mhpa Medicaid Health Plans of America

July 21, 2026

Submitted via http://www.regulations.gov

Administrator Mehmet Oz
Deputy Administrator Daniel Brillman
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2449-P

Re: Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments Proposed Rule (CMS-2449-P)

Dear Administrator Oz,

On behalf of the Medicaid Health Plans of America (MHPA), we appreciate the opportunity to comment on the Medicaid Managed Care State Directed Payments (SDP) proposed rule (CMS-2449-P). MHPA and its member Medicaid health plans are grateful for the opportunity to share specific recommendations to refine CMS' proposal to improve financial integrity and operational efficiency in the Medicaid program.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 160 Medicaid managed care organizations (MCOs) serving nearly 47 million Medicaid enrollees in 40 states, the District of Columbia (DC) and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid enrollees receive health care through MCOs, and MHPA provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost- effective, and quality health care for Medicaid enrollees.

MHPA shares in CMS's commitment to improve transparency and financial integrity with respect to how taxpayer dollars are being used. However, we note that provisions in this proposed rule could reduce Medicaid payment flexibility in ways that result in decreased provider participation, network instability, and reduced access to care. States should continue to have the ability to fund their programs in a way that meets the needs of their enrollees. This flexibility is the mechanism that supports network adequacy efforts and provider retention in Medicaid. Providers who cannot cover their costs from the Medicaid program, particularly safety net providers, will ultimately be forced to reduce their Medicaid participation or no longer be able to serve their community entirely. The result is a foreseeable risk to patient access to care: reduced provider availability, longer wait times, and, in some cases, the loss of the only accessible source of care for certain communities of Medicaid beneficiaries.

Our specific feedback on the proposed rule is as follows:

New SDP Payment Limits

While we recognize that CMS is implementing statutory requirements for the four mandated provider types from the Working Families Tax Cut (WFTC) Legislation, including inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers, we note that these SDP types are tied to the highest dollar amounts of funding for providers. The new, reduced payment limits are going to have a significant impact on the resiliency and integrity of MCO's total network of providers and the Medicaid program itself.

MHPA member plans have reported they are already entering into provider contract negotiations which account for the anticipated impact of lower SDP payment limits. As providers seek to offset reduced SDP revenue through higher contracted rates, plans face pressure to agree to rate increases that may exceed what their capitation rate can support, particularly where capitation rates have not yet been adjusted to reflect the new SDP payment landscape. SDPs are determined, designed, and directed by the state, and require CMS approval. MCOs do not independently design SDP structure or decide whether to utilize them as a payment tool. Though the administrative nature of an MCOs role may vary by state, serving mostly as a pass through for the payment, they contend with the consequences of changes to SDP structure and usage in the form of operational challenges and network instability that limits their ability to serve enrollees.

Recommendations

MHPA has significant concerns with the proposed effective dates for the new SDP payment limits. States, providers, and MCOs face an enormous amount of implementation work, including legislative changes, systems changes, and provider negotiations, on a timeline that does not adequately account for these complex changes. State officials will require education on Medicare payment policy which will demand considerable time and effort to learn. These same state officials are also tasked with implementing other provisions from the WFTC Legislation on a tight timeframe while continuing to meet compliance deadlines for certain provisions of the 2024 Managed Care Final Rule. Additional time is needed to account for these competing dynamics that allow MCOs and state officials to properly address the operational work needed for implementation. We urge CMS to delay by at least one calendar year the applicability and compliance dates for any finalized SDP limits or related requirements whose timing is not specified by statute and, as necessary, to exercise appropriate enforcement discretion during the transition period.

MHPA also recommends that CMS update the Medicaid Managed Care Rate Development Guide (the "Rate Guide") to provide explicit guidance to states on actuarial soundness, rate adequacy, and the addition of any risk mitigation mechanisms, as they implement new SDP payment limits. We recommend that the Rate Guide requires states to account for likely provider contracted rate increases as the new SDP payment caps are implemented. The Rate Guide should also clarify data sources, comparison methodologies, and documentation expectations for Medicare/Medicaid payment rate comparisons.

