THE PARTNERSHIP FOR MEDICAID

July 21, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2449-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

Dear Administrator Oz,

On behalf of the Partnership for Medicaid—a nonpartisan, nationwide coalition made up of organizations representing clinicians, health care providers, safety net plans, and counties— the undersigned organizations appreciate the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS') "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments" proposed rule. Our comments below highlight our concerns with the proposed requirements within the rule and the negative impact these changes would have on access to health care for Medicaid beneficiaries.

Medicaid currently provides health coverage to nearly 80 million people, including half of children with special health care needs, 3 million children in military connected families, more than 40% of children living in rural areas and small towns, pregnant women, adults, seniors, and individuals with disabilities. In communities across the country, including those in rural and underserved areas, Medicaid plays an important role in keeping their hospitals, clinics, community health centers and other health care organizations open, and clinicians and other health care personnel employed. Keeping these provider doors open preserves vital patient access to primary and dental care, to maternity care, labor and delivery services, pediatric services, behavioral health services, primary and dental care, long-term services and supports, and other necessary services for patients who cannot afford other options for care. Any policy changes that weaken Medicaid's ability to support providers and patients risk undermining access to care for the populations and communities that depend on the program most.

We are concerned that several provisions in the proposed rule could jeopardize access to critical health care services for millions of Medicaid beneficiaries and have broader consequences for all patients who depend on the providers that may face reduced funding, diminished capacity, or service disruptions as a result of these policies. The comments below

describe our key concerns and areas where changes are needed to avoid unintended harm to patients and providers.

State Directed Payments Support Access to Care

State directed payments (SDPs) are a critical tool that enable states to strengthen their Medicaid programs by addressing chronic underpayment in Medicaid fee-for-service (FFS) and managed care rates and ensuring beneficiaries have access to needed services. By providing states with the flexibility to direct targeted supplemental payments to providers, SDPs help preserve access to care for millions of Medicaid enrollees, particularly in rural, underserved, and high-need communities where financial pressures can threaten the availability of essential health services. These payments support a broad range of providers that serve Medicaid beneficiaries, including hospitals, physician practices, behavioral health providers, home and community-based service providers, dental providers, nursing facilities, and other safety-net organizations. SDPs also allow states to advance policy goals such as improving quality, expanding access, promoting value-based care, and addressing workforce shortages.

In many states, SDPs have become an essential source of funding that helps providers cover the costs of caring for Medicaid patients, sustain critical services, and invest in care delivery improvements. Without the flexibility afforded by SDPs, many providers—including rural hospitals, mental health providers, hospital-based dental programs, and other essential community providers—could face significant financial strain, potentially resulting in reduced service availability and diminished access to care for the Medicaid beneficiaries who rely on them.

Proposed Policies Beyond the Scope of OBBBA

Applying the Medicare-based Limit to All SDPs

CMS proposes applying the Medicare-based limit to all SDPs, not only the four service types included in the One Big Beautiful Bill Act (OBBBA). **We urge CMS to revert this policy and apply the Medicare-based limit to only the four service types included in OBBBA.** Many of the SDPs that would be affected by this proposal are targeted to behavioral health providers, home and community-based service (HCBS) providers, dental, and specialty care. This broad-brush approach largely replaces state discretion to set Medicaid payments with federally-established rates that were developed to cover the costs of serving Medicare beneficiaries. For those services without a Medicare equivalent, states will be forced to cap SDPs at a lower rate. As a result, this policy would undermine states' ability to address provider shortages and access challenges through targeted payment strategies, potentially reducing beneficiary access to critical services and weakening the Medicaid safety net for vulnerable populations.

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Applying the Medicare Limit to "Targeted" Services in Medicaid FFS

CMS proposes to establish a new provider- or practitioner-specific limit on total Medicaid FFS payments when any portion of those payments is "targeted." **We recommend CMS withdraw its proposal to establish a new Medicare-based limit for targeted Medicaid FFS payments, as this policy exceeds the requirements of OBBBA.**

Medicaid reimbursement rates have historically fallen below the cost of furnishing care, making supplemental payment programs a critical tool for preserving access to services for millions of Medicaid beneficiaries. These funding mechanisms enable states to support providers that serve a large share of Medicaid patients and help address longstanding gaps between Medicaid payment rates and the actual cost of delivering care. Supplemental payments play a vital role in sustaining providers across the health care continuum, including hospitals, physician practices, behavioral health providers, dental providers, long-term care providers, and other safety-net organizations that serve Medicaid beneficiaries. Without these payments, many providers would face significant financial challenges that could affect their ability to maintain services, invest in their workforce, and meet the needs of their communities.

Congress has long recognized that base Medicaid payment rates alone are often insufficient to ensure adequate provider participation and beneficiary access to care. As a result, supplemental payment programs have become an essential component of Medicaid payments, enabling states to strengthen provider networks, address workforce shortages, and preserve access to care in rural, underserved, and high-need communities. The proposal to establish a new Medicare-based limit would undermine these longstanding investments by restricting states' ability to direct additional resources to providers serving large numbers of Medicaid beneficiaries, despite no clear statutory requirement in OBBBA to do so. By further constraining Medicaid payments at a time when states and providers are already adapting to significant cuts to Medicaid enacted through OBBBA, the proposal would exacerbate financial pressures throughout the health care system.

