Federation of American Hospitals

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Via electronic submission at *http://www.regulations.gov*

The Honorable Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2449–P
P.O. Box 8013
Baltimore, MD 21244–8013

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

Dear Dr. Oz:

The Federation of American Hospitals (FAH) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments Proposed Rule, published in the Federal Register on May 22, 2026 (91 Fed. Reg. 30,400). FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

FAH shares the goals of a Medicaid program that spends responsibly, pays for value rather than volume, and is transparent and accountable to taxpayers. Hospitals and health systems are committed partners in that work. Our members care for everyone who walks through their doors, regardless of their ability to pay or their insurance coverage. State directed payments are essential to that mission. They help offset Medicaid rates that fall well below the cost of care, and they let states offer direct support to the providers and communities that need it most, including rural hospitals, maternity units, and behavioral health services. They help cover the substantial unpaid costs hospitals absorb every day in caring for Medicaid patients.

Congress made a deliberate choice in the Working Families Tax Cut (WFTC) legislation to limit the total payment rate for certain SDPs to a Medicare-based benchmark, and Congress set a defined fiscal target when it did so. FAH's concern is that the Proposed Rule reaches well past that target, in two distinct ways.

First, it goes beyond the fiscal result Congress intended. CMS projects that the Proposed Rule would reduce federal Medicaid spending by $510 billion over ten years. That is more than three times the $149 billion the Congressional Budget Office attributed to the SDP provisions of Section 71116.[1] Second, it goes beyond the statutory scope. The Proposed Rule extends new Medicare-based payment limits to services, providers, and SDPs that Congress did not address, and it enforces those limits through a code- and payment-group-level compliance test that the statute does not require.

This is where CMS's policy choice is misplaced. The agency can achieve its objectives more effectively through the tools it already has. CMS possesses the authority, the data, and the proven methodologies to hold SDP spending to a Medicare benchmark and to see how SDP dollars are spent, and the Medicaid fee-for-service upper payment limit framework has done exactly this for decades. The code- and payment-group-level test the Proposed Rule adopts is not necessary to reach the same result. It would require states to reprice millions of Medicaid encounters through Medicare payment systems that were never built for that purpose, rebuilding a fee-for-service pricing apparatus inside managed

care. That works against the value-based payment models CMS has encouraged states to adopt, and it adds substantial cost and burden for states, plans, and providers without adding meaningful protection against excess payment.

The burden does not stay in Washington. Faced with this framework, states would be left to choose among hard options: cut Medicaid services, reduce provider payments, raise taxes, or divert funds from other priorities. Providers operating on the thinnest margins would feel it first.

FAH shares CMS's commitment to transparency and accountability. Providers want SDP dollars to be visible and well targeted, and the tools to make that happen already exist and can be strengthened without the proposed repricing regime. CMS has a long history of working in partnership with states and providers to control costs while keeping administrative burden low and processes transparent. This rule is an opportunity to build on that record.

At FAH's request, the credentialed actuaries at Incline Actuarial Group independently examined whether the proposed per-bill code and per-line-item discharge test can be reconciled with the actuarial soundness standards that have governed Medicaid managed care since 2003. Their report, attached as Appendix A, documents specific structural conflicts — including the absence of Medicare benchmarks for a substantial share of Medicaid bill codes and the lack of an established method for translating per-bill compliance back into a certified PMPM rate in some cases — and concludes that the existing aggregate, population-level approach fits that standard while the proposed code-level test, as drafted, does not.

Accordingly, FAH respectfully urges CMS to:

- **Implement the payment limit through an aggregate, UPL-style methodology.** Measure the four services subject to section 71116 at the service-category level against a Medicare-based benchmark for each provider class, consistent with the longstanding fee-for-service UPL framework, rather than through a code- and payment-group-level test.

- **Keep the rule within the fiscal target and scope Congress set.** Do not extend the payment limits to services or SDPs beyond the four Congress contemplated, and calculate the total payment rate to reflect the actual effect of SDPs on provider payment, including by accounting for the provider taxes that partially finance them.

- **Adopt the phase down Congress intended.** Reduce the difference between the total payment rate and the Medicare-based limit by 10 percentage points each year, producing a gradual, even transition over ten years, consistent with CMS's own practice of phasing major Medicaid payment changes over fixed, multi-year periods.

- **Preserve the tools that make SDPs efficient and transparent.** Retain uniform increase SDPs and separate payment terms, which let states target funding efficiently and track SDP spending distinctly at the provider level, and pursue any added transparency through the reporting authority and systems CMS already has.

- **Deliver accountability without abandoning value-based payment.** An aggregate approach measures total payments against a Medicare benchmark and preserves the flexibility value-based arrangements need, rather than capping each service in isolation. It serves CMS's own goals of fiscal integrity and payment for value.

FAH develops each of these points, with the supporting legal, actuarial, and operational analysis, in the comments that follow.

I. Payment Limit for SDPs (Part II.A.1)

FAH strongly objects to CMS' proposal to apply a code-level methodology to implementation of the payment limit under section 71116. In the Proposed Rule, CMS describes this as a payment limit at the "service" level, but the proposal is in fact far more granular, speaking to *individual codes* and *payment groups* rather than the four specific services subject to the payment limitation under section 71116. These codes generally consist of CPT and HCPCS codes, while the payment groups would include Medicare Severity Diagnosis-Related Groups (MS-DRGs) for acute inpatient hospital discharges, ambulatory payment classifications (APCs) for outpatient episodes, long-term care hospital (LTCH) DRGs (MS-LTC-DRGs) for LTCH discharges, various case-mix groups represented by health insurance prospective payment system codes (HIPPS codes) for inpatient rehabilitation facility discharges and skilled nursing facility discharges, and others. Congress did not reference any code- or grouper-level limits on Medicare payments, and there is no indication in WFTC legislation that Congress intended to link Medicaid SDPs and the Medicaid managed care system to Medicare codes and groups.

Instead, Congress provided a simple and straightforward instruction—the total payment rate for the four services currently subject to the requirements of § 438.6(c)(2)(iii) must be limited to either 100 or 110 percent of the total published Medicare payment rate. These four services are: (1) inpatient hospital services, (2) outpatient hospital services, (3) nursing facility services, or (4) qualified practitioner services at academic medical centers. **Consistent with the clear language of the statute and long-standing Medicaid managed care policies, we urge CMS to abandon the proposed, granular code- and payment-group-based payment limits and instead adopt a broader service-level approach to payment limits, similar to Medicaid's existing Upper Payment Limit (UPL) methodology.** Under this approach, for each of the four services subject to section 71116, payments would be aggregated to measure the effect of Medicaid SDPs on total payments for that service as compared to Medicare payments for that service (*e.g.*, inpatient hospital services). Structuring the payment limits in this manner would leverage existing federal and state expertise. It would fit within the actuarial processes that undergird Medicaid managed care programs, pragmatically retain coding- and grouper-level differences between Medicaid managed care payments and Medicare fee-for-service payments while faithfully implementing payment limits under section 71116. It would minimize unnecessary regulatory burdens without jeopardizing transparency and oversight. And it would preserve states' flexibility to develop and experiment with local solutions to local problems. More broadly, a UPL-style approach is the only interpretation of section 71116 that is consistent with the structure of the Medicaid program, which is designed by Congress as a federal-state partnership that does not mandate one-size-fits-all Medicaid plans.

State Medicaid Programs Need Flexibility to Target Needs and to Innovate to Solve Local Problems

Since its inception, the Medicaid program has been structured as a cooperative venture that is jointly funded by the federal and state governments to assist states in furnishing medical assistance to eligible needy persons. Medicaid is thus intentionally unlike the Medicare program, which is a federal health insurance program that is funded and administered on a national level. In light of the state-level variability of the Medicaid program, state Medicaid programs have long diverged from one another, with states looking to design the program based on state-level preferences within federal parameters. CMS properly describes SDPs as consistent with this uninterrupted history of partnership and flexibility: "SDPs were created to give States *flexibility* to pursue provider payment initiatives and delivery system reform efforts that further advance access to care, enhance quality of care in Medicaid managed care, and to help reach the goals they defined in their quality strategy."[2]

In light of larger stressors on the health care delivery system, it is critically important that the Medicaid program continue to allow state-level innovation and experimentation, with accountability to ensure that each Medicaid program operates to furnish high-quality services in the right place, to the right person, and at the right time. SDPs can be a critical tool for achieving these goals because states can use them to target particular providers on which Medicaid beneficiaries depend (*e.g.*, rural hospitals or labor and delivery units in health professional shortage areas). The Proposed Rule, however, eliminates that flexibility by capping every payment to every provider for every code or Medicare payment group based on Medicare rates, even where the Medicare population's needs materially differ from the Medicaid population. Under this approach, for inpatient hospital care, states will have no flexibility to direct managed care plans to pay particular discharges or hospitals in ways that produce per-discharge payments in excess of the repriced Medicare inpatient prospective payment system rate for that discharge, even if other discharges and other hospitals are paid below the Medicare rate. This approach deviates from what is allowed in the Medicaid fee-for-service program, where some claims or providers may receive payments at 125 percent of Medicare, while other claims or providers may receive payments at 75 percent of Medicare so long as aggregate payments do not exceed 100 percent of Medicare. This UPL approach appropriately balances flexibility and fiscal responsibility to allow state innovation in the fee-for-service context. CMS should pull from this experience in implementing section 71116. Applying a UPL-style approach to payment limits under the WFTC legislation will retain appropriate flexibility to direct SDPs to achieve quality goals or address delivery system challenges.

The Proposed Rule's discussion of value-based payment (VBP) and uniform increase SDPs further demonstrates the excessive rigidity of the code- and payment-group-level payment limit methodology. In discussing monitoring and compliance of SDPs, CMS notes that "there is greater risk of unintentionally exceeding the payment limit given how VBP SDP models are developed" and acknowledges that the proposed code- and payment-group-based "per service payment limit may pose operational and logistical complexities, particularly in the context of population and condition-based SDP arrangements."[3] Along similar lines, CMS notes "concerns with ensuring compliance with the new proposed payment limit, which we have proposed would apply to each service rendered by a provider" at the code or payment-group level.[4] The challenges that CMS identifies with respect to VBP and uniform increase SDPs, however, are not the necessary result of section 71116, and there is no indication that Congress anticipated or desired to limit or eliminate any type of SDP. Congress chose to impose a payment limit in section 71116, but it did not direct CMS to eliminate or render impracticable one of the most commonly used SDP methodologies (uniform increase SDPs) or any type of VBP. To the extent the Proposed Rule's implementation methodology cannot readily accommodate VBPs and uniform

increase SDPs, that result confirms that a code- and payment-group-level methodology is the wrong mechanism for implementing section 71116.

Differences between the populations served by and the utilization patterns in the Medicare and Medicaid programs further demonstrate that the rote application of Medicare rates at the code or payment group level will produce an inappropriate mismatch between payments and programmatic needs. For example, Medicaid programs cover approximately 41 percent of all births in the United States, but the Medicare program (individuals 65 and older and disabled individuals) covers relatively few births nationally.[5] In fact, in rulemaking for FY 2026, CMS identified seven newborn and neonate codes that fell below the minimum threshold of 10 cases for Medicare rate-setting purposes. As described in the attached report (Section 4.B.2), these low-volume MS-DRG weights are based on adjustments to the prior year's weight for the code, which in turn may trace back to original data from the development of the IPPS in the early 1980s. When a Medicare-based payment limit is applied to inpatient hospital services as a whole (*i.e.*, at the service level rather than at the MS-DRG code level), the aggregation across discharge codes tempers the distorting impact of population and utilization differences between the Medicare and Medicaid programs. This aggregation creates a broad category of service-level payment limit that more appropriately constrains payment for widely used Medicaid discharge codes. On the other hand, it is inappropriate and unduly limiting to apply a Medicare MS-DRG rate derived from a low volume of claims to limit Medicaid payments, especially for voluminous claims, including the over 4-in-10 births in the United States that are covered by Medicaid.

The granularity of the proposed payment limit methodology is particularly problematic in light of evidence that Medicare rates are not sufficient to cover the cost of care. The June 2026 MedPAC Report to Congress identified an overall Medicare margin of negative 12.1 percent, meaning that the provision of Medicare services generally represents a loss to hospitals.[6] The margin is projected to remain at negative 10 percent in 2026. These underpayments are even present in data for efficient hospitals, where Medicare payments left a median margin of negative 1 percent.[7] Using the proposed code- and payment-grouper-based approach to the payment limit under section 71116 means that the state must import each inadequate Medicare payment for an individual line-item. The state cannot offset payments above the Medicare rate for one code with payments below the Medicare rate for another. Yet that balancing is precisely what would allow a state to maintain an aggregate total payment rate that remains below the Medicare-based payment limit while effectively addressing local delivery-system challenges.

Maximizing flexibility while applying an overall service-level limit (in lieu of a code- or payment-group-level limit) also ensures that there is room for market-level forces and private innovation within the Medicaid managed care program. CMS has long recognized the value of market-based approaches to health care, but market-driven solutions would be unnecessarily constrained by the proposed approach to section 71116. CMS should instead permit Medicaid managed care programs to experiment with alternative payment methodologies by deploying a UPL-style payment limit methodology for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers.

A Code-Level Payment Limit is Unworkable

As an operational matter, FAH is also concerned that the code- and payment-group-level payment limit proposed is unworkable, unduly burdensome, and a significant and unwarranted departure from longstanding approaches to Medicaid financing and oversight. Unlike existing Medicaid financing safeguards, including the Medicaid fee-for-service UPL framework, the Proposed Rule would apply the payment limit at the code or payment-group level rather than at the level of the covered service category as a whole. This represents a significant departure from longstanding Medicaid financing approaches, which have traditionally focused on aggregate payment limits rather than claim-by-claim payment validation.

