement that the SDP also currently exceeds the applicable Medicare-based cap.) The preamble argues that CMS does not believe this will exclude any SDPs from grandfathering status. But this could potentially exclude some SDPs for which states were moving ahead prior to enactment. Moreover, by requiring a SDP to also have written approval by CMS, this means that CMS could still reject some SDPs for which a state has submitted a completed preprint application before enactment, even though such SDPs should be grandfathered under H.R. 1. **The SDP NPRM grandfathering definition should be amended to be fully consistent with the statutory language of H.R. 1.**

In addition, H.R. 1 provides a phase-down of grandfathered SDPs starting with the rating period on or after January 1, 2028. It states that the "total amount of such payment" will be reduced by 10 percentage points each year until meeting the applicable payment rate (either 100 percent of the Medicare rate for expansion states or 110 percent of the Medicare rate for non-expansion states). In acknowledging multiple times in the preamble that the language of this phase-down provision is open to interpretation, the SDP NPRM then asserts that the annual phasedown would be equal to 10 percent of the total dollar amount provided under a grandfathered SDP as approved by CMS, irrespective of how much the SDP payment rate exceeds the applicable Medicare cap. This would effectively result in phasedowns that are far less than ten years. It also would result in a non-uniform phase-down period: states with SDPs that exceed Medicare rates to a substantially lesser extent — that is, less of the total SDP dollar amounts are attributable to payment rates above the Medicare cap — will have faster phasedowns than those with SDPs that exceed Medicare rates to a much larger extent.

CMS notes that it considered only one other alternative — a reduction in the payment rate by 10 percentage points annually until the applicable Medicare rate is met — but claims without evidence that this could impose significant administrative burdens on states to keep track of each SDP phasedown. However, this approach too, as the Regulatory Impact Analysis notes, would result in non-uniform phase-down periods with SDPs that exceed

Medicare rates to a greater extent having longer phase-down periods than SDPs that exceed Medicare rates to a lesser extent.

A far better, more reasonable interpretation, which is consistent with the statutory language and intent of H.R. 1, would reduce the SDP rate by 10 percent of the difference between such rate and the applicable Medicare-based cap each year. That would result in a uniform 10-year phase-down period for all SDPs subject to the restrictions of H.R. 1. It would create consistency across SDPs and give states and providers predictable and sufficient transition periods to account for payment changes. Notably, as discussed above, CMS has already acknowledged that "total amount of such payment" could be interpreted as the SDP rate, not the dollar amount provided under the SDP. **Any final rule should adopt this approach to the grandfathering phase-down.**

Moreover, the restrictions on SDPs that go beyond H.R. 1 requirements — such as the extension to other services in addition to the four services identified in section 71116 — and the restrictions on fee-for-service supplemental payments not subject to UPLs (as discussed below) include no grandfathering phaseout at all, once those restrictions take effect.

Payment Limits in the Absence of Medicare Rates (§438.6(a) "State plan approved rates" and "payment limit")

H.R. 1 specifies SDP payment limits for a subset of SDPs equal to100% and 110% of Medicare payment rates for expansion and non-expansion states, respectively, but further stipulates that if no Medicare rate is available, the state should use 100% or 110% of the state plan rate. Since these state plan rates may be far below Medicare levels, this will result in a major loss for providers furnishing services where no Medicare rate is available and may sometimes effectively block state efforts to increase inadequate rates using SDPs for such services.[8] CMS should do everything possible to minimize the harms of this policy, by two methods — properly interpreting H.R. 1 and setting sensible exceptions.

First and foremost, CMS should reduce the scope of this problem by properly limiting the SDP payment limits to the set of four services listed in H.R. 1 (as described above). Many services that are outside of four enumerated specified services, such as pediatric, maternal health, mental health, and HCBS services, are precisely the types of services that likely do not have a published Medicare rate. For many of these providers there are also network shortages in states, meaning the new policy will deepen health care access problems for patients enrolled in Medicaid. **CMS should protect all services outside the four required services from the "no available Medicare rate" problem by properly interpreting H.R. 1 and not applying H.R. 1 payment limits to those services.**

[8] Cindy Mann and Adam Striar, "How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost," Commonwealth Fund (August 17, 2022), available at https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact.

Furthermore, CMS has interpreted the statute in an unnecessary, misrepresentative, and narrow way. While H.R. 1 authorizes payment at "the payment rate under a Medicaid State plan," the SDP NPRM only allows consideration of *base* payment rates. Such a standard ignores the actual effective payment rate in Medicaid and sets the lowest possible payment benchmark. Such a standard is likely not only below Medicare levels but in most cases it is well below current effective Medicaid payment levels. **CMS should revise the definition of "State plan approved rates" at §438.6(a) to remove the exclusion of supplemental payments from that definition.**

Second, in all cases, including for services among the four services subject to H.R. 1, CMS should work with states, providers, and other stakeholders to instead develop different methods to identify appropriate Medicare-equivalent payment rates and apply those rates when doing so is consistent with access to care. For example, for some pediatric services where Medicare rates exist but systematically understate the resource intensity of caring for children, **CMS should permit states to apply pediatric adjustment factors to Medicare rates rather than treating an inadequate Medicare rate as an adequate ceiling**. **For services with no Medicare rate at all, CMS should develop alternative benchmark methodologies in collaboration with states and providers, rather than defaulting to state plan rates that are widely recognized as insufficient to sustain provider participation in the Medicaid program**.

