July 21, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via regulations.gov

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

Dear Administrator Oz,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,500 family physicians and medical students across the country, we appreciate the opportunity to comment on the proposed rule published in the Federal Register on May 22, 2026, regarding State Directed Payments (SDPs) in Medicaid managed care. The rule proposes caps to certain Medicaid provider reimbursement mechanisms in response to the directives in the One Big Beautiful Bill Act (OBBBA) enacted July 4, 2025, and extends those payment limitations to additional providers under Medicaid managed care and fee-for-service (FFS).

Medicaid is a vital payer for family physicians, particularly in underserved and rural areas where they provide more care than any other specialty and often serve as the initial point of access for patients facing significant barriers to affordable care.[i] At the same time, Medicaid payment for primary care remains substantially below Medicare, averaging roughly two-thirds of Medicare rates.[ii] To address this, SDPs have become an essential tool for States to address longstanding underpayment in Medicaid managed care by directing targeted rate enhancements that improve access, particularly for primary care, behavioral health, and safety-net providers. Additional reductions in SDP-supported provider reimbursement would risk directly weakening primary care capacity and indirectly destabilizing referral networks, maternity supports, children's specialty services, and community-based services that family physicians rely on to care for Medicaid patients effectively.

While we recognize the statutory directive to establish Medicare-based limits for specific service categories identified in OBBBA, we are deeply concerned that the proposed rule goes significantly beyond those statutory requirements. In the proposed rule, CMS notes that "when used correctly, SDPs can properly fulfill their role to expand access, lower cost, and improve quality of care and health outcomes for Medicaid enrollees." We agree.

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Accordingly, we strongly recommend CMS implement the statute in a manner that preserves the core role of SDPs in supporting access to care. Specifically, we urge CMS to:

- Withdraw the proposed extension of Medicare-based payment limits to all non-grandfathered SDPs, and limit implementation of section 71116 of the OBBBA to the four service categories identified in the statute;
- Withdraw the proposed prohibition on uniform rate increases;
- Exclude service categories without a meaningful Medicare equivalent (including maternal health, pediatric services, and Home- and Community-Based Services (HCBS)) from Medicare-based limits;
- Revise the implementation timeline to ensure that *all* proposed methodology and validation requirements do not take effect before completion of the initial phase-down period for grandfathered SDPs. CMS should also provide, at a minimum, a two-rating-period transition, ending no earlier than rating periods beginning on or after January 1, 2030, to allow for orderly redesign of SDP arrangements and to avoid requiring States to implement methodology, reporting, and validation changes concurrently with the phase-down;
- Replace the proposed aggregate-dollar phase-down of grandfathered SDPs with a percentage-of-Medicare phase-down methodology;
- Substantially narrow the State reporting and validation requirements so that any final rule is administrable for States, plans, and providers and does not cause States to abandon vital, access-supporting SDPs because of avoidable compliance burden;
- Preserve State flexibility to target supplemental FFS payment methodologies to documented access gaps, particularly in primary care; and
- Reinstate the aggregate compliance methodology for all SDP payment limits, consistent with the current definition of "total payment rate" in 42 C.F.R. § 438.6(a), or at minimum establish a safe harbor for administratively feasible methodologies where claim-level Medicare crosswalks are not practical (i.e. uniform increases and value-based arrangements).

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

Medicare-Based Payment Limits for SDPs

CMS proposes implementing Section 71116 of the OBBBA by revising 42 C.F.R. § 438.6(c)(2)(iii) to replace the current 100 percent Average Commercial Rate (ACR) benchmark with a Medicare-based payment limit for four specified service categories: inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services at

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academic medical centers. If finalized, SDPs for those services will be capped at 100 percent of the total published Medicare payment rate in Medicaid expansion States and 110 percent of the total published Medicare payment rate in non-expansion States.

The proposed limits would apply at the individual claim or service level (e.g., HCPCS codes or DRGs), rather than in the aggregate, and would incorporate all applicable Medicare payment adjustments (e.g., geographic adjustments, add-ons, and modifiers). Where no Medicare rate exists, CMS proposes to cap payments at 100 percent of the applicable Medicaid State plan rate, waiver rate, or a cost-based rate derived using validated cost reporting methodologies. For providers reimbursed on a cost basis under Medicare (e.g., critical access hospitals and children's hospitals), CMS proposes to use Medicare cost reports to establish service-level benchmarks, with future guidance expected on cost reporting and allocation methodologies.

