July 21, 2026

The Honorable Robert Kennedy
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Notice of Proposed Rulemaking, Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to submit comments on the Notice of Proposed Rulemaking (NPRM) on Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments ("SDP NPRM").

Our organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on Medicaid coverage. We have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In Public Law 119–21, Congress set new limits on the use of State Directed Payments (SDPs) in Medicaid. SDPs are a legal authority that states can use to improve payment rates in Medicaid managed care and have been critical to improving access for individuals living with serious and chronic illnesses by ensuring they can access the providers they need.[1] The limitations set out in PL 119-21 were already projected to lead to harmful funding losses for states – an estimated $149 billion over ten years in reduced federal funding, according to the Congressional Budget Office (CBO).[2] However, the SDP NPRM to implement the law goes far beyond the limitations on SDP payments established by Congress. CMS has estimated that the regulation would reduce federal funding for states by $515 billion over ten years – well over three times the CBO estimate based on the actual letter of the law.[3] These massive additional funding losses would harm access to care for individuals with serious and chronic conditions.

Our organizations recommend that CMS not finalize the provisions that have no basis in PL 119-21 and would harm individuals living with serious and chronic illnesses, as described further below. Instead, CMS should finalize only the provisions of regulations that are actually required by PL 119-21, consistent with the statute and in consideration of access to care for all individuals enrolled in Medicaid.

CMS should not finalize any provisions in the SDP NPRM that have no basis in PL 119-21

The SDP NPRM includes numerous constraints on SDP payments that go far beyond the standards in PL 119-21. We recommend that CMS not finalize any of these provisions, described below, which will impact providers and health systems that are critical for individuals with serious and chronic illnesses to access the care that they need.

PL 119-21 specifically applies new SDP payment limits to only four types of providers (inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center), but the SDP NPRM applies the payment limits to all types of providers. For example, most home care providers that individuals with serious and chronic illnesses rely upon should not be subject to SDP payment limits under the law, but could be impacted by the SDP NPRM. A wide range of providers could be impacted by this overbroad policy; the Medicaid and CHIP Payment and Access Commission estimated that 19% of SDPs enhance payments for Mental Health/Substance Use Disorder providers, 10% for Home and Community Based Services (HCBS) providers, 11% for physicians, and 3% for dental.[4] Many of these types of providers that Congress protected in PL 119-21 would be

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

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

[3] This figure of $515 billion includes $510.1 billion from SDP policy plus $5.34 billion of impacts on "other policy," including the fee-for-service limits proposed in the rule.

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

harmed by the SDP NPRM – along with their patients. CMS should finalize the SDP NPRM to only apply to the four types of providers specified in PL 119-21.

Additionally, although in PL 119-21 Congress set limits on how high uniform payment rates can be (in the form of caps based on Medicare payment rates), the SDP NPRM eliminates uniform payment SDPs altogether, starting with rating periods beginning on or after January 1, 2028. Uniform payment SDPs are a critical type of SDP, accounting for approximately 70% of SDP spending, under which payments to providers are increased by a certain dollar payment or percentage rate increase.[5] It is virtually certain that states will not be able to restructure all of these SDPs to preserve the current levels of funding, and will face an incredibly heavy administrative burden to replace any of it. This will represent a massive loss of financing for state health care systems, including safety net and rural hospitals, and will have harmful impacts on access to care well beyond the negative impact of the SDP limits included in PL 119-21. CMS should not finalize provisions affecting the use of uniform payment rate SDPs, outside of the payment limits set out in PL 119-21.

The SDP NPRM also sets limits on all types of SDPs, instead of only SDPs for which states must get written prior approval; extends the NPRM to include all U.S. territories, including Puerto Rico; changes the SDP accounting methodology, requiring a per-service and per-provider compliance standard instead of an aggregate payment level; and creates a new payment limit policy for fee-for-service supplemental payments. Again, these changes all go beyond the scope of PL 119-21 and should not be finalized. CMS should also not finalize provisions related to grandfathering in the SDP NPRM, including narrowing the definition of a grandfathered SDP and implementing a restrictive compliance timeline, that are inconsistent with the protections in PL 119-21.

CMS should not finalize policies which reduce access to care when Medicare rates are not available. The SDP NPRM's approach to services where Medicare rates are not available will also reduce access to care for people with serious and chronic illnesses. The SDP payment limits set under PL 119-21 are based on Medicare payment levels. Under the SDP NPRM, when Medicare payment rates are not available for a particular service, states must use Medicaid state plan payment rates as the payment limit. Since these state plan rates - that is, fee schedule rates - are typically far below Medicare levels, this will result in a major loss for providers furnishing services where no Medicare rate is available.[6] The impact of this policy is exacerbated by the fact that CMS's proposed rule expands the types of services subject to the payment limits to many types of services which Congress meant to insulate from the new SDP policy (as described above) and for which there are less likely to be existing Medicare rates, such as pediatric, maternal health, and HCBS services. For many of these providers there are also network shortages in states, meaning the new policy will deepen health care access problems for individuals. Under the SDP NPRM, states are effectively unable to use SDPs at all (above Medicaid payment rates). CMS should not finalize this provision of the SDP NPRM, and work with states, providers, and other stakeholders to instead develop different methods to identify an appropriate Medicare-equivalent payment rate.

