July 21, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Re: Value-Based Payment Considerations for Medicaid Managed Care State Directed Payments and Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)

Dear Administrator Oz:

The undersigned organizations committed to aligning Medicaid payment policies with value for patients and taxpayers write to share concerns about how the proposed rule implementing the state directed payment (SDP) provisions of the Working Families Tax Cut legislation (WFTCL) may undermine this goal. Specifically, **we are concerned that the proposed rule's overly prescriptive application of Medicare-based limits will interfere with state efforts to advance value-based payment (VBP) models that are tailored to the unique needs of Medicaid beneficiaries.**

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

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

CMS' proposed rule is likely to undermine this recent progress by requiring SDPs to fit into an overly narrow definition of Medicare-based limits at the service code or discharge level, deviating from CMS' prior practice of comparing Medicaid payments to Medicare using the broad category of service defined in the Medicaid statute. In addition, CMS proposes to further restrict Medicaid VBP models by retrospectively comparing payments to what would have been paid under Medicare FFS without any consideration of how shifts in care to more cost-effective settings have lowered costs for the health system. As a result, the rule will limit states' ability to reward providers for high-value care, even when total payments are less than what Medicare would have paid.

Below we offer suggestions for how CMS can better achieve its goals of rewarding quality care within federal fiscal guardrails.

1. States and MCOs should continue to have flexibility to implement VBP models

To preserve flexibility for states to implement VBP models, CMS should shift its focus from provider and service-code-specific limits and instead consider overall costs to states and

the federal government. This approach would allow states to target payments to providers who provide access to quality care. In addition, CMS should consider exceptions to Medicare-based limits for value-based payment models that can demonstrate cost effectiveness in other ways.

CMS should also ensure that efforts to regulate SDPs do not interfere with the ability of MCOs to negotiate their own VBP models with providers. In particular, we are concerned that CMS' proposal to prohibit uniform rate increase SDPs will require states to adopt minimum fee schedules that reduce the ability of MCOs to negotiate their own payment policies with providers to reward value-based care.

2. **CMS should align the calculation of Medicare-based payment limits with the simpler process used in Medicaid FFS**

Instead of creating an entirely new, burdensome process to enforce Medicare-based limits for SDPs, CMS should consider using the same methodologies that have long been used to establish the Medicare-based upper payment limit (UPL) in FFS Medicaid. CMS has already issued extensive guidance on options that states can use to calculate a reasonable estimate of what Medicare would pay for the broad categories of services outlined in the Medicaid statute, and Congress has recently taken action to improve the transparency and accountability of this process.[2] The UPL methodology allows states to make adjustments that account for the unique needs of the Medicaid population and services that do not have a clear Medicare equivalent. In addition, the policy allows states to implement VBP models that reward high-value providers as long as aggregate payments are below what Medicare would have paid. This simpler approach maintains reasonable federal fiscal guardrails without distracting from state efforts to improve access to quality care for Medicaid beneficiaries.

3. **CMS should not impose new limits on high-value services that are not required by statute and could increase costs to the overall health system**

CMS' proposed rule extends new SDP limits to other services not required by the WFTCL, such as behavioral health, primary, and specialty care, without consideration of how lack of access to these services could increase avoidable hospital use and other costs to the health system. In addition, the rule adds new limits on targeted practitioner services that will limit states' ability to target payments to providers who provide access to high quality care. These extensions are especially consequential for multispecialty medical groups and integrated systems of care, which rely on SDP-funded arrangements to invest in team-based primary care, behavioral health integration, and specialty access for Medicaid beneficiaries. Constraining these payments risks undermining the same coordinated, value-based models of care that CMS has otherwise encouraged providers to adopt. **Instead of imposing one-size-fits-all limits, CMS should continue to allow states the flexibility to design payment policies that efficiently and economically advance quality and access goals.**

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We appreciate CMS' stated commitment to rewarding value in Medicaid and welcome the opportunity to work together to ensure this rule advances—rather than limits—states' ability to pursue effective VBP models.

Sincerely,

Alliance of Community Health Plans
American Academy of Family Physicians
American Medical Group Association

American Nurses Association
America's Essential Hospitals
America's Physician Groups
Association for Clinicians for the Underserved
Association for Community Affiliated Plans
Association of American Medical Colleges
Catholic Health Association
Children's Hospital Association
First Focus on Children
Health Care Transformation Task Force
Leading Age
Medicaid Group Management Association
National Association for Behavioral Health
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Council for Mental Wellbeing
National Healthcare for the Homeless Council
National Rural Health Association
Primary Care Collaborative
Society of General Internal Medicine
Vizient, Inc.

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[1] Kozminski J. *State Directed Payments: Closing Medicaid Payment Gaps for Essential Hospitals*. Sept. 2024. https://essentialhospitals.org/wp-content/uploads/2024/09/Policy-Brief-Directed-Payments-September-2024.pdf. Accessed June 5, 2026.
[2] Section 202, Consolidated Appropriations Act, 2021 (P.L. 116-260)