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THE VOICE FOR HEALTH CARE CONSUMERS

July 21, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: CMS–2449–P

Submitted electronically via Medicaid.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,

On behalf of Families USA, thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS') proposed rule implementing Public Law 119-21 §71116 and expanding the state-directed payment limits set by Congress to Medicaid payments across the system in Medicaid managed care and Medicaid fee-for-service.

As the longtime national, non-partisan health care consumer advocacy organization, dedicated to achieving high-quality, affordable health care and improved health for all, Families USA supports health care payment policies that will achieve fiscal sustainability for the Medicaid program as part of our ultimate goal of ensuring access to care for low-income Americans and their families. We caution that the payment limitations proposed under this Notice of Proposed Rulemaking (NPRM) are not appropriate in all settings and for all providers, nor do they always incentivize the highest-value or most cost-effective care. Furthermore, the policies proposed by CMS go beyond the statute in ways that may undermine states' ability to ensure adequate access to care.

While we agree that Medicare sets the benchmark across most health care payers, and we support CMS' efforts to raise Medicaid rates to be at least on par with Medicare rates, we also believe that CMS' proposed rule oversteps the agency's statutory mandate under Public Law 119-21 (referred to by several different names but referred to as "H.R. 1" throughout this comment letter) and does not ensure that state Medicaid programs have the ability to enlist enough providers to ensure the "proper and efficient operation" of the Medicaid program, as required by the Social Security Act. Further, rigid payment caps and limits on the types of directed payments states can issue may reduce Medicaid patient access to health care providers; unreasonably limit state flexibility to address gaps in access and incentivize quality care; and shift Medicaid program costs from the federal government to the states in ways that will undermine the sustainability of the Medicaid program.

We respectfully request CMS to withdraw the portions of the proposed rule that go beyond H.R.1 and retain flexibility for states to test innovative payment models across Medicaid, even if these payment rates need to exceed the Medicare rate to support Medicaid program goals. Rather than a rigid approach that sets blanket restrictions on the amount and types of payment mechanisms available to states, we urge CMS to take a Medicaid payment approach that ensures:

- Provider payment rates elicit a sufficient supply of providers and services for Medicaid enrollees.
- States have adequate flexibility to structure payments that give health care providers incentives to work in underserved areas, serve Medicaid patients in primary care and community settings, offer higher-value care and meet other health care system goals.
- CMS and states use data and evaluation to drive stronger metrics for Medicaid payment.
- States have an adequate level of federal Medicaid support to maintain access and quality.

With these perspectives in mind, we urge CMS to consider and incorporate the following four comprehensive recommendations before finalizing the rule:

(1) Withdraw portions of the proposed rule that are not required under H.R.1.
(2) Approve of uniform increase directed payments that follow the evidence base and compensate providers at a level appropriate to maximize patient access to providers that will offer them high-quality care.
(3) Set a Medicaid reimbursement floor using Medicare as the national benchmark, but ensure states have the flexibility to supplement Medicaid reimbursement rates above the Medicare benchmark where necessary to maintain adequate provider networks and access to care for Medicaid beneficiaries.
(4) Make better use of the oversight tools CMS has in place—including managed care payment data being submitted by states and the ability to set higher standards for states to evaluate SDPs—to better understand how payment approaches in place today impact provider networks and access to care, using lessons learned to help push the system toward value-based models in the future.

Families USA stands ready to assist CMS in developing a thoughtful and strategic approach that meets the agency's goals while ensuring access to care for low-income Americans and their families.

I. CMS has overstepped its authority to regulate and must withdraw portions of the proposed rule that are not mandated under Public Law 119-21 § 71116, including proposals to extend H.R. 1's provider payment limitations to all state directed payments (SDPs) and all provider types, and proposals to curtail the use of "uniform increase" SDPs.