Additionally, Medicare payment rates can change during a Medicaid rating period through annual fee schedule updates, federal sequestration, or other policy actions, potentially causing SDPs that were compliant at the time of submission to fall out of compliance through no fault of the state or MCO. We request CMS finalize regulations that do not penalize states or MCOs for these operational/policy changes mid-rating period. Specifically, CMS should issue clear guidance confirming that SDP compliance will be assessed against the Medicare rate in effect at the time of the SDP's submission to CMS. Clarity from CMS on this will ensure capitation rates reflect actual Medicare payment limits and that plans are not found to be out of compliance for any changes to the Medicare fee schedule during a rating period.

Extending the New Payment Limits to All SDPs

While MHPA supports CMS's broader goal of fiscal responsibility and operational efficiency, we oppose the extension of the new Medicare-based SDP payment limits to all other services outside of the four statutorily required services. This proposal goes beyond the authority granted by the WFTC Legislation and does not include a grandfathering period or transition period. If finalized, this proposal would have a negative impact on provider participation in the Medicaid program and would lead to operational and financial burdens on MCOs, states, and providers, particularly as they work to implement other provisions of the WFTC Legislation. We urge CMS not to finalize this proposal.

Extending the new payment limits to all SDPs, as proposed, will have a different and varied level of impact across all states. Section 71116(d)(3) of the WFTC Legislation defines "State" to mean the 50 states and DC. As a part of this proposal, CMS goes beyond the statutory requirements by extending the SDP payment limits to Puerto Rico and all U.S. territories. This proposal will have a particularly devastating impact on the U.S. territories. In U.S. territories, Medicaid operates under a capped allotment financing structure that is fundamentally different from the 50 states and DC. In the states and DC, federal Medicaid funding is open-ended: the Federal government matches every dollar of spending at the applicable Federal Medical Assistance Percentage (FMAP). In the territories, federal funding is subject to a statutory annual cap, which already limits the federal exposure that the SDP payment limit is designed to protect. Applying a payment limit does not advance the fiscal-integrity goals stated by CMS and instead constrains an already limited program.

This proposal will also cause some level of disruption to Medicaid enrollees' access to care in almost all states and DC. In one state, as an example, this provision will have an impact on several important service areas, including behavioral health, substance use disorder (SUD), home and community-based services (HCBS), and dental and specialty care services, all which are already facing significant provider shortages and rely on SDP funding to support adequate provider reimbursement. Most of these SDP types address service categories that have faced longstanding gaps in Medicaid reimbursement and support provider participation in underserved or high-need markets.

Additionally, many service areas covered by Medicaid including, but not limited to, long-term nursing home care, HCBS, personal care services, non-emergency medical transportation,

early and periodic screening, diagnostic and treatment (EPSDT) pediatric services, and community-based behavioral health and support services, do not have parallel Medicare reimbursement rates. These areas will then be subject to the Medicaid state plan approved rates, which are significantly lower across the country than Medicare payment rates where comparable. According to 2024 data from KFF[1] the Medicaid-to-Medicare fee index shows that Medicaid pays physicians on average for all services in the United States 75 percent of what Medicare pays for comparable services, meaning providers who serve Medicaid patients are already operating at a significant payment disadvantage before any additional payment reductions are considered. For "other services", outside of primary and obstetric care, Medicaid providers are paid 84 percent of the Medicare rate. MACPAC data[2] from 2017 shows that nationally, the average Medicaid base payment (i.e., excluding supplemental payments) for the 18 Medicare-Severity Diagnosis Related Group (MS-DRGs) measured was less than Medicare, ranging from 70 percent of Medicare for heart failure & shock with major complications or comorbidities (MS-DRG 291) to 92 percent of Medicare for pulmonary edema & respiratory failure (MS-DRG 189). Overall, Medicaid was 78 percent of Medicare across the 18 MS-DRGs. The average Medicaid base payment was below Medicare for 35 of the 47 states included in their analysis.

