July 21, 2026

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

Dear Administrator Oz,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on the proposed rule, Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments.

Executive Summary

Medicaid agencies share CMS' commitment to effectively steward taxpayer resources and safeguard program integrity while ensuring access and robust quality of care for Medicaid members. State directed payments (SDPs) serve as an important tool for states and territories to strengthen provider networks, advance quality initiatives, support delivery system transformation, and improve access to care. While Medicaid agencies support CMS' goal of establishing clear and sustainable parameters for SDP financing, **agencies encourage CMS to preserve state and territory flexibility in key areas, minimize unnecessary administrative burden, and provide sufficient transition time and clear pathways for existing arrangements. Specifically, NAMD encourages CMS to:**

- **Limit application of the new Medicare-based payment limits to the inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services identified in Public Law 119-21.**[1] If CMS finalizes broader application of the payment limits, it should extend the proposed grandfathering provisions to all affected service categories after the effective date of the limits.
- **Provide greater flexibility and clarity for services without a meaningful Medicare equivalent.** Many Medicaid services have no direct Medicare counterpart, and states and territories rely on SDPs to support access to these services, particularly in rural and underserved communities. CMS should provide additional flexibility and clear guidance regarding how payment limits should be applied in these circumstances.
- **Partner with Medicaid agencies to surface and address operational challenges with provider- and service-level data reporting and analysis comparing Medicaid payment rates to applicable Medicare payment rates, jointly develop reporting methodologies with NAMD's membership, and in the interim, allow the use of alternative methodologies.**

[1] Public Law 119-21 is also referred to as H.R. 1, the Working Families Tax Cut (WFTC) legislation, and the One Big Beautiful Bill Act (OBBBA).

Many of NAMD's members are concerned that some proposed policies could inadvertently undermine access to care, quality improvement efforts, and value-based payment initiatives in their programs. Medicaid agencies have also engaged for years on increasing the adoption of value-based payments in their programs as a mechanism for both fiscal accountability and quality enhancement, including in direct partnership with the Centers for Medicare & Medicaid Innovation's pilots and models. These approaches would likely be inhibited under this rule.

About NAMD

NAMD is a professional community of state and territory leaders who provide health insurance to almost 75 million individuals and families through Medicaid and the Children's Health Insurance Program (CHIP) in each of the 50 states, the District of Columbia, and the U.S. territories. NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives. In addition to supporting Medicaid Directors, NAMD serves over 500 other senior Medicaid leaders, including convenings with subject matter experts in finance and budget, technology, eligibility policy, and communications to share operational expertise, support policy implementation, and exchange promising practices across states and territories.

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Expanding Medicare-Based Payment Limits to all Services

Medicaid agencies are concerned with CMS' proposal to extend Medicare-based payment limits to all SDP service categories beyond the inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services identified in Public Law 119-21. **We recommend CMS limit application of the new payment limits to the services specified in statute and refrain from expanding the policy to additional provider and service categories absent further Congressional direction.**

If CMS does apply the new payment limits to SDP service categories beyond inpatient hospital, outpatient hospital, nursing facilities, and qualified practitioner services, CMS

should apply the grandfathering provision to all service categories. A uniform transition framework would simplify implementation, improve predictability for states and territories, providers, and reduce administrative complexity. States and territories also question the need for different transition schedules across provider types and SDP arrangements if all arrangements are ultimately transitioning to the same payment limit framework.

The changes described in the proposed rule could have significant financial implications for providers. As a result, the proposal could undermine states' and territories' efforts to maintain provider participation, preserve access to care, and support broader health care system sustainability.

States and territories are particularly concerned about the impact of the proposal on provider types and services that have historically received targeted investments due to chronic underfunding, including primary care, behavioral health, and home and community-based services. In some cases, states and territories have intentionally adopted reimbursement approaches that exceed Medicare rates to address workforce shortages, improve access, or support services that have no direct Medicare equivalent. Applying a Medicare-based payment limit in these circumstances may constrain states or territories' ability to respond to local program needs and advance policy priorities, such as ensuring access to these critical Medicaid services in rural or frontier communities.