Section 71116(a) of Public Law 119-21 grants CMS authority to limit certain Medicaid provider payments to the Medicare rate.[1] The statute authorizes this payment cap "with respect to a payment described" under 42 C.F.R. § 438.6(c)(2)(iii). This section of the code of federal regulations refers only to:

(1) Medicaid payments made through the SDP mechanism; and
(2) Payments related to four classes of providers: *inpatient hospitals, outpatient hospitals, nursing facilities and academic medical centers*.[2]

H.R. 1 does not grant CMS authority to extend payment limits to other types of providers or payments outside of the SDP mechanism, including Medicaid fee-for-service payments. CMS acknowledges this statutory limitation in the proposed rule, stating: "Section 71116 of the WFTC legislation directed the Secretary to reduce the total payment rate limit for certain SDPs for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an [academic medical center]."[3]

However, the NPRM proposes to extend H.R. 1's payment limitations to *all* SDPs and for *all* Medicaid providers — including primary care, behavioral health, dental, home- and community-based service providers and other provider types — along with other proposals that would significantly curtail the use of SDPs nationwide and restrict similar payments made through Medicaid fee-for-service. Because these Medicaid provider payment reductions are not permitted by H.R. 1, they are permissible only if they meet other requirements of the Social Security Act.

CMS' proposed approach threatens to undermine access to Medicaid providers in violation of Social Security Act requirements.

Without specific direction from Congress to set new limits on Medicaid payment beyond those specified by H.R. 1, CMS must follow Social Security Act requirements under § 1902(a) which state that state Medicaid plans must:

- Maintain methods of administration "necessary for the proper and efficient operation of the plan."[4]
- Contain procedures to ensure that reimbursement rates for health care providers are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" in the geographic area.[5]

While we acknowledge that courts have determined that the Social Security Act does not guarantee a minimum level of provider reimbursement,[6] the Act mandates—and common-sense dictates—that Medicaid payment rates need to be sufficient to attract enough providers so that services are available to Medicaid beneficiaries to the same extent that they are available to the general population. Without this requirement, states cannot "enlist enough providers" to ensure the "proper and efficient operation" of the Medicaid program.

Despite these statutory requirements, Medicaid patients have far greater difficulty accessing needed primary and specialty care compared to patients with other health insurance types[7] due to widespread Medicaid provider shortages, lack of available appointments and refusal of health care providers to accept new Medicaid patients.[8] Rural areas consistently have fewer Medicaid-participating primary care providers per capita compared to urban counties and have severe shortages of specialty providers willing to see Medicaid patients.[9] Medicaid patients in urban areas are not guaranteed provider access either: A recent survey of 15 major metro areas found that just over half (53%) of providers accepted Medicaid as a form of payment.[10] In addition, Medicaid participation on paper does equate to patient access, as a 2026 study found that more than one-fourth of Medicaid-enrolled physicians do not see any Medicaid patients.[11]

Challenges with attracting providers to serve Medicaid are multifaceted,[12] but research shows that increasing Medicaid rates, even through small rate increases, translates to more providers participating in Medicaid and increased access to care for patients.[13] The research confirms what the Social Security Act recognizes: Medicaid payment rates *do matter*.

SDPs are one mechanism for raising Medicaid rates through Medicaid managed care, born out of the fact that Medicaid managed care organizations (MCOs) habitually underpay providers in their networks. Because Medicaid base rates are already very low, and MCOs keep what they do not spend, these plans have an incentive to deny claims or delay payments. These forms of "underpayment" create financial strain for healthcare providers.[14] One way of correcting for these dynamics is to instruct MCOs to increase provider rates through SDPs. SDPs serve many goals, including increasing beneficiary access to primary and specialty providers, addressing workforce shortages, supporting rural and safety-net providers, shifting care to lower-cost community settings and incentivizing high-value preventive care.[15] The overarching goal is to ensure that managed care members have at least as much access to providers and services as accessible by individuals with other insurance types. Via SDPs, state Medicaid departments can test and evaluate the effectiveness of various payments to determine their utility and whether to subsequently include such payment or quality metric requirements in their next MCO contracts.[16]

While H.R. 1 installed blunt policies to limit payment rates through the SDP mechanism for inpatient hospitals, outpatient hospitals, nursing facilities and academic medical centers (and CMS must implement those provisions), H.R. 1 did not install these policies for other provider types or across the Medicaid system outside of managed care. CMS, therefore, is still obliged by § 1902(a) to set policies that ensure appropriate reimbursement rates for provider types not included under H.R. 1—including primary care, behavioral health, dental, home- and community-based service providers and others—and appropriate reimbursement rates in Medicaid fee-for-service. In short, **H.R. 1 does not instruct CMS to dismantle Medicaid payment broadly, and CMS is still obligated to give states flexibility to make program choices that will elicit provider participation and member access to services**.