Under the Proposed Rule, Medicaid managed care encounters would need to be systematically "repriced" under Medicare payment methodologies at the code or payment-group level. Thus, inpatient hospital claims, which are generally grouped under the all-patient refined diagnosis related groups (APR-DRGs), would need to be assigned and analyzed by MS-DRG. The APR-DRG and MS-DRG grouper logics, however, do not neatly crosswalk. For example, CMS' MS-DRG system uses complications and comorbidities (CCs) and major complications and comorbidities (MCCs) to distinguish between simpler cases and those that are more costly due to complications and comorbidities. State Medicaid agencies frequently use Solventum's APR-DRGs, and these are more finely gradated than MS-DRGs, with four classes of severity of illness and risk of mortality. Because APR-DRGs and MS-DRGs are structurally divergent, Medicaid claims and encounters cannot be assigned MS-DRGs based on the APR-DRG assignments, and converting between these payment group systems would generally necessitate re-processing the clinical data, including diagnoses, procedures, age, and discharge disposition, through a grouper on an encounter-by-encounter basis.

Likewise, with respect to outpatient hospital care, the payment groupers used in the Medicare program (APCs) and most Medicaid programs (EAPGs) have differing grouping methodologies that preclude the simple crosswalking of group assignments. EAPGs use extensive packaging and clinical grouping methodologies to produce an EAPG assignment at the visit level based on CPT and HCPCS codes along with diagnosis codes. In contrast, the range of CPT and HCPCS codes describing a single outpatient encounter might produce a number of APC assignments. These same issues repeat themselves across payment systems, with differences in payment grouper methodologies precluding the simple cross walking of claims and necessitating the reprocessing of encounter data to assign Medicare payment groupers.

More fundamentally, Medicaid claims and encounters generally are not created, grouped, priced, or adjudicated under Medicare payment methodologies. As a result, determining compliance with the proposed payment limit would require the retrospective conversion of Medicaid encounters into Medicare payment classifications that often do not directly correspond to the methodologies used by state Medicaid programs.

The difficulties with identifying the Medicare-equivalent code(s) or payment group for a Medicaid encounter, however, become more significant when assessing the practical realities of processing all Medicaid encounters through the Medicare groupers. Although CMS provides free versions of the CMS MS-DRG Grouper (inpatient) and the "integrated" outpatient code editor (I/OCE) (outpatient), these versions lack billing features and hospital-specific encoders and/or the volume capabilities that a state Medicaid agency would require to reprice encounters under the proposed rule. As a result, state Medicaid agencies would likely incur significant licensing fees to access commercial software versions of the groupers offered by private consulting firms. In addition, once the codes or discharges are converted to a Medicare payment group (*e.g.*, MS-DRG or APC), state Medicaid agencies will need to derive the applicable Medicare rate for the discharge or encounter. Because the CMS Web Pricer is inefficient to price large volumes of claims, state Medicaid agencies would likely need to purchase access to one of the Medicare pricing systems developed by private consulting firms. These proprietary systems and software, however, create transparency concerns because they incorporate the consulting firm's proprietary data, codes, and assumptions, producing some differences with the CMS Web Pricer.

Overall, the Proposed Rule would effectively require states to recreate a Medicare claims processing system inside a Medicaid managed care program—an endeavor that significantly and unnecessarily increases administrative burdens, bureaucracy, and costs. State Medicaid programs would need to increase staffing, incurring unnecessary programmatic costs that would increase Medicaid administrative spending and divert resources from other priorities. In this way, the code- and payment-group-level implementation of the payment limits would undercut many of the administrative efficiencies that led states to shift substantial portions of their Medicaid programs to managed care in the first place.

Under a managed care delivery system, states generally establish capitation rates and performance expectations while allowing managed care plans to negotiate provider reimbursement arrangements and administer claims. The Proposed Rule would effectively require states and their contractors to reconstruct a fee-for-service-style payment system solely for purposes of determining compliance with the payment limit. States would need to identify the applicable Medicare payment methodology, map Medicaid encounters to Medicare payment classifications, calculate the corresponding Medicare payment amount, and maintain systems capable of validating compliance at the individual service or payment-group level.

These are not functions that are otherwise necessary to operate a Medicaid managed care program. Rather, they replicate many of the administrative activities associated with Medicare claims processing and pricing. As a practical matter, the Proposed Rule would require states to incur the costs of repricing Medicaid managed care claims as though they were Medicare claims, notwithstanding that the claims are not being paid under Medicare rules and serve a population with materially different characteristics and service needs.

Moreover, the substantial administrative effort required by this approach extends far beyond what is necessary to achieve the statutory objective of ensuring that the total payment rate does not exceed the applicable Medicare benchmark. The Proposed Rule would require states to re-group, re-price, and validate individual encounters across millions of claims despite the availability of less burdensome payment limit methodologies. The same fiscal safeguard could be achieved through an aggregate methodology analogous to the UPL framework without requiring the re-grouping and re-pricing of every Medicaid encounter.

This burden is especially difficult to justify during the phase down period. During the phase down, the applicable requirement is a comparison of aggregate total payments against the applicable Medicare-based benchmark. That comparison confirms that the total payment rate is moving toward the statutory limit. An aggregate comparison of this kind does not require encounter-by-encounter repricing. Nor is it made more accurate by such repricing. The appropriate

methodology once the payment limit is fully in effect is a separate question. But even setting that question aside, CMS has not explained why claim-level repricing is necessary to perform an aggregate comparison during the phase down. Nor has CMS explained why the established UPL methodology is inadequate for that purpose. CMS has refined that methodology over more than four decades. Before departing from it, CMS should demonstrate that the proposed alternative produces a more accurate or more reliable result.

Transparency Does Not Require a Code- and Payment-Group Level Compliance Architecture Because CMS Can Collect and Review Detailed Payment Data

CMS suggests that a code- and payment-group-level limit on payments is warranted in part because it would enhance the transparency of SDPs. FAH agrees that transparency and accountability are important objectives, but the drastic and burdensome changes CMS proposes are not necessary to achieve these goals. CMS already has established operational tools and methods to obtain precise, provider-level payment data, and it can leverage this expertise and experience for detailed reviews of SDP payments without imposing the substantial and unnecessary administrative burden of repricing every Medicaid encounter under Medicare methodologies. In short, transparency can be achieved without administering the payment limit at the code or payment-group level.

In the Medicaid fee-for-service context, CMS has already designed and now operates a provider-level payment transparency system that is anchored to aggregate, UPL-based compliance rather than code-level repricing. Section 202 of the Consolidated Appropriations Act, 2021, added section 1903(bb) to the Social Security Act, establishing detailed reporting requirements for non-DSH supplemental payments and directing that the reports and related data be made publicly available on a timely basis.[8] To implement this authority, CMS designated the Medicaid Budget and Expenditure System (MBES) as the reporting system and collects Supplemental Payment Validation (SPV) data through provider, payment, and narrative files.[9] The SPV Provider File identifies each provider receiving payments, including a unique provider identifier and standard identifiers (including Medicaid IDs, NPIs, and Medicare CMS Certification Numbers) and the provider's ownership category (state government, non-state government, or private). This crosswalks to the SPV Payment Data File, which includes unique provider identifiers, “ensur[ing] that payments can be linked to the specific provider.”[10] This provides exactly the provider-level visibility the Proposed Rule identifies as necessary for transparency, including the ability to identify narrowly targeted or single-provider arrangements.

The SPV Payment Data File reports, for each provider and by category of service (for example, inpatient hospital, outpatient hospital, nursing facility, and physician services), both the base payment and the supplemental payment dollar amounts. CMS collects this data expressly “to ensure that total payments do not exceed UPLs for specific provider types and help states demonstrate compliance with these federal limits.”[11] In other words, CMS's own established transparency-and-compliance system measures payments against an aggregate, service-category-level Medicare-equivalent benchmark, the very UPL-style structure FAH urges CMS to adopt for section 71116, and does so without repricing individual encounters through Medicare groupers.

The SPV Narrative File requires states to explain, for each supplemental payment line, how the payment is consistent with the efficiency, economy, quality of care, and access standards of section 1902(a)(30)(A), along with its purpose and intended effects; the criteria used to determine which providers are eligible; and a comprehensive description of the methodology used to calculate, distribute, and time the payment. These narrative elements capture exactly the information, purpose, provider targeting, and methodology that CMS associates with meaningful transparency into provider payments.

Finally, CMS merges the SPV Provider and Payment Data File to produce provider-specific reports showing total base and supplemental dollars received by each provider, enabling provider-level accountability using an aggregated, UPL methodology.

This framework demonstrates two points that are central to CMS's transparency rationale. First, CMS already can and does obtain granular, provider-level payment information, down to the individual provider, its ownership type, and the dollars it receives, without requiring states to reconstruct a Medicare claims-processing system inside their Medicaid managed care programs. Second, CMS has built this transparency on top of an aggregate, UPL-anchored compliance structure organized around service categories, not around individual CPT and HCPCS codes or MS-DRG and APC payment groups. The SPV framework thus refutes any suggestion that transparency and a UPL-style methodology are in tension. To the contrary, CMS's principal existing transparency system for Medicaid supplemental payments is built on the aggregate approach. While the SPV requirements apply to non-DSH supplemental payments in the fee-for-service context rather than to SDPs, they provide a proven and readily adaptable model for obtaining transparency into directed payments without resorting to code- and payment-group-level repricing.

Separate payment terms are a further example of an existing tool that advances transparency without any code-level compliance architecture. Separate payment terms allow SDP dollars to be tracked distinctly from base capitation payments. This lets states, CMS, and the public see how much SDP funding a given provider or provider class actually receives. MACPAC has observed that a substantial share of SDP spending flows through separate payment terms. Of the roughly $81.5 billion in spending on uniform rate increases that MACPAC identified, approximately 87 percent, or $70.6 billion, was delivered through separate payment terms.[12] Separate payment terms therefore make a large volume of SDP spending separately visible and auditable at the provider level. This is transparency achieved through distinct tracking, not through repricing every encounter under Medicare methodologies. Separate payment terms are also the mechanism that allows states to target SDPs to particular providers, such as rural and safety net hospitals, rather than distributing funding uniformly across all providers. That same targeting capability is essential to value-based payment arrangements, which direct payments to specific providers and outcomes rather than to individual service codes. Eliminating separate payment terms would reduce the transparency and provider-level visibility of SDP spending, and would undercut the very value-based models the Proposed Rule states it wishes to support. FAH therefore urges CMS to preserve separate payment terms as a durable transparency and targeting tool, rather than allowing the scheduled prohibition to take effect.

CMS has also developed transparency tools specific to SDPs. In the 2024 managed care final rule, CMS expanded SDP reporting requirements, including documentation on quality evaluations, and it has continued to implement and enforce these requirements through guidance to states. MACPAC has likewise recommended that CMS make SDP approvals and evaluations public and provide clearer guidance on assessing SDPs. None of these measures depends on a per-code or per-payment-group compliance test. To the extent CMS seeks additional visibility into how SDP dollars are distributed at a more granular level, it can obtain that information through its existing encounter data, reporting, and preprint-review processes, or through targeted reporting requirements modeled on the SPV framework, each of which imposes far less burden than the proposed repricing architecture.

Unlike the familiar UPL-style framework, the proposed methodology would tend to reduce transparency rather than enhance it. As explained above, determining compliance at the code or payment-group level would require states and plans to rely on proprietary grouping and pricing software that incorporates each vendor's own data, codes and assumptions, producing results that may not be readily auditable by states, providers, CMS or the public. Rather than increasing transparency, this approach would shift payment-limit compliance into a fragmented and opaque process dependent on managed care organizations, contractors, and third-party software vendors properly repricing and analyzing voluminous individual claims, codes, and payment groups. By contrast, an aggregate, UPL-style methodology permits compliance to be demonstrated through verifiable comparisons of aggregate payments against established Medicare-based benchmarks using publicly available and audited data. The aggregate approach is therefore not only less burdensome but, in important respects, more transparent and more accountable than the proposed code- and payment-group-level architecture.

Accordingly, CMS's transparency objectives provide no basis for adopting the code- and payment-group-level payment limit. Those objectives can be fully achieved through the authority and tools CMS already possesses, including a well-established, provider-level reporting system already anchored to aggregate UPL compliance, coupled, if CMS deems it necessary, with targeted enhancements to existing reporting requirements. Moreover, the existing UPL framework can be deployed to ensure that Medicaid payments do not exceed Medicare-equivalent levels through an aggregate methodology that minimizes administrative burden. FAH therefore urges CMS to pursue transparency through these established, less burdensome channels and to adopt an aggregate, UPL-style payment limit methodology.

The Statutory Language Permits a More Appropriate UPL-Style Approach to Payment Limits Rather than the Proposed Code- and Payment-Group-Level Approach

A UPL-style approach to payment limits under section 71116 is not only preferable as a matter of policy and operational efficiency, but also the approach required by the statutory text. Section 71116(a) requires CMS to revise 42 C.F.R. § 438.6(c)(2)(iii) "such that, with respect to a payment described in such section made for a service furnished during a rating period beginning on or after the date of enactment of [the WFTC legislation], the total payment rate for such service is limited to" either 100 percent or 110 percent of the "specified total published Medicare payment rate." Congress did not define the "total payment rate" in the WFTC legislation, but the statutory reference to existing regulations suggests that Congress was operating within the existing definition of this term. The "total payment rate" is "the ***aggregate*** for each managed care program" of the average payment rate paid to providers included in the specified provider class for each service identified in the SDP, the effect of the SDP on the average rate paid to such providers for such service, the effect of other SDPs on the average rate paid to such providers for such service, and the effect of allowable pass-through payments.[13] This language expressly references an aggregation methodology. Moreover, services are described in the regulation as inpatient hospital services, outpatient hospital services, nursing facility

services, or qualified practitioner services at an academic medical center, suggesting that the total payment rate is no more granular than the aggregate rate for each of these four listed services. Thus, when Congress required CMS to change the total payment rate from the average commercial rate under existing § 438.6(c)(2)(iii), Congress required an aggregate, UPL-style total payment limit for each of the four specific services referenced in the regulation.

Notably, the statute does not reference codes, coding, payment groups, or line-items. There are wide disparities between Medicare fee-for-service and Medicaid managed care payments at the payment code and payment group level. As a result, there are significant differences between the cost, feasibility and consequences of imposing a Medicare-based payment limit for four services and imposing a Medicare-based payment limit at the code or payment group level for each of these services. Congress' silence with respect to codes and payment groups therefore strongly supports FAH's view that the WFTC legislation did not impose a granular code-level or payment-group-level limit.