In addition to implementing the statutory Medicare-based cap for the four named services, CMS proposes extending a payment rate limit framework to all non-grandfathered SDPs, not only those expressly addressed in section 71116. If finalized, this extension would be effective on the first rating period on or after January 1, 2029.

CMS would also impose significant reporting and compliance requirements, including submission of clinician-level NPI lists, service-level benchmark data, and detailed methodologies demonstrating compliance with the applicable payment limits. For SDPs structured as value-based payment (VBP) arrangements, States would be required to submit validation methodologies demonstrating that payments do not exceed the payment limit on a per-service basis.

Grandfathered SDPs (§438.6(a) and (c)(2)(iii))

CMS proposes a temporary grandfathering policy for certain SDP preprints submitted before July 4, 2025, for rating periods spanning October 11, 2024, through March 27, 2026. For these arrangements, the approved aggregate payment amount would serve as the payment limit, and States would retain flexibility to adjust service-level payments so long as total payments remain within the approved amount and consistent with ACR.

Beginning with rating periods on or after January 1, 2028, CMS also proposes to phase down grandfathered SDPs by 10 percent annually, based on the original approved aggregate amount, until compliance with the Medicare-based limits is achieved. States would not be permitted to increase aggregate payment levels during this period. CMS does not propose to require service-level comparisons for grandfathered SDPs at this time but acknowledges that further guidance may be necessary. CMS proposes to allow grandfathered SDPs to continue using separate payment terms during the transition period. However, once an SDP achieves

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compliance with the Medicare-based limit, payments must be incorporated into actuarially sound capitation rates, and separate payment terms would no longer be permitted. Beginning in 2027, States will be required to submit actuarially certified analyses comparing SDP payment rates to Medicare benchmarks.

Types of Permissible SDPs and Provider Classes (§438.6(c)(1)(iii), (c)(2)(i), and (c)(2)(iii)(E))

Minimum and Maximum Fee Schedule

CMS proposes to permit States to direct managed care plans to adopt minimum and maximum fee schedules without prior approval, provided those schedules do not exceed the applicable payment limit and plans retain discretion to manage risk. These policies would take effect for rating periods beginning on or after January 1, 2028.

Prohibition on Uniform Rate Increases

CMS also proposes to prohibit the use of uniform rate increases as an SDP methodology for non-grandfathered arrangements beginning with rating periods on or after January 1, 2028. For grandfathered SDPs, uniform rate increases will continue to be permitted until the payment limit of 100% of Medicare or 110% of Medicare is reached through the phasedown. Under current rules, States are permitted to structure SDPs as VBP arrangements, minimum fee schedules, maximum fee schedules, or uniform increases. Under a uniform increase, States determine a fixed dollar or percentage increase that is applied to base reimbursement for every service covered under the SDP. CMS proposes to eliminate this option. However, States with grandfathered SDPs would be permitted to use uniform increases until the SDP reaches the Medicare-based limit, after which they would be required to use a different methodology (e.g., minimum fee schedule).

Provider Classes

CMS solicits comment on whether and how to define "provider class" in regulation, citing concerns that States may define provider classes too narrowly or in ways tied to financing arrangements rather than programmatic goals.

Targeted Medicaid Payment Limit in an FFS Delivery System (§447.381)

CMS proposes to establish a Medicare-based payment limit for certain targeted FFS practitioner and provider payments, aligning these limits with those proposed for Medicaid managed care. Payments would generally be capped at 100 percent of Medicare in expansion States and 110 percent in non-expansion States, applied on a per-service basis.

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Payments would be considered "targeted" where they are not uniformly available to all providers furnishing a covered service under the State plan. CMS also clarifies that the targeted payment limit cannot be less than statutorily required Medicaid payment rates, including the prospective payment system applicable to federally qualified health centers (FQHCs) and rural health centers (RHCs). The proposal includes two exceptions for targeted payments: services without a Medicare equivalent; and payment methodologies reconciled to actual costs. States would have until the first State fiscal year on or after January 1, 2029, to comply with the new limits. States with approved State plan payments exceeding the proposed limits must revise their State plan amendments to explicitly demonstrate that targeted Medicaid FFS payments comply with the Medicare-based cap, or risk denial, no later than the first State fiscal year beginning on or after Jan 1, 2029.