As discussed in the following sections of this comment letter, CMS' proposed policies outlined in the NPRM remove key aspects of state payment flexibility that will hamstring state Medicaid

programs from appropriately testing payment models that will best serve enrolled individuals. These proposed Medicaid payment limitations are impermissible under § 1902(a) and beyond H.R. 1's mandate, but, moreover, restrict innovation in payment design that the Medicaid program needs to achieve higher-quality, higher-value care.

II. Uniform increase SDPs have value in ensuring access to care. Instead of abolishing these payments altogether, CMS should allow states to retain flexibility to test evidence-based payment methods that compensate providers appropriately to support their state's unique health care system needs.

CMS proposes to restrict the types of SDPs states can pursue, eventually eliminating all SDPs that set a uniform dollar or percentage increase.[17] As "uniform increase" payments are the most common type of SDP,[18] if this proposal moves forward, beginning January 1, 2028, many states will have to redesign SDPs to meet CMS' new standards, restructuring them instead as a minimum or maximum fee schedule.[19]

Given the complexity of the financial arrangements involved, it may not be easy to simply flip every uniform increase payment to a minimum/maximum fee schedule. CMS assumes that many states will have trouble converting some or all of such payments (the bulk of the overall savings projected by CMS come from this proposed change), but the NPRM does not propose any grandfathering or phase-down period to help states adjust.

Eliminating uniform increase payments will hamper state efforts to incentivize providers to address important chronic disease and public health goals. For example:

- Since 2018, Tennessee has offered an enhanced fee to primary care providers who complete Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings.[20] These add-on payments ($4 per member per month to providers participating in patient-centered medical homes) have been successful in increasing EPSDT well-child visits: in 2024, the state reported its EPSDT screening rate reached a historical high of 75%, up from below 60% in 2020.[21] Numerous studies show that EPSDT screenings give the health care system greater opportunity to address issues early in life, preventing serious and costly health problems down the road.[22]
- An SDP in Utah increases payment rates (5% per claim) to help mitigate behavioral health provider shortages in the state that threaten access to care.[23] Utah's efforts have paid off, with large managed care plans in the state expanding behavioral health networks[24] and improved access to behavioral health as compared to neighboring states.[25] A body of research shows that increased access to behavioral health services results in cost savings:[26] One study found that medical claims fell by $109 for every $100 invested in mental health services.[27]

These two examples show how uniform increase SDPs can lead to the outcomes CMS seeks. These payment mechanisms create flexibility for states to ensure Medicaid patients receive

evidence-based, high-value and cost-effective services. Tennessee's ability to structure directed payments towards delivering high-value care is a major accomplishment, particularly given that even with these add-on payments, Medicaid providers in the state take home just 72.01% of the Medicare rate for providing appropriate EPSDT services. In Utah, the total reimbursement for behavioral health providers is just 105% of the Medicaid state plan approved rate. However, because these SDPs are structured as uniform dollar and percentage increases, Tennessee and Utah—and other states with similar SDPs—will have to abandon them in 2028 despite their value to patients and payers alike.

Of course, Tennessee and Utah could restructure these payments as a minimum or maximum fee schedule instead. However, even assuming either state can achieve this financial restructuring, such a change may not necessarily yield the same positive outcomes:

- Three recent systematic reviews have found mixed results when examining an increase in fee-for-service payments: while increased pay routinely leads to greater health care access and more patients being seen by providers, it does not always translate to increased quality of care.[28] The problem with set fee schedule payments is that they drive up the volume of care with no link to quality, paying providers to deliver a service without providing any financial incentive to improve health outcomes or reduce costs, including through SDPs with minimum or maximum fee schedules.[29]
- On the other hand, systematic reviews examining incentive dollar or percentage payment increase for providing a specific type of care show these are generally more successful than increased fee-for-service payments as they can reduce provision of non-optimal services and increase provision of preventive care.[30] However, these types of payment arrangements often fail to meaningfully drive improvements in quality. Instead, these payments tend to be more successful in increasing a defined activity (such as immunization rates), but less successful when outcomes are produced based on effectively managing both individual and population-level health outcomes (such as for chronic disease management).[31]