The aggregate impact of these payment reductions will not occur in isolation. Reductions in SDP caps will affect provider participation and beneficiary access beyond the Medicaid population. Safety net hospitals, community health centers, and other providers that depend on SDP funding to remain financially stable to serve patients across all payer types. The consequences of these changes will likely affect the entire community that is served by these providers. This dynamic is particularly apparent in high-need and medically underserved areas, including rural areas where workforce shortages already strain the health care system and where the loss of a single provider can leave an entire community without access to important services.

Recommendations

If CMS decides to move forward with these proposals, we strongly recommend the agency consider the following recommendations when extending the cap to additional services, and for services without a Medicare parallel, to avoid disruption to providers and network instability:

- SDPs related to services in addition to the original four services will experience a sharp payment cliff as of January 1, 2029. At a minimum, CMS should delay the effective date or include a substantial grandfathering or transition period for implementing the SDP limits for services and providers beyond the four statutorily limited categories. This would allow MCOs and states more time to manage network dynamics and adjust after implementing the major SDP changes for the four

[1] https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[2] https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf

statutorily required services before expanding those limits more broadly. This phased-in approach would also be more in line with intent of the WFTC Legislation.

- MHPA does not support extending the SDP payment limit to the U.S. territories. CMS should adhere to the statutory construct and only apply the new SDP payment limits to the 50 states and DC.
- CMS should pursue a phased, data-informed approach toward its longer-term goal of limiting all SDPs, rather than establishing a fixed implementation date before the impact of the statutory requirements can be assessed. As the initial changes take effect, CMS should prioritize collecting and analyzing data on how reduced SDP funding is affecting network adequacy and access. These insights should inform any subsequent policy decisions regarding the application of SDP limits to the broader set of services and providers.
- MHPA urges CMS to reconsider their approach to services that do not have a comparable Medicare rate and develop a more appropriate methodology for those services. CMS should set up a rate advisory workgroup to analyze various methodologies in order to implement a data informed approach. We recommend CMS work with states to establish service specific payment benchmarks grounded in cost of care data and evidenced-based methodologies that accurately reflect the cost of services for which no comparable Medicare rate exists. Limiting these services to the Medicaid state plan approved rate will negatively impact networks as Medicaid rates are generally known to be insufficient to attract and retain providers, as described above.

Methodology

CMS's proposal to apply a Medicare-based cap at the service level or discharge level could materially reduce payments for providers that have long relied on class-level aggregate payment levels. This will prove administratively burdensome and impractical for MCOs, where they need to disaggregate each claim to match the payment rate limit. Moreover, it will create access risks where Medicaid base rates plus SDP funding currently exceed the Medicare ceiling. Longstanding use of upper payment level (UPL) methodologies in Medicaid regulations have not created program integrity risks and have been accepted widely as a methodology framework.

This proposal goes beyond what Congress specified in the WFTC Legislation to impose more stringent methodological requirements. Finalizing this change, when paired with other administratively burdensome changes, could create additional complications and decrease efficiencies in the program. We ask that CMS not finalize the provision to calculate the new limits at the per-service/per-claim level. We instead ask CMS to apply the existing UPL methodology to calculate the new SDP payment limits in the final rule.

Uniform Increase SDPs

CMS also proposes to prohibit new uniform increase SDPs or renewals of non-grandfathered uniform increase SDPs, effective for the first rating period on or after January 1, 2028. We urge CMS to consider whether standardization of SDP reporting requirements and

documentation tied to the new payment limit framework would better serve the goals of transparency, program integrity, and alignment with utilization. Uniform increase SDPs are one of the most administratively straightforward SDP structures. Prohibiting these SDPs removes a payment tool that preserves states' flexibility to structure payments in ways that support provider participation and beneficiary access.