AAFP Comments on Payment Limit for SDPs (§438.6 (a), 438.6(c)(2)(ii)(I) and 438.6(c)(8))

Medicare-Based Payment Limits for SDPs

We recognize that section 71116 of OBBBA requires CMS to replace the current ACR-based benchmark with a Medicare-based payment limit for the four specified SDP service categories: inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers. However, we are deeply concerned that many provisions in this proposed rule risk undermining beneficiary access to Medicaid services by extending the payment limits to all non-grandfathered SDPs and by adopting implementation and compliance methodologies that are substantially more restrictive than the statute requires.

a. *Extending Medicare-based limits to all non-grandfathered SDPs*

Section 71116 is tailored to four service categories that account for a substantial share of SDP spending. As of May 2026, an estimated 84 percent of federal SDP spend covers hospital services, totaling an estimated $78 billion annually.[iii] Professional services at academic medical centers ($3.2 billion) and nursing facility services ($2.1 billion) account for the next-largest shares of federal SDP spending each year.[iv] By limiting the statutory changes to those categories, Congress intended to target high-impact, Medicare-aligned services. And SDP limits in the four statutorily affected service categories are already expected to have significant financial and access implications across dozens of States, potentially affecting access to care and quality outcomes. These effects are compounded by broader Medicaid policy changes under OBBBA, which the Congressional Budget Office projects will increase the number of uninsured individuals by approximately 10 to 11 million.[v] Coverage losses of this magnitude are expected to increase uncompensated care and place additional financial pressure on hospitals, particularly in rural communities where nearly half of facilities already operate with negative margins.[vi]

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Thus, we are deeply concerned with CMS's proposal to extend Medicare-based payment limits to all non-grandfathered SDPs beginning with rating periods on or after January 1, 2029. **That approach exceeds the scope of the statutory directive in Section 71116 of the OBBBA and imposes a substantially steeper reduction in Medicaid financing than Congress originally intended.** In this proposed rule, CMS estimates that the combined statutory and regulatory changes would reduce federal Medicaid spending by approximately $510 billion over 10 years—more than three times the reduction estimated by the Congressional Budget Office for the statute alone.[vii]

The AAFP recognizes health as a basic human right for every person and has strongly advocated to maintain and expand federal health care coverage programs to ensure that all Americans, regardless of social, economic status, race, religion, gender or sexual orientation have the right to universal access to timely, high quality, and affordable essential health care services. **Thus, the AAFP strongly opposes the proposed expansion of Medicare-based payment limits to all non-grandfathered SDPs.** SDPs are foundational financing mechanisms used by States to improve access for eligible beneficiaries, provider participation, network adequacy, and care delivery deficiencies in Medicaid managed care. 41 States and the District of Columbia currently use SDPs, and 36 of those States use SDPs to primarily support primary care, behavioral health, and safety-net physicians, clinicians, and health systems.[viii,ix] States design these arrangements to address persistent underpayment and workforce shortages in community-based settings rather than to finance excessive payment.

The proposed expansion is especially consequential for family physicians, as Medicaid access already depends on the primary care workforce operating under persistently inadequate payment levels. In 2021, 76 percent family physicians were accepting new Medicaid patients, significantly more than many other specialties.[x] And as mentioned earlier, by 2023, just one-third of primary care physicians delivered roughly 90 percent of all Medicaid office visits, underscoring the outsized role family medicine plays in sustaining access to care for Medicaid beneficiaries.[xi] At the same time, Medicaid payment for primary care remains substantially below Medicare, averaging roughly two-thirds of Medicare rates, and can be as low as 33 percent in some States.[xii] If finalized, this expansion risks substantially reducing provider payments, constraining State flexibility, discouraging provider participation, and threatening widespread access to essential primary care services for Medicaid beneficiaries, precisely where Medicaid's access challenges are most severe.