NAMD also encourages CMS to provide additional clarity regarding how the proposed payment limits would apply to Medicaid-specific payment methodologies and provider types. For example, the proposed rule does not clearly address how payment limits would be calculated for state-plan-approved bundled payment arrangements, managed-care-only services without a state plan equivalent, or services furnished by Federally Qualified Health Centers, where Medicaid payment methodologies differ significantly from Medicare reimbursement approaches.

Provider- and Service-Level Analysis

CMS has previously partnered with Medicaid agencies in obtaining reliable provider-level data on Medicaid payments in other contexts, such as supplemental reporting under Section 1903 (bb), recognizing that standardized reporting is a significant undertaking that requires operational planning, data validation, and implementation on behalf of the Medicaid agency. The proposed rule would build on those reporting requirements by requiring Medicaid agencies to conduct provider-level and service-level analyses comparing Medicaid payment rates to applicable Medicare payment rates. NAMD is concerned with moving to this level of analysis too abruptly, given the historical complexity of collecting and reporting provider-level payment data and the operational complexity of assigning supplemental payments to individual providers and services for comparison to Medicare rates.

Therefore, **NAMD encourages CMS to partner with Medicaid agencies to jointly resolve operational challenges with this data reporting and analysis before requiring it in regulation.** This could include developing reporting templates and methodologies to effectuate the degree of oversight CMS is looking to achieve. In the interim, while this work is underway, NAMD recommends that CMS permit states and territories to demonstrate compliance using alternative methodologies, such as aggregate analyses, actuarial certifications, or other

approaches that reasonably effectuate near-term application of the Medicare payment limits until standardized provider-level and service-level analytic methods have been established.

Additionally, **applying payment limits at the individual provider level may have unintended consequences for quality improvement and value-based payment initiatives, including initiatives designed by CMS' Centers for Medicare & Medicaid Innovation in which state Medicaid programs participate**. Existing SDP regulations require states and territories to offer performance-based initiatives to provider classes using consistent terms and conditions. Under the approach described in the proposed rule, providers that have reached the payment limit could become ineligible for additional performance incentives, limiting states' and territories' ability to reward high-quality care and potentially weakening incentives that support quality improvement efforts and value-based payment. In addition, provider participation may vary across managed care plans, creating operational challenges for states and territories as they calculate performance, develop capitation rates, and administer SDP arrangements.

Finally, mechanisms such as bundled payments are typically introduced, when clinically appropriate, to increase fiscal accountability, and undermining such accountability with a rigid per service approach is counter to the goals of the original legislation. One of the accountability mechanisms CMS is proposing, Medicare Severity Diagnosis Related Groups (MS-DRGs) under inpatient hospital prospective payment systems (IPPS), is a bundled payment mechanism. Given this, **NAMD recommends CMS create pathways for other payment models as such models are generally designed to enhance financial accountability, which aligns with the statute and CMS' goals.**

Feedback on Definitions and Other Terms

Defining Payment Limit Methodology

In the proposed rule, CMS proposes to define the payment limit as 100 percent of the total published Medicare payment rate for an expansion state, 110 percent of the total published Medicare payment rate for a non-expansion state, and 100 percent of the state plan approved rate when there is no total published Medicare payment rate for the covered service. CMS is proposing to implement the payment limit on a retrospective per service or per discharge basis, including at the Healthcare Common Procedure Coding System (HCPCS) code level and MS-DRGs for IPPS.

CMS acknowledges this includes adjustments such as geographic and quality adjustments. CMS cites the statutory language of "payment rate" and the June 6, 2025 Presidential memorandum as reasoning to define payment limit on a per service/per discharge basis. For Medicare providers paid on a cost-basis (e.g., critical access hospitals), CMS proposes setting the payment limit to the most recent and complete Medicare cost report to establish the prospective SDP payment limit on a per service or discharge basis.