Likewise, CMS's existing SDP regulations expressly focus on a service-level analysis with respect to the total payment rate. The definition of the total payment rate refers exclusively to the services identified in the SDP without reference to codes. In contrast, other portions of the SDP regulations do reference codes, reflecting the intentional use of service-level terminology in some circumstances and code-level terminology in others. For example, existing law requires the exclusion of commercial data for non-covered codes when determining the average commercial rate,[14] indicating that adjustments are made to produce comparable aggregate payment amounts for the four services subject to the average commercial rate limit and that the limit is not imposed on a code or payment-group level. Existing law requires that the Medicaid MCO, PIHP or PAHP contract include the "procedure and diagnosis codes" to which the fee schedule or uniform dollar or percentage increase applies.[15] Again, the specificity of this terminology indicates that the word "service" on its own does not equate to specific codes, and that the total payment rate limit is focused at the level of the four listed services (*e.g.*, inpatient hospital services).

The Proposed Rule, however, rejects a UPL-style methodology to the payment limit under section 71116 of the WFTC legislation because "[n]either section 71116 of the WFTC nor the Presidential Memorandum references aggregate Medicare-equivalent payments or a UPL methodology."[16] The absence of an express reference to aggregation or the UPL in these documents, however, does not suggest that Congress intended to depart from an aggregate, service-level approach modeled after the UPL. In the absence of references to a code- or payment-group-level limit on payments, the overall language of the statute, and the language of the existing SDP regulations all point to an aggregate, UPL-style methodology for the Medicare-based payment limit under section 71116. Even if the textual analysis of the statute and regulation left some uncertainty as to Congress' intention with respect to section 71116, the infeasibility of the code-level and payment-group-level approach and its inconsistency with the actuarial processes that undergird evaluation of Medicaid managed care programs weigh against it. The code-level and payment-group-level approach also conflicts with the longstanding principles of equal access and state-specific tailoring in Medicaid. These considerations together support interpreting section 71116 as speaking to aggregated payment limits that apply at the level of the four services identified in § 438.6(c)(2)(iii).

Calculation of the Total Medicaid Payment Must Focus on the Actual Effect of SDPs on Payment by Netting Out Provider Taxes that Fund the Payments

We are also concerned that CMS's proposed methodology implementing the payment limit under section 71116 fails to account for Medicaid provider taxes in calculating the "total payment rate," thus overstates the effects of SDPs and inflates the "total payment rate." ***To accurately calculate the difference between the total payment rate and the total published Medicare rate, we strongly urge CMS to control for the burden of provider taxes and remove the provider tax contributions that partially financed the SDPs when calculating the total payment rate.*** This effects-based approach is consistent with the definition of "total payment rate" under existing law and aligns with congressional intent with respect to implementing a Medicare-based limit on SDPs. Moreover, this effects-based approach also supports the overall objective of ensuring that Medicaid rates are sufficient to meet the needs of the individuals and families they serve and that the program conforms to the Social Security Act's broader Medicaid requirements. If provider taxes are not addressed when calculating the total payment rate, the total payment rate will obscure actual provider payments well below Medicare rates and the payment limit will create an unsustainably underfunded Medicaid program with consequences for the entire health care delivery system.

CMS's existing regulation in 42 C.F.R. § 438.6(a) defines the "total payment rate" as including base rates and "the effect of the State directed payment[s] on the average rate paid to providers included in the specified provider class for the same service." Although the Proposed Rule cites and retains this definition of "total payment rate,"[17] CMS does not apply the total payment rate's express limitation to the "effect" of the SDP on the rate paid to providers. At the same time, CMS concludes that 80.8 percent of SDPs that exceeded Medicare payment rates were funded in part or wholly

via IGTs and/or provider taxes,[18] indicating that provider taxes would be of great significance when assessing the "effect" of an SDP on provider rates.

Failing to account for providers' tax costs in determining the total payment rate would give the illusion of a total payment rate that is on par with the Medicare rate, when in fact the provider's role in financing the Medicaid program reduces total Medicaid payments well below the Medicare rate. By way of an example, MACPAC's June 2024 report illustrates this dynamic with the case of a private Texas hospital that received 65 percent of the Medicare rate in base payments and an additional 87 percent of the Medicare rate in SDPs.[19] Merely summing these two figures together produces a gross payment amount of 152 percent of the Medicare rate. But, when the hospital's tax costs are accounted for, the number drops to an unsustainably low amount—just 89 percent of the Medicare rate. Although CMS notes this MACPAC analysis in the Proposed Rule, it does so only with respect to the impact analysis and fails to address the policy implications.[20] In this example, the effect of the SDPs on the average rate paid falls from 87 percent to 24 percent, making it critical that the effects of the SDP on payments be analyzed in a manner that accounts for the provider tax burden. Even if the provider's tax burden dropped commensurate with the contraction in SDPs once the payment limit under section 71116(a) was fully implemented (*i.e.*, more than 72 percent of the remaining SDPs are paid in provider taxes), netting out the provider taxes for this Texas hospital is the difference between an effective total payment rate of 110 percent of the Medicare rate if the provider taxes are netted out when applying the Medicare-based payment limit and an effective total payment rate of less than 78 percent of the Medicare rate if the payment limit is applied to a total payment rate that includes the provider taxes (base payments totaling 65 percent of the Medicare rate plus SDPs totaling 45 percent of the Medicare rate, minus provider taxes totaling 32.4 percent of the Medicare rate).

This netting approach is consistent with how the effect of provider taxes has been characterized by the federal courts and the Executive Branch. Federal courts have recognized that Medicaid payments financed by provider taxes are linked to and offset by those taxes. Those payments overstate actual Medicaid reimbursement for services rendered. The Presidential Memorandum that informed the Proposed Rule likewise describes the return of funds to taxed providers through Medicaid payments.[21] To the extent CMS relies on this characterization, the provider tax component cannot also count as reimbursement for services when the total payment rate is measured against the total published Medicare payment rate. Accordingly, netting out provider taxes when applying the payment limit is consistent with judicial precedent and the authorities invoked in the Proposed Rule.

Equal access is a longstanding foundation of the Medicaid program. In the fee-for-service context, Congress requires that Medicaid rates be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[22] This equal access mandate is extended to enrollees in Medicaid managed care plans, which must be provided with access to services "to the same extent as such services are made accessible" through traditional Medicaid.[23] Section 71116 of the WFTC legislation must therefore be interpreted against this backdrop. Failing to net out taxes when applying the payment limit will produce effective payments well below Medicare rates, and these unsustainably low rates risk compromising equal access to services among Medicaid managed care enrollees. The WFTC legislation does not provide any indication of an intent to compromise the longstanding equal access requirements of the Medicaid program and therefore should be interpreted consistent with that mandate. Here, the best interpretation of "total payment rate" is that it is limited to the base rate plus the "effect" of SDPs, which is necessarily net of associated provider taxes. This is the only methodology that is consistent with Congress' intent and language, which contemplates a holistic comparison between the total payment rate and a Medicare benchmark. Ultimately, CMS should make every effort to guard against Medicaid payment rates falling below Medicare benchmarks due to financing mechanisms rather than actual provider reimbursement.

The Proposed Monitoring and Compliance Framework Further Illustrates the Problems with a Code- and Payment-Group-Level Methodology

The proposed monitoring and compliance framework for the payment limits highlights many of the practical shortcomings of implementing the payment limit at the code or payment-group level. As CMS explains, states would be responsible for developing mechanisms to prospectively monitor the effect of SDPs on applicable payment limits and for retrospectively validating compliance after payments are made. These requirements may be manageable under an aggregate payment-limit methodology, but they become significantly more complicated and resource-intensive when applied separately to individual codes and payment groups.

To prospectively assess compliance, states would effectively need to predict how SDP payments will interact with service-specific Medicare payment limits across a vast number of claims, providers, and payment categories. As detailed above and in the attached actuarial report (Section 5.B), this endeavor is burdensome and fundamentally flawed. The Proposed Rule, however, includes an additional phase of monitoring and compliance—the retrospective

validation of compliance through claim-level analyses, including identifying the applicable Medicare payment classification and determining the corresponding Medicare payment amount for potentially millions of Medicaid managed care encounters. As discussed above, Medicaid claims generally are not created, grouped, priced, or adjudicated under Medicare payment methodologies, making these retrospective validation activities particularly burdensome and susceptible to error.

FAH is particularly concerned with CMS's proposal to address retrospective noncompliance through the Medicaid managed care overpayment framework. Unlike traditional provider overpayments, compliance with the proposed payment limit would largely depend on payment calculations, Medicare repricing methodologies, and retrospective validation activities performed by managed care plans and state agencies rather than providers themselves. Moreover, a focus on the retrospective identification of purported overpayments—identified with the benefit of 20/20 hindsight—is incompatible with the prospective nature of Medicaid managed care rate setting and actuarial review. As discussed in the attached report (Section 5.A), a capitation rate certified as actuarially sound prospectively could later be shown at the code level to have funded payments above the limit once updated Medicare rates or reconciled cost reports become available — a structurally retrospective test bolted onto a prospective certification, and one that compounds for every rating period in which Medicare's own annual rule cycle does not align with the state's Medicaid rating period.

Under the proposed approach, providers could become subject to alleged overpayments based on retrospective determinations that SDP payments exceeded a service-specific Medicare payment limit, even though providers generally would have no practical ability to determine whether a particular payment complied with the applicable payment ceiling. Providers do not control the operation of SDP arrangements, the methodologies used to calculate the applicable Medicare benchmark, or the retrospective analyses used to assess compliance. As a result, the proposed framework risks imposing significant financial consequences on entities that are poorly positioned to identify, prevent, or independently verify the alleged noncompliance.

The proposed framework also raises concerns regarding the incentives associated with retrospective recovery activities. Medicaid managed care plans generally play a central role in determining payment amounts and identifying potential overpayments, but Medicaid managed care plans are not necessarily obligated to return overpayment recoveries to the government. Under 42 C.F.R. § 438.608(d), state contracts with a Medicaid MCO, PIHP, or PAHP must specify the "retention policy for the treatment of recoveries of all overpayments." In providing states the flexibility to set these overpayment retention policies, CMS asserted that "the ability of managed care plans to retain overpayments that they identified and recovered is a reasonable mechanism to incentivize managed care plans to oversee the billing practices of network providers."[24] The retention of overpayment recoveries by Medicaid managed care plans, however, would be particularly inappropriate in the context of recoveries of payments in excess of the payment limit under section 71116. Overpayment retention arrangements, in particular, may create incentives for plans to adopt aggressive interpretations of applicable payment limits or retrospective compliance methodologies.

At the same time, providers and states may face substantial challenges in independently validating the underlying calculations. Determining whether a payment exceeded a service-specific Medicare payment limit may require access to proprietary grouping software, Medicare pricing methodologies, encounter-level repricing analyses, and other technical information that may not be readily available or easily auditable. This dynamic risks creating disputes over payment-limit compliance that are difficult, expensive, and time-consuming to resolve.

These compliance and oversight concerns further support adoption of an aggregate payment-limit methodology modeled on the Medicaid fee-for-service UPL framework. Under a UPL-style approach, states can demonstrate compliance through verifiable comparisons of aggregate payments against established Medicare-based benchmarks using audited cost report data and other transparent methodologies. As explained in the attached actuarial report (Section 5.F), such an approach aligns naturally with the actuarial soundness framework governing Medicaid managed care, which focuses on the reasonableness and adequacy of aggregate payments rather than claim-level repricing and retrospective validation. Compliance can be assessed through a single, auditable demonstration rather than through retrospective review of innumerable individual claims, codes, and payment groups. An aggregate methodology therefore promotes transparency, accountability, and administrability while still ensuring that total payments remain below the applicable Medicare-based payment limit.

Congress Did Not Intend to Chill Innovations in Value-Based Payments (VBPs)

FAH is further concerned that the Proposed Rule's line-item limit is in tension with value-based payment (VBP) approaches. VBP arrangements are a cornerstone of state innovation under the Medicaid program because they allow states to align payment incentives with local quality and access goals, including supporting rural providers, improving maternal health outcomes, and expanding behavioral health services. Unlike traditional fee-for-service reimbursement

methodologies, VBP arrangements are designed to reward outcomes, care coordination, and delivery-system performance rather than the provision of individual services viewed in isolation. To that end, a 2025 study published in *JAMA Health Forum* examined 430 unique SDP arrangements approved between February 2023 and May 2024 and found that SDPs offer states a meaningful lever to scale VBP approaches that MCOs may not implement independently due to financial risk, limited provider engagement, and misaligned incentives.[25]

This tension reflects a deeper problem with the code- and payment-group-level methodology. A central purpose of Medicaid managed care is to move away from fee-for-service payment, which reimburses discrete services by code, and toward payment for outcomes, care coordination, and total cost of care. VBP arrangements are the clearest expression of that shift. The Proposed Rule, however, would require states to test SDP compliance code by code and payment group by payment group. In effect, it would compel states to reconstruct a fee-for-service pricing apparatus inside their managed care programs solely to administer the payment limit. This is self-defeating. It imposes the very payment logic that managed care and VBP models were designed to supplant, limiting Medicaid managed care's potential to implement the very value-based models CMS has encouraged states and other payers to adopt. This is not only the wrong result, but it is also unnecessary to full implementation of the statutory payment limits for SDPs: An aggregate, UPL-style approach measures compliance at the level of the service category rather than forcing every value-based payment back into a code-level frame.

To elaborate, the Proposed Rule's flawed, line-item approach would force VBP arrangements back into the very code-by-code payment framework that emphasizes volume over value and is fundamentally at odds with the aim of value-based payment strategies. VBP structures often involve bundled and blended payment models in which episodes of care, outcomes, quality improvements, and population-level performance are the focus of payments, rather than isolated codes. But, as described in the attached actuarial report (Section 5.D), a strict code- and payment-group-level payment limit leaves little or no practical ability to pay a quality bonus, a shared-savings distribution, or any other outcomes-based payment above the Medicare-equivalent rate for any individual underlying service, even where the aggregate VBP arrangement remains actuarially sound and the total payments under the arrangement remain below the applicable Medicare-based payment limit. This mismatch between the structure of VBP arrangements and the proposed line-item payment limit underscores that a UPL-style payment limit is more appropriate, and consistent with Congress's intent.