Building on concerns articulated throughout this comment letter, this proposal will negatively impact provider participation in the Medicaid program and therefore restrict care options for enrollees. As CMS acknowledged, most providers rely on uniform increase SDPs. Removing this type of SDP could impact MCO networks and make it more challenging for beneficiaries to find care. MCOs will also face another layer of administrative burden working to transition these SDPs to minimum or maximum fee schedule SDPs.

Uniform increase SDPs serve distinct purposes, such as aiming to address workforce shortages or needs in rural areas. Removing states' ability to design a uniform increase SDP which meet the specific needs of their populations would be counterintuitive to the design of the Medicaid program. We urge CMS to not finalize this policy and retain uniform increase SDPs to ensure states have flexibility when designing SDPs.

MHPA also encourages CMS to consider the cumulative impact of prohibiting uniform dollar increase SDPs in the context of the payment limits the proposed rule simultaneously imposes. If uniform increase SDPs were to continue to be allowed, they would be subject to the same payment limit as all other SDPs, any new cap finalized would constrain how high these payments can go. A uniform increase SDP cannot exceed the payment limit regardless of how it is structured. Given that the payment cap provides a strict ceiling on all SDP payments including uniform increase type SDPs, the additional step of prohibiting this payment structure entirely is not necessary to achieve CMS's stated policy goals. It appears duplicative of a protection that already exists within this proposed rule. We oppose the prohibition of uniform increase SDPs within this new context and believe it ultimately goes beyond what is necessary or statutorily authorized to address CMS's concerns.

We would also like to remind CMS that prohibiting this type of SDP will require coordinated systems changes to administer and report new payments properly, as SDPs transition to minimum or maximum fee schedule SDPs. States will need sufficient time to update claims and encounter systems to identify SDP eligible services and apply new caps correctly within the new structure.

Rather than prohibiting uniform dollar increase SDPs entirely, we urge CMS to consider whether simplification and standardization of SDP methodologies would better serve the goals of transparency, program integrity, and alignment with utilization, without eliminating a payment tool that states and providers have relied upon to maintain Medicaid network stability. Uniform increase SDPs are one of the most administratively straightforward SDP structures. With appropriate reporting requirements and standardized documentation tied to the new payment limit framework, uniform increase SDPs could be made more transparent than more complex SDP structures that require detailed service-level tracking. Understanding that CMS is concerned that uniform increases are insufficiently connected

to utilization and service delivery, we believe that enhanced reporting could demonstrate that connection to support program integrity. Prohibiting these SDPs removes a longstanding and straightforward payment tool that preserves states' and MCOs' flexibility to structure payments in ways that maintain provider participation and beneficiary access.

Value-Based Payment SDPs

The original goals of value-based payment (VBP) arrangements are to encourage providers to treat patients with the most appropriate care tied to quality and outcomes, rather than simply providing more services to increase reimbursement. As part of these arrangements, incentives for providers are included when predetermined benchmarks are met successfully. We are concerned that the provisions limiting payments for VBP SDPs and requiring claw-back of any overpayments may have the unintended consequence of further limiting these incentives and reducing the willingness of providers to enter these arrangements with MCOs. Safety net and rural providers with limited financial reserves especially are unlikely to enter VBP arrangements under these conditions, and those already in such arrangements may seek to leave. The proposed limit would negatively impact almost 20 percent of SDPs currently structured as VBP models.[3] It would effectively prevent the use of VBP in Medicaid managed care at scale going forward, causing promising models designed to keep enrollees healthy and reduce Medicaid costs to lose their appeal. Ultimately, capping the rewards available for meeting pre-determined performance standards and the retrospective financial exposure makes VBP SDPs significantly less viable. We urge CMS to reconsider this provision and to develop a VBP-specific SDP framework that advances the program integrity goals of the proposed rule without sacrificing the clinical and financial incentives that make value-based care function.