Medicaid agencies are concerned that the proposed methodology will be challenging to implement or even operationally infeasible absent significant additional support from CMS. Implementing a provider-level, service-level payment limit would require states and territories, managed care plans, and providers to develop and maintain complex crosswalks between Medicaid reimbursement methodologies and Medicare payment methodologies. **NAMD encourages CMS to partner with Medicaid agencies to resolve these operational and**

administrative challenges before requiring provider-level, service-level limits in regulation. This collaboration could result in reporting templates, example methodology, technical guidance, and other tools to support the significant new work required of Medicaid agencies, actuaries, managed care plans, and providers. Additionally, some Medicaid agencies also anticipate increased administrative costs for managed care plans and providers associated with new data collection, analysis, and reporting requirements necessary to comply with provider-level, service-level payment limits.

Medicaid agencies also noted that Medicaid and Medicare payment systems are not always directly comparable. Differences in patient populations, service utilization patterns, covered benefits, and reimbursement methodologies can make it difficult to establish a one-to-one crosswalk between the programs. For example, some states use Medicare MS-DRGs but develop their own weights to reflect Medicaid utilization patterns, including for services such as obstetrics and neonatal intensive care. This is particularly important as states indicate that the existing MS-DRG weights for common Medicaid service lines, such as neonatal, obstetric, and pediatric services, are largely placeholder values that do not appropriately reflect the costs of these services given their very limited footprint in Medicare. This could result in artificially low payment limits on core Medicaid services. In previous Medicare rulemaking, CMS stated that it did not have sufficient Medicare cases to develop accurate MS-DRG weights for pediatric services and that other payors would need to develop their own DRGs or relative weights. As such, other Medicaid services may be appropriately reimbursed using per diem methodologies or alternative payment approaches that do not align directly with Medicare payment structures. As a result, application of Medicare payment limits at the service or discharge level may produce unintended distortions and inaccurate comparisons.

Defining State Plan Approved Rate

CMS also proposes revising the definition of "State Plan Approved Rate" to require that the applicable state plan rate be approved by CMS before the start of the rating period.

While Medicaid agencies appreciate CMS' desire to align payment limit calculations with prospective rate setting processes, the proposed approach could create significant operational challenges and payment disparities between FFS and managed care delivery systems.

CMS further proposes revising the existing definition of “State Plan Approved Rate” to remove “CMS approved” to instead say “described under rate methodologies in the Medicaid state plan submitted to CMS before the start of the rating period.”

Medicaid agencies and CMS work collaboratively to submit and review rates. However, a number of factors can lead to delays in the approval timeline, including delays because of the volume of requests CMS must review. The proposed rule itself does not account for these realities or the operational challenges they create for Medicaid agencies administering both FFS and managed care delivery systems. Without clear CMS review timelines, the proposal could prove difficult to operationalize for both Medicaid agencies and CMS.

Absent these consistent timelines, states and territories anticipate that CMS approval lags would create significant disconnects in payments between providers in managed care and FFS. State

plan rates can take effect six months or more before state plan amendment approval is ultimately obtained, which will typically be too late to consider in annual capitation rate setting timelines, resulting in major lag between managed care and FFS rates. This lag could create payment discrepancies between managed care and FFS providers and may discourage provider participation in managed care networks.

Therefore, we recommend CMS reconsider this proposal and allow Medicaid agencies to rely on state plan rates that are effective under approved state plan methodologies, even if formal CMS approval occurs after the start of the rating period. This approach would preserve alignment between FFS and managed care payment rates while recognizing the practical realities of the state plan amendment review process.

Payment Limit Monitoring and Compliance

CMS proposes requiring Medicaid agencies to submit detailed documentation demonstrating compliance with the payment limits, including:

1. A list of all providers eligible for the SDP and their National Provider Identifier (NPI);
2. The total published Medicare payment rate or state plan approved rate; and
3. A detailed description of how the state would ensure that the payment for each provider for each furnished service would not exceed the payment limit. This includes detailed information about the processes, systems, technology, or other controls they would use to ensure the payment limit.