The code- and payment-group-level test also fails to account for how value-based arrangements reduce total costs across the health care system. VBP models frequently lower overall spending by shifting care to more cost-effective settings and by preventing avoidable hospitalizations and complications. A code-level Medicare ceiling does not recognize those system-wide savings. It caps the payment for an individual line item in isolation, even where the arrangement as a whole delivers care at a total cost below what Medicare would have paid. As a result, the Proposed Rule would prevent states from rewarding providers for high-value, cost-reducing care, precisely the care that managed care and VBP models are designed to promote.

CMS' proposal to require detailed validation methodologies for VBP arrangements stems from the inherent mismatch of applying a payment limit to these SDPs at the code or payment-group level. Indeed, CMS explicitly recognized that the proposed code- and payment-group-level limits could "pose operational and logistical complexities, particularly in the context of population and condition-based SDP arrangements." Those complexities are not a reason to restrict VBP arrangements; rather, they reflect the difficulty of imposing a code- and payment-group-level payment cap on payment models that are designed to operate across episodes, conditions, populations, and quality measures. An aggregate approach, by contrast, would not require the same overly burdensome validation because compliance could be demonstrated by comparing total payments against an aggregate Medicare-based benchmark. **FAH therefore urges CMS to reconsider the proposed line-item limits and instead adopt an aggregate, UPL-style payment limit that better accommodates VBP models while reducing unnecessary administrative burden.**

CMS Should Not Extend the Payment Limits Beyond the Four Services in 42 C.F.R. § 438.6(c)(2)(iii) and Lacks Authority to Do So

FAH objects to CMS' proposal to extend the SDP payment limits for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at academic medical centers to all SDPs for all services nationally for rating periods beginning on or after January 1, 2029. Section 71116 of the WFTC legislation speaks only to those SDPs currently subject to section 438.6(c)(2)(iii) and provides no authority for the application of any SDP limits—whether tied to Medicare rates or otherwise—to other SDPs. The Proposed Rule, accordingly, does not suggest that the WFTC legislation requires or permits SDP payment limits outside of the four identified services. But, CMS nonetheless asserts authority under the Medicaid Act to extend the statutory limits on SDPs to other types of SDPs.

The Act does not contemplate the imposition of Federal limits on provider payments under the Medicaid managed care delivery system. Under the Medicaid FFS delivery system, section 1902(a)(30)(A) of the Act requires that payment to *providers* for care and services under an approved state plan be consistent with efficiency, economy, and quality of care. To ensure that provider payments were consistent with the statutory goals of economy and efficiency, CMS established an upper limit on aggregate FFS payments for certain types of services or providers.[26]

Provider payments under the Medicaid managed care delivery system are not subject to similar requirements. Rather, the actuarial soundness requirement in section 1903(m)(2)(A)(iii) of the Act speaks only to the prepaid (capitation) payments made under the contract between *the state and the Medicaid managed care plan*. This provision specifies that services must be provided "in accordance with a contract between the State and the [Medicaid managed care organization (MCO)] under which prepaid payments to the entity are made on an actuarially sound basis." As CMS explained in the 2016 final rule:

> The underlying concept of managed care and actuarial soundness is that the state is transferring the risk of providing services to the MCO and is paying the MCO an amount that is reasonable, appropriate, and attainable compared to the costs associated with providing the services in a free market.[27]

Similarly, the actuarial soundness requirements in § 438.4(a) provide that capitation rates must be projected to "provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract" between the state and the plan and be developed in accordance with § 438.4(b).

In short, the requirement for payments to be "actuarially sound" and "reasonable, appropriate and attainable," applies to the capitation payments made by states to plans, not by plans to providers. There simply is no requirement that the payments made by the plans to providers must be actuarially sound (*i.e.*, "reasonable, appropriate and attainable"), and such an interpretation would be inconsistent with CMS' past interpretation of the actuarial soundness requirement. Moreover, actuarial soundness requirements are common in the regulation of managed care plans and insurers, and such requirements are not interpreted by regulators as inviting the imposition of maximum payment rates to providers.

The Proposed Rule also cites to CMS's authority under section 1902(a)(4) of the Act to establish methods of administration that are necessary for the proper and efficient operation of the state plan. These additional SDP types, however, have not been subject to a payment limit at any point in the history of the Medicaid program, and FAH does not believe that these additional payment limits are necessary or appropriate. The Proposed Rule does not indicate that CMS' current processes with respect to these additional SDPs are inadequate such that a regulatory cap on total provider payments is necessary. By their very nature, capitation payments incentivize Medicaid managed care plans to simultaneously manage the care of their enrollees, while also allocating resources efficiently to provide covered benefits to enrollees. No more is required. Rather, the imposition of a payment limit on Medicaid managed care payments to providers impacted by other SDPs could potentially limit the ability of states to address particular challenges or otherwise impede innovative payment arrangements designed to promote high-value, cost-effective care. Finally, existing and other proposed standards for SDPs are sufficient to ensure that these additional categories of SDPs are properly aligned with programmatic goals. For example, uniform increases must be based on the utilization and delivery of services under existing § 438.6(c)(2)(ii)(A) and (vii). These standards also offer appropriate flexibility for states to address access and quality goals in the program. As such, the imposition of a regulatory limit on total payment rates for SDPs not subject to section 71116 of the WFTC legislation is unnecessary.

Additionally, ensuring individuals who need mental health and substance use treatment have access to appropriate care must continue to be a top CMS priority, including through sufficient Medicaid funding. Mental and substance use disorder treatment providers serving Medicaid beneficiaries are often reimbursed below the costs of care. Capping state directed payments for behavioral health services at Medicare rates will likely lead to the reduction of inpatient beds and outpatient programs that provide life-saving mental health treatment for many Americans.

We urge CMS not to finalize the proposed changes to Medicaid managed care SDPs, as CMS has exceeded Congressional intent by extending SDP limits to all Medicaid services. As described above, Section 71116(a) of the WFTC legislation directed CMS to revise 42 C.F.R. § 438.6(c)(2)(iii) "such that, with respect to a payment described in such section . . . the total payment rate for such service is limited to" 100% of the Medicare payment rate in expansion states, and 110% of the Medicare payment rate in non-expansion states. However, §438.6(c)(2)(iii) only identifies SDPs for four service types; "inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center."

CMS contends that imposing the same limit on all SDPs would be "a reasonable and appropriate approach because it would prevent states from cost-shifting payments to other providers and services that "could be used to obscure fraud,

waste and abuse." FAH supports CMS' efforts to reduce waste and ensure health care providers and payers are operating ethically and in accordance with all federal requirements. However, CMS provides no evidence for its claim that SDPs currently obscure fraud, waste and abuse, nor that removing state flexibility to provide SDPs for other services, including behavioral health services, will lead to wasteful or unethical payments. Importantly, increased utilization of services is not the same as fraud, waste, or abuse. In the case of mental and substance use disorder treatment, U.S. national spending has increased because more people who need treatment are receiving it.

States cannot continue to improve behavioral health care access and outcomes for Medicaid beneficiaries if they do not have the financing tools needed to maintain and build their provider networks. In some states, FAH members that operate psychiatric hospitals rely on adequate SDP payments to remain in Medicaid managed care contracts. If CMS caps SDPs for behavioral health services, many providers may be left with no choice but to leave the network. Recognizing this, Congress intentionally excluded two major categories of behavioral health care services – IMDs and non-hospital outpatient behavioral health care services – from Section 71116 of the WFTC legislation.

The Trump Administration has consistently deemed expansion of behavioral health services, especially inpatient psychiatric beds, as a policy goal. The President's July 24, 2025, Executive Order on Ending Crime and Disorder on America's Streets correctly identifies the importance of access to inpatient psychiatric care for people with serious mental illness and the need to address the shortage of psychiatric beds.[28] Executive Order 14379, addressing addiction through the White House Great American Recovery Initiative, identifies evidence-based treatment as a key method of addressing the impact of substance use disorders, including "declining workforce participation, increased health care costs, homelessness, family instability, and lost productivity that together cost the United States hundreds of billions of dollars each year."[29]

Extending SDP Medicare limits to behavioral health services, including inpatient psychiatric facilities, residential treatment, intensive outpatient services, and Opioid Treatment Programs, is counter to the Administration's goal of expanding access to behavioral health care. Many states efficiently direct SDPs to behavioral health care providers to ensure that communities have adequate behavioral health services, including sufficient numbers of inpatient beds, and to drive higher quality care. Removing this state-level tool will undermine federal goals of addressing the nation's mental health needs.

An Independent Actuarial Analysis Raises Serious Doubts About Whether the Code- and Payment-Group-Level Approach Can Be Reconciled With Actuarial Soundness

FAH engaged Incline Actuarial Group to independently assess whether the proposed code- and payment-group-level compliance methodology can be reconciled with the actuarial soundness standards governing Medicaid managed care. That analysis, prepared by credentialed actuaries with direct experience in Medicaid managed care capitation rate development and certification, is attached as Appendix A. Its findings confirm and deepen the concerns described above, and they are central to FAH's position that CMS should implement the payment limit through an aggregate, UPL-style approach.

The report finds that actuarial soundness is measured in the aggregate, not at the code or payment-group level. The unit of certification throughout the governing regulations is the capitation rate for a rate cell, a per-member-per-month figure covering a defined population and set prospectively before the rating period begins. Nothing in the rate development methodology is structured around code- or payment-group-level pricing. The existing total payment rate standard fits this framework because it is itself an aggregate measure. Critically, the report identifies no established actuarial methodology, anywhere in the regulations, CMS's sub-regulatory guidance, or the applicable Actuarial Standards of Practice, for translating a code-level compliance result into a population-level capitation rate. **FAH is deeply concerned by this finding. It means the Proposed Rule would layer a code- and payment-group-level test onto a rate-setting process, adding significant administrative burden, creating essentially the need to build up and test rates twice—once in aggregate and once at the code or payment group level.** These two separate approaches cannot always be reconciled back to each other through legitimate rate-development adjustments. This additional bolted-on framework could compromise the integrity of the capitation rate certification that safeguards Medicaid managed care solvency.

The report grounds this concern in several specific conflicts, each of which FAH has described above and each of which the report confirms from an actuarial perspective. Many Medicaid services and provider types have no Medicare benchmark to test against, because Medicare either does not cover the service or covers a population that does not reflect those receiving the service under Medicaid. Where a Medicare code nominally exists, it is frequently not derived from real Medicare claims experience for the relevant population. The report also confirms a timing conflict, because capitation rates are certified prospectively while a code-level test keyed to annually updating Medicare rates and

retrospective cost reports can only be validated after the fact. And it confirms that a code- and payment-group-level ceiling removes the flexibility value-based payment arrangements require, because it caps each underlying service even where the aggregate arrangement remains reasonable, appropriate, and attainable.

The report further confirms that CMS's own record supports the aggregate approach. As the report notes, CMS reasoned in the 2024 final rule that SDP compliance testing should be more flexible than the aggregate FFS UPL framework, not more granular than it. CMS's own rate development guidance and its definition of the total payment rate are likewise built entirely around aggregate, population-level measurement. The Proposed Rule departs from that architecture without reconciling the departure.

These findings confirm that the code- and payment-group-level methodology is not a workable refinement of the existing framework but a departure from the aggregate architecture that has made SDP compliance compatible with actuarial soundness certification. **FAH urges CMS to abandon the code- and payment-group-level test and to implement the payment limit through an aggregate, UPL-style methodology, which aligns with the actuarial soundness framework because both operate at the same population level and can be demonstrated through a single, auditable comparison.**

II. Grandfathered SDPs (Part II.A.2)

CMS Should Finalize Its Appropriate Business Days and Separate Payment Terms Approach for Grandfathered SDPs

FAH appreciates and supports CMS' proposed approach to the definition of a grandfathered SDP as part of its implementation of section 71116(b). As noted in the Proposed Rule, work on SDP preprints occurs on business days. As a result, the exclusion of weekends and Federal holidays aligns the temporal requirements with Federal practice. An alternative interpretation would be inappropriate in light of this administrative reality, and FAH applauds CMS for properly defining grandfathered SDPs under section 71116(b).

In addition, FAH supports delaying compliance with the separate payment term prohibition and the preprint timing submission requirements through the temporary grandfathering period, as described in proposed § 438.6(c)(2)(iii)(F). This brief, time-limited exemption for eligible grandfathered SDPs would appropriately minimize burdens during the grandfathering period. The alternatives set forth in the Proposed Rule would not be as transparent and administratively feasible, compromising monitoring and oversight of the phase down process. It is simply not administratively feasible to apply the statutory phase down to grandfathered SDPs without existing SDP structures such as separate payment terms, specific aggregate payment amounts, and post-rating-period reconciliations.[30]

More fundamentally, and as discussed in FAH's comments on transparency above, separate payment terms are not merely an administrative convenience during the grandfathering period. They are a durable tool that makes SDP spending separately visible at the provider level and allows states to target funding to the providers that need it most. FAH accordingly urges CMS to preserve separate payment terms beyond the grandfathering period rather than allowing the scheduled prohibition to take effect.

