July 20, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2449-P
P.O. Box 8016
Baltimore, MD 21244-8016

[CMS-2449-P**]** Medicaid Program; Medicaid Managed Care State Directed Payments (SDPs) and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Submitted electronically via: https://www.regulations.gov/commenton/CMS-2026-1916-0001

Dear Administrator Oz,

LeadingAge appreciates the intent of CMS to protect the integrity of the Medicaid program through the rule making process. We are grateful for the opportunity to submit comments on the CMS notice of proposed rulemaking: [CMS-2449-P**]** Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments.

We, along with our state partners, represent more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home.

SDPs Support Access to Care

State directed payments (SDPs) are an important tool that enable states to strengthen their Medicaid programs by addressing chronic underpayment in Medicaid fee-for-service (FFS) and managed care rates and ensuring beneficiaries have access to needed services. By providing states with the flexibility to direct targeted supplemental payments to providers, SDPs play an important role in preserving access to care for millions of Medicaid enrollees, particularly in rural, underserved, and high-need communities where financial pressures can threaten the availability of essential health services. These payments support a broad range of providers that serve Medicaid beneficiaries, including hospitals, physician practices, behavioral health providers, home and community-based service providers, dental providers, nursing facilities, and other safety-net organizations. SDPs also allow states to advance policy goals such as improving quality, expanding access, promoting value-based care, and addressing workforce shortages.

CMS' Proposed Implementation of the SDP Provisions of HR 1 Exceed Congressional Intent and Should Be Modified

In Section 71116 of HR 1, Congress directed CMS to establish caps on state-directed payments. HR 1 imposes new limits on directed payments in managed care arrangements to the Medicare-related cap for outpatient hospital services, inpatient hospital services, nursing home services, and qualified practitioner services at academic medical centers. Examples of "qualified practitioners" stretch beyond physicians to include physical and occupational therapists, along with other individuals trained or licensed in orthotics or prosthetics. For states that have not undertaken Medicaid expansion or similar policies, SDPs are capped at 110% of the posted Medicare rate, while for states that are providing expansion or expansion-like coverage, the cap is 100% of the posted Medicare rate. CMS says that they will use the state plan fee schedule for services that don't have a Medicare equivalency.

In this proposed rule, LeadingAge cautions that CMS exceeds their statutory mandate and what was intended by Congress in three key ways, which we describe further below. First, CMS proposes to apply the Medicare-based payment cap to all services provided through Medicaid Managed care rather than the four explicitly enumerated in the legislative text. Second, CMS requires states to establish caps on targeted payments in their FFS delivery models. Thirdly, compliance with the caps will be assessed at the service- or claim-level.

CMS should also withdraw their proposed limitations on uniform rate increases. The statute does not extend limitations on these arrangements which supports states' policy goals promoting access to services, cultivating provider networks, and offsetting traditionally low Medicaid reimbursements for providers caring for high percentages of Medicaid recipients. Uniform rate increases give states the ability to invest in specific provider categories, without the administrative burden of establishing minimum fee schedules.

LeadingAge urges CMS to reassess each of the rule's significant expansions beyond the law and revert back to regulatory policy that aligns with the law.

The rule as proposed increases the complexity of the policies and adds significant cost and burden for states without basis in the enabling statute and without adequate analysis or justification for such expansion in the rule itself.

CMS Should Revert to the Limits Enumerated in Statute- Applicable Caps in Four Services in Managed Care Only.

HR 1 was clear in limiting Medicare-based caps to four service categories within managed care contracting arrangements. These limits alone will be harmful to older adults and people with disabilities. CMS' proposed expansion includes primary care, dental, and community-based services – all of which are examples of services that struggle with access in the Medicaid program; this proposed policy will worsen that crisis. Payment limits on hospital and qualified practitioner services will cause provider and practitioner closures, and departure from Medicaid participation. When this happens, access to specialist, preventive, and emergency care will suffer for all individuals in a community, even those not accessing healthcare via Medicaid. Closures and retirements of providers will lead to longer wait times for appointments and increased travel distance to providers, including for older adults and people with disabilities. While abiding by the limits outlined in statute will cause access issues, CMS can temper the harm by reversing their proposal to expand SDP limits beyond what they are required to do by statute. Furthermore, the caps should only apply to the four specified services in managed care, not in FFS as proposed.

CMS Upends Decades of Guidance and Precedent in Using Service-Level Compliance
The rule proposes to assess compliance with the Medicare-based limits at a service level, diverging from former standards for institutional services that have calculated Upper Payment Limits (UPLs) at the statewide aggregate level.

