July 21, 2026

The Honorable Dr. Mehmet Oz
Administrator, Centers for Medicare &
Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Oz,

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the notice of proposed rulemaking (NPRM) on Medicaid managed care state directed payments (SDPs) and fee-for-service (FFS) targeted practitioner payments published on May 22, 2026 (CMS 2026). MACPAC is a nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program.

This proposed rule includes several provisions to implement statutory limits on SDPs pursuant to Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act). Consistent with the 2025 Budget Reconciliation Act, the proposed rule defines the Medicare-based payment limit applicable to new SDPs and specifies how SDPs that are grandfathered under the statute would be phased down over time. In addition, it extends the Medicare-based payment limits to all SDPs and certain targeted Medicaid FFS practitioner payments.

MACPAC appreciates this opportunity to share insights from our extensive body of work on SDPs. In the Commission's June 2022 report to Congress, we examined the oversight of managed care directed payments and made recommendations to improve their transparency, including that the Secretary make directed payment approval documents, evaluations, and provider-level payment data publicly available and require states to clarify how directed payment amounts compare to prior supplemental payments and whether these payments are necessary to meet access standards (MACPAC 2022). In an October 2024 issue brief, we found that directed payments are a large and growing share of Medicaid spending, that the largest arrangements are typically targeted to hospitals and financed in part through health care-related taxes or intergovernmental transfers, and that improving access to care is the most commonly stated goal of these arrangements (MACPAC 2024).

The Commission supports efforts to ensure that Medicaid payments are consistent with the statutory principles of economy, efficiency, access, and quality (§ 1902(a)(30)(A) of the Social Security Act (the Act)). However, the Commission has

concern that the proposed application of the Medicare-based limits on SDPs and targeted FFS practitioner payments at the service level as detailed in the proposed rule may limit states' flexibility to use payment policy to achieve policy goals of access and quality.

Service-specific limits

This proposed rule implements payment limits on total payment rates for both SDPs in Medicaid managed care and targeted practitioner payments under FFS. As specified in the 2025 Budget Reconciliation Act, the proposed rule promulgates changes for SDPs requiring prior written approval by the Centers for Medicare & Medicaid Services (CMS) (e.g., uniform rate increase, value-based payment (VBP)) to replace the average commercial rate ceiling for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center with a Medicare-based limit. This Medicare-based limit is 100 percent of the total published Medicare payment rate in expansion states and 110 percent of the Medicare rate in non-expansion states. If there is not a published Medicare payment rate for a particular service or provider, the limit is the Medicaid state plan approved rate.

The proposed rule defines the total published Medicare payment rate as the amounts calculated as payment for specific services that have been developed for Medicare Parts A and B. Additionally, the proposed rule interprets the term "payment rate" to mean the specific payment rate for a service furnished by a provider, meaning the Medicare-based limit would apply on a claim-level basis specific to each service and provider. For example, the payment limit for most inpatient hospital services would be derived using the Medicare Severity Diagnosis Related Groups (MS-DRG). Each MS-DRG reflects the anticipated cost of inpatient treatment for patients in that group compared to the anticipated cost across all Medicare patient groups (MedPAC 2023).

The proposed rule would extend the Medicare-based limit beyond the service categories specified in statute to all services covered under SDPs for rating periods beginning on or after January 1, 2029. Furthermore, the proposed rule would apply the same Medicare-based limits in expansion and non-expansion states to the total FFS payment when all or a portion of the payment is targeted to a subset of participating practitioners or providers furnishing the service within the state or within a specified geographic region (i.e., county, parish, borough, or municipality). Similar to the proposed SDP provisions, the Medicare-based limit would apply at the service level with the payment ceiling defined as the Medicare FFS payment rate that would be paid to the practitioner or provider for the service if it were paid under the applicable Medicare payment rates established under Parts A and B.

State flexibility in payment policy

The Commission has concern that the proposed application of Medicare-based limits on SDPs and targeted FFS practitioner payments at the service level may limit states' flexibility to use payment as a tool to achieve policy goals. SDPs have been leveraged to allow states to require managed care organizations (MCOs) to make specific payments or to fund specific initiatives for health care providers to support Medicaid programmatic goals such as quality and access to care. MACPAC has found that improving or maintaining access to care is the most commonly stated goal of directed payment arrangements (MACPAC 2024). States have used directed payments to promote access to care for specific services and populations and to support specific provider types, including critical access hospitals, rural health clinics, children's hospitals, and community mental health centers, as well as for specific services such as behavioral and maternal health services (MACPAC 2024).