As discussed above, NAMD is concerned that these documentation requirements would create substantial administrative burden for Medicaid agencies given the well-documented operational challenges in generating provider-level reporting in other contexts. To comply with the proposed requirements, states and territories may need to develop, maintain, and potentially submit thousands of data points for CMS review. This would likely require significant new investments in information technology systems, vendor support, data analytics, and ongoing compliance monitoring. CMS itself will need to design systems and analytics to conduct oversight of this large amount of data in an actionable manner.

Further, provider participation and NPIs frequently change during plan years. While Medicaid managed care providers must enroll with the state or territory, Medicaid agencies do not always have readily accessible information regarding which providers participate in which managed care plans for specific services. As a result, developing and maintaining SDP-specific provider lists may be challenging and, in some circumstances, impracticable. This is an area where additional technical assistance from CMS would be of benefit to NAMD's members.

Therefore, we reiterate our recommendation that CMS work with Medicaid agencies to identify and ameliorate operational challenges for provider-level and service-level documentation before requiring this in regulation and allow alternative reporting approaches in the interim.

Temporary Grandfathering Period

Medicaid agencies appreciate CMS' efforts to establish a transition period for grandfathered SDPs and support the agency's goal of providing a clear pathway to the new payment framework. **As CMS finalizes these provisions, we encourage CMS to reconsider the**

proposal to use Item 4 of the SDP preprint as the sole basis for determining the grandfathered total dollar amount.

Item 4 was intended to capture an estimated total dollar amount associated with the SDP and was not understood by states and territories to function as a binding spending limit. As a result, using Item 4 as the grandfathered amount may create implementation challenges for existing SDP arrangements that were developed based on different assumptions and guidance.

Historically, some states and territories may have reported only the incremental increase associated with the directed payment, while others may have reported the total value of payments associated with the affected services using Item 4. As a result, similarly situated SDP arrangements could have different grandfathered amounts based solely on differing interpretations of the preprint instructions rather than underlying policy differences.

Additionally, Item 4 may only represent an estimate and may not accurately reflect actual SDP expenditures. Total spending under an SDP can fluctuate significantly due to changes in enrollment, utilization, provider participation, and other factors outside the control of the state or territory. This is particularly true for fee schedule-based arrangements and population-based value-based payment models.

Next, CMS proposes to continue allowing separate payment terms for grandfathered SDPs due to operational realities. NAMD agrees that **additional flexibility is warranted during the grandfathering period and supports CMS' proposal to continue permitting separate payment terms for grandfathered SDPs.** Allowing separate payment terms on a temporary basis would provide states, territories, managed care plans, and providers additional time to transition existing arrangements to the new requirements while reducing operational disruption, reducing fiscal risk, and supporting a more orderly implementation process.

Finally, NAMD requests additional clarification regarding the interaction between the proposed grandfathering provisions and the Medicare payment limit framework. The proposed rule references the Medicare payment limit both as a measure for determining whether an SDP remains grandfathered and as a test for determining when an SDP has "graduated" from grandfathered status. It is unclear whether these are distinct tests, how they differ operationally, and whether the calculations would be performed at the provider level, service level, or another level of aggregation.

Therefore, we encourage CMS to provide additional flexibility in determining grandfathered SDP spending limits, consider alternatives to relying solely on Item 4 of the preprint, continue permitting separate payment terms during the grandfathering period, and provide additional clarification regarding the calculation and application of the grandfathering and graduation tests. These changes would help support a smoother transition to the new payment framework while preserving CMS' goals of promoting program and fiscal integrity.

Phase Down of Grandfathered SDPs

In the proposed rule, CMS is proposing to reduce the total grandfathered dollar amount by 10 percentage points each year beginning with the first rating period on or after January 1, 2028.

Medicaid agencies appreciate CMS' approach to apply the 10-percentage point phase down to the original grandfathered amount, rather than the prior year's reduced amount. This approach provides a more predictable and manageable phase down from a budgetary perspective.

