National
MLTSS
Health Plan Association

July 21, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
Attention: CMS-2449-P

RE: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Dear Administrator Oz,

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to provide input on the Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments proposed rule.[1]

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid.[2] Our member plans assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Many MLTSS Association member plans are also leaders in integrated care for dually eligible individuals, offering Dual Eligible Special Needs Plans (D-SNPs) across the full spectrum of integration.

Overview

The MLTSS Association appreciates CMS's efforts to protect access to quality care for members and shares in CMS's commitment to promoting financial and operational integrity in the Medicaid program. State Directed Payments (SDPs) have been a foundational feature of Medicaid managed care financing since their creation in 2016, permitting states to direct Medicaid managed care plans to make targeted payments to certain providers to support state Medicaid goals and supplement Medicaid reimbursement rates. In the decade since, the number of states using SDPs to support their Medicaid programs has grown to 41.[3] States have come to rely on SDPs as a regular Medicaid financing structure in times of growing health care costs, and we are concerned that this policy change, combined with the other provisions within the One Big Beautiful Bill Act (OBBBA),

[1] Federal Register :: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

[2] Members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Humana, Lakeland Care, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community Health Choices.

[3] Kaiser Family Foundation | Federal Medicaid Spending Through State Directed Payments Nears $100 Billion Annually Across 41 States

will create significant fiscal challenges for states. When state Medicaid funding is reduced, states may respond by limiting optional benefits, including Home and Community Based Services (HCBS). For example, as a result of the 2009 recession, all 50 states reduced spending on at least one of their HCBS programs.[4]

We are concerned that the SDP limits outlined in the proposed rule could negatively impact provider participation, network adequacy, and members' access to care across many different types of Medicaid services and providers. Medicaid managed care organizations (MCOs) are accountable for the network adequacy and access requirements included within their contracts with states, but do not have control over the SDP policies that may alter provider participation. States determine whether to use SDPs, design them, and submit them to CMS for approval, while MCOs' role is administrative.

Additionally, while the OBBBA only required SDP limits for inpatient and outpatient hospital services, nursing facility services, and professional services at academic medical centers, this proposed rule expands these limits to all Medicaid-covered services. Many of the SDPs included in this expanded interpretation of the 2025 legislation have been necessary to fill longstanding gaps in Medicaid reimbursement and support provider participation in underserved or high-need areas.

Recommendations

1. Limit or phase in the expansion of SDP payment limits beyond the four statutory categories

As noted above, the OBBBA limited the payment rate for SDPs in four service categories. However, CMS goes beyond the legislative language in this proposed rule, extending the same payment limit to all SDPs for all services, beginning with the first rating period on or after January 1, 2029. This expansion would apply the new payment limit to additional service categories, including HCBS, that states have not yet had the opportunity to assess for compliance. The MLTSS Association is concerned that extending the payment limit beyond the four categories Congress specified, and doing so on a fixed 2029 timeline, could result in access gaps, rate instability, and declines in provider participation for the populations our members serve.

Recommendation: The MLTSS Association recommends that CMS limit the application of the new payment limit to the four service categories specified in OBBBA, consistent with what Congress mandated in section 71116.[5] Extending the limit to additional services and providers goes beyond what OBBBA requires and would impose new burdens on states, plans, and providers for service categories Congress did not address. Should CMS determine not to limit the scope of the payment limit to the four statutory categories, we recommend extending the timeline for implementing SDP limits for services beyond those categories. Rather than a fixed 2029 implementation date, CMS should consider a phased, data-informed approach toward its longer-term goal of limiting all SDPs. This would allow CMS to collect best practices from states while prioritizing data collection on how

[4] Health Affairs | History Repeats? Faced With Medicaid Cuts, States Reduced Support For Older Adults And Disabled People
[5] Centers for Medicare and Medicaid Services | Section 71116 of the Working Families Tax Cuts Legislation on State Directed

reduced SDP funding is affecting network adequacy and access to care. These insights could then inform the application of SDP limits to the broader set of services and providers.

2. Provide clear methodology and technical assistance for establishing a payment limit when comparison rates are limited

CMS acknowledges in the proposed rule that some Medicaid benefits lack a corresponding total published Medicare payment rate, noting that Medicaid covers a broader array of services than Medicare, including HCBS.[6] Where neither a Medicare rate nor a state plan rate exists or is easily identifiable, states may face difficulties in determining an appropriate payment limit without clearer guidance from CMS, particularly given the complexity and variation of HCBS payment structures across states.

Recommendation: CMS should provide greater clarity and guidance on establishing a payment limit when no Medicare rate or state plan rate is available, and should provide technical assistance to support states in navigating these circumstances, particularly for HCBS and other service categories where standard comparator rates are limited or difficult to apply. CMS should also work with states to identify an alternative, more workable approach that can continue to support adequate payment levels when necessary.

3. Clarify how CMS and states will account for the impacts of these SDP payment changes in network adequacy and access

SDPs have been used to supplement payments to providers who serve vulnerable populations, including those who deliver HCBS.[7] We are concerned that lower provider payments as a result of reduced SDPs will lead to providers choosing not to serve the aforementioned populations, leaving vulnerable individuals with fewer provider options and decreased access to needed services. Additionally, if the payment limits in this proposed rule lead providers to reduce their participation in Medicaid managed care, plans could face consequences related to network adequacy and access obligations under their contracts with states.

Recommendation: CMS should clarify how it and states will measure the impacts of this proposed rule on provider participation rates and access to care. Additionally, CMS and states should not hold plans accountable for the impacts of decreased provider participation as a result of reductions in SDPs.

4. Provide guidance on actuarial soundness as states implement the new SDP payment limits

As the MLTSS Association noted in our May 2026 letter to CMS regarding MLTSS rate setting, managed care capitation rates are developed prospectively, and policy or mandated payment level changes are best absorbed by Medicaid managed care programs when their effective dates align

[6] Centers for Medicare and Medicaid Services | Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments Proposed Rule
[7] Centers for Medicare and Medicaid Services | Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments Proposed Rule

with the rating period.[8] The transition to the new SDP payment limits raises this same concern. The Medicare rate updates, the multi-year grandfathering phase-down, and the new comparator rate documentation requirements are each set on their own schedules rather than the state's rating period, which means states and plans may be forced to reflect these changes in MLTSS capitation rates and contracts outside the timing they would otherwise choose.

Recommendation: CMS should provide guidance on actuarial soundness, rate adequacy, and the appropriate use of risk mitigation tools, such as risk corridors, as states implement the new SDP payment limits. This guidance should address how states can maintain actuarially sound, reasonable, appropriate, and attainable rates throughout the multi-year transition, including when Medicare rate updates or phase-down requirements fall outside a state's rating period. Additionally, to reduce administrative burden on states, CMS should grant states the flexibility to wait until all grandfathered SDPs reach the new Medicare threshold before payments are phased into capitation rates.

Conclusion

The MLTSS Association shares CMS's goal of ensuring that Medicaid managed care expenditures are directed toward improving access to and the quality of care for Medicaid members. We believe our recommendations will allow CMS to achieve its goals without destabilizing the managed care, LTSS, and HCBS delivery systems that serve some of the most vulnerable Medicaid beneficiaries. We appreciate the opportunity to comment on this proposed rule and welcome the opportunity to serve as a resource to CMS. If you have any questions, please feel free to contact me at mkaschak@mltss.org.

Sincerely,

Mary Kaschak
Chief Executive Officer

[8] National MLTSS Health Plan Association | May 2026 Letter to CMS on MLTSS Rate Setting