Grandfathering Period and Separate Payment Terms

We understand that in alignment with the WFTC Legislation, CMS is allowing certain existing SDPs to be grandfathered and remain at their current rates through the end of 2027. However, deviating from statute, CMS is proposing that for each rating period beginning on or after January 1, 2028, states must reduce the grandfathered *total dollar amount,* compared with the statutory requirement of reducing by *the payment rate,* by at least 10 percentage points annually until the applicable payment limit is reached.

The final Medicaid Managed Care rule of 2024 eliminated the use of separate payment terms (SPTs) to operationalize SDPs. This provision was set to go into effect in 2027 or 2028, depending on plan contract year, until the agency decided to implement a temporary exemption to the prohibition on SPTs as a part of this proposed rule. SPTs, a payment method providing a fixed amount of directed payment funding outside of a managed care organization’s base capitation rate, are used in most SDPs across the country.

Given the range of rate adjustments required under the WFTC Legislation, plans face considerable uncertainty as to whether capitation payments will adequately account for the costs of SDPs, especially as MCOs assume full financial risk for the payment obligations

[3] https://80million.substack.com/p/make-value-based-payment-work-again

they represent. Higher capitation premiums generate higher risk-based capital (RBC) requirements, meaning MCOs must hold materially more capital in reserve simply because of the structural migration from directed payments to capitation-embedded payments, even if the total dollars flowing to providers remain the same. The concern is compounded by the compressed timeline. MCOs and their actuaries need sufficient lead time to model the capital implications of SDP migration, assess the adequacy of existing reserves against the new RBC requirements, and develop plans for meeting any capital shortfalls.

Recommendations

We recommend that CMS allow state flexibility for how they calculate the annual 10 percentage point reduction given how SDPs vary across states. CMS has accelerated the phase down by requiring states to reduce the grandfathered total dollar amount until the applicable payment limit is reached. The structure of this rapid phase-down will build on the burden MCOs already face in operationalizing the many changes to SDPs. The SDPs will reach the payment limit significantly faster, meaning MCOs will have limited time to transition these SDPs to minimum or maximum fee schedule SDPs, build up RBC reserves, and ensure provider networks are stable under the new SDP structure.

We understand that the SPT prohibition may not be under consideration by CMS and in that case, plans are grateful for the time-limited opportunity to continue to utilize SPT while grandfathered SDPs are being phased down. We recommend that CMS grant states flexibility to wait until **all** grandfathered SDPs reach the new Medicare threshold before payments are phased into the capitation rates. The current wording suggests that States will need to phase SDPs into the capitation rates once the SDP meets the new threshold, meaning SDPs will be phased in during different rating periods. This will cause significant administrative burden and complexity for the states. CMS would also need to track SDPs in different ways to evaluate the payments within and outside of the capitation rates.

To further support actuarial soundness in rates, CMS should include language in the final rule to emphasize that the administrative costs related to the SDPs that were previously captured in the SPT should be incorporated in the capitation rates moving forward. The current proposed rule language notes that an administrative load cannot be included in the SPT and states “as capitation rates already include a non-benefit component to cover reasonable administrative costs”. We are respectfully requesting a change to the language to clearly state that the capitation rates will need to be increased when states remove the administrative load from the SPT.

Additionally, we are advocating for implementation of a risk mitigation mechanism to protect MCOs from rate inadequacy during the transition period, as the prohibition on SPTs comes into effect. Risk mitigation mechanisms could include risk corridors and risk pools. Risk corridors could also serve as an anti-fraud tool, one that prevents MCOs from being systematically overfunded or underfunded due to SDP structural changes outside MCO control. For SDPs being implemented as a capitation rate adjustment, after formerly being a SPT, implementing a risk pool around SDP funding included in the capitation rate, along with a narrow risk corridor would help mitigate the risk-based capitation structure. Part of this

implementation would include establishing a clear exit plan for the risk mechanism, risk pool and/or risk corridor, such as a three-year duration or until SDP trend stabilizes. This gives the state and MCOs defined parameters and expectations during the transition period.