As CMS attempts to define service-level compliance for services where there is no comparable Medicare service, the calculations will get very complicated and imprecise. CMS's proposed policy creates an impossible puzzle for providers, states, and for CMS themselves. For example, Medicare payment under the Patient Driven Payment Model (PDPM) for skilled nursing and under the Patient Driven Groupings Model (PDGM) for home health use patient-specific characteristics to establish payment rates for each individual, then modifies those rates based on other factors including geographic factors such as the wage index. If CMS were to extrapolate this standard to this rule, it could be construed that compliance with the new limits requires states to establish patient-specific payment limits for each individual in a nursing home or receiving Medicaid-covered home health.

To comply, providers would likely be burdened with additional patient assessments, along with a constantly fluctuating ledger of Medicaid accounts receivable. This process would be exceedingly complex, with almost no baseline for standard service costs, and every nursing home and home health recipient receiving a fully unique and personalized rate. This personalized rate in the Medicare population undergoes annual rebasing upon CMS analysis and calculations of utilization and payments. Maintaining accurate Medicare-based rates for each individual, to serve as the record for compliance with service-level rate cap limits, would be administratively impossible for providers, states, and managed care organizations, let alone how CMS would determine compliance. For individuals in nursing homes, where rates are then offset by patient-pay liabilities, the complexity and room for error increases exponentially.

Medicare coverage for both nursing home and home health are limited to post-acute episodes of care, therefore limiting the duration of the payment rate established via PDPM or PDGM. Though there are intermittent assessments completed on both populations remaining enrolled in Medicare, there is no equivalency for individuals receiving similar long-term services and supports for people only enrolled in Medicaid. The ways states use data from Medicare-required assessments in Medicaid rate setting is variable across states and in some instances inadequately contemplates costly patient characteristics like long-term medication management, attention to and management of psychosocial needs, behaviors either connected to or independent from dementia diagnosis, high acuity needs like tracheostomies and tube feeds. These under-attributed costs mean that establishing a comparable Medicare-based rate would be nearly impossible without the adoption of a new assessment tool at significant time and cost burden to providers.

Additionally, the Medicare-based rate would be updated on each person quarterly, under the existing assessment schedule. Compliance with individual caps would be nearly impossible, not to mention reconciliation of payments for compliance. With Medicare-baselines moving quarterly, compliance may mean Medicaid rate rebasing for each person to align with Medicare baselines. The timing between assessment and newly attributable rate-caps is unlikely to be conducted in real time, therefore requiring retrospective review, and likely reconciliation payments or recoupments.

CMS' ambition to establish compliance at the service level leaves more questions than answers for providers, MCOs, and states. Would the service-level payment compliance be gauged on a per-day basis or per month? What about for home health, would that be assessed on a per-visit, per day, or per course of treatment? In some instances, home health enrollees could receive multiple visits in a day, but not necessitate round-the-clock care; would each of those visits have a unique payment rate, based on the

actions completed within the service or would the rate be attributable to the person, regardless of the service provided under the umbrella category?

CMS should instead revert to longstanding policy for calculation of Medicaid UUPLs using Medicare benchmarks. States should have flexibility to establish payment parameters that are judged on the statewide aggregate within a provider class, giving states space to establish payment policies for providers, and locations that require additional incentive. For states, MCOs and providers, claims-level compliance will be administratively impossible, and there is already an established practice for using aggregate upper payment limits for Medicaid, making compliance assessment easier for both states and CMS.

At a minimum, CMS needs to expand the opportunity for exclusionary criteria to be used by states. As outlined in this comment, we oppose the expansion of the SDP caps to additional services and to FFS. In the context of what is proposed, we do appreciate that CMS proposes to provide states with an option to submit documentation for exclusion of certain services without Medicare comparable services in FFS, the same grace should be considered in managed care. In section § 447.381(d), CMS indicates some instances where exceptions to the standard Medicare-based payment limit could exist. The preamble indicates this exclusion to be applicable to broad service categories like personal care. For these services, states will need to demonstrate payments are aligned with efficiency and economy and submit supporting documentation to CMS for approval of the exemption.

As described above, service level compliance for many services will be unworkable. While our preferred solution is to revert to current policy regarding UPLs, we also ask that CMS consider including all long-term services and supports should be included in the exclusionary exception as long-stay (Medicaid long-term care funded) and post-acute (Medicare funded) patients exhibit significantly different characteristics and receive markedly different kinds of services within the same service category names (i.e.,- nursing home, home health, etc.). However, the process of seeking an exemption, as outlined in the rule, would add administrative burden for states, in preparing, submitting, and undergoing the RAI and approval process. CMS could limit the burden on both themselves and states by limiting the applicability of the rule to the statutory intent, outlined in HR 1 and keeping current policy regarding UPLs in place for nursing homes where the SDP cap must apply according to the statute.

CMS Should Align with the Statute, Abandoning Limits on Targeted Payments in FFS.
States use targeted payments in FFS to offset historically low Medicaid rates and promote program objectives like value, quality, economy, and access. Restricting states abilities to incentivize provider participation and improvement limits states' ability to effectively administer and improve the efficiency of their Medicaid program. CMS should withdraw their proposal to impose Medicare-based limits on services paid through FFS arrangements.

