July 21, 2026

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

Re: Comments on CMS's Proposed Rule, Proposed Medicaid Program: Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payment

To Whom It May Concern:

On behalf of the American Academy of Actuaries'[1] Medicaid Committee (Committee) I appreciate the opportunity to provide comments in response to the May 22, 2026, proposed rule on Medicaid Managed Care State Directed Payments (SDPs) and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments.[2] The Committee has focused its comments on the payment limits, value-based payments and grandfathered SDP provisions in the Medicaid Managed Care section of the proposed rule, as it applies to the Medicaid work performed by actuaries.

State Directed Payments in Medicaid Managed Care

1. Payment Limit for SDPs (§438.6(a), §438.6(c)(2)(ii)(I) and §438.6(c)(8)) Definition of Payment Limit (§438.6(a))

Determining the applicable payment limit

While many Medicaid services will have a Medicare equivalent, we have concerns regarding the applicability of the payment limit when the apparent Medicare equivalent may not cover comparable services. Medicaid routinely (and by design) finances services and provider types that have little or no Medicare equivalent, and many of the populations covered by Medicaid have significantly different morbidity profiles from the Medicare population. For example:

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For 60 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

[2] "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments"; *Federal Register*; May 22, 2026.

- Hospital services: Children's hospitals are a particularly clear example. They serve limited Medicare populations, often lack representative Medicare utilization and payment data, and provide specialized pediatric services that are largely outside the Medicare program. Furthermore, it is not uncommon for state Medicaid programs to reimburse hospital inpatient or hospital outpatient services differently than the fee schedule platform Medicare uses. For example, while Medicare reimbursement for inpatient hospital services is based on a Medicare Severity Diagnosis-Related Grouping (MS-DRG) system, many state Medicaid agencies use per diems or other reimbursement arrangements.

- Nursing facility services: This is one of the four services identified when CMS references the payment limits under the "Working Families Tax Cut" legislation.[3] Medicaid typically covers a mix of both custodial care and skilled care in a nursing facility, whereas Medicare coverage is limited to skilled care following an inpatient hospital stay. As a result, Medicare has no custodial care payment analog to Medicaid.

- Behavioral Health Services: While Medicare covers an array of behavioral health services, state Medicaid programs may reimburse services providers differently from how Medicare covers these types of services. For example, states may design episodic payment structures that comprise a blend of Medicare-covered and non-Medicare-covered services, or the unit basis may differ between Medicaid and Medicare reimbursement.

In these examples, there may be varying payment methodologies between Medicaid and Medicare regarding which services are included or excluded in the respective program's payment rate. There may be other situations and service categories where this is the case. It is therefore unclear whether the percentage of Medicare is the applicable payment limit. Additional CMS guidance or flexibility may be required to determine appropriate and applicable payment limits. If there is not complete overlap of covered services reflected in the Medicare and Medicaid payment rates, is the State Plan rate or an alternative benchmark the applicable payment limit?

Additionally, as we consider some operational items when considering the applicable payment limit, the proposed definition of "payment limit" indicates that the applicable payment limit is 100% of the State plan approved rate "[o]nly in instances when there is no total published Medicare payment rate for the covered service."

[3] "**Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments**"; *Federal Register*; May 22, 2026; p. 30401.

- There are services within the Medicaid program that do not have a fee-for-service amount established within the State Plan. These services are reimbursed under various methods, including a percentage discount, cost-based, or other methodology. Additional CMS guidance on the reconciliation methodology for these services may be necessary.

- For services without a Medicare or Medicaid State Plan fee schedule amount, the managed care plans may reimburse providers using different methodologies. These methodologies may not align with the reimbursement methodology used by the State Medicaid program. However, the reimbursement amounts are reflected in the capitation rate setting certification process. Additional guidance on the applicable payment limits for these services would be prudent.

Timing Inconsistencies When Benchmarking Against State Plan Approved Rates

The proposed definition of "State Plan approved rates" could create inconsistencies by tying SDP limits to State Plan rates approved before the start of the rating period, particularly for services that may be newly implemented for a rating period. There may be situations that involve the following characteristics:

- The implementation of a new service requires a state plan amendment (SPA).
- The SPA might not be approved prior to the start of the rating period, but is approved during the rating period and the managed care capitation rates either prospectively include or are amended to reflect the inclusion of the approved service.
- There could be a state legislative mandate to implement an SDP (for example: a minimum fee schedule) for this service.

The Committee suggests that CMS offer additional guidance for the implementation of the SDP for these types of situations.

On page 30412, the proposed rule states, "We believe that requiring States to use the State plan rates approved before the start of the rating period would be consistent with prospective rate-setting processes and would add stability and predictability to SDPs. This change does not alter SPA approval authority under title XIX of the Act, but instead specifies how approved State plan rates may be implemented as a minimum fee schedule SDP and used for prospective capitation rate development in managed care."[4] It is unclear whether the proposed rule is referring to the actual fee schedule rate amounts or the rate methodology and warrants additional clarification from CMS.

