ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

July 21, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

Re: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)

Dear Administrator Oz:

As the nation's largest source of health coverage, Medicaid plays a critical role in ensuring access to care for children, families, older adults and people with disabilities. The Alliance of Community Health Plans (ACHP) supports CMS' efforts to strengthen program integrity for this vital program and ensure responsible stewardship of taxpayer dollars. Medicaid financing reforms should strengthen the program's long-term stability while preserving access to care for the millions of Americans who rely on it. We encourage CMS to implement the provisions of the One Big Beautiful Bill Act (OBBBA) while preserving state flexibility, supporting innovation in care delivery and adopting operationally feasible compliance standards.

ACHP is the only national organization advancing a unique payer-provider aligned model of health care that fosters true competition, delivering both high-quality coverage and care. As local insurers, ACHP member companies provide affordable coverage options to tens of millions of Americans in nearly 40 states and D.C. ACHP's member companies serve all lines of business, including Medicaid, where they collectively cover more than four million Medicaid consumers across 14 states. ACHP member companies operate in close partnership with physicians, hospitals, community providers and state Medicaid agencies to improve health outcomes and strengthen access to care.

The proposed rule would substantially change how states finance Medicaid managed care and structure state directed payments. In several instances, the proposed rule extends beyond the parameters of OBBBA by restricting state flexibility and imposing operational approaches that create significant complexity without clear program integrity benefits. We encourage CMS to strengthen fiscal accountability while minimizing unnecessary disruption to states, plans, providers and Medicaid enrollees.

The recommendations that follow focus on four themes: preserving the statutory framework established by Congress, aligning compliance requirements with Medicaid managed care operations, supporting value-based care and delivery system innovation and ensuring clear, practical implementation.

Strengthen Program Integrity Through Targeted Reforms

ACHP supports strengthening accountability and transparency within the Medicaid program. However, expanding the statutory payment-limit framework beyond the requirements in OBBBA

would unnecessarily restrict state flexibility while increasing operational complexity for states, plans and providers.

ACHP recommends CMS limit Medicare-based payment caps to the four statutory service categories. States rely on state directed payments to strengthen provider networks, address workforce shortages, improve access to specialty care and support care delivery in underserved communities. For example, many states use state directed payments to support behavioral health, substance use disorder, ambulatory and other services that have historically faced provider shortages and Medicaid reimbursement challenges. Extending Medicare-based payment limits to all state directed payment services would constrain states' ability to respond to these needs, support sustainable provider reimbursement and maintain provider participation.

If CMS finalizes its proposal to extend Medicare-based payment limits beyond the four statutory service categories, it should delay implementation until the effects of the OBBBA reforms can be evaluated. A phased approach would allow CMS to determine whether the statutory payment limits achieve the agency's program integrity objectives before imposing additional restrictions.

CMS should not extend state directed payment payment-limit policies to Medicaid fee-for-service practitioner payments. States, plans and providers are already preparing for significant Medicaid financing changes. Adding new requirements across multiple financing mechanisms simultaneously will increase administrative burden, raise implementation costs and divert resources from improving access without meaningfully advancing program integrity objectives.

ACHP recommends CMS adopt a more predictable phase-down methodology for grandfathered state directed payments. We are concerned that implementing the statutory ten percentage-point phase-down of grandfathered state directed payments by reducing the aggregate grandfathered state directed payment amount each year could create uneven and potentially disruptive state impacts. States with higher existing state directed payment levels may experience larger near-term reductions even though a phase-down tied directly to the applicable Medicare-based payment limit could achieve the same statutory objective more predictably. Because Medicaid managed care rates, provider contracts and state directed payment arrangements are developed prospectively, abrupt changes in state directed payment funding will disrupt state budgeting, rate development and provider contracting. CMS should implement a percentage-of-Medicare phase-down methodology that better aligns with the statutory payment-limit framework while reducing unnecessary disruption for states, plans and providers.