Phase Down of Grandfathered SDPs

Section 71116(b) appropriately grandfathers certain SDPs, with a 10 percent annual phase down to 100 or 110 percent of the specified total published Medicare rate beginning January 1, 2028. This phase down has no statutory deadline; rather, Congress expressly ensured that it be gradual with a 10-percentage-point annual limit to payment reductions until the total payment rate reaches 100 or 110 percent of the specified total published Medicare rate. **FAH, however, is concerned that CMS' proposed approach to the phase down unnecessarily and unevenly accelerates payment reductions, and urges CMS to instead adopt its alternative proposal, reducing the difference between the total payment rate and the total published Medicare payment rate by 10 percentage points annually.**

Under CMS' proposal, the 10 percent annual phase down applies to the amount of the grandfathered SDP, without regard to the relative difference between the total payment rate and the Medicare rate. For example, if a grandfathered SDP of $1 billion is combined with a base rate of $1 billion to produce a total payment rate of $2 billion when the total published Medicare rate totals $1.9 billion, the phase down under the proposed rule would be a blunt, one-year cliff. In this scenario, the annual phase down would be $100 million, which is 10 percent of the $1 billion in SDPs and also the entire delta between the grandfathered total payment rate and the total published Medicare rate. In contrast, if another state had an identical total payment rate ($2 billion), but the total payment rate was largely driven by base rate payments, the phase down under the Proposed Rule would be far more gradual. For example, a $100 million grandfathered SDP would be reduced by $10 million per year, which would produce a decade-long phase down to bring the total payment

rate ($2 billion) down to the Medicare rate ($1.9 billion). Because the proposed phase down is not scaled based on the difference between the total payment rate and the Medicare rate in setting the annual rate cuts, this proposal produces wildly different results for states with total payment rates that are the same percentage of the Medicare rate.

FAH believes that Congress did not intend this uneven phase down and instead contemplated a 10-year phase down that would be achieved in the statutory 10-percentage-point increments. In other words, **FAH supports applying the 10-percentage-point phase down to the difference between the total payment rate produced by grandfathered SDPs and the applicable Medicare-based payment limit.** In the alternatives considered, CMS considered a slightly different proposal that would be scaled to the difference between the total payment rate and the total published Medicare payment rate, but expressed concern that this approach would result in a phase down that could extend 40 to 50 years.[31] This prolonged phase down, however, is not the necessary result of a phase down focused on the relative difference between the total payment amount and the target Medicare payment limit. By breaking the difference between the total payment amount and the target Medicare payment limit into 10-percentage-point increments (e.g., $10 million increments for each of the hypothetical states described above), CMS would ensure that the phase down is complete within 10 years but is gradual across the board. This achieves the statutory, multi-year phase down with 10 percentage point reductions "each year," and it fully addresses the concerns with the alternative approach identified in the Proposed Rule. But it does so in a manner that achieves a smooth transition away from grandfathered payment amounts, providing the time states need to focus on promoting network access and quality despite the phase down.

A gradual, multi-year transition of this kind is also consistent with CMS's longstanding practice. CMS has repeatedly implemented significant Medicaid payment changes over fixed, multi-year periods.[32]

III. Uniform Increase SDPs (Part II.A.3.c)

The Proposed Rule would amend paragraph (c)(1)(iii)(B) to only permit minimum or maximum fee schedule SDPs. This would effectively prohibit new uniform increase SDPs and renewals of non-grandfathered uniform increase SDPs for rating periods beginning on or after January 1, 2028. **FAH strongly opposes the elimination of uniform increase SDPs.**

Uniform increase SDPs are critical tools that states use to efficiently administer Medicaid managed care delivery systems and target resources toward local health care priorities. This flexibility enables states to experiment with approaches to promote high-quality, value-based care and to adopt the approaches that have the best outcomes and highest impact on the most pressing issues each state is facing.

Congress spoke to the continued existence of uniform increase SDPs in section 71116 and did not authorize elimination of this important mechanism for improving the value and quality of high-priority health care services. Without uniform increase SDPs, states will be left with fewer and more administratively burdensome options for achieving their unique health care goals. This result is inconsistent with Medicaid's federal-state partnership model, which is designed to promote flexibility, efficiency, and responsiveness to local health care needs.

Uniform Increase SDPs Support State Flexibility and Efficiency

As CMS is aware, uniform increase SDPs are the most common type of SDP. The widespread use of uniform increase SDPs in state Medicaid programs is not surprising. Uniform increase SDPs provide states with the flexibility to address health care priorities consistent with the needs of their unique populations and have promoted high-quality and value-based care. For example, the Texas Health and Human Services Commission reported that, as of May 2026, the state's Comprehensive Hospital Increase Reimbursement Program or CHIRP has, among other things, improved maternal care and hospital safety outcomes.[33] Other uniform increase SDPs illustrate their use in supporting rural hospitals providing access to care in their communities (*e.g.*, New Mexico)[34] and the provision of inpatient and outpatient behavioral health services (*e.g.*, Colorado).[35]

Uniform increase SDPs are also efficient. As explained in section 438.6(a), uniform increase SDPs allow states to direct "the MCO, PIHP, or PAHP to pay the same amount (the same dollar amount or the same percentage increase) per Medicaid covered service(s) in addition to the rates the MCO, PIHP or PAHP negotiated with the providers included in the specified provider class for the service(s) identified in the State directed payment." Even if a state were able to achieve the programmatic goals, including those set forth in the state's quality strategy, doing so exclusively through minimum fee schedule SDPs across the board would increase administrative burdens while compromising the targeting that can be achieved with a uniform increase SDP. A uniform increase methodology allows states to build upon the payment rates negotiated between managed care plans and providers by applying a consistent increase designed to

advance specified programmatic objectives. By contrast, minimum- and maximum-fee-schedule SDPs require the development, monitoring and periodic updating of fee schedules across numerous services and provider types, creating substantial administrative costs for states, plans, and providers while increasing the risk of implementation delays and payment inaccuracies. Uniform increase SDPs also accommodate changes in utilization, service mix, and underlying negotiated payment rates without requiring states to continually revise complex fee schedules. Hospitals rely on stable and timely funding that states specifically designed to advance access to care, workforce investments and high-quality services for hard-working individuals enrolled in Medicaid. Uniform increase methodologies advance these objectives without imposing the operational burdens associated with fee-schedule-based arrangements—the same types of burdens that make a line-item limit unworkable.

CMS should preserve the important tool of uniform increase SDPs to maintain state flexibility and avoid unnecessary administrative burden.

Congress Has Endorsed Uniform Increase SDPs

Congress has demonstrated its endorsement of uniform increase SDPs by expressly amending the total payment rate applicable to uniform increase SDPs. Specifically, section 71116 directs CMS to revise paragraph (c)(2)(iii), which pertains to the "total payment rate for each State directed payment for which written prior approval is required under paragraph (c)(2)(i)." Paragraph (c)(2)(i) expressly includes the "uniform dollar or percentage increase" SDP type described in paragraph (c)(1)(iii)(D). Accordingly, Congress specifically spoke to the continued existence of uniform increase SDPs when it instructed CMS to modify paragraph (c)(2)(iii), which applies to this SDP type. CMS' proposal to eliminate the uniform increase SDP is inconsistent with Congress's direct instruction to amend the "total payment rate" for this very type of SDP.

Congress's plain direction to amend the total payment rate for uniform increase SDPs also shows that Congress did not intend to generate savings by eliminating this SDP type. This disconnect may help explain why CMS' predicted reduction in Federal Medicaid spending under the Proposed Rule is more than three times the savings the Congressional Budget Office estimated for the SDP provisions of section 71116.[36]

Nothing in section 71116 directs CMS to eliminate uniform increase SDPs, and the statute is reasonably implemented without eliminating this longstanding SDP methodology. Indeed, the operational difficulties CMS itself identifies in applying code- and payment-group-level payment limits to uniform increase SDPs confirms that Congress could not have anticipated, let alone condoned, applying a line-item limit to any SDP, including to uniform increase SDPs.

CMS should decline to adopt a policy that is, on its face, inconsistent with Congress's direction in section 71116.

CMS Should Consider Tailored Approaches That Build Upon Existing Transparency and Quality Efforts

While FAH appreciates CMS' commitment to promoting program integrity through the Medicaid managed care delivery system, CMS' proposal to eliminate uniform increase SDPs is not appropriately tailored to address its concerns. **Instead of phasing out and eventually prohibiting uniform increase SDPs, CMS should look to enhanced preprint transparency and provider-level reporting and evaluation requirements as tools for improving oversight of SDPs.** CMS has already developed targeted transparency measures and could continue to build from them. For example, in the 2024 managed care final rule,[37] CMS expanded reporting requirements, including documentation on quality evaluations. CMS has continued to implement and enforce these requirements in guidance letters.[38] MACPAC has also made recommendations to CMS regarding transparency and oversight, including making SDP approvals and evaluations public and providing guidance on assessments of SDPs.[39]

Further developing such methods, in conjunction with stakeholders, would represent a tailored approach that reduces the administrative burden of redesigning SDPs and supports state flexibility to determine how to best meet local health care needs. Indeed, tailored approaches could be designed to address CMS' concerns regarding the use of uniform increase SDPs to target narrow classes of providers and to facilitate payment to providers who fund the non-federal share of the SDP, as well as its concerns regarding providers receiving payment through uniform increase SDPs even where utilization does not fluctuate. Moreover, the fact that a provider receives payment under a uniform increase SDP despite stable or declining utilization does not necessarily signal payment ineffectiveness. States frequently use uniform increase SDPs to address broad issues like network adequacy, provider participation and financial sustainability, which do not necessarily correlate with utilization. FAH also notes that, importantly, higher utilization should not be the benchmark of a successful uniform increase SDP, as lower utilization often reflects achievement of other goals like the

provision of effective care that addresses patients' needs efficiently, or effective population health strategies that reduce avoidable higher-cost care.

If CMS instead adopted the blunt phase-down and ultimate elimination of uniform increase SDPs, states would be left with SDP structures that are far less efficient and far more rigid. This amounts to a significant disincentive for states to experiment with different approaches to meeting the unique health care needs of their populations. Moreover, it does not further the Medicaid program's federal-state partnership model that promotes state flexibility to test innovative approaches to high-quality care without excessive administrative burdens. If uniform increase SDPs are eliminated, Medicaid programs will be forced to devote substantial resources to redesigning SDP arrangements and administering more complex and less efficient alternatives.

CMS should preserve the value that uniform increase SDPs offer and explore practical ways to oversee their use instead of significantly departing from current policy. CMS should decline to finalize its proposal eliminating uniform increase SDPs and achieve its objectives through other less disruptive policies.

IV. Provider Classes (Part II.A.3.e)

The Proposed Rule solicits comments on whether and how to define "provider class," expressing concerns about overly narrow provider classes, including single-provider classes. FAH appreciates CMS' engagement on this issue and its concerns in advance of any rulemaking on the topic. Overall, FAH believes that any definition of "provider class" must retain adequate flexibility so that states can address particular challenges by appropriately targeting SDPs based on relevant provider characteristics. These provider characteristics might include geographic factors (*e.g.*, rural location), size, and specialty services. Indeed, SDPs are a primary tool for addressing particular access challenges including preserving access to labor-and-delivery care in rural areas, and Medicaid cuts could leave 96 rural counties without any labor and delivery unit, following continuous closures of such units.[40] In addition, at a minimum, states should define provider classes that appropriately distinguish between provider types—including, among others, general acute care hospitals (section 1886(d) of the Act), inpatient rehabilitation facilities (section 1886(j) of the Act), inpatient psychiatric facilities (section 1886(s) of the Act), and long-term care hospitals (section 1886(m) of the Act)—which are materially different provider types that provide distinct inpatient care in their communities. It is therefore critical that CMS preserve states' abilities to design SDPs in ways that address such pressing issues and are targeted based on relevant provider characteristics. A definition focused on the group of providers defined in the Medicaid state plan would be inappropriately limited, precluding common and widely accepted strategies to appropriately target SDPs.

V. Targeted Medicaid Payment Limit in an FFS Delivery System (Part II.B)

The Proposed Rule extends beyond managed care to establish a new payment limit on targeted Medicaid practitioner and provider payments in the fee-for-service delivery system, at proposed 42 CFR § 447.381. This limit would apply to payments for physicians, dentists and other licensed practitioners, ground and air ambulance providers, non-emergency medical transportation providers and others, in instances where all or a portion of a payment is targeted to a subset of those furnishing a covered service.

FAH objects to this FFS payment limit and urges CMS not to finalize it. Section 71116 of the WFTC legislation addresses managed care state directed payments. It does not require, or even reference, a new payment limit on fee-for-service practitioner and provider payments. CMS proposes this limit on its own initiative, resting solely on the economy and efficiency standard of section 1902(a)(30)(A) of the Act. As CMS acknowledges, there is currently no Federal upper payment limit requirement applicable to these practitioner services. The Proposed Rule would create one where Congress did not, and would do so through the same Medicare-based benchmark that is ill-suited to the Medicaid population.

The FFS limit also repeats the central methodological flaw that runs throughout the Proposed Rule. CMS proposes to apply the limit as a practitioner or provider-specific limit, and states expressly that it would not be applied as an aggregate UPL. This is the same departure from the longstanding aggregate methodology that FAH objects to in the managed care context. The reasons an aggregate approach is more workable, more consistent with the structure of Medicaid and more appropriate to a benchmark drawn from a different population apply with equal force here. A provider-specific test carries the same benchmark mismatch, the same administrative burden and the same disregard for the differences between the Medicare and Medicaid populations that FAH describes above.

FAH is further concerned that CMS has not demonstrated that this new limit is necessary or that it examined the consequences of imposing it, particularly with respect to the impact on beneficiary access. Targeted FFS payment

methodologies, including value-based and bundled arrangements, have developed over many years within the parameters CMS itself approved through the State plan amendment process. The Proposed Rule would constrain these arrangements without a showing that the existing economy and efficiency review under section 1902(a)(30)(A), together with the State plan approval process, is inadequate to protect program integrity. Moreover, while the Proposed Rule references section 1902(a)(30)(A) and generally questions whether targeted payments improve access to care, it does not analyze the policy's consistency with (a)(30)(A)'s equal access mandate, which is tied to availability of care to the "general population" (including those with commercial insurance). **CMS should decline to finalize the targeted FFS payment limit and should instead continue to rely on the existing State plan review process and the economy and efficiency standard that already govern these payments.**

To the extent CMS proceeds despite these objections, any FFS limit should be structured on an aggregate basis consistent with the existing UPL framework, rather than as a practitioner or provider-specific test.

Taken together, the expansions in the Proposed Rule—including the extension of a Medicare-based payment limit to a granular, code- and payment-group level—reach well beyond the categories and arrangements Congress addressed, and their cumulative effect is what most concerns FAH. Applying Medicare-based limits at the code- and payment-group level and across additional services, additional payment arrangements and additional delivery systems produces deeper and more widespread reductions in provider payment than the statute contemplated. Those reductions fall on hospitals and health systems that already absorb substantial unpaid costs in caring for Medicaid patients. As payments contract, providers will face difficult decisions about workforce and the services they can sustain, and the patients who depend on them will feel the consequences.