The literature points to the fact that different payment structures can add value for different reasons, but more evidence is needed to understand optimal payment approaches, including how various current payment structures inform the ongoing design and implementation of value-based payment model.[32] Families USA has long supported efforts to shift health care payments and reimbursement across payers, including Medicaid, towards value-based and alternative payment models because these types of payment arrangements create financial incentives to motivate the delivery of certain high-value services, such as primary care and behavioral health. In addition, these models have stronger linkages to health care quality and can hold health care providers accountable for patient outcomes and the total cost of care. **In building an alternative payment model strategy for Medicaid reimbursement, CMS should want to foster state experimentation via SDPs to learn which payment methods work best for which types of patient care, where uniform increase SDPs may be appropriate or have value as compared to other approaches, and where the system is best positioned to adopt value-**

based and alternative payment arrangement designs. Eliminating uniform increase SDPs altogether does not advance the knowledge base and would jeopardize the high-quality patient care already happening in states like Tennessee and Utah.

Furthermore, getting the incentives *right* should also be a goal. Studies find that supplemental incentive payments run the risk of being ineffective both when the incentive is too small to motivate behavior change (e.g., provider participation in Medicaid managed care networks or provision of high-value care) and when the size of the reward is more than necessary to bring about desired outcomes.[33] States need room to continue to test various approaches to better understand the balance between sufficient provider reimbursement and the level of financial risk Medicaid providers can bear to drive accountability for health outcomes and total cost of care. Uniform increase SDPs can serve as an important testing ground to build the capacity of Medicaid providers to be successful in these types of arrangements.

Ultimately, SDPs are a critical payment tool that states rely on to increase Medicaid reimbursement to providers for evidence-based health care services that increase access to care and help drive improvements in health care quality. In absence of a more holistic, comprehensive restructuring of Medicaid payment that ensures Medicaid providers are reimbursed at an increased and adequate rate compared to current reimbursement levels, SDPs, including uniform increase SDPs, continue to be essential options for states to build adequate and sufficient Medicaid reimbursement to sustain their Medicaid programs and ensure that Medicaid beneficiaries receive the health services they need.

We urge CMS to continue to approve of uniform increase SDPs that follow the evidence base and compensate providers at a level appropriate to maximize patient access to providers that will offer them high-quality care. Retaining the uniform increase SDP as an allowable type of SDP offers states flexibility in payment design but does not mean CMS loses its ability to scrutinize submitted SDP preprints and set reasonable expectations of states that they evaluate and monitor spending, access and quality performance.

III. **We agree that Medicare serves as the payment benchmark across all payers, including Medicaid fee-for-service and Medicaid managed care.** Despite the flaws in the Medicare payment system, Medicare offers the best evidence-based, national benchmark available. However, because Medicare does not offer reimbursement for certain Medicaid services, **states must have the flexibility to establish appropriate and adequate reimbursement rates across the full suite of Medicaid services. Rather than set a rigid upper limit, we urge CMS to set a Medicaid reimbursement floor using Medicare as the national benchmark. Furthermore, we urge CMS to maintain the standard of approving SDPs that are "reasonable, appropriate, and attainable." This will ensure states have the flexibility they need to maintain primary care and behavioral health provider networks.**

The NPRM proposes to extend H.R. 1's Medicare payment cap to all SDPs, including those that offer supplemental payment to primary care, behavioral health, dental, and home- and community-based service providers. Further, CMS proposes to apply the Medicare-based

payment limits for SDPs to many fee-for-service payments. Importantly, unlike for SDPs cut under H.R. 1, CMS' proposed rule does not include a grandfathering period or a multi-year phase-down for these payment cuts. If finalized, this policy would mean that unless a payment qualifies for H.R. 1's grandfathering period, then it must abruptly recede to the Medicare rate by 2029.