The application of service-level payment limits for SDPs and targeted FFS practitioner payments may limit states' ability to implement innovative payment models. For example, the Commission has examined Medicaid payment

initiatives intended to improve maternal and birth outcomes, a category of services for which Medicaid is the primary payer for a large share of births and for which Medicare covers comparatively few enrollees. MACPAC has documented that states have adopted payment models specifically designed to advance maternity-related quality and access goals, including bundled payments, blended payments for delivery, pay for performance, and medical homes (MACPAC 2019). In 2011, Tennessee's Medicaid program implemented a blended provider payment for all vaginal and cesarean deliveries in Medicaid managed care (a single payment for a birth regardless of the mode of delivery) with the aim of reducing the financial incentive to perform non-medically indicated cesarean sections. At the time of its adoption, the vaginal delivery payment rate was increased by 17 percent, and cesarean delivery payment rates were lowered to match the new vaginal delivery rate. This payment differential was gradually lowered; by 2014, the blended payment rate was closer to rates paid for vaginal delivery rates prior to 2011 (MACPAC 2019). It is not clear whether a state would be able to use a similar strategy to develop a blended rate under SDP arrangements because it would be difficult to increase the payment for vaginal delivery enough to create a sufficient blended rate and still remain under the payment amount made under Medicare. Additionally, because cesarean deliveries have a higher Medicare payment rate, establishing the limit at the service level may create a financial incentive to shift toward more non-medically indicated cesarean deliveries to increase revenues.

Applying the Medicare-based limits at the service level may limit a state's ability to implement VBP models with upside risk for providers, particularly when Medicaid base rates already approximate or are close to Medicare rates (SHVS 2026). The Commission has found that directed payments allow states to require MCOs to increase the use of VBP models, including pay-for-performance incentives, shared savings arrangements, and other alternative payment models (MACPAC 2024, 2022). MACPAC's review found that VBP directed payment arrangements were more likely than other types to address goals tied to quality of care and patient outcomes (e.g., reducing avoidable hospital use and increasing receipt of preventive screenings) and were also more likely to advance goals related to cost-effectiveness (MACPAC 2024).

Medicare as a benchmark for Medicaid

Medicare is a commonly used payment benchmark in Medicaid. For example, CMS established an upper limit on FFS payments to institutional providers (e.g., hospitals, nursing facilities) based on an estimate of what would have been paid for the same service under Medicare payment principles (42 CFR 447.272 and 447.321). This limit is referred to as the upper payment limit (UPL). Additionally, Section 1903(i)(27) of the Act institutes a FFS spending limit for certain durable medical equipment (DME) based on what Medicare would have paid for such items. These UPLs on institutional providers and DME are typically applied in the aggregate, in contrast to the service-level limits proposed for SDPs and the targeted FFS practitioner payments.

Medicare payment rates for individual services may not reflect the relative costs to provide services at appropriate levels of access to non-Medicare beneficiaries. Medicare payment rates have been developed to promote goals specific to the Medicare population, who are primarily over age 65 or have qualifying disabilities. The care needs and use of specific services within the Medicare population differs substantially from a large portion of the Medicaid population, such as children and pregnant women. For example, in the 2007 rule that implemented the new MS-DRG algorithm, CMS stated that the MS-DRGs were specifically designed for the purposes of Medicare inpatient hospital payment and use Medicare-specific data to evaluate DRG classification changes and to recalibrate the weights. Therefore, newborns, maternity, and pediatric patients are not well represented in the data used in the design of the MS-DRGs. CMS encouraged others using the MS-DRGs for non-Medicare populations to make relevant refinements to better serve the needs of those patients (CMS 2007).

Similarly, Medicare payment rates to specific providers may not support states' policy goals, such as increasing payment to rural providers to improve access. For example, Mississippi pays the same rate to all hospitals without

the labor-market adjustments that Medicare uses. The state adopted this approach to promote access to hospital care in rural areas because labor-market adjustments typically reduce payments in rural areas (MS DOM 2025).

These examples illustrate how the development of Medicare payment may not be well aligned with the populations enrolled in Medicaid and the services and providers they use. Applying the Medicare-based limits at the service level may inhibit states' ability to use different payment models and rates to address their particular access concerns and policy goals.

Monitoring and compliance

The administration of Medicare-based payment rate limits at the provider and service level will be administratively complex and burdensome compared to other alternatives such as aggregate limits. Under the proposed rule, states are required to submit a list of all providers eligible for the SDP and their National Provider Identifiers, the total published Medicare payment rate (or state plan approved rate if applicable) that serves as the basis of the payment limit for each service covered under the SDP, and a detailed description of how the state will ensure that payment to each provider for each furnished service does not exceed the payment limit. To ensure compliance with the limits, states would need to review millions of individual service claims from their MCOs to ensure that each was paid under the limit. This would entail the state repricing each claim to verify the payment was below the appropriate limit, which may involve the application of complex payment methodologies such as outlier payments or development of a comparable Medicare payment rate for a comparable Medicare-covered service when there is not an exact Medicare equivalent, as required under the proposed FFS targeted practitioner limit.