[4] "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments"; *Federal Register*; May 22, 2026; p. 30412.

Minimum Fee Schedule SDPs (§438.6(c)(1)(iii)(B)(1))

CMS indicates at §438.6(c)(1)(iii)(B)(1) that, for rating periods beginning on or after January 1, 2028, minimum fee schedule SDPs are not permitted to be greater than the payment limit, without apparent exception.[5] This provision may be inconsistent with other areas of the proposed regulation, as well as the preamble to the regulation:

- §438.6(c)(8) indicates that the total payment rate can be no greater than the payment limit. Therefore, §438.6(c)(1)(iii)(B)(1), in combination with §438.6(c)(8), would mean that MCOs would not be permitted to make payments beyond the SDP amount in cases where a minimum fee schedule SDP is set at the applicable payment limit.

- §438.6(c)(1)(iii)(B)(2) discusses considerations for maximum fee schedule SDPs "so long as the MCO, PIHP, or PAHP retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract without exceeding the payment limit."

- On page 30411, the proposed rule states "Absent SDPs, Medicaid managed care plans may continue to negotiate provider payment rates that exceed this payment limit when necessary to ensure a sufficient provider network."

Clarification of CMS's intention to allow MCO payment flexibility in the proposed provisions related to minimum fee schedule SDPs, including for both MCO rate negotiations with providers and MCO-driven value-based payment initiatives, is requested.

Implementation of payment limit on a per service or per discharge basis (§438.6(c)(8)(ii)

For services where the percentage of Medicare is the payment limit, the Medicare payment rates at the individual service level may not be reflective of a Medicaid population's needs, such as for newborn or maternity inpatient services. We believe it is reasonable to assume that "the payment rate for such service"[6] referenced by CMS could be assessed at the aggregate service level (i.e., all inpatient hospital services at the provider type or provider class level) to allow flexibility in

[5] "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments"; *Federal Register*; May 22, 2026; p. 30463.

[6] "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments"; *Federal Register*; May 22, 2026; p. 30413.

the application of Medicare payment to a Medicaid population, while still achieving the goals of the total payment rate comparison to Medicare.

Granularity of required information for payment limit monitoring and compliance (§438.6(c)(8)(ii)(A)(1))

CMS is proposing to monitor State compliance with the new payment limit by requiring States to submit detailed information for providers eligible to receive SDPs. Tracking individual National Provider Identifiers (NPIs) would be overly burdensome since providers can change groups and the information is only current at a point in time. As an alternative, we suggest using taxonomy codes or broader criteria based on provider types, rather than specific NPIs.

Prospective SDP payment limit for hospital types using a cost-based methodology

CMS requested comments on the data sources for total payment rates: the total published Medicare payment rate, the State plan-approved rate, or the most recent and complete Medicare cost report.[7] We support the default proposal, including the most recent and complete Medicare cost report, rather than the two alternatives, using either the State plan approved rate or requiring the use of only total published Medicare payment rates that undergo the rule-making process (for example, the Medicare IPPS rate or Medicare PFS rate).

Payment limit monitoring and compliance for Value-Based Payment (VBP) SDPs (§438.6(c)(8)(ii)(B))

CMS is proposing that payments under VBP SDP arrangements would need to be reconciled on a per-service basis to ensure that the applicable payment limit is not exceeded. We encourage CMS to consider how Medicare-based payment limits may interact with existing and developing value-based payment arrangements. Many VBP models are designed to reward providers for improving efficiency across the healthcare system. As such, Medicaid payment policies that limit these initiatives may restrict some efforts to lower overall costs.

Prospective Actuarial Certification Approach for VBP SDPs

We appreciate CMS's recognition of the operational complexity associated with retrospective reconciliations and potential provider payment adjustments in VBP SDPs. We support the consideration of a prospective actuarial certification approach for VBP SDPs.[8] Such an approach could reduce administrative burden and provide greater predictability for participating entities. At the same time, we encourage CMS to consider how the rules impact incentives for providers

[7] "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments"; *Federal Register*; May 22, 2026; p. 30414.

[8] "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments"; *Federal Register*; May 22, 2026; p. 30417.

to shift care toward higher-value services and interventions that improve outcomes while reducing overall costs.

Additionally, the approach should consider potential data limitations. If lack of appropriate data causes limitations in comparing the VBP SDP to the applicable payment limit on a per-service basis, CMS could consider an approach that evaluates value-based payment interventions using a total-cost-of-care or budget neutrality framework. Under such an approach, states could demonstrate that aggregate spending under the VBP initiative is no greater than expected spending in the absence of the initiative. This framework, for example, could recognize circumstances in which increased investments in primary care generate offsetting reductions in emergency department utilization, hospitalizations, or other avoidable costs.