The proposed SDP changes from the WFTC Legislation and the 2024 Managed Care Final Rule are complex. The requirement to move SDPs into the capitation rate is especially technical in nature. To support actuarial soundness and stakeholder clarity, we recommend that the forthcoming annual SDP guidance and the annual Rate Guide be released in tandem and provide appropriate cross-references to provisions within each document. We believe this will elucidate important linkages between the prospective rate setting process and the use of risk-based SDPs to promote quality and access with Medicaid providers.

We have a few additional suggestions to be included in the Rate Guide to support successful implementation of the proposed regulations:

- CMS should encourage States to implement risk mitigation strategies during this period of uncertainty.
- CMS should require that when states transition SDPs to at-risk (away from SPTs), they integrate appropriate utilization assumptions, quality withhold structures, administrative expenses and MCO margin, so that the addition of SDPs to base capitation rates is done in a way that preserves the actuarial soundness of those rates.
- CMS should require states to consider and address cost of capital and RBC impact as SDP payments move to capitation.
- As a part of implementation of these new changes, we also request that CMS reiterate and remind states in the SDP final rule that per existing federal regulations[4], SDPs are to be treated as incurred claims and included in the MLR numerator as finalized in the 2024 Medicaid Managed Care Rule.

We thank CMS for understanding the depth of guidance that states and stakeholders will need to successfully implement any changes to SDPs. We recommend that CMS address the following actuarial and capitation rate matters in any future subregulatory guidance:

- Guidance on how states should recalibrate risk adjustment after risk-sharing mechanisms are removed from SDP funding in capitation rates. Risk adjustment will likely need to be modified once risk mitigation mechanisms are removed.
- Guidance that states should conduct early and iterative actuarial modeling, including repricing and utilization-sensitivity testing to support sound rate development as SDPs transition to a risk-based structure.
- Guidance on the importance of modeling potential risk-adjustment recalibration early and collaborate with MCOs on results.

[4] *See* 42 CFR 438.8(e)(2)(iii)(C).

Additional Comments and Recommendations

Network Adequacy and Plan Accountability

Overall, MHPA member plans hope to avoid policies that unintentionally destabilize Medicaid managed care provider networks or shift undue responsibility for state payment policy changes to MCOs. If provider participation declines given reductions or redesigns of SDP funding, enrollees may face access challenges and plans may face network adequacy challenges. CMS should clarify how states and CMS will account for these impacts in network adequacy oversight and plan accountability.

Compounding this concern is the risk that providers will seek to recover lost SDP revenue through higher negotiated contract rates, further pressuring MCOs' ability to manage costs within actuarially sound capitation rates and potentially accelerating the network disruption that reduced SDP funding was already likely to cause. CMS should clarify how states and CMS will account for these impacts in network adequacy oversight and should confirm that MCOs will not be held accountable for network adequacy failures that are directly attributable to state SDP policy changes outside the MCO's control.

CMS should reconsider telehealth limitations to promote network adequacy in this environment. Specifically, MHPA asks that CMS remove the requirement under the 2024 Medicaid Managed Care and Access Final Rule that a physician must have a physical location to count toward meeting network adequacy requirements. This requirement is inconsistent with the realities of modern health care delivery and disproportionately limits network adequacy credit in rural and underserved communities where telehealth providers are often the most accessible option for Medicaid beneficiaries. CMS should also commit to providing dedicated resources and technical assistance to states as they navigate the intersection of telehealth policy and the network adequacy demands created by SDP restructuring.