Even with the application of the Medicare-based limits at the provider and service level, CMS could consider ways to reduce the administrative burden of oversight and reporting on states and plans. For example, CMS could require that more detailed claim-level verification is only necessary if an analysis of summary-level data indicated that the total amount spent exceeded what it would have been under Medicare. This type of approach would decrease the oversight burden on states and MCOs. MACPAC's work on the oversight of directed payments and on the transparency of Medicaid payment and financing has documented that oversight and the associated data collection already impose meaningful administrative burden on states, and that CMS should seek ways to reduce that burden, including by streamlining reporting where possible (MACPAC 2024a, 2022).

Technical comments

MACPAC submits the following technical comments on areas where CMS could provide additional clarifications and guidance on how the Medicare-based payment limits are applied in situations that are not direct SDP arrangements, the provider does not submit a Medicare cost report, or where Medicare payment methods and rates may exist but Medicare has not actually paid for that particular provider or service.

Actuarial soundness

In the preamble of the proposed rule, CMS states that the proposed limits would only apply when providers receive payments through SDPs, and that absent SDPs, Medicaid managed care plans may continue to negotiate provider payment rates that exceed the Medicare-based payment limit when necessary to ensure a sufficient provider network. CMS also indicates that it would consider situations in which the state directs actuaries to develop capitation rates assuming higher provider payment rates as implicit SDPs because the state is directing assumptions about provider payment levels through the rate development process. CMS includes an example whereby a state legislature appropriates funding for enhanced provider payment rates, and the state requires the actuaries to include that appropriation as an assumption for increased provider payment rates for capitation rate development. This example raises questions as to the difference between implicit SDPs and typical policy and programmatic changes or adjustments to support access that actuaries would normally include in capitation rate

development. In the case of the provided example, if the enhanced provider rates are applied in FFS, then it may be a reasonable assumption for the actuaries to expect these providers to negotiate similar payment rates with the managed care plans in the upcoming rate year. CMS should provide additional guidance clarifying when actuaries can include certain payment rate assumptions to meet actuarial soundness requirements without being considered implicit SDP arrangements, particularly if those assumptions would raise payment above the SDP limits.

Medicare cost reports

Medicare reimburses certain providers, such as critical access hospitals, certain cancer hospitals, and freestanding children's hospitals, on a cost basis. For these providers, CMS would consider the cost-based payment approach as the total published Medicare payment rate for the purpose of the SDP payment limit. For purposes of validating how the state establishes the prospective SDP payment limit on a per service or discharge basis to these cost-based providers, CMS proposes to require the state to submit the most recent and complete Medicare cost report and the appropriate cost allocation methodologies used to derive service-level payment amounts. The Commission notes that some Medicaid providers, including many children's hospitals, do not submit Medicare cost reports. Requiring these providers to submit Medicare cost reports would increase their administrative burden. CMS should provide guidance on whether and how states and providers can document and report costs through other methods outside of the Medicare cost report.

Establishing appropriate SDP limit

CMS may want to clarify what SDP payment limit would apply to providers who have not been paid by Medicare, such as some children's hospitals, but could be paid under a Medicare-based methodology. In these situations, CMS could clarify whether the SDP payment limit applied to the provider would be the theoretical Medicare payment (e.g., cost-based), the approved state plan rate, or the state's choice between the two methodologies.

Similarly, CMS could clarify whether states have any flexibility in the payment limits when Medicare's payment rates could be used broadly to pay for a service, but do not necessarily reflect the provision of that specific service. For example, providers frequently receive a Medicare new technology add-on payment (NTAP) for high-cost cell and gene therapies (CGT) in addition to the MS-DRG payment. However, the NTAP payment may not cover the full cost of the CGT. This could be particularly true for CGTs indicated for pediatric populations, for which Medicare may not assess the cost of these therapies for payment adjustments due to the low applicability to the Medicare population. Under the Medicaid Drug Rebate Program, states must cover these CGTs. For these pediatric CGTs, Medicare may theoretically pay for the service under a broad CGT-related DRG and NTAP that may not reflect the specific cost of the pediatric CGT and ancillary services sufficiently, creating potential access issues for beneficiaries accessing services through the Medicaid program. In addition, many states carve out the cost of the CGT from the bundled DRG payment to ensure that they get the rebate for the drug and to manage the financial risk on the provider; this type of payment methodology may not map cleanly to a Medicare payment rate. CMS could provide guidance to states on how the Medicare-based payment limits would be applied in these situations and whether states have any flexibility to use a cost-based or approved state plan rate methodology instead of a Medicare rate that may not be specific to that individual service.

Conclusion

While MACPAC supports efforts to ensure that Medicaid payments are consistent with statutory principles of economy, efficiency, access, and quality, the Commission notes that Medicare payment rates are not designed to support the different populations covered under Medicaid, such as children and pregnant women, and that applying payment limits at the service level can restrict states' flexibility to design payment rates and methods that support policy goals of access or quality. The Commission encourages CMS, while finalizing this rule, to consider

providing states with additional flexibility in developing payment rates. The Commission remains committed to publishing research and analysis on Medicaid payment and financing and would welcome the opportunity to provide any further information that would assist CMS as it finalizes the rule.

Sincerely,

Verlon Johnson, MPA
Chair

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