Rather than setting Medicare rates as the payment ceiling, we urge CMS to set the Medicare benchmark as the *floor*. Under this approach, CMS preserves the ability of states to use other tools, including SDPs, to establish reimbursement rates for services not covered by Medicare, and to increase reimbursement rates above Medicare where appropriate, particularly to preserve access to primary care, behavioral health and community-based providers—services that function as the backbone to any high-value health care system. These payment flexibilities are needed because there are well-known flaws and existing distortions in the Medicare reimbursement system, including the Medicare Physician Fee Schedule, which, until they are addressed in full, prevent Medicare from serving as a wholly adequate benchmark across the entirety of the Medicaid program. For example:

- **Medicare rates undervalue and under-reimburse primary care and behavioral health services. To strengthen Medicare as the national benchmark, CMS must address the flaws in the Medicare Physician Fee Schedule that lead to primary care provider shortages and poor access to primary care.** While Medicare remains the only national, evidence-backed effort to establish fair prices for health care services, the methodology it uses has historically perpetuated distortions in payment that undervalue primary care providers and critical services like preventive care and behavioral health.[34] In the CY 2026 Medicare Physician Fee Schedule proposed rule, CMS acknowledged that distortions and flaws in Medicare valuation, such as limitations of RUC survey data, contribute to the "passive devaluation of E/M [evaluation and management] services under the constraints of budget neutrality."[35] The undervaluing of time-based services, such as the time spent with patients or on care coordination, has contributed to the increasing primary care and behavioral health care shortage.[36] CMS has previously found that setting a rigid rate ceiling for these provider types in Medicaid would make it difficult for states to meet Medicaid program goals and objectives related to primary care and behavioral health.[37]

  We urge CMS to strengthen the Medicare fee schedule by continuing its work to revalue relative value units that lead to overpayment of specialty care at the expense of primary care. These efforts will help to ensure more adequate Medicare reimbursement through the fee schedule including addressing a key dimension of our nation's primary care shortage and crisis. Only with these changes will establishing Medicare as the benchmark—in addition to state flexibility to levy SDPs or other payment mechanisms above the benchmark—be more successful in furthering the objectives of the Medicaid program. In the meantime, as state Medicaid programs work to sustain sufficient beneficiary access to care, SDPs above the Medicare rate could reasonably be needed to adequately compensate providers and maintain provider networks.

- **Because Medicaid is the predominate payer for numerous services (such as substance use disorder (SUD) services[38]) and Medicare rates are designed based on the care needs of a different population, Medicare billing codes do not adequately reflect the full, comprehensive set of services offered under Medicaid. States cannot rely on Medicare as the benchmark to reimburse for these services unless they have the financial tools to supplement Medicare payment rates, where needed, to establish sufficient reimbursement.** For example, in the case of SUD services, Medicare does not cover essential, intermediate-level SUD treatments, excludes many licensed addiction counselors and does not cover treatment in community-based settings—essentially leaving it to the Medicaid system to sort out payment and delivery for these services.[39] As a result, the Medicare reimbursement rate for SUD services is based on a smaller set of services, making it insufficient to serve as a benchmark for SUD reimbursement under Medicaid without additional flexibility. This means that under CMS' proposal, using Medicare as the reimbursement ceiling without providing states additional reimbursement flexibility would result in Medicaid providers being underpaid and care becoming less accessible. There are numerous other services for which Medicaid is the most common or sole payer—including home- and community-based services (HCBS),[40] mental health services,[41] and obstetrics and gynecology[42]—and similar payment inadequacies surface when trying to use Medicare as the benchmark.[43] Medicare is also an imperfect benchmark for services delivered to children, as Medicare rates are designed around the care needs and resource intensity of older adults and people with disabilities and do not fully reflect pediatric care delivery.[44]

  For these reasons, if Medicare were to serve as the benchmark across Medicaid, CMS would need to: 1) set Medicare rates as the *floor*, not the limit; 2) establish needed billing codes for a more comprehensive set of services where Medicaid is currently the predominate payer; and 3) ensure states maintain flexibility to deploy other payment mechanisms, where needed, to provide adequate reimbursement rates that cultivate a strong provider network and access to quality care.

