October 6, 2026

Daniel Brillman
Director, Center for Medicaid & CHIP Services
Deputy Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: State Directed Payments and Risk-Based Capital

Dear Director Brillman:

Thank you again for joining the Alliance of Community Health Plans' (ACHP's) Board of Trustees at our Annual Symposium. During that discussion, Trustees raised a timely concern: state directed payment policy often creates capital requirements that do not match the risk plans actually bear. As requested, we are following up with a brief overview of the risk-based capital implications of state directed payment (SDP) policy and our recommendations for addressing them.

As CMS finalizes the state directed payment rule, we urge the agency to preserve flexibility for separate payment terms and coordinate with state insurance regulators and the National Association of Insurance Commissioners (NAIC) on appropriate risk-based capital treatment.

ACHP is the only national organization advancing the payer-provider aligned model. Our locally-owned and operated plans serve all lines of business, including Medicaid, where they collectively cover more than four million enrollees. That payer-provider alignment gives ACHP members a distinct perspective on the challenges state directed payment (SDP) financing rules create when regulatory treatment does not reflect the underlying financial risk.

As you know, SDPs allow states to direct plans to pay providers specified amounts, leaving plans with limited discretion over the funds. SDP dollars effectively function as a pass-through to providers rather than as payments for which plans assume ordinary insurance underwriting risk. Separate payment terms allow the money to be paid outside of a plan's regular claims capitation payment, better reflecting the limited financial risk borne by the plan.

If state directed funds are included in capitation, they increase the revenue used to calculate a plan's risk-based capital requirement even when the plan has little control over the payments and bears no meaningful insurance risk. If SDPs are treated like traditional premium with underwriting risk, plans would have to hold additional capital against dollars designated for providers. Given the size of some SDP arrangements, even a modest increase in required capital could have multi-million dollar implications for plans.

ACHP raised this issue in our comments on CMS's SDP proposed rule, supporting continued flexibility for separate payment terms and asking CMS to clarify how the new requirements will interact with managed care financing requirements. As CMS finalizes the SDP rule and develops implementation guidance, ACHP encourages CMS to:

- Preserve flexibility to use separate payment terms for provider-directed funds when health plans bear little or no financial risk.
- Coordinate with the NAIC and state insurance regulators to ensure risk-based capital treatment reflects the actual financial risk borne by health plans, including when SDP funding is provided through capitation. The NAIC's ongoing examination of SDPs and separate payment terms makes that coordination particularly timely.

If CMS requires SDP funding to be provided through capitation payments, CMS should provide clear guidance on how the money will be treated for rate development, actuarial soundness, risk-based capital and other managed care financial requirements.

We appreciate your willingness to engage on this issue and urge CMS to ensure that SDP policy appropriately reflects the financial risk borne by health plans. We welcome the opportunity to work with you and your team as CMS finalizes the rule and develops implementation guidance. Please contact Emma Liebman, Associate Director of Policy, ACHP (eliebman@achp.org) with any questions.

Sincerely,

Ceci Connolly

Ceci Connolly
President and CEO
Alliance of Community Health Plans