The practical significance of that risk is evident in how States currently use SDPs. For example, CMS-approved SDPs in Maryland have expanded access to Medicaid provider networks for primary care.[xiii] Similarly, the Georgia's Advancing Innovation to Deliver Equity,

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or GA-AIDE, program, which is a value-based SDP program, enabled the opening of two outpatient centers in underserved areas of Fulton County, GA, expanding access to primary care, specialty care, mammography, laboratory, pharmacy, and rehabilitation services.[xiv] **Extending Medicare-based limits across all non-grandfathered SDPs, including these, would therefore limit a broad range of vital Medicaid payment strategies and services that Congress did not expressly target in section 71116.**

These impacts will be particularly salient in rural communities, where Medicaid covers roughly one in four rural residents, and Medicaid finances 47 percent of births in rural communities.[xv,xvi] Rural physicians already face persistent workforce shortages, thin operating margins, and limited alternative revenue sources, particularly against the backdrop of parallel Medicaid funding reductions resulting from OBBBA. The Kaiser Family Foundation estimates that these combined Medicaid funding reductions could place more than 300 rural hospitals at risk of closure.[xvii] Further limiting State flexibility to use SDPs in rural markets would likely intensify access problems in communities with fewer clinicians, fewer referral options, and greater dependence on Medicaid financing. Further limiting State flexibility to use SDPs, beyond what is statutorily required, will intensify these existential access challenges in communities with fewer clinicians, fewer referral options, and greater dependence on Medicaid financing.

b. Medicare-based payment limits for services without Medicare equivalent

We are also concerned that the proposed rule would apply a Medicare-based limit, or where no Medicare rate exists, a fallback to State plan, waiver, or cost-based rates, to service categories for which Medicare is not an appropriate or meaningful benchmark. Section 71116 applies to four specified categories. It does not direct CMS to impose payment limits on additional service lines that fall outside those categories and, in many cases, outside the Medicare benefit framework.

We are particularly concerned about these limits applied to maternal, pediatric, and Home- and Community-Based Services (HCBS), for which Medicaid is the primary payer and Medicare often does not have an analogous service. Regarding maternal health, a Medicare-based ceiling would limit States' ability to direct targeted payment support to maternity-related provider networks where access is already fragile. This endangers, for example, Georgia's Rural Obstetrics Services Directed Payment Program, which has been employed to helping stabilize rural maternity units, support the recruitment and retention of OB physicians and clinicians, and expand access to prenatal and postpartum services.[xviii] Further, Medicaid data show that 86.2 percent of Medicaid Long-Term Services and Supports (LTSS) users received HCBS in 2021 and that 63.2 percent of LTSS expenditures were for HCBS. Meeting this demand, North Carolina employed an SDP to establish a uniform dollar increase and minimum fee schedule to increase wages for HCBS providers, helping maintain network

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capacity and support HCBS availability across the State.[xix] Thus, applying Medicare-based ceilings or defaulting to State plan rates in the absence of an equivalent Medicare service would constrain one of the few tools States have to stabilize these workforces and preserve access.

c. SDP payment limit methodology and Operational implications for States

Under current regulation at 42 C.F.R. 438.6(a), the "total payment rate" is defined as an aggregate measure that accounts for base managed care payments, the SDP under review, other SDPs, and allowable pass-through payments for the relevant provider class and service. However, the proposed rule would move away from that aggregate approach and require compliance with the Medicare-based limit at the individual claim or service level instead.

Many SDPs are currently structured as uniform dollar increases, uniform percentage increases, or value-based payment arrangements that are designed and certified at the program level instead of the individual claim or service level. If finalized, many SDPs that are lawful and feasible under the current aggregate methodology may become functionally noncompliant under the proposed service-level methodology. This would force States and managed care plans to face the substantial operational burden of reconfiguring their Medicaid payment methodologies to individual Medicare prices including add-ons, modifiers, and geographic adjustments across a broad range of claims, providers, and payment arrangements. However, repricing Medicaid managed care SDPs to Medicare on a service-by-service basis is highly complex, especially where Medicaid and Medicare payment structures differ or where the SDP is designed around quality incentives or value-based performance. **This burden may discourage States from maintaining or redesigning SDPs that support community-based providers, even where those arrangements are advancing network adequacy and access.**