- **Medicare payment rates as applied to Medicaid managed care result in lower pay for providers due to managed care administrative costs; CMS should end this practice.** When states use SDPs to boost provider rates, MCOs often take a cut for administrative fees or a profit margin before the provider is paid. As a result, the actual payout to the provider ends up being less than the target rate. While the NPRM proposes to prevent states from directing that a portion of the SDP be allocated to managed care plan administrative activities associated with the SDP (and we support the proposed revision to 42 CFR § 438.6(c)(2)(ii)(A)), this is not the same as preventing the MCO itself from consuming a portion of the payment for administration or profit. The NPRM states, "capitation rates already include a non-benefit component to cover reasonable administrative costs."[45] We agree and we urge CMS to be more explicit in its rules that MCOs *cannot* take any administrative cut from a directed payment meant for the benefit of Medicaid providers.

  If CMS does not set this as a rule, then it must contend with the fact that an SDP targeting primary care or other providers at 100% of the Medicare rate will result in payment less

than the Medicare rate. Given this reality, there may be circumstances where states need to direct payment *higher* than the Medicare rate for the payment to achieve access and quality goals. Unless CMS corrects for this managed care practice, then it must continue to allow states flexibility to set rates that truly compete with Medicare rates in their state.

- **Transitioning away from fee-for-service towards innovative value-based payment (VBP) models requires flexibility to pay providers higher rates to incentivize participation and reward the delivery of high-quality, high-value care.** Limiting payment rates to the Medicare rate may pose significant challenges for states looking to implement VBP models that include upside risk or two-sided risk arrangements.[46] In such arrangements, providers can receive positively adjusted payment rates if they successfully meet select cost or quality benchmarks. In states where base Medicaid payment rates are already close to the Medicare rate, such VBP arrangements would risk violating proposed SDP payment limits, discouraging states from implementing payment models that drive the delivery of high quality care.[47] In this way, the proposed expansion of H.R. 1's SDP payment limits runs directly counter to CMS' stated goals of moving more payment arrangements away from traditional fee-for-service and towards value-based care arrangements.

While we agree that Medicare can serve as a national benchmark and provide the floor for the reimbursement of most health care services, CMS must contend with the challenges that come with applying the Medicare benchmark to Medicaid, as Medicare rates: undervalue and under-reimburse primary care and behavioral health services; cannot be seamlessly applied to services for which Medicaid is the most common or sole payer; do not account for the administrative fees taken by the managed care system; and may discourage states from implementing VBP models. For these many reasons, **we urge CMS to ensure states have the flexibility to supplement Medicaid reimbursement rates above the Medicare benchmark, where needed, to maintain adequate provider networks and access to care for Medicaid beneficiaries.**

Importantly, flexibility in payment design does not mean states can set *any* rate they want to. Existing regulatory guardrails are in place to ensure Medicaid rates are appropriate. Current regulations under § 438.6(c)(2)(ii)(I) require the total payment rate offered to providers under each SDP to be "reasonable, appropriate, and attainable."[48] This means rates must align with real-world, necessary costs and health plans and doctors must be able to reach the quality and service goals set for them with the compensation provided.[49] This requirement echoes the framework in the Social Security Act that reimbursement rates be sufficient to meet quality of care standards and enlist enough providers to serve Medicaid patients. **We urge CMS to use the current regulatory standard of "reasonable, appropriate, and attainable" to assess state requests to supplement Medicaid reimbursement above Medicare rates.** Under this standard, CMS retains the authority to deny SDP preprints where states propose payment rates that are not reasonable, appropriate or attainable; states retain the ability to set rates that most appropriately serve the unique needs of their Medicaid population.

IV. Better data is needed to drive stronger metrics for SDPs and Medicaid payment going forward. Rather than set policy choices based on limited data, we urge CMS to make use

of the oversight tools it has in place—including managed care payment data being submitted by states and the ability to set higher standards for states to evaluate SDPs—to evaluate how payment approaches in place today impact provider networks and access to care.