In These Policy Expansions, CMS Fails to Assess Impacts on the Regulated and Downstream Entities.
Due to this SDP policy and other policies in HR 1, all Medicaid providers are at high risk of significant reductions in Medicaid reimbursements. As providers then assess their viability in a new normal of reduced Medicaid revenues, it is anticipated many will disenroll as Medicaid providers, with some closing their practices entirely. With CMS expanding the applicability of caps to all services in managed care and fee for service, individuals who interact more with the health care system, namely older adults and individuals with disabilities will inevitably bear a disproportionate burden in finding new providers. Even for individuals who still receive their health insurance coverage in other ways, closures of providers, and narrowing of the Medicaid provider landscape will impose pressures on the broader healthcare system. People who previously used newly disenrolled providers will now be seeking new Medicaid providers, which will add to

the patient loads of those who remain in the program leading to longer appointment scheduling wait times and potentially longer travel distances to get to their appointments. Any provider leaving the Medicaid program will inevitably lead to more pressure on remaining providers to meet ongoing and growing demographic demand. CMS' proposed medical frailty definition, which requires proof of inability to work, will also squeeze certain provider availability.

PACE Programs Were Not Contemplated in the Regulatory Analysis

The rule does not apply to the Program of All-inclusive Care for the Elderly (PACE). The PACE program is governed by a completely separate set of regulations, without cross reference by the proposed rule, but their business models and the people they serve will be affected.

PACE provides fully integrated care and services to nearly 100,000 older adults across the country. The majority of enrollees are dually enrolled in Medicare and Medicaid. PACE programs receive per-member per-month capitation payments from both Medicare and Medicaid. The Medicaid rate is set based on an amount that would otherwise be paid (AWOP) for the same population. States use rates paid to Medicaid MCOs covering the long-term services and supports population in many instances to calculate the AWOP. As states are forced to reduce payments across their Medicaid system, the AWOP will similarly be reduced. Because PACE programs are full-risk provider agreements, absorbing reduced reimbursement for a clinically complex population will imperil viability of the program across the country and limit access for existing and future participants.

To offset harms to PACE programs, states may be forced to recalculate AWOPs or determine ways to otherwise enhance PACE program rates to maintain access to PACE across their state.

Additionally, PACE programs are required to contract for a specified list of specialist services, while also contracting for all other clinical and community-based services to meet their participants' needs. These contracts are executed with Medicaid enrolled providers. If limits in Medicaid payments outside of PACE contracting lead to provider decisions to not renew Medicaid provider enrollment, PACE participants could face new providers and longer wait and drive times for appointments. Each of these new barriers could affect the PACE program's bottom line- longer drive times cost the program more to transport individuals, while longer wait times for clinical care can lead to delayed diagnosis and more acute short and long-term needs. Therefore, provider shortages could result in PACE programs being unable to manage the risk of their populations as they would normally result in a less effective care model and reduced reimbursement.

Conclusion

Among their many responsibilities, states are currently facing the following related to HR 1 implementation and other CMS directives related to Medicaid:

- Policies and information technology changes related to the implementation of the community engagement and increased eligibility check requirements by the end of CY2026. The Interim Final Rule (IFR) on community engagement included policies that states were not expecting around the determination of medical frailty exemptions which has made what was already an expedited, expensive, and challenging problem even more so;
- Ensuring compliance with directives from CMS around program integrity including plans for off cycle revalidations and assessing the effectiveness of their Medicaid Fraud Control Units (MFCUs);
- Rolling out the Rural Health Transformation Fund;
- Ensuring alignment across agencies related to new requirements in Medicaid and the Supplemental Nutrition Assistance Program (SNAP);

- For some states, re-examining their 1115 waivers or filing renewals in light of new guidance from CMS;
- For some states, evaluating their provider tax arrangements to ensure compliance;
- Regular daily work of administering the Medicaid program; and
- Preparing for or dealing with decreased budgets to do all of this work.

CMS' proposal to expand the scope of the SDP provisions in HR 1 adds yet another administrative burden and policy making challenge on already stretched systems. This level of change will inevitably have impacts on providers and beneficiaries – but asking for the best policies that will ensure viability of a strained system under these circumstances is asking for errors that will cause harm. We urge CMS to continue to support states in their use of flexible financing through state directed payments by limiting the scope of the rule to congressionally enacted parameters and to enact our other recommendations to ensure the easiest possible transitions for those impacted by the SDP policy changes in the law.

As advocates for high quality long-term services and supports across the aging services continuum, LeadingAge members will continue to serve the Medicaid population where they can, though structural changes to financing mechanisms must be carefully considered to assure ongoing access to all healthcare services for older adults across the country. We support CMS' efforts to maintain Medicaid as a viable and vibrant program to support older adults, wherever they call home. Please contact Georgia Goodman (ggoodman@leadingage.org) with questions.

Sincerely,

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