Extreme and Uncontrollable Circumstances

CMS should consider establishing a formal process for addressing extreme and uncontrollable circumstances, such as natural disasters, public health emergencies, or other catastrophic events, that may require states to temporarily exceed the Medicare-based payment limits established under the proposed rule. In the wake of disasters, provider capacity is often severely constrained, costs increase rapidly, and access to care depends on the ability to mobilize and retain providers under conditions that normal payment limits were not designed to accommodate. A time-limited, narrowly defined exception process, subject to CMS approval and robust documentation requirements, would allow states to respond effectively to these circumstances without permanently exceeding payment limits or undermining the integrity of the SDP framework. The rigidity of the proposed payment limits could impair states' ability to maintain access to care during emergencies.

Overpayments

MHPA appreciates that the proposed rule expressly acknowledges that absent SDPs, Medicaid managed care plans may continue to negotiate provider payment rates that exceed the SDP payment limit when necessary to ensure a sufficient provider network. This is an

important recognition of MCOs' contracting authority and their responsibility to maintain adequate networks. MHPA thanks CMS for its inclusion.

However, clarity is needed on a related topic. If a plan negotiates a provider rate for a specific service or provider type that exceeds the amount that would have been paid under an applicable SDP, will that negotiated rate be characterized as an overpayment subject to recoupment? MHPA respectfully requests that CMS explicitly confirm in the final rule that negotiated rates above the SDP payment limit do not constitute overpayments and are not subject to recoupment.

Information Transparency

Meaningful compliance with the proposed SDP framework requires that MCOs have access to clear, accurate, and timely information about the SDPs for which they are responsible. While MCOs serve as a pass-through to execute directed payments to providers, states retain responsibility for SDP oversight. However, even within this role, MCOs find that the information available through state actuarial rate certifications is insufficient to support the level of oversight required by the proposed rule. CMS should require states to provide MCOs with a centralized listing of all SDPs for which MCOs are responsible including: SDP name, if the SDP is captured as a capitation rate adjustment or a separate payment term, and type of SDP (e.g., uniform increase, minimum fee schedule, etc.). While MCOs generally have this information, this requirement would ensure what is captured in each state's rate certification is consistent with each state Medicaid agency's understanding.

CMS should also require states to provide MCOs with additional information about all SDPs for which MCOs are responsible including:

- Which SDPs are approved by CMS for the temporary grandfathering period,
- Which SDPs are not grandfathered,
- Percent of Medicare equivalency for each service,
- For grandfathered SDPs, expected phase down timeline, and
- For uniform increase SDPs, what type will they transition to effective 1/1/28.

MCOs do not currently have access to this information in state's actuarial rate certifications. This will help managed care plans understand which SDPs are subject to which rules under the proposed rule, better understand the state's strategy to conform to the proposed rule, and support overall compliance with the proposals if finalized.

MHPA is also concerned that the new SDP payment limit framework will inadvertently reduce transparency for MCOs. Under the 2024 Medicaid Managed Care Final Rule, states are explicitly exempt from submitting written preprints and seeking prior approval for SDPs if the state requires MCOs to pay providers 100 percent of the total published Medicare payment rate. This means preprints will not be required for expansion states once the grandfathered SDPs are phased-in and meet the payment limit. We recommend that CMS requires states to share SDP documentation with MCOs. With the new upper bound for SDPs in expansion states being 100 percent of Medicare payment rates, this will result in reduced transparency

for MCOs if states will no longer need to submit the preprints that are shared on the CMS preprint website.

The 2026-2027 CMS Rate Guide requires additional SDP transparency in the Actuarial Rate Certifications, but the documents are not necessarily shared with MCOs. If the CMS preprints are no longer required, we request that states be required to share the SDP section of the rate certification with MCOs to ensure transparency is maintained. Since the state will already be sharing the SDP information with CMS, this approach would not result in any additional work for the state.

Once again, thank you for the opportunity to provide comments on the Medicaid Managed Care SDP proposed rule. We appreciate the opportunity to share our perspective on addressing these challenges and look forward to continuing to work with CMS to make a meaningful difference in the lives of Medicaid enrollees.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/S/

Shannon Attanasio
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