VI. Conclusion

FAH appreciates the opportunity to comment on the Proposed Rule and shares CMS's commitment to a fiscally sound and accountable Medicaid program. We urge CMS to adopt the recommendations described above. If you have questions, please contact Alyssa Keefe, Senior Vice President, Head of Policy, at akeefe@fah.org or 202-624-1500.

Sincerely,

/s/
Charlene MacDonald
President and CEO
Federation of American Hospitals

ENDNOTES

[1] Cong. Budget Office, Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline (July 21, 2025), https://www.cbo.gov/publication/61570.
[2] 91 Fed. Reg. at 30,426.
[3] 91 Fed. Reg. at 30,416–17.
[4] 91 Fed. Reg. at 30,427.
[5] 91 Fed. Reg. 30,400.
[6] MedPAC, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf.
[7] *Id.*
[8] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, sec. 202 (adding section 1903(bb) of the Social Security Act).
[9] CMS, State Medicaid Director Letter #21-006, New Supplemental Payment Reporting and Medicaid Disproportionate Share Hospital Requirements under the Consolidated Appropriations Act, 2021 (Dec. 10, 2021).
[10] CMS, Narrative Description of Data Files, FY 2023 Medicaid Supplement Payment Expenditure Data (Dec. 19, 2024), available at https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes/medicaid-supplemental-payment-expenditure-reporting.
[11] CMS, Center for Medicaid and CHIP Services, Narrative Description of Data Files (Supplemental Payment Reporting).
[12] Medicaid and CHIP Payment and Access Commission, Directed Payments in Medicaid Managed Care (Oct. 2024).
[13] 42 C.F.R. § 438.6(a) (emphasis added).
[14] 42 C.F.R. § 438.6(c)(2)(iii)(A)(6).
[15] 42 C.F.R. § 438.6(c)(5)(iii)(A)(2), (B)(2), (C)(2).
[16] 91 Fed. Reg. at 30,413.
[17] 91 Fed. Reg. at 30,405.
[18] 91 Fed. Reg. at 30,410. CMS also acknowledges that the actual provider impact of SDP policy changes would necessarily account for the role of provider taxes and IGTs in SDPs in connection with the impacts analysis of the Proposed Rule. 91 Fed. Reg. at 30,453, 30,457 (discussing the net change in provider revenue).
[19] MACPAC, *Report to Congress on Medicaid and CHIP*, ch. 1, p. 19, fig. 1-4 (June 2024), https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-WEB-508.pdf.
[20] 91 Fed. Reg. at 30,452.
[21] See Abraham Lincoln Memorial Hospital v. Sebelius, 698 F.3d 536, 550 (7th Cir. 2012); Breckenridge Health, Inc. v. Price, 869 F.3d 422, 424 (6th Cir. 2017); Presidential Memorandum, Eliminating Waste, Fraud, and Abuse in Medicaid (June 6, 2025).
[22] Social Security Act § 1902(a)(30)(A).
[23] Social Security Act § 1903(m)(1)(A)(i); *see also* Social Security Act § 1903(m)(2)(A)(iii).
[24] 81 Fed. Reg. 27,498, 27,609 (May 6, 2016).
[25] Max Yates, Jonathan Gonzalez-Smith, Kun Li, Andrew Wang & Robert R. Saunders, Value-Based State-Directed Payments in Medicaid Managed Care, 6 *JAMA Health Forum* e251666 (2025), https://doi.org/10.1001/jamahealthforum.2025.1666.
[26] *See* 42 C.F.R. §§ 447.272 and 447.321.
[27] 81 Fed. Reg. 27,497, 27,588 (May 6, 2016).
[28] President Donald J. Trump, "Ending Crime and Disorder on America's Streets," executive order, July 24, 2025.
[29]President Donald J. Trump, "Addressing Addiction Through the Great American Recovery Initiative," executive order 14379, January 28, 2026.
[30] Along similar lines, FAH supports the continued use of uniform increase SDPs during the grandfathered period. As explained further below, uniform increase SDPs should be retained for both grandfathered and non-grandfathered plans as they provide the requisite flexibility.
[31] 91 Fed. Reg. 30,458–59.
[32] See, e.g., 42 C.F.R. sec. 438.6(d)(3) (phase down of hospital pass-through payments); 42 C.F.R. sec. 438.6(d)(4) (transition period for physician and nursing facility pass-through payments); CMCS Informational Bulletin, Exercise of Enforcement Discretion until Calendar Year 2028 for Existing Health Care-Related Tax Programs with Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments (Apr. 22, 2024). Congress has similarly recognized the need for extended transitions by repeatedly delaying scheduled reductions to the Medicaid Disproportionate Share Hospital program.
[33] Tex. Health & Hum. Servs. Comm'n, *Evaluation of Four State Directed Payment Programs: State Fiscal Years 2022–2025* 2, 10 (May 2026), https://www.hhs.texas.gov/sites/default/files/documents/y4-chirp-bhs-rapps-tipps-evaluation-report.pdf.
[34] Letter from John Giles, Dir., Managed Care Grp., Ctr. for Medicaid & CHIP Servs., to Dana Flannery, Medicaid Dir., N.M. Med. Assistance Div. (Dec. 2, 2025), https://www.medicaid.gov/medicaid/managed-care/downloads/NM_Fee_IPH.OPH7_New_20250101-20251231_Approval%20Letter.pdf.
[35] Letter from Meagan T. Khau, Deputy Dir., Managed Care Grp., Ctr. for Medicaid & CHIP Servs., to Adela Flores-Brennan, Medicaid Dir., Health First Colo., Dep't of Health Care Pol'y & Fin. (Apr. 24, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/CO_Fee_IPH.OPH.BHI.BHO_New_20250701-20260630.pdf.
[36] Cong. Budget Office, Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline (July 21, 2025), https://www.cbo.gov/publication/61570.
[37] 89 Fed. Reg. 41,002 (May 10, 2024).
[38] Caprice Knapp, Acting Dir., Ctr. for Medicaid & CHIP Servs., CMCS Informational Bulletin: State Directed Payment Quality Evaluations (Sept. 10, 2025), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/cib09102025.pdf.

[39] Medicaid & CHIP Payment & Access Comm'n, *Directed Payments in Medicaid Managed Care* (Oct. 2024), https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf.
[40] March of Dimes, *How Medicaid Cuts Could Accelerate the Rural Care Access Crisis* (Mar. 18, 2026), https://www.marchofdimes.org/sites/default/files/2026-03/MCDR-Supplemental-Issue-Brief-3.18.26.pdf.

APPENDIX A

Actuarial Impacts from Proposed Rule CMS-2449-P (91 FR 30400)

Federation of American Hospitals

Prepared for the Federation of American Hospitals by

Colby Schaeffer, ASA, MAAA
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Final Report | July 20, 2026

Table of Contents

Section 1: Purpose, Scope, and Qualifications

This report has been prepared by Colby Schaeffer, ASA, MAAA, and Shelley Moss, FSA, MAAA, at the request of the Federation of American Hospitals ("FAH"), for inclusion in FAH's public comment letter on CMS-2449-P, Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments[1], 91 Fed. Reg. 30400 (proposed May 22, 2026). Its purpose is to independently analyze whether the proposed per-bill code and per-line item discharge payment limit for Medicaid managed care state directed payments ("SDPs") can be reconciled with the actuarial soundness requirements governing Medicaid managed care capitation rates under 42 CFR §§ 438.4–438.7.

This report identifies structural conflicts between the proposed rule's per-bill code/per-line-item discharge compliance framework and the existing, population-based, prospective actuarial soundness standard, and it identifies specific areas that CMS should resolve to reconcile the two. This report is diagnostic and not fully exhaustive. It does not address, for example, issues with the grandfathered phase-down approach. Nor does it take a position on the underlying policy goals of CMS-2449-P or assert that the proposed rule is impossible to implement; it identifies where the current proposal, as drafted, creates actuarial and operational conflicts, leaving policy judgments about how to resolve them to CMS and the public comment process.

The authors are credentialed actuaries — Fellows and Associates of the Society of Actuaries and Members of the American Academy of Actuaries — with professional experience in Medicaid managed care capitation rate development and certification. This report has been prepared in accordance with the applicable Actuarial Standards of Practice ("ASOPs") promulgated by the Actuarial Standards Board, including ASOP No. 41, Actuarial Communications, governing the disclosures required in an actuarial report of this kind.

This report does not involve the development or application of actuarial models, the use of client-provided or proprietary data, or the selection of quantitative actuarial assumptions. Its analysis and conclusions reflect the professional judgment of the undersigned actuaries, applied to publicly available sources cited throughout the report — including the text of CMS-2449-P, 42 CFR Part 438, CMS sub-regulatory guidance, and applicable ASOPs — and rely on no data, analysis, or other input from FAH or any other party. It reflects these authorities as of its date, and the authors undertake no obligation to update it for subsequent developments, including changes CMS may make in finalizing the rule, additional sub-regulatory guidance, or revisions to any ASOP discussed herein, including the pending revision of ASOP No. 49 addressed in Section 4.

This report has been prepared solely for inclusion in FAH's public comment letter on CMS-2449-P, and its intended users are FAH and CMS as the recipient of that letter. The report should not be relied upon for any other purpose, including as a certification of any specific Medicaid managed care capitation rate or as legal advice on the validity of CMS-2449-P. Any other recipient of this report is an "other user" under ASOP No. 41 and should not rely on it without consulting the authors. The authors were engaged and are compensated by FAH to prepare this report. Compensation for this engagement is a fixed fee that does not depend on the report's findings or conclusions. The authors are not aware of any other financial, organizational, or professional relationship with FAH, CMS, or any other party with a material interest in the outcome of CMS-2449-P that should be disclosed under ASOP No. 41.

The authors would also like to thank Cindy Beane, former West Virginia Medicaid Director, for her thoughtful peer review of this report.

[1] Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments, 91 Fed. Reg. 30400 (proposed May 22, 2026) (CMS-2449-P; RIN 0938-AV69), https://www.federalregister.gov/documents/2026/05/22/2026-10292/medicaid-program-medicaid-managed-care-state-directed-payments-and-medicaid-fee-for-service-targeted

Section 2: Executive Summary

CMS-2449-P proposes to test whether Medicaid managed care state directed payments ("SDPs") comply with a new Medicare-based payment limit by checking every individual bill code and line-item hospital discharge separately, rather than checking a single combined average rate in aggregate or at the broad service level (e.g., inpatient services), which is the current compliance standard. This report finds that this shift — from an aggregate or broad service level, average-based test to a code-by-code level test — will have several ramifications on the actuarial rate setting process and its stakeholders:

1. **Actuarial rate setting uses aggregated data, and the granular approach to payment limits (at a bill code or per-discharge level) will greatly amplify the time and resources required to certify rates.** Actuarial soundness standards that governed Medicaid managed care rates since 2003 are built around population-level averages, set in advance, rather than individual bill code prices. This transforms the rate setting priority from overall rate adequacy to bill code-level projection accuracy.
2. **Many Medicaid bill code level services and provider types have no Medicare price, making the calculated SDP limit unmeaningful.** Childbirth, behavioral health, home- and community-based care, and other services do not have a Medicare equivalent, so SDPs in those areas will not be able to achieve the same goals as SDPs where Medicare equivalents exist.
3. **Bill code-level SDPs undermine value-based payment (VBP) arrangements, pushing states toward FFS reimbursement.** When the maximum payment is prescribed at a bill code level, VBP arrangements lose their levers to encourage results-oriented service.
4. **The proposed compliance test is fundamentally retrospective while capitation rate development is prospective.** Unclear guidance seems to indicate the proposed compliance test can only be confirmed once updated Medicare rates or reconciled cost reports become available, often years later — while Medicaid capitation rates must be certified as actuarially sound prospectively before the rating period begins, a structural timing mismatch this report addresses at length.

Section 6 of this report catalogs eight specific, unresolved items we believe CMS must address before finalizing this approach, to avoid undermining actuarial soundness certification and Medicaid managed care solvency itself:

1. How the Medicare benchmark is defined,
2. What methodology applies where no Medicare price exists,
3. How to reconcile prospective rate-setting with a fundamentally after-the-fact compliance test,
4. Whether CMS's existing sub-regulatory guidance needs to be updated,
5. Who is responsible for performing the compliance check,
6. Whether and how a state is expected to monitor or account for changes to the SDP preprint negotiated base payment after the total payment rate comparison has been submitted,
7. The practical administrative burden the new approach would impose on states, health plans, and CMS's review staff, and
8. A defined validation methodology for VBP and episode-based SDPs, addressing how a bundled or total-cost-of-care arrangement is to be tested.

Note that the administrative burden for all of these items is not immaterial. Shifting the compliance test to the bill-code or line-item discharge level does not simply add a check at the end of the rate-setting process — it requires actuaries to build up the rate twice: once in aggregate, as required for actuarial soundness certification, and again at the granular bill-code level, as required for SDP compliance testing. That duplication of the rate development process itself — not merely an additional review step — is what drives the administrative burden. The resulting volume of data would also cause long-term slowdowns to the rate-setting process, requiring significant additional staffing at health plans, states, and CMS.

Resolving these issues may require CMS to develop and publish new methodology, in most cases through additional guidance beyond the rule text itself. Given the scope of the open items identified in this report, we believe resolving them in a way that gives states and their actuaries a workable, CMS-sanctioned path to compliance would take considerably longer than the time available between the July 21, 2026 close of the public comment period and any near-term finalization of the rule.