Uniform Increase SDPs

In the proposed rule, CMS proposes prohibiting uniform rate increase SDPs and renewals of non-grandfathered uniform increase SDPs, beginning the first rating period on or after January 1, 2028. After the first rating period a grandfathered SDP meets the payment limit, the state or territory would need to modify their SDP design, because they would no longer be permitted to operationalize the SDP as a uniform increase.

NAMD appreciates CMS' efforts to establish appropriate safeguards around Medicaid reimbursement levels. However, **we encourage CMS to reconsider the proposed prohibition on uniform rate increase SDPs considering CMS' concurrent proposal to establish Medicare-based payment limits.** If finalized, the proposed payment limits would provide significant guardrails on reimbursement by limiting state flexibility in SDP design. Maintaining uniform rate increase SDPs as an available option would help states and territories continue to support access, quality, and delivery system goals while transitioning to the new payment framework.

Therefore, we urge CMS to maintain uniform rate increase SDPs as an available tool for states and territories. The proposed payment limits already establish appropriate guardrails on reimbursement levels, making an additional prohibition on uniform increases unnecessary and potentially disruptive to existing financing and delivery system strategies.

Medicaid FFS Targeted Medicaid Practitioner Payments.

In the proposed rule, CMS invites feedback on whether additional guidance would be helpful for states and territories seeking to preserve or expand the supply of providers in rural areas, including whether there are other appropriate means of identifying state-defined rural districts, provided such approaches do not allow states and territories to define rural districts in a manner that targets a particular practitioner or provider. **Medicaid agencies would welcome additional guidance in this area. However, CMS should not limit its consideration solely to rural areas.** States and territories may need to account for access challenges and service delivery structures that are not county-based and are not necessarily rural in nature. For example, ambulance service regions, public health regions, and other operationally defined service areas may more accurately reflect how care is delivered and accessed. **NAMD encourages CMS to allow reasonable state-defined regions, provided they are clearly specified in the state plan and are not designed to target individual practitioners or providers.**

CMS also seeks feedback on whether geographically uniform payment rates should be subject to the new payment limits. **Medicaid agencies generally support CMS' decision not to propose this requirement.** The geographic uniformity exclusion provides states and territories with an important tool for addressing localized challenges. Subjecting all geographically uniform payment arrangements to the new payment limits could make it more difficult for states and territories to respond to regional workforce shortages or access concerns, and may require

broader statewide rate increases to address issues that are limited to a particular geographic area.

Finally, Medicaid agencies would benefit from additional guidance regarding when states and territories should seek to identify and apply equivalent Medicare services for purposes of calculating the targeted Medicaid practitioner payment limit. While this approach may be feasible in certain circumstances, CMS should provide greater clarity regarding the methodology and factors states and territories should consider when making these determinations. The example of personal care services included in the proposed rule is helpful, but Medicaid agencies would benefit from additional examples and a more comprehensive, though not necessarily exhaustive, discussion of services that may or may not have an appropriate Medicare equivalent. Such guidance would promote consistency in implementation and reduce uncertainty as Medicaid agencies operationalize these requirements.

Conclusion

NAMD looks forward to continued collaboration with CMS to ensure effective and efficient use of taxpayer dollars and that all Medicaid members have access to high-quality care. For example, NAMD regularly convenes Medicaid budget and financial leaders to discuss emerging policy and operational issues, share promising practices, and learn from each other on innovative approaches implemented across states and territories. NAMD can also help connect members to existing technical assistance resources and federal forums to support successful implementation of federal financing policies.

We appreciate CMS' consideration of Medicaid agencies' perspectives on these important financing issues. Medicaid agencies share CMS' commitment to delivering strong fiscal and program integrity, while promoting improved access and robust quality of care to Medicaid members.

Sincerely,

Stuart Portman

Stuart Portman
NAMD Board President
Georgia Medicaid Director

Lee Grossman
NAMD Board President Elect
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