Preserving flexibility for states to set uniform increase SDPs or to reimburse primary care, behavioral health and other providers at a rate different from the Medicare benchmark does not mean CMS is without the ability to ensure payments are reasonable and tied to measurable results. However, CMS and states lack the data needed to drive better payment policies, including data on: (1) payment differences between Medicaid and Medicare for services where Medicaid is the dominant payer; and (2) whether SDPs achieve their intended impact:

- **CMS is on the cusp of collecting the data it needs to better understand adequate benchmarks for Medicaid provider payment. We urge CMS to wait until it has better data to drive agency decision making.** In prior rulemaking, CMS set expectations for states to collect and submit to CMS a managed care payment analysis to assess the adequacy of payments to providers participating in Medicaid managed care.[50] Under the rule, for rating periods beginning on or after July 9, 2026, states must submit an annual payment analysis that compares Medicaid managed care plans' payment rates to published Medicare rates related to primary care, obstetrics and gynecology, and mental health and substance use disorder services—services where states have found it difficult to determine the appropriate payment rate using other benchmarks because Medicaid is the most common or only payer.[51]

  States are only *just* beginning to analyze and report this important payment data, and it should provide needed information on how Medicaid payment levels affect provider networks and access to care which may help determine alternative benchmarks or payment mechanisms for primary care, behavioral health and other services. In addition, this data may illuminate where state-level flexibility is needed to address specific gaps in access to care. Finally, this data may also provide evidence that Medicare payment rates *are* a reasonable benchmark for certain services provided to Medicaid beneficiaries.

- **Many states fail to submit the necessary data—or the level of data needed—to properly evaluate SDPs, making it difficult to assess whether these arrangements achieve their intended impact. CMS should set a higher bar for states to evaluate and publish the impact of directed payments.** Although CMS requires states to evaluate SDPs, the Medicaid and CHIP Payment and Access Commission (MACPAC) has described the need for better evaluation of the SDP mechanism, recommending that states develop rigorous, multiyear evaluation plans.[52] Mathematica has outlined gaps in SDP data collection and the need for a continuous improvement cycle to ensure these payments achieve desired outcomes.[53] In prior rulemaking, CMS set requirements for states to design SDP evaluation plans for rating periods beginning on or after July 9, 2027.[54] States must track and evaluate at least two metrics that measure effectiveness of the SDP to meet state-defined goals, however the

regulation requires states to submit an evaluation report *only* if the SDP exceeds 1.5 percent of total managed care costs.

CMS states in this NPRM it may issue further guidance for SDP evaluation,[55] and we agree this guidance is warranted as states and CMS need further metrics to evaluate whether increased rates enhance provider networks, improve access to care, drive positive patient outcomes or meet any number of state health care system goals. In addition, evaluations can determine whether it is appropriate for states to shift payment or quality metrics in MCO contracting going forward. **We urge CMS to require states to evaluate and publish the impact of *all* SDPs (even if payments do not exceed 1.5%) on a publicly accessible database. Public access to SDP evaluation data is important not only for maintaining transparency in how Medicaid dollars are spent, but also for allowing states to draw on successes and lessons learned from payment approaches in other states to design evidence-based payments in their own jurisdictions.** This is not to say that CMS should require a state Medicaid department to definitively know that a payment mechanism *will* work before it is able to test it out, but CMS can foster better data-sharing to help states design payments based on evidence if they have access to evaluation data from other states.

Ultimately, CMS and states should deploy and test innovative payment models across Medicaid and spread successful and cost-effective innovations across the system. We do not think this goal is achieved by placing attention solely on payment benchmarks or on payment type without greater attention to the *impact* of any chosen payment policy. After all, as CMS explains in the NPRM, after its 2024 policy setting the benchmark for hospital and nursing facility services at the average commercial rate, many states elevated directed payments to that level, whether or not supported by evidence that those payment levels were appropriate or would yield quality outcomes. CMS is again proposing a policy that may yield costly unintended consequences:

- Capping rates at Medicare for primary care, behavioral health and other community-based services could drive a similar upward payment trend for these services, even though, under current regulation, most of these payments do not rise to Medicare rates (for example, the Tennessee and Utah examples outlined above). Without better SDP evaluation information and comparative payment data, it would be difficult for states to have a reasoned approach to modifying current payment rates and they may instead simply raise rates following CMS' lead, as states have done in the past, without properly considering the many factors that should go into rate setting.
- Likewise, narrowing SDP types to a minimum/maximum fee schedule will drive states to design SDPs as those payment types, even though these types of payments have mixed results in successfully increasing quality of care (as described above).