That timing also has direct, practical consequences beyond CMS's rulemaking. CMS's Medicaid Managed Care Rate Development Guide (RDG) is generally issued annually, in the months before each new rating-period cycle begins; the current edition, covering rating periods from July 2026 through June 2027, was issued in February 2026, making it unlikely that CMS would be able to finalize this rule before the next edition of the RDG would ordinarily be prepared and issued — leaving states and their actuaries to build rate certifications without CMS-sanctioned methodology for per-bill code level compliance testing, and creating a real risk that the RDG would not reflect the final rule's requirements until the following cycle. Some states set provider fee schedules through state legislative action, adding a further layer of timing constraints tied to legislative calendars. Even if CMS were able to finalize the rule and issue adequate guidance quickly, there would not be enough time left for states and health plans to plan and implement the required changes. **It appears to be near impossible that CMS address the items identified in Section 6 before finalizing this rule, and provide additional sub-regulatory guidance, methodology, and lead time that states, health plans, and their actuaries need to implement any final rule in an actuarially sound manner before the proposed effective dates.** Delaying the effective date until CMS has resolved the items identified in Section 6 would directly address each of the timing problems described above and could be an effective path forward.

Section 3: Background on the Proposed Rule

CMS-2449-P implements Section 71116 of Public Law 119-21 (the "Working Families Tax Cut," or "WFTC" legislation — more widely known as the One Big Beautiful Bill Act, or "OBBBA" — enacted July 4, 2025)[2], which directs CMS to revise 42 CFR § 438.6(c)(2)(iii) to lower the payment-rate limit governing SDPs for four service types — inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services at an academic medical center — and to implement a temporary grandfathering and phase-down mechanism for existing SDPs, beginning with the first rating period on or after January 1, 2028. The rule also implements the June 6, 2025 Presidential Memorandum, "Eliminating Waste, Fraud, and Abuse in Medicaid,"[3] which directs HHS to ensure Medicaid payment rates do not exceed Medicare rates "to the extent permitted by applicable law." CMS's proposal extends beyond the statutory floor: rather than limiting the new payment-rate ceiling to the four WFTC-designated service types, CMS proposes to apply the same Medicare-based limit to all SDPs and all service types, in all states, the District of Columbia, and the territories.

CMS grounds this rulemaking primarily in its authority under Section 1903(m)(2)(A)(iii) of the Social Security Act[4], which requires that risk-based managed care contracts provide for payment that is actuarially sound, and Section 1902(a)(4) of the Act[5], its general authority to establish methods of administration necessary for the proper and efficient operation of the state plan — historically the authority used to extend the actuarial soundness requirement to PIHPs and PAHPs, which are not named directly in Section 1903(m). These two provisions are the exclusive statutory foundation for applying the new Medicare-based payment limit beyond the four services addressed by Section 71116, and Section 71116 provides the statutory foundation to extend the Medicare based payment limit to managed care SDPs. This report evaluates whether a per-bill code level/per- line-item discharge compliance test can be reconciled with the actuarial soundness standard that these provisions impose. By contrast, CMS cites the separate efficiency-economy-quality-of-care standard in Section 1902(a)(30)(A) of the Act as authority for the parallel fee-for-service provision (new 42 CFR § 447.381, applicable to targeted Medicaid practitioner payments outside of managed care) — a materially different statutory hook that is not at issue in this report.

The proposed rule defines a new "payment limit" at § 438.6(a) equal to 100 percent of the total published Medicare payment rate for an expansion state, 110 percent for a non-expansion state, and, where no Medicare rate exists for the covered service, 100 percent of the state plan approved rate. The proposed rule would also amend § 438.6(c)(2)(iii)(D) to require states to submit actuary-certified total payment rate comparisons, expressed as a percentage of the total Medicare payment rate, for grandfathered SDPs, beginning with the first rating period on or after January 1, 2027[6] — one year before the grandfathering phase-down itself begins.

The single most consequential feature of the proposed rule, and the feature this report treats as the core of the actuarial soundness conflict, is CMS's decision to depart from an aggregate, broad service level-based compliance methodology in favor of a per-bill code level, per-line-item discharge test. CMS states directly that

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[2] Working Families Tax Cut Act, Pub. L. No. 119-21, § 71116, https://www.congress.gov/119/plaws/publ21/PLAW-119publ21.pdf

[3] Presidential Memorandum, Eliminating Waste, Fraud, and Abuse in Medicaid (June 6, 2025), https://www.whitehouse.gov/presidential-actions/2025/06/eliminating-waste-fraud-and-abuse-in-medicaid/

[4] Social Security Act § 1903(m)(2)(A)(iii), https://www.ssa.gov/OP_Home/ssact/title19/1903.htm

[5] Social Security Act § 1902(a)(4), https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

[6] CMS Proposes Major Changes to Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments, Myers and Stauffer, https://myersandstauffer.com/insights/cms-proposes-major-changes-to-medicaid-managed-care-state-directed-payments-and-medicaid-fee-for-service-targeted-medicaid-practitioner-payments/

it interprets "payment rate(s)" in the WFTC legislation and the Presidential Memorandum to refer to the rate paid for a specific bill code or line-item discharge furnished by a specific provider, not an aggregate. CMS states, the SDP payment limit "would not be calculated at an aggregate level, using a UPL-like approach that mirrors what is done to implement many existing payment limits in Medicaid FFS," and instead would apply "at the HCPCS code level or for Medicare Severity Diagnosis-Related Groups (MS-DRGs)." CMS states that neither the WFTC legislation nor the Presidential Memorandum references an aggregate Medicare-equivalent or UPL methodology[7]. This stands in direct contrast to the FFS upper payment limit ("UPL") framework CMS describes elsewhere in the same preamble, under which UPLs apply an aggregate payment ceiling so that facility-specific payments for a broad service category (e.g., inpatient hospital services) can vary "sometimes widely" so long as the class-wide total does not exceed the Medicare-equivalent estimate for the service[8]. As discussed in Section 5 of this report, **CMS's choice to abandon this aggregate architecture — the same architecture that governs the existing SDP total-payment-rate standard — in favor of a granular, code-level test is the source of nearly every structural conflict identified in this report.**

The proposed rule also layers a new documentation and validation framework onto the existing capitation rate-certification and retroactive-adjustment structure at 42 CFR § 438.7(c)[9]. A new § 438.6(c)(8), "Payment Limit Monitoring and Compliance," would require states to submit, for each SDP, an NPI-level list of every provider eligible for the SDP, the total published Medicare payment rate (or state plan approved rate) that serves as basis for the payment limit, and a description — in substance, a validation methodology — demonstrating per-bill code level compliance, particularly for SDPs structured as value-based payment arrangements. Because retroactive adjustments to a certified capitation rate are permitted under § 438.7(c)(5) to add or amend an SDP or to correct a "material error," a later determination — on audit, or once updated Medicare rates or reconciled cost reports become available — that per-bill code level payments under an SDP exceeded the limit would flow through this same correction mechanism. Demonstrating compliance will cause near constant reconciliation and could result in continued retroactive adjustments to capitations rates, resulting in additional administrative resources for health plans, states, and CMS. This overpayment/recoupment dynamic, and its interaction with incurred-but-not-reported claims reserving, is addressed in detail in Section 5.E below.

[7] 91 Fed. Reg. 30400, at 30405–06.

[8] 91 Fed. Reg. 30400, at 30402–03 (Background, Section I.D); see also Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 Fed. Reg. 41002 (May 10, 2024), https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf

[9] 42 CFR § 438.7, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7

Section 4: The Actuarial Soundness Framework

A. The Regulatory Framework: 42 CFR §§ 438.4–438.7

Section 438.4[10] defines actuarially sound capitation rates as those "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract." Rates must be developed in accordance with § 438.5 and generally accepted actuarial principles, must be appropriate for the populations and services covered, and must be developed so that the plan would reasonably be expected to achieve a medical loss ratio of at least 85 percent for the rate year.

Section 438.5[11] establishes rate development standards. It requires that rates be:

- based on the most recent three years of validated encounter or fee-for-service data and audited financial information for the population to be covered,
- non-benefit components reflecting reasonable administrative, tax, licensing, reserve, and risk margin costs,
- and developed from actual Medicaid, or comparable, population experience.

Every building block in § 438.5 — base data, trend, adjustments, non-benefit load — operates at the population level; and while certifying actuaries analyze and consider bill code level adjustments and repricing, § 438.5 does not require or suggest around bill code-level allowable payment variation tests.

Section 438.6[12] focuses on special contract provisions related to payment and it:

- defines "state directed payment" and "pass-through payment,"
- requires that SDPs be reflected in and reconciled through the certified capitation rate,
- imposes the current 100-percent-of-average-commercial-rate limit for the four historically covered service types, which was amended by the 2024 final rule.

Critically, the 2024 final rule defines "total payment rate" as an aggregate: the average rate paid across all providers in a specified provider class for a specified bill code or line-item discharge, inclusive of the effects of other SDPs and pass-through payments on that same class and bill code or line-item discharge.

Section 438.7[13] requires state actuaries to certify, and CMS to review and approve, capitation rates concurrent with contract review, with documentation sufficient for a reviewing actuary to evaluate the reasonableness of every adjustment.

Two structural features of this framework bear directly on the analysis in Section 5. First, the regulatory unit of measurement throughout §§ 438.4–438.7 is the capitation rate itself — a per-member-per-month ("PMPM") figure covering a defined population and time period, certified before the rating period begins — not a per-bill code payment. Nothing in § 438.4(a)–(b) references bill code-level or per-line-item discharge testing; the standard is inherently a population-based, aggregate, and prospective construct. Second, the "reasonable, appropriate, and attainable" standard in § 438.4(a) has historically been applied to SDPs specifically at the aggregate rate level, not the claims level. State Medicaid Director Letter #21-001 (January 8,

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[10] 42 CFR § 438.4, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4

[11] 42 CFR § 438.5, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.5

[12] 42 CFR § 438.6, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6

[13] See supra note 9.

2021)[14] required states to demonstrate that SDPs result in provider payment rates that are reasonable, appropriate, and attainable as part of the preprint review process, and the 2024 final rule codified this at § 438.6(c)(2)(ii)(I): each SDP must ensure that the total payment rate for each service and provider class — again, an aggregate, broad service-level figure, not a bill code-level figure — is reasonable, appropriate, and attainable. CMS-2449-P does not propose to change this underlying language; it changes how compliance with it is measured, substituting a per-bill code, per-line-Item discharge test for the aggregate test the standard was written to support.

All of this regulatory incongruence creates significant additional administrative burden which may require additional state and federal budget resources to administer.

B. Where the Data Does Not Exist: Concrete Proof Points

A per-bill code, per-line-item discharge compliance test is only as sound as the Medicare benchmark it relies upon. In a substantial number of cases relevant to hospital-based and non-hospital Medicaid providers alike, no such benchmark exists, or the benchmark that nominally exists is not derived from real Medicare claims experience. This is not a hypothetical concern; it is documented in CMS's rulemaking history and in the design of the coding and grouping systems the proposed rule would rely on. CMS states directly in the CMS-2449-P preamble that "many Medicaid benefits continue to lack a corresponding total published Medicare payment rate," specifically citing behavioral health/substance use disorder treatment and LTSS, including HCBS, and using the State plan approved rate as the fallback payment limit in those cases.

1. Deliveries and Maternal Health

Medicare does not maintain a payment infrastructure for routine labor, delivery, and maternal health services because its beneficiary population — individuals aged 65 and older, and individuals who qualify on the basis of disability or end-stage renal disease — does not, as a structural matter, include women of childbearing age giving birth in any material volume[15]. Medicaid, by contrast, finances approximately 41 percent of all births in the United States[16]. For a subset of inpatient visits that constitutes a substantial share of Medicaid hospital volume, there is, as a structural and permanent matter, no appropriate, bill code-level Medicare payment rate to test against — not a temporary data gap, but a permanent design feature of the Medicare program.

2. No Genuine Medicare Neonate DRG

The proposed rule's reliance on Medicare Severity Diagnosis-Related Groups ("MS-DRGs") for inpatient hospital compliance testing runs into the same structural problem at the code level. MS-DRGs group newborn and neonatal admissions into a total of seven diagnostic categories (MS-DRGs 789 through 795, Major Diagnostic Category 15)[17]. CMS has acknowledged, in its prior rulemaking, that these categories were never designed for, and have never been updated to reflect, the clinical and cost variation present in a non-Medicare, pediatric and neonatal population: "for this reason, we encourage those who want to use MS-DRGs for patient populations other than Medicare [to] make the relevant refinements to our system so it better

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[14] State Medicaid Director Letter #21-001 (Jan. 8, 2021), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf

[15] Medicare beneficiaries qualify by age (65+) or by disability/ESRD; newborns and birthing parents are not a population Medicare is designed to serve, except in rare dual-eligible or disability edge cases. See Q&A: Base MS-DRGs and the newborns/other neonates MDC, ACDIS, https://acdis.org/articles/qa-base-ms-drgs-and-newbornsother-neonates-mdc

[16] 91 Fed. Reg. 30400 (citing CMS's maternal health coverage statistics).

[17] Conditions that Impact MS-DRG Assignment for Newborns, MedLearn Publishing, https://medlearn.com/icd10monitor/conditions-that-impact-ms-drg-assignment-for-newborns/

serves the needs of those patients."[18] This is not a data-collection gap that better reporting would close. In the FY2026 IPPS final rule, CMS confirmed that a stable DRG weight requires a minimum of ten cases in the annual MedPAR claims file and identified nine MS-DRGs nationwide — seven of them the newborn and neonate codes at issue here — that fell below that threshold using FY2024 claims data alone. Where volume is insufficient to compute a weight directly, CMS's practice is to adjust the prior year's weight by the average percentage change across other DRGs rather than recompute it from current claims; the original low-volume DRG weights this adjustment methodology still carries forward were built by supplementing Medicare claims data with hospital records from Maryland and Michigan collected in the early 1980s, and have not been independently rebuilt since.[19,20] A "total published Medicare payment rate" for a neonatal admission is, in a meaningful sense, a mathematical placeholder rather than a market-tested benchmark.

The same mismatch recurs one level up, in how Medicare's payment system absorbs unusually high-cost cases. IPPS outlier payments — which CMS projects at roughly 5.1 percent of total IPPS operating payments for FY2026[21] — are governed by a fixed-loss cost threshold and a cost-sharing formula built around the distribution of costs Medicare observes. Because that distribution reflects a population with very few neonatal or pediatric admissions, the same threshold and cost-sharing terms would apply to Medicaid-heavy neonatal and pediatric cases without having been calibrated to their cost patterns. Medicare's new technology add-on payment process carries a related limitation: because that review is scoped to cost impact on the Medicare population, technologies that matter primarily for non-Medicare patients receive correspondingly limited review, so their cost may not be reflected in the published rate at all[22].