Providers that disproportionately serve Medicaid beneficiaries are particularly vulnerable to these changes because they rely on supplemental payments to offset chronic underpayment within the Medicaid program. The proposed limits on targeted Medicaid FFS payments would widen the gap between Medicaid reimbursement and the cost of delivering care. The proposal also curtails state flexibility to target limited resources to address local health care needs and advance state-specific policy goals. Reductions in these payments would threaten the financial stability of providers across the continuum of care, including those serving rural and underserved communities, and could exacerbate existing shortages of physicians, behavioral health professionals, dentists, and other health care practitioners. Most importantly, the proposed policy risks reducing access to essential health care services for millions of

Medicaid beneficiaries through diminished provider participation, service reductions, and longer wait times for care. Therefore, we recommend that CMS withdraw its proposal to establish a new Medicare-based limit for targeted Medicaid FFS payments and preserve the flexibility states need to support providers and maintain access to care for Medicaid beneficiaries.

Proposed Limits on Value-based Payment SDPs

We urge CMS to withdraw the proposed restrictions on the use of value-based payment (VBP) models in managed care. We are concerned that the proposed rule's overly prescriptive application of Medicare-based limits will interfere with state efforts to advance VBP models that are tailored to the unique needs of Medicaid beneficiaries.

In recent years, CMS has encouraged states and other payers to adopt VBP models that move away from FFS payment methods and reward the value of services instead of the volume of services. By focusing on patient outcomes and the total cost of care instead of payment rates for specific service codes, VBP models have enabled providers to invest more in high-value care and help patients access care in more cost-effective settings.

Medicaid SDPs have been an important tool for enabling states to advance VBP efforts in managed care delivery systems. SDPs help offset low Medicaid payment rates, which have been a barrier preventing safety net providers from participating in alternative payment models and delivery system reforms. Evaluations of SDPs have found that they have helped to reduce infant mortality, improve treatment for patients with opioid use disorder, and reduce avoidable hospital use in ways that make the overall health system more efficient.[1]

CMS' proposed rule is likely to undermine this recent progress by requiring SDPs to fit into an overly narrow definition of Medicare-based limits at the service code or discharge level, deviating from CMS' prior practice of comparing Medicaid payments to Medicare using the broad category of service defined in the Medicaid statute. In addition, CMS proposes to further restrict Medicaid VBP models by retrospectively comparing payments to what would have been paid under Medicare FFS without any consideration of how shifts in care to more cost-effective settings have lowered costs for the health system. As a result, the rule will limit states' ability to reward providers for high-value care, even when total payments are less than what Medicare would have paid. To ensure that VBP SDPs can continue to promote better health outcomes for Medicaid beneficiaries, CMS should preserve states' flexibility to design value-based payment arrangements and evaluate Medicare-based limits at the broader service category level, consistent with longstanding agency policy and the realities of value-based care delivery.

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[1] Kozminski J. State Directed Payments: Closing Medicaid Payment Gaps for Essential Hospitals. Sept. 2024. https://essentialhospitals.org/wp-content/uploads/2024/09/Policy-Brief-Directed-Payments-September-2024.pdf. Accessed June 5, 2026.

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Prohibition of Uniform Increase SDPs

We recommend that CMS withdraw its proposal to prohibit uniform increases for the first rating period on or after Jan. 1, 2028, for new and non-grandfathered SDPs. OBBBA does not require states to limit provider-directed payments to a provider's individual Medicare payment rate or to base payments exclusively on Medicare fee schedules. Prohibiting uniform rate increases would impose restrictions that extend beyond the law's requirements and would unnecessarily constrain states' ability to address longstanding payment inadequacies within the Medicaid program.

States have historically relied on uniform payment increases and other targeted payment strategies to strengthen their provider networks, maintain access to essential services, and support providers that care for a disproportionate share of Medicaid beneficiaries. Removing states' ability to design a uniform increase SDP to meet the specific needs of their populations would be counterintuitive to the design of the Medicaid program. We urge CMS to not finalize this policy and retain uniform increase SDPs to ensure states have flexibility when designing SDPs.

Delaying the Requirement to Phase Out Separate Payment Terms

We appreciate CMS' decision to maintain separate payment terms during the phase down of grandfathered SDPs. Separate payment terms are an important tool to ensure transparency and accountability for SDP funding and they help reduce administrative burden. Preserving this flexibility will enable states to continue directing resources more accurately to providers, helping ensure that payments reflect the unique patient populations they serve and the costs associated with delivering care. Many providers incur higher costs related to caring for patients with complex medical needs, maintaining specialized services, and supporting highly trained clinical professionals and care teams. Temporarily maintaining separate payment terms will help sustain provider financial stability during the grandfathering period, preserve access to essential services for Medicaid beneficiaries, and better align Medicaid funding with the critical role providers play in delivering specialized, high-quality, and comprehensive care to their communities.

The Partnership for Medicaid appreciates the opportunity to comment on this proposed rule. We stand ready to work with you to ensure that the Medicaid program continues to provide access to care for the millions of people who rely on it. Please contact Milena Berhane at milena.berhane@childrenshospitals.org or (202) 753-5521 with any questions.

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Sincerely,

American Academy of Family Physicians
American Academy of Pediatrics
American College of Obstetricians & Gynecologists
American Dental Education Association
American Nurses Association
America's Essential Hospitals
Association for Community Affiliated Plans
Association of Clinicians for the Underserved
Catholic Health Association of the United States
Children's Hospital Association
Easterseals
LeadingAge
Medicaid Health Plans of America
National Association of Pediatric Nurse Practitioners
National Rural Health Association