Furthermore, consistent with the above recommendation, CMS should clarify and improve the exception created for IPPS-exempt providers. Medicare pays most hospital inpatient care via the Inpatient Prospective Payment System (IPPS). However, out of recognition that these rates are inappropriate for some hospitals — such as freestanding children's hospitals — Medicare pays these hospitals based on actual cost reports. CMS indicates *in the preamble only* that it proposes to use the cost report as an alternative benchmark to set SDP payment limits for these hospitals (instead of subjecting them to a state plan payment limit). We also have concerns that retrospective cost reports will be an operational mismatch for the prospective SDP methodologies CMS has proposed. **We therefore recommend that CMS work with IPPS-exempt hospitals to develop operationally feasible alternatives (based on cost reports or other methods) *and* explicitly establish this standard in regulatory text to protect these critical rates**.

We note that the regulatory text is also missing another critical policy included in the preamble, and based on the text of H.R. 1, allowing the SDP payment limit to be based on a *waiver* of the State plan rate in certain situations. **CMS should add to the operative definition of "State plan approved rates" at §438.6(a) by including an explicit reference to rates based on waivers of the State plan.**

Finally, we believe the SDP NPRM also sets this component of the payment limit inconsistent with the design of H.R. 1 for nonexpansion states. Under H.R. 1, nonexpansion states should receive 110% of the applicable Medicare or non-Medicare limit. However, under the SDP NPRM, when no Medicare rate is available, nonexpansion states would receive only 100% of the substitute state plan rate. Whatever the limit, nonexpansion states should receive 110% of the limit based on the text and intent of H.R. 1. CMS should also

clarify that partial expansion states are nonexpansion states for the purpose of the SDP NPRM.

Fee-for-Service Supplemental Payments (§ 447.381)

Section 71116 of H.R. 1 does not include any provision restricting or otherwise affecting fee-for-service supplemental payments to practitioners and other providers not currently subject to UPLs. The SDP NPRM however, again goes beyond H.R. 1 and applies H.R. 1 Medicare-based limits to any such supplemental fee-for-service payments if they are targeted to a subset of providers effective January 1, 2029. The proposed rule further defines a uniform payment as being limited to payments that are uniform within a state or within a geographic region of the state (only counties, parishes, boroughs, or municipalities). This means that existing supplemental payments provided to a sub-area within a geographic region (such as to providers within a specific hospital district or within rural parts of a county) would be restricted and be newly subject to the caps.

Finally, in extending H.R. 1 Medicare-based caps to fee-for-service supplemental payments, the SDP NPRM significantly deviates from the use of aggregate limits for other fee-for-service supplemental payments (which is how UPLs are applied) by applying these new caps on an individual practitioner or provider level. The preamble states that applying aggregate limits would allow higher payments to certain providers while setting lower payments for other providers. But that is exactly how permissible supplemental payments subject to UPLs work today. Yet the preamble offers no compelling reason why aggregate UPL-like limits should not be used in this case and provider-level caps would apply instead.

H.R. 1 is a technically sophisticated law that made deliberate changes to Medicaid financing, including, among others, in the areas of SDPs, provider taxes, and waiver budget neutrality. Congress knows the difference between SDPs and fee-for-service supplemental payments, and Congress made changes to SDPs but not to fee-for-service supplemental payments, many of which have been operating for decades. There is no new statutory authority to make changes to fee-for-service supplemental payments. That Congress made explicit changes to SDPs while staying silent on fee-for-service supplemental payments creates no sudden ambiguity to be filled by agency discretion.

These restrictions of fee-for-service supplemental payments not currently subject to UPLs should be entirely dropped.

Other Significant Concerns

According to the Congressional Budget Office, section 71116 of H.R. 1 reduces federal Medicaid spending by $149.4 billion over ten years (fiscal years 2025-2034).[9] In contrast, according to the Regulatory Impact Analysis for the SDP NPRM, as described in Tables 19, 21, and 28, CMS projects that all of the provisions of the proposed rule, if finalized, will cut federal Medicaid spending by $515.2 billion over ten years (fiscal years 2026 through

[9] Congressional Budget Office, *op cit.*

2035). These estimates are not directly comparable to the CBO estimates (including due to a modestly different timeframe and assumed methodological and data differences). Nonetheless, they clearly illustrate the extent to which the SDP NPRM is far exceeding H.R. 1 requirements in restricting SDPs (as well as adding restrictions to fee-for-service supplemental payments) and instituting much deeper Medicaid spending cuts that are several times larger than the cuts actually enacted under H.R. 1. Moreover, as the Regulatory Impact Analysis notes, the estimates do not include the interactive effects of other sections of H.R. 1 that restrict the use of provider taxes, which would reduce state financing for Medicaid including for SDPs and fee-for-service supplemental payments and which would likely further increase the size of the spending cuts under the SDP NPRM.

In addition, the preamble to the SDP NPRM includes extraneous language on several occasions that inappropriately implies that state use of provider taxes or intergovernmental transfers (IGTs) to finance SDPs, fee-for-service supplemental payments, or any other Medicaid costs is somehow always questionable or suspect. Provider taxes and IGTs, however, are longstanding, allowable financing sources to generate the state share of Medicaid costs, so long as they are in compliance with various federal statutory and regulatory requirements. That includes compliance with the new provider tax restrictions included in sections 71115 and 71117 of H.R. 1. (Notably, H.R. 1 did not include any new restrictions on state use of IGTs.) Provider taxes and IGTs thus continue to be vital, legally permissible financing sources used by the vast majority of states. **Any final rule, including in the preamble, should drop any language to the contrary (as it is inconsistent with federal law).** If there is any discussion of use of provider taxes and IGTs in the final rule, it should merely reiterate that state use of provider taxes and IGTs to finance Medicaid remains permissible and legitimate.

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Thank you again for the opportunity to make the above comments to the SDP NPRM. Please contact us at Leo.Cuello@georgetown.edu and Edwin.Park@georgetown.edu if you have any questions or if we can be of further assistance.

Respectfully submitted,

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