Rather than set policy choices based on limited data, we urge CMS to analyze managed care payment data submitted by states and set higher standards for states to evaluate SDPs. While CMS awaits this critical data, it should allow states to retain the flexibility they have today to design and test payment approaches and incubate ideas that solve specific problems. However,

before CMS approves payments that are above the Medicare benchmark, it should ask states to demonstrate that payments are tailored to address specific access and quality challenges. Down the road, with better data in hand, CMS can set stronger metrics for which directed payments it will approve going forward and use data to drive toward value-based payment—whether through SDPs or other mechanisms.

Conclusion

SDPs are an important mechanism relied upon by states to ensure Medicaid programs can enlist enough providers to ensure the "proper and efficient operation" of the Medicaid program, as required by the Social Security Act. As described in this letter, restricting states' use of uniform increase SDPs will hamper efforts in states to incentivize providers to offer evidence-based, high-value and cost-effective services. Likewise, benchmarking all Medicaid payments to the Medicare rate without offering appropriate flexibilities to supplement Medicaid reimbursement constricts state ability to design payments that are "reasonable, appropriate and attainable" and advance access to high-value primary care and behavioral health services. **While we agree that Medicare can serve as a national benchmark and should serve as the floor for the reimbursement of most health care services, the NPRM removes critical flexibilities each state needs to run an efficient program, appropriate for the unique needs of their Medicaid population. We respectfully request CMS to withdraw the portions of the proposed rule that are not required under H.R.1 and retain flexibility for states to test innovative, evidence-based payment models across Medicaid, even if payment rates need to exceed the Medicare rate to support Medicaid program goals.**

Of course, SDPs are not the only potential way to secure adequate payment for providers that participate in Medicaid networks, nor the only way to foster state experimentation in Medicaid payment approaches. After all, SDPs are a relatively new payment mechanism, having replaced former methods for supplementing Medicaid provider pay to offset low base rates.[56] CMS can modify SDPs, return to former payment policies or design new ones, but **CMS' underlying focus must be to ensure state Medicaid programs can pay providers well enough to secure their participation in the program.**

Even if CMS moves forward with its proposed policies to significantly limit the SDP mechanism, it has not done away with the problem: states must now find other ways to adequately pay providers and properly fund Medicaid patient care. CMS is putting states in the difficult position of having to make up for the estimated over $780 billion in cuts to provider payment that will result from this proposed rule.

Until it has clear evidence of the soundest payment approaches—and the agency is on the cusp of collecting data that would illuminate optimal payment mechanisms and rates—CMS should want to continue to foster state experimentation. In the end, the federal government needs to support state Medicaid programs in paying honest rates to providers. Health care is costly, and Medicaid is no exception. We agree that health costs are not sustainable, but CMS is not putting forward any *solutions* to the problem. CMS is only painting states into a corner, forcing them to

restrict access to care or find other ways to fund Medicaid. This is a kick-the-can-down-the-road approach, one that will have steep consequences for access to care and will put states in no-win scenarios to figure out new ways to pay providers, without driving the change we need. CMS does not have to continue to put states in this position. CMS can work collaboratively with states to allow payment flexibility above the Medicare floor where it is warranted but require rigorous evaluation of such approaches. CMS can continue to support provider payments that work today while fostering the state innovation needed to help push the system toward value-based models in the future.

Families USA stands ready to assist CMS in developing a thoughtful and strategic approach that meets agency goals while ensuring access to care for low-income Americans and their families, and fiscal sustainability for the Medicaid program.

We thank you for the opportunity to comment on CMS' implementation Public Law 119-21 § 71116. For questions or comments regarding the recommendations in this letter, please contact Mary-Beth Malcarney, Senior Advisor on Medicaid Policy, Families USA at mmalcarney@familiesusa.org.

Thank you for your time and consideration.

Sincerely,

Sophia Tripoli
Senior Director of Health Policy

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