2. Grandfathered SDPs (§438.6(a), §438.6(c)(2)(iii))

Definition of a Grandfathered SDP (§ 438.6(a))

CMS is proposing that "the grandfathering provisions apply only where an SDP exceeds the payment limit set forth in §438.6(c)(8)."[9] However, the payment limit referenced in the proposed regulation at §438.6(c)(8) is applicable to the total payment rate and not the SDP portion alone, as it appears to be noted in the definition of a Grandfathered SDP. We anticipate that CMS's intent was to reference the total payment rate, rather than just the SDP portion for the application of the payment limit in the definition of a Grandfathered SDP and request further clarification or appropriate modification of the language.

Phase down of grandfathered SDPs (§ 438.6(c)(2)(iii)(B))

CMS is proposing that the grandfathered total dollar amount be phased down until the applicable payment limit is reached. There may be grandfathered SDP arrangements where the Medicaid base payment level from the Medicaid managed care plans already exceeds the applicable payment limit. Additional guidance on the application of the phasedown for grandfathered SDPs in these situations is requested.

Actuarial certification of Medicare payment rate comparison (§ 438.6(c)(2)(iii)(D))

CMS is proposing to monitor the phase-down of grandfathered SDPs using state-submitted total payment rate comparisons and that these comparisons be "certified by an actuary." The Committee has several questions for CMS:

- CMS also indicated its expectation that this comparison be developed consistently with the rate development assumptions. In many SDPs, the underlying analytics and average payment rate comparisons have historically been developed without direct involvement from the actuaries certifying the capitation rates. We request CMS clarify if any actuary

[9] "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments"; *Federal Register*; May 22, 2026; p. 30420.

meeting the existing § 438.2 definition of actuary can do the certification or if CMS will require that the actuary certifying the total payment rate comparison be the same actuary that certifies the capitation rates on behalf of the state. If it needs to be the same actuary, but the underlying SDP analysis was performed independently, it may put that actuary in a position where they are required to certify analyses over which they have had limited involvement or visibility; therefore, the actuary may have to render a qualified actuarial opinion.

- Medicaid actuaries generally do not work directly with providers and are often several steps removed from the development of provider payment analyses that would support these demonstrations. Suppose the payment rate comparison is confirmed or described by someone other than an actuary as being consistent with rate development assumptions; would it meet CMS's needs without the actuarial certification?

- Does CMS expect that the total payment rate comparison prepared for CMS monitoring be consistent with the methodology utilized to develop Table 2 of the Grandfathered SDP preprint?

- What is the actuary certifying? That the model, assumptions, and data follow federal regulations and the Actuarial Standards of Practice in calculating the total payment rate comparison? We request guidance on what CMS envisions is being certified, including examples of what does or does not count as the expected certification.

- Will the SDP preprint template be updated to include a field for the actuarial certification?

- CMS indicates that States will be required to submit the total payment rate comparison using Medicare or State plan approved rates as the point of comparison on an annual basis, beginning with the first rating period on or after January 1, 2027. This timing raises concerns for the Committee. States that are on a Calendar Year rating period have less than six months to comply, which may be challenging to implement if the final rule is released later this summer. Due to this, CMS should consider delaying the implementation of the total payment rate comparison.

Delay in compliance of separate payment term prohibition (§ 438.6(c)(2)(iii)(F))

The Committee believes that CMS's proposal to delay the separate payment term prohibition for eligible grandfathered SDPs in order for it to coincide with the rating period in which the payment limit is met is reasonable.

Other considerations

- We encourage CMS to consider the potential impacts of the proposed regulation on Medicaid costs outside of SDPs, as well as impacts on healthcare markets outside of Medicaid. For example, some providers may look to other markets or other sources of revenue to make up for lost SDP funding. Please reference the Academy's Interconnectedness of Health Coverage Sources Issue Brief for more information about dynamics across insurance markets.
- CMS has played a leading role in advancing multi-payer alternative payment models through initiatives such as AHEAD and Making Care Primary, as well as broader efforts to strengthen primary care and support rural health transformation. These initiatives and corresponding investments recognize the value of moving beyond traditional fee-for-service incentives and toward models that support population health and coordinated care. We encourage CMS to consider how SDP policies can allow for Medicaid program alignment with these ongoing efforts. For example, CMS may want to consider granting waivers of the SDP rules for state participation in CMMI initiatives.

The Committee appreciates the opportunity to provide these comments to CMS. If you have any questions or would like to discuss these comments further, please contact Michelle Anaba, Policy Project Manager, Health, (anaba@actuary.org).

Sincerely,

Marlene Howard, MAAA, FSA
Chairperson, Medicaid Committee