This illustrates a structural limitation in applying Medicare's MS-DRG's to a Medicaid population. Accuracy in setting SDP payment levels matters. Inaccuracy could cause arbitrary underpayments or overpayments that impact providers unevenly, creating financial pressure that could have downstream effects on access to care.

3. DRG Grouper Divergence: MS-DRG vs. APR-DRG

This gap is precisely why roughly half of state Medicaid programs do not use MS-DRGs for hospital payment at all. Instead, they use 3M's All Patient Refined Diagnosis-Related Groups ("APR-DRGs"), a substantially more

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[18] Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, 72 Fed. Reg. 47130, 47158 (Aug. 22, 2007); see also 69 Fed. Reg. 48916, 48939 (Aug. 11, 2004), both cited in Selection of a DRG Grouper for a Medicaid Population, https://www.azahcccs.gov/PlansProviders/Downloads/DRGGrouper.pdf

[19] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year (FY) 2026 Rates, 90 Fed. Reg. 36536 (Aug. 4, 2025) (finalizing a ten-case minimum threshold for computing a stable MS-DRG relative weight from the FY2024 MedPAR file, and identifying nine MS-DRGs nationwide that fell below that threshold, seven of them the newborn/neonate codes at issue here).

[20] See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1993 Rates, 57 Fed. Reg. 39758 (Sept. 1, 1992) (describing the low-volume DRG weight methodology, under which weights not directly computable from current Medicare claims are adjusted from the prior year's weight by the average percentage change across other DRGs; noting the original low-volume DRG weights were computed by supplementing Medicare claims data with hospital records from Maryland and Michigan, citing 48 Fed. Reg. 39768 (Sept. 1, 1983)).

[21] 90 Fed. Reg. 36536 (Aug. 4, 2025) (finalizing FY2026 IPPS operating outlier payments at approximately 5.1 percent of total operating payments); see also Outlier Payments, CMS, https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/outlier-payments

[22] See New Medical Services and New Technologies, CMS, https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/new-medical-services-and-new-technologies

granular system built specifically to capture severity of illness across the full population Medicaid actually serves — including neonates, pediatric patients, and obstetric patients — rather than the elderly and disabled population MS-DRGs were designed around[23]. Where MS-DRGs classify the entire newborn population into seven groups, APR-DRGs devote an entire major diagnostic category (MDC 15) to newborns alone, with 28 distinct base APR-DRGs in that category as of Version 20.0[24], further refined by birthweight range and gestational age. For a state whose managed care plans price and pay hospital claims using APR-DRG weights — as roughly half of all state Medicaid programs do — there is no direct, one-to-one crosswalk to an MS-DRG-based Medicare benchmark. Any such crosswalk would need to be constructed, would necessarily involve actuarial judgment and approximation rather than a clean lookup, and would produce a different result depending on the crosswalk methodology chosen — precisely the kind of judgment call the current aggregate, total-payment-rate standard was designed to avoid needing to make at the individual code or discharge level.

4. Code-Level Examples in Behavioral Health

Medicaid behavioral health and substance use disorder (SUD) benefits routinely use HCPCS Level II codes describing bundled or per-diem behavioral health services — for example, codes describing day treatment, per-diem residential SUD treatment, and certain community-based behavioral health services — that have no corresponding code, and therefore no corresponding published payment rate, on the Medicare physician fee schedule or any other Medicare fee schedule at all. Medicare's behavioral health benefit is narrower in scope and structured differently than Medicaid's, particularly with respect to substance use disorder treatment settings and HCBS-delivered behavioral supports, which Medicare simply does not cover as a benefit category. The following specific examples help illustrate the issue:

- HCPCS Level II "H" codes make the gap concrete at the individual code level. HCPCS H2036 ("Alcohol and/or other drug treatment program, per diem") carries a Medicare coverage indicator of "I" — not payable by Medicare — and no Medicare fee schedule amount has been assigned to it at all[25].
- HCPCS H0018 ("Behavioral health; short-term residential ... treatment program, without room and board, per diem") and H0019, its long-term residential counterpart, are billed almost exclusively to state Medicaid programs and community behavioral health payers and are not part of the Medicare physician fee schedule[26].
- HCPCS H0015 ("Alcohol and/or drug services; intensive outpatient") is likewise absent from Medicare's covered code set[27].

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[23] California Department of Health Care Services, Medi-Cal DRG FAQ (2022–23): "Half of Medicaid programs use All Patient Refined Diagnosis Related Groups (APR-DRG), rather than Medicare DRGs, because APR-DRGs are much more appropriate for neonatal, pediatric, and obstetric care. Medicare DRGs were designed for a Medicare population." https://www.dhcs.ca.gov/wp-content/uploads/2025/10/SFY2022-23-Medi-Cal-DRG-FAQ.pdf

[24] All Patient Refined Diagnosis Related Groups (APR-DRGs) Version 20.0: Methodology Overview and Bibliography, AHRQ HCUP, at 4–5, https://hcup-us.ahrq.gov/db/nation/nis/APR-DRGsV20MethodologyOverviewandBibliography.pdf

[25] HCPCS Code H2036: Alcohol and/or Other Drug Treatment Program, Per Diem, Pabau (identifying the code's CMS Medicare coverage designation as "I" — not payable by Medicare — with no Medicare fee schedule amount assigned), https://pabau.com/procedure-codes/hcpcs-code-h2036

[26] See, e.g., Residential CPT Codes: H0017-H0019, Behave Health, https://behavehealth.com/blog/understanding-hcpcs-and-cpt-billing-codes-for-residential-addiction-treatment-h0017-h0018-h0019; HCPCS Codes for Behavioral Health, Behave Health, https://behavehealth.com/blog/behavioral-health-hcpcs-codes-reference-guide

[27] HCPCS Codes Glossary Definition, Behave Health, https://behavehealth.com/glossary/hcpcs-codes

Where a Medicaid managed care plan's SDP directs payment for one of these services, there is no Medicare rate to test the per-bill code level payment against, and the proposed rule's state-plan-approved-rate fallback substitutes an entirely different type of benchmark for a subset of the same capitation rate's covered services.

5. Beyond-Hospital Provider Types

The Medicare comparison problem is not limited to hospitals. Home- and community-based services ("HCBS") waiver providers — personal care attendants, habilitation providers, respite providers — deliver a category of service for which Medicare has no genuine equivalent; Medicare's closest analogous benefits, home health and skilled nursing facility care, are post-acute and time-limited by design, not ongoing custodial or habilitative care. The following specific examples help illustrate the issue:

- HCPCS T1019 ("Personal care services, per 15 minutes"): T-codes are a series established by CMS specifically for use by state Medicaid agencies, which is precisely why no single national Medicare payment rate exists for T1019[28].
- HCPCS A0100 ("Non-emergency transportation, taxi") and the related state-specific code T2003 ("Non-emergency transportation, encounter/trip") are billed routinely to Medicaid but are generally not payable by Medicare, since Medicare's ambulance transportation benefit does not extend to routine non-emergency transportation by taxi, van, or public transit[29].

Non-emergency medical transportation, adult dental services, and doula and community health worker services — all common subjects of Medicaid SDPs — are similarly outside Medicare's covered-benefit structure altogether. Intermediate care facilities for individuals with intellectual disabilities ("ICF/IID") are a Medicaid-specific institutional benefit with no Medicare institutional analog whatsoever. For every one of these provider types, a per-bill code level Medicare benchmark is not merely difficult to construct — it does not exist, and the proposed rule's reliance on the state plan approved rate as a fallback means that an increasing share of a plan's capitation rate would be tested against a benchmark that has nothing to do with Medicare at all, which is in tension with the stated rationale for the rule.

C. ASOP 49: A Standard That Has Not Caught Up

ASOP No. 49[30], the actuarial standard most directly on point for Medicaid managed care capitation rate development and certification, was adopted in 2015 — before the 2016 Medicaid managed care final rule, before the 2020 and 2024 SDP rulemakings, and before any conception of a per-bill code or per-line-item discharge Medicare-based payment limit. The Actuarial Standards Board has a revision in progress: an exposure draft, retitled Medicaid Managed Care Capitation Rates, was approved for exposure in March 2026, with a public comment deadline of September 1, 2026[31]. That timing is instructive: the exposure draft was approved roughly two months before CMS-2449-P was published, meaning the task force that drafted it could not have been responding to the specific per-bill code/per-line-item discharge mechanism this report addresses. Neither version of ASOP 49 addresses aggregate-versus-per-bill code level compliance testing,

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[28] HCPCS Code T1019: Personal care services billing guide 2026, Pabau (noting that T-codes are maintained by CMS for use by state Medicaid agencies, "which is why you will not find a single national Medicare payment rate for T1019"), https://pabau.com/procedure-codes/hcpcs-code-t1019/

[29] HCPCS Code A0100: Non-Emergency Transportation; Taxi, Carepatron, https://www.carepatron.com/procedure-code/hcpcs-code-a0100/

[30] ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification (2015), https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf

[31] Actuarial Standards Board, Exposure Draft, Medicaid Managed Care Capitation Rates (proposed revision of ASOP No. 49) (approved for exposure March 2026), https://www.actuarialstandardsboard.org/wp-content/uploads/2026/06/ASOP-No.-49-exposure-draft_March-2026.pdf

Medicare-based payment limits, or anything resembling the mechanism CMS-2449-P proposes. That gap is not a defect in the actuarial standard; it reflects the fact that no such mechanism has previously existed for the standard to address.

Two features of the March 2026 exposure draft are nonetheless directly relevant to this report's analysis, and both point toward the need for CMS to conduct additional diligence before this kind of mandate can be squared with existing actuarial practice. First, the exposure draft's revision of the SDP-relevant provision (2015 § 3.2.6, "Special Payments") was undertaken specifically[32], to keep pace with "current federal nomenclature," and the resulting text is deliberately genericized — it no longer uses the term "state directed payment" or cites § 438.6(c) by section number at all. The standard, in other words, is being written to be more agnostic to the specific mechanics of any one CFR provision, even as CMS proposes a substantially more granular and mechanically specific compliance test under that same provision. Second, and more consequentially, the exposure draft's new § 3.4, "Qualified Opinion on Actuarial Soundness," was expanded to address situations where capitation rates are adjusted based on a mandate without an appropriate adjustment available under § 3.2 of the standard. The draft text states that the certifying actuary's opinion should be qualified if the capitation rates were developed based on a mandate without an appropriate adjustment. If a per-bill code, per-line-item discharge Medicare-based limit forces a payment change that cannot always be reconciled back into the PMPM through a legitimate rate-development adjustment — the precise conflict this report describes in Section 5 — the forthcoming guidance contemplates that the correct response may be a qualified opinion, not a clean certification of full actuarial soundness.

This is the through-line for Section 4: the actuarial standards governing this work have not been updated to contemplate a per-bill code level compliance mechanism, existing sub-regulatory guidance (addressed further in Section 5) has not been updated either, and the forthcoming revision to ASOP 49 — the profession's considered judgment about what good practice requires — points toward qualification rather than resolution as the likely consequence if CMS finalizes the per-bill code level approach without further work on solvency and methodological consistency. This underscores the importance of further clarification to ensure the rule and actuarial soundness certification work together as intended to support Medicaid managed care solvency.

D. Actuarial Soundness Is Measured in Aggregate, Not at the Hospital or Bill Code Level

Nothing in §§ 438.4–438.7 tests actuarial soundness at the individual hospital, provider, HCPCS code, or MS-DRG level. The unit of certification throughout is the capitation rate per rate cell — a population-based, prospective, PMPM figure. This is not merely an implication of the regulatory text; CMS has said so directly. In the 2024 final rule, CMS explained that § 438.6(c)(2)(ii)(B) gives states broader flexibility than the FFS UPL framework specifically because SDP compliance is not tied to the ownership-class structure used for aggregate FFS UPL testing — CMS stated it "could face challenges applying a similar UPL standard across provider classes under an SDP without some alignment between State-defined classes and the FFS UPL framework"[33]. In other words, CMS itself has previously reasoned — in a final rule published just two years before CMS-2449-P — that SDP compliance testing is structurally different from, and should be more flexible than, a service- or class-level FFS UPL test. CMS-2449-P does not address how the per-bill code level approach relates to this earlier reasoning. That tension, and its practical consequences, is the subject of Section 5.

[32] See ASOP No. 49 Exposure Draft Transmittal Memo, under "Request for Comments" #3

[33] 89 Fed. Reg. 41002, at 41057

Section 5: The Structural Conflict

This section identifies the structural conflicts between the proposed per-bill code/per-line-item discharge compliance framework and the actuarial soundness standard described in Section 4.

A. Prospective Rate Certification vs. Retrospective Per-Bill Code Level Testing

Sections 438.4(a)–(b) and 438.7(a) require prospective certification of the composite PMPM capitation rate before the rating period begins. The preamble to CMS-2449-P acknowledges a direct consequence of this timing for a subset of providers: certain Medicare providers — critical access hospitals, certain cancer hospitals, freestanding children's hospitals — are paid on a retrospective cost-report reconciliation basis rather than a prospectively published rate[34]. CMS states this "poses operational and policy concerns for determining compliance with the applicable payment limit for SDPs," precisely because Medicaid managed care capitation rates — and, beginning with rating periods on or after July 9, 2026, SDP preprints must be submitted prospectively. CMS's proposed workaround, using the most recent complete Medicare cost report (as validated by CMS) to derive a prospective per-bill code level equivalent, is an acknowledgment that a genuine prospective/retrospective mismatch exists; it is a technical patch for a subset of providers, not a resolution of the underlying design problem. The workaround also leaves at least two mechanical gaps unaddressed: it does not describe any trend or inflation adjustment to bring a historical cost report forward to the rating period it would govern, and it does not address how a prospective limit would be established for a hospital with no historical Medicare cost report to draw from at all, such as a newly opened facility or one that has recently changed ownership. A capitation rate certified as actuarially sound