The proposed reporting and validation obligations would further compound the administrative burden on States, plans and physicians. If finalized, CMS would require States to submit provider-level NPI lists, service-level Medicare or Medicaid benchmark data, detailed methodologies describing how payment to each provider for each service will remain within the applicable cap, and additional validation approaches for SDPs structured as value-based arrangements. These burdens also carry substantial financial considerations, as States may attempt to offset SDP reductions through increases in base rates to keep these vital mechanisms afloat, however such offsets may be difficult given fiscal constraints and parallel Medicaid financing changes from OBBBA. As a result, many States may scale back or discontinue SDPs altogether because the compliance framework is too burdensome to maintain. These administrative and structural changes will ultimately affect family physicians and other frontline clinicians by altering how they are reimbursed, creating uncertainty in payment structures, and potentially reducing participation in Medicaid.

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The AAFP is further concerned that the proposed implementation timeline combines multiple major policy changes within a compressed timeframe. States would be required to begin phasing down existing SDPs in 2028 while simultaneously redesigning payment methodologies and implementing new reporting and validation requirements, ahead of full application of Medicare-based limits to all non-grandfathered SDPs in 2029. This sequencing increases operational risk and makes it more likely that States will discontinue, rather than redesign, SDPs that support access to care.

Given the magnitude of implementation requirements, the AAFP recommends that CMS revise the implementation timeline to ensure that all new methodology and validation requirements do not take effect before completion of the initial phase-down period for grandfathered SDPs. CMS should also provide, at a minimum, a two-rating-period transition between major policy changes so that States can redesign SDP arrangements in a sequential manner and are not required to implement methodology, reporting, and validation changes concurrently with the phase-down. Because Medicaid managed care rates must be developed, actuarially certified, and approved by CMS on a rating-period basis, changes to SDP methodologies cannot be implemented outside the rate-setting cycle. Accordingly, States will require at least one full rating period to redesign and secure approval of SDP structures and an additional period to operationalize those changes, making shorter timelines operationally infeasible. Thus, a minimum two-rating-period transition is necessary to reflect the operational and actuarial realities of Medicaid managed care rate-setting.

Additionally, we are concerned that the proposed requirement to validate VBP SDPs against the Medicare-based payment limit on a per-service basis is not required by statute and risks misalignment with the structure of value-based arrangements. Section 71116 establishes a total payment rate limit but does not require service-level attribution or impose specific validation methodologies for value-based arrangements. By contrast, the proposed rule would effectively require States to translate population-based or performance-based payments into service-level equivalents. That approach is conceptually inconsistent with how VBP models are typically designed and implemented, as VBP SDPs typically incentive payments based on performance across populations, episodes of care, or quality measures, rather than on the price of individual services. Requiring States to attribute those payments to specific services in order to demonstrate compliance with a Medicare-based payment cap would introduce additional methodological complexity and ambiguity. Further, this requirement risks discouraging the use of VBP SDPs altogether. SDPs have been an important mechanism for advancing value-based care in Medicaid managed care, including quality improvement, care coordination, and population health management. Imposing a validation framework that is difficult to operationalize may lead States to scale back or eliminate VBP arrangements, undermining longstanding CMS and CMMI policy priorities to uplift value-based care.

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To ensure that SDPs can properly fulfill their role to expand access, lower cost, and improve quality of care and health outcomes for Medicaid enrollees, the AAFP respectfully urges CMS to revise §438.6 (a), 438.6(c)(2)(ii)(I) and 438.6(c)(8) as follows:

- Limit implementation of section 71116 of the OBBBA to the four service categories identified in the statute and withdraw the proposal to extend Medicare-based payment limits to all non-grandfathered SDPs;
- Retain the aggregate compliance methodology for all SDP payment limits, consistent with the current definition of "total payment rate" in 42 C.F.R. § 438.6(a), or at minimum establish a safe harbor for administratively feasible methodologies where claim-level Medicare crosswalks are not practical (i.e. uniform increases, separate payment terms, or value-based arrangements);
- Exclude service categories without a meaningfully equivalent service in Medicare (including, but not limited to, maternal health services, pediatric services, HCBS, and other community-based services) from the Medicare-based payment limits;
- Substantially narrow the State reporting and validation requirements so that any final rule is administrable for States, plans, and providers and does not cause States to abandon vital, access-supporting SDPs because of avoidable compliance burden.

AAFP Comments on Grandfathered SDPs (§438.6(a) and (c)(2)(iii))

Grandfathering existing SDPs is essential to avoid abrupt disruption in Medicaid managed care financing, particularly for arrangements that States and providers have already operationalized in reliance on prior federal policy. Thus, we appreciate CMS's proposal to allow certain completed SDP preprints submitted before July 4, 2025, to qualify for temporary grandfathering, and to permit continued use of separate payment terms during the transition period, appropriately acknowledges the administrative and operational realities of these programs. However, a transition policy is most effective when it provides predictability. The proposed aggregate-dollar, phase-down approach for grandfathered SDPs presents an unnecessarily methodologically complex means of implementing section 71116 not explicitly required by statute. The statute calls for a phased transition toward the new Medicare-based limit, however CMS proposes to reduce the total computable amount of each grandfathered SDP by 10 percent annually based on the original approved aggregate payment amount, rather than reducing the SDP's payment level relative to Medicare by 10 percentage points per year. This proposed fixed reduction to the aggregate dollar amount may accelerate reductions for some SDP arrangements far more quickly than others.

This proposed approach also introduces avoidable uncertainty for States. While we appreciate CMS' acknowledgement that additional guidance may be needed to determine when a grandfathered SDP has reached the applicable service-level limit and does not

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propose to require service-level comparisons for grandfathered SDPs at this time, that acknowledgement underscores the underlying and avoidable uncertainty created by this approach: the phase-down applies to the aggregate approved amount, while the broader payment-limits will increasingly rely on service- and claim-level comparisons. The resulting incongruencies will complicate compliance, make State planning more difficult, and reduce the intended value of the grandfathering provision.

The AAFP respectfully urges CMS to take the following actions to revise the provision on Grandfathered SDPs (§438.6(a) and (c)(2)(iii)):

- Finalize the permitted use of separate payment terms for grandfathered SDPs during the transition period;
- Replace the proposed aggregate-dollar phase-down with a percentage-of-Medicare phase-down methodology;
- Issue detailed prospective guidance on grandfathered SDP compliance before the phase-down period begins, including how compliance will be assessed where the grandfathered amount and the ongoing payment-limit methodology use different units of measurement.

AAFP Comments on Types of Permissible SDPs and Provider Classes (§438.6(c)(1)(iii), (c)(2)(i), and (c)(2)(iii)(E))

Prohibition of Uniform Rate Increases

The AAFP strongly opposes CMS's proposal to prohibit uniform rate increases as an SDP methodology for non-grandfathered arrangements beginning with rating periods on or after January 1, 2028. Uniform dollar and uniform percentage increases are among the most commonly used SDP structures.[xx] These arrangements have become an increasingly important mechanism for States to improve clinician participation and preserve access where base rates are insufficient. As mentioned above, States have used SDPs to expand provider networks for primary care and behavioral health, to support HCBS workforce capacity, and to strengthen community-based access in ways that are administratively feasible under current payment structures. Prohibiting this payment methodology would require States to redesign established SDP structures that have already been incorporated into contracts, rate development, and clinician financing expectations. And if finalized, while some States may succeed in redesigning these programs, others may scale them back or allow them to expire because the redesign burden is too great relative to the payment levels that would remain permissible under the rule.

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The AAFP therefore urges CMS to withdraw the proposed prohibition on uniform rate increases. At a minimum, if CMS proceeds with finalization, States should be provided with a significantly longer transition period and a simplified pathway to convert existing uniform-increase SDPs into minimum or maximum fee schedules without jeopardizing funding continuity.

Minimum and Maximum Fee Schedules

Minimum fee schedules are a critical tool for establishing baseline provider reimbursement levels that support participation, particularly in primary care, behavioral health, and rural markets. Constraining maximum schedules to Medicare-based ceilings reduces States' ability to respond to local market conditions, workforce shortages, and access gaps. While CMS appropriately requires that plans retain the ability to manage risk and fulfill contract obligations, the combined effect of payment ceilings and methodology restrictions may reduce flexibility for both States and plans to negotiate provider payment arrangements that sustain network adequacy. We are particularly concerned about the interaction between these changes and other elements of the proposed rule. CMS is simultaneously proposing to prohibit uniform rate increases, impose service-level payment limits, and constrain maximum fee schedules under Medicare-based ceilings. Together, these policies significantly narrow the range of permissible SDP designs, reducing flexibility beyond statutory direction.

Provider Classes

While we understand the value in transparency around how States define "provider class" for SDPs, any regulatory definition must preserve the flexibility States need to target legitimate access and quality challenges in Medicaid managed care. In the background section of this proposed rule, CMS notes prior approval of SDPs targeted to provider classes such as all providers certified as Patient-Centered Medical Homes, precisely because those providers were furnishing enhanced care coordination and delivery-system functions relevant to the Medicaid program's quality goals. CMS also recognizes that not all providers furnishing a service under contract must be included in an SDP so long as the State directs expenditures equally within the defined class. This flexibility is particularly important for family physicians, who play a central role in Medicaid by providing comprehensive primary care, care coordination, and longitudinal management of patients across settings, including strengthening Patient-Centered Medical Home models, and addressing access gaps in underserved and rural communities. In many cases, legitimate provider classes are defined by service capability, safety-net role, participation in a qualified value-based model, geography, rurality, or specialized capacity. **Thus, we believe CMS should avoid adopting an overly rigid provider-class definition that would prevent States from focusing SDPs on primary care, behavioral health, rural providers, safety-net providers, community-based**

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practitioners, or other legitimate categories tied to documented Medicaid access challenges. Further, we recommend CMS provide sub-regulatory examples of permissible and impermissible provider class definitions rather than adopting an overly rigid regulatory definition that could impede targeted access interventions.

AAFP Comments on the Targeted Medicaid Payment Limit in an FFS Delivery Systems (§447.381)

We are primarily concerned that the proposed targeted Medicaid FFS payment limits are not directed by section 71116 of the OBBBA, which is focused on SDPs for specified service categories. These FFS provisions instead arise from a separate exercise of CMS authority under section 1902(a)(30)(A) of the Social Security Act and were not included in the statutory mandate Congress provided. Given this distinction, the AAFP is concerned that combining these policies within a single rulemaking effectively extends the scope of section 71116 beyond what Congress authorized and limits meaningful opportunity for stakeholders to comprehensively evaluate these separate policy changes.

That said, the AAFP appreciates CMS's recognition that the targeted Medicaid payment limit may not undercut statutory payment protections, including the prospective payment system applicable to FQHCs and RHCs. CMS appropriately clarifies that the targeted Medicaid payment limit cannot be less than Medicaid payment rates subject to a statutory floor, such as PPS requirements, and we urge CMS to retain this clarification in the final rule.

We also appreciate CMS's proposal to exempt targeted Medicaid FFS payments for services without a Medicare equivalent, and payment methodologies reconciled to actual practitioner or provider costs. These exceptions appropriately recognize that Medicare does not provide a universal or appropriate benchmark across all Medicaid service lines and payment structures. However, CMS does not extend that same principle to SDPs despite the underlying rationale for the FFS exceptions applying with equal force to SDPs. For SDPs, the proposed rule instead applies Medicare-based limits or fallback methodologies even where Medicare does not provide a meaningful benchmark. We respectfully urge CMS to apply a consistent policy approach and provide comparable flexibility for SDPs supporting services for which Medicare is not an appropriate benchmark, particularly where access challenges necessitate targeted State intervention.

Further, in the proposed rule, a payment would not be considered targeted if it is available uniformly across the State or a region of the State but would be targeted if limited to a narrower subset of physicians or providers. We are concerned that this framing may discourage States from designing precise access interventions and may instead incentivize broader, less targeted payment strategies solely to avoid the regulatory limit. If finalized, this

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rule should preserve the ability of States to target supplemental payment methodologies to documented access gaps so long as the State can demonstrate that the arrangement is economic, efficient, and directed toward legitimate Medicaid access objectives.

Thank you for the opportunity to provide comments on this important matter. For additional questions, please contact Sahana Chakravartti, Regulatory Strategist, at schakravartti@aafp.org.

Sincerely,

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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[i] National Rural Health Association. (n.d.). *About rural health care*. https://www.ruralhealth.us/about-us/about-rural-health-care
[ii] McDermott, D., Cox, C., & Claxton, G. (2022). *How differences in Medicaid, Medicare, and commercial health insurance payment rates impact access and affordability*. The Commonwealth Fund. https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact
[iii] Burns, A., et al. (June 2026). *Spending on Medicaid state-directed payments before new limits take effect*. Kaiser Family Foundation. https://www.kff.org/medicaid/spending-on-medicaid-state-directed-payments-before-new-limits-take-effect/
[iv] Burns, A., et al. (June 2026). *Spending on Medicaid state-directed payments before new limits take effect*. Kaiser Family Foundation. https://www.kff.org/medicaid/spending-on-medicaid-state-directed-payments-before-new-limits-take-effect/
[v] Congressional Budget Office. (2026). *Budgetary effects of health provisions*. https://www.cbo.gov/publication/61463
[vi] Haught, R., et al. (May 2025). *Federal cuts to Medicaid could end Medicaid expansion and affect hospitals*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2025/may/federal-cuts-medicaid-could-end-medicaid-expansion-affect-hospitals
[vii] Congressional Budget Office. (2026). *Additional health policy analysis*. https://www.cbo.gov/publication/61570
[viii] Centers for Medicare & Medicaid Services. (n.d.). *Approved state-directed payment preprints*. https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints
[ix] Malcarney, M. (January 2026). *Medicaid state-directed payment for primary care and behavioral health providers: Opportunities that remain and challenges ahead*. Families USA. https://www.familiesusa.org/resources/medicaid-state-directed-payment-for-primary-care-and-behavioral-health-providers-opportunities-that-remain-and-challenges-ahead/

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[x] Medicaid and CHIP Payment and Access Commission. (2021). *Physician acceptance of new Medicaid patients: Findings from the National Electronic Health Records Survey*. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf
[xi] Ding, D., & Glied, S. A. (January 2023). *Medicaid patients and high-quality primary care in office practices*. The Commonwealth Fund https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/medicaid-patients-office-practices-high-quality-primary-care
[xii] Skopec, L., Pugazhendhi, A., & Zuckerman, S. (2025). Updated Medicaid-to-Medicare fee index: Medicaid physician fees still lag behind Medicare physician fees. *Health Affairs, 44*(5), e01530. https://doi.org/10.1377/hlthaff.2024.01530
[xiii] Centers for Medicare & Medicaid Services. (2026). *Maryland value-based primary care state-directed payment renewal (2026–2027)*. https://www.medicaid.gov/medicaid/managed-care/downloads/MD_VBP_PC_Renewal_20260101-20261231.pdf
[xiv] Georgia Department of Community Health. (n.d.). *State directed payment programs*. https://dch.georgia.gov/programs/state-directed-payment-programs
[xv] Zhang, E. (February 2026). *Medicaid plays an important role in providing health coverage to key populations*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-plays-an-important-role-in-providing-health-coverage-to-key-populations
[xvi] Raji, U., et al. (May 2025). *5 key facts about Medicaid and pregnancy*. Kaiser Family Foundation. https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-pregnancy/
[xvii] Euhus R., Cervantes S., Burns, A., & Rudowitz, R. (June 2025). *5 key facts about Medicaid coverage for people living in rural areas*. Kaiser Family Foundation. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-living-in-rural-areas/
[xviii] Georgia Department of Community Health. (n.d.). *State directed payment programs*. https://dch.georgia.gov/programs/state-directed-payment-programs
[xix] Centers for Medicare & Medicaid Services. (2025). *North Carolina HCBS state-directed payment renewal*. https://www.medicaid.gov/medicaid/managed-care/downloads/NC_Fee_HCBS.BHO_Renewal_20250701-20260630.pdf
[xx] Burns, A., Hinton E., Hulver S., Mathers, J., & Rudowitz, R. (2026). *Forthcoming policy changes to Medicaid state-directed payments*. Kaiser Family Foundation. https://www.kff.org/medicaid/forthcoming-policy-changes-to-medicaid-state-directed-payments/

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