Align Compliance Requirements with Managed Care Operations

The proposed rule would apply state directed payment limits at the service- or discharge-specific level rather than through a broader aggregate methodology. Under this approach, states would need to identify the applicable Medicare-based payment limit for each state directed payment service and demonstrate compliance at the individual service level. This represents a significant departure from how Medicaid managed care programs are financed and administered. Managed care relies on prospective capitation rates, provider contracts and population-based financing arrangements. The proposed rule would require states and plans to convert managed care financing into a service-level compliance exercise, creating new processes to track, validate and monitor individual service payments.

Medicare payment rates vary by service, provider and numerous hospital-specific adjustments. To demonstrate compliance, states would be required to identify, calculate and maintain thousands of separate Medicare payment benchmarks across providers and services. Reconciling a prospective, population-based payment model with thousands of service-level Medicare benchmarks would create substantial implementation challenges. It would also complicate actuarial rate development and certification by requiring prospective capitation rates to align with payment methodologies that do not reflect how managed care rates are developed.

The proposed methodology also reduces states' flexibility to structure state directed payments around provider classes and service categories, even where overall payments remain within the applicable payment limit. For providers that have historically relied on class-level aggregate payment methodologies, this approach could result in unnecessary payment reductions, increasing the risk of provider attrition in areas with longstanding Medicaid reimbursement challenges.

CMS should permit states to demonstrate compliance using aggregate payment methodologies rather than requiring service- or discharge-level validation for every state directed payment. Absent evidence that a service-level compliance framework provides materially greater program integrity benefits than alternative methodologies, CMS should permit aggregate, provider-class or actuarially certified approaches that align with Medicaid managed care financing, such as the longstanding upper payment limit framework. At a minimum, CMS should provide standardized methodologies, clear reporting templates and prospective safe harbors before these requirements take effect.

Preserve Delivery System Innovation

CMS should allow value-based state directed payments to demonstrate compliance at the arrangement level, rather than the individual service or discharge level. Many state directed payments support value-based payment arrangements that reward providers for improving quality, coordinating care and reducing unnecessary utilization. Unlike fee-for-service payment models, these arrangements often include shared savings, quality incentives or population-based payments that are not readily evaluated using service-level Medicare payment benchmarks.

ACHP is concerned that the proposed validation requirements for value-based payment arrangements may discourage states from pursuing payment models that improve quality, strengthen provider accountability and advance delivery system reform. They may also weaken the incentives that make these arrangements effective by limiting providers' ability to retain savings generated through improved care coordination, reduced avoidable utilization and better health outcomes. Medicaid enrollees benefit when states and plans have the flexibility to pursue innovative payment arrangements that incentivize quality and reduce unnecessary spending.

Provide Clear Implementation Guidance

CMS should provide standardized methodologies, reporting templates, acceptable data sources and other operational guidance that promote consistent implementation, reduce unnecessary administrative burden and avoid duplicative oversight. For example, CMS should clarify the appropriate comparator methodology for services where no Medicare payment rate or

Medicaid state plan rate exists, including circumstances in which providers are not reimbursed using cost-based methodologies. CMS should also provide timely guidance on how the new requirements will be incorporated into actuarial soundness reviews, rate development, rate adequacy determinations and risk corridor calculations so states and plans can implement the framework consistently.

ACHP supports appropriate oversight of annual actuarially certified payment comparisons and ongoing monitoring for grandfathered state directed payment arrangements. However, maintaining multiple overlapping compliance processes may increase administrative costs for states, plans and CMS without improving program integrity. Following implementation, CMS should evaluate whether annual average commercial rate demonstrations continue to provide meaningful oversight.

ACHP requests CMS provide operational flexibility for grandfathered state directed payments beyond the transition period. Separate payment terms provide states and plans with a practical mechanism to administer state directed payments and monitor compliance while remaining consistent with the statutory payment limits.

ACHP supports CMS' commitment to strengthening Medicaid program integrity and implementing OBBBA in a thoughtful, workable manner. As CMS finalizes this rule, we encourage the agency to preserve the balance Congress established between program integrity, state flexibility and practical implementation. A measured approach will help states maintain strong Medicaid programs and protect access to care for America's most vulnerable. Disruptions beyond the confines of the new law run the risk of a rise in the uninsured and a spiral of cost implications.

We appreciate the opportunity to comment and look forward to continuing to work with CMS to implement these important reforms. 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