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[5] *Id*.

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

The SDP NPRM will be extremely harmful to individuals with serious and chronic health conditions. The SDP NPRM will unduly restrict the capacity of states to improve Medicaid provider rates and will worsen existing provider shortages. Adequacy of payment rates is already a huge problem for Medicaid programs, including among providers serving those with serious and chronic illnesses. One key example is rates for hospitals. Base Medicaid payment rates (without SDPs and other supplemental payments including fee-for-service) are generally far below Medicare and private payer rates.[7] This has contributed to hospital closures, hospital unit closures, and many other hospitals operating with losses or razor thin budget margins that are at risk of closures.[8] This is particularly a problem for safety-net hospitals that are disproportionately dependent on Medicaid payment and rural hospitals.[9] Medicaid payment rates are also a problem for many other types of providers.[10] Once Medicaid provider networks collapse–either because providers go bankrupt or cease to accept Medicaid payment–they cannot be easily or quickly rebuilt, meaning the health care system damage is often irreversible in the near or middle-term. SDPs and other supplemental payments are thus critical for access not just for Medicaid enrollees, including those with serious and chronic illnesses, but for communities overall.

The SDP NPRM will also have a significant impact on many types of services and providers that individuals with serious and chronic illnesses rely upon. For example, the eventual elimination of uniform payment increases will harm access to hospital (inpatient and outpatient) and nursing facility care that is critical for individuals with serious and chronic illnesses.[11] As another example, the SDP NPRM provisions that create new payment limits for SDP providers such as mental health and HCBS providers will limit access to providers that individuals with serious and chronic illness also rely upon heavily.[12] Reduced access to these and other types of providers will have significant, harmful, and sometimes irreversible health consequences for individuals with serious and chronic conditions.

Finally, our organizations note that the harm of CMS's overly restrictive SDP policy will be compounded by other CMS regulations and subregulatory guidance implementing PL 119-21 also going well beyond the requirements of the law. For example, individuals with serious and chronic illnesses will also be heavily impacted by additional coverage losses related to new and unduly restrictive interpretations of medical frailty and self-attestation for compliance with Medicaid work reporting requirements. We urge CMS to recognize the immediate and multiplying harms created for individuals with serious and chronic

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[7] *Id*.

[8] Cecil G. Sheps Center for Health Services Research, "197 Rural Hospital Closures and Conversions since January 2005," available at https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures; Center for Healthcare Quality & Payment Reform, "Rural Hospitals at Risk of Closing" (May 2026), available at https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.

[9] *Id.*; Eileen O'Grady, "The Big Ugly Threat to Safety Net Hospitals," Public Citizen (March 31, 2026), available at https://www.citizen.org/article/big-ugly-threat; Kevin Bennett et al., "Why Rural Hospitals Are Facing a Funding Crisis — and How It Could Get Worse," Commonwealth Fund (February 9, 2026), available at https://www.commonwealthfund.org/publications/explainer/2026/feb/why-rural-hospitals-face-funding-crisis-how-it-could-get-worse.

[10] Stephen Zuckerman et al., "Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019," Health Affairs (Feb. 1, 2021), available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00611.

[11] Melissa De Regge et al., "The role of hospitals in bridging the care continuum: a systematic review of coordination of care and follow-up for adults with chronic conditions," BMC Health Services Research (2017), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC5551032/pdf/12913_2017_Article_2500.pdf.

[12] Barbora Sprorinova, "Association of Mental Health Disorders With Health Care Utilization and Costs Among Adults With Chronic Disease," JAMA Network Open (August 2019), https://pubmed.ncbi.nlm.nih.gov/31441939.

illnesses in these policies going beyond PL 119-21, and retract policies that are unnecessarily harming these individuals.

Sincerely,

AiArthritis
American Cancer Society Cancer Action Network
American Kidney Fund
American Lung Association
Asthma and Allergy Foundation of America
Autoimmune Association
Blood Cancer United
Cancer Nation
Cancer*Care*
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Family Voices National
Foundation for Sarcoidosis Research
Hypertrophic Cardiomyopathy Association
Legal Action Center
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
The AIDS Institute
The Coalition for Hemophilia B
UsAgainstAlzheimer's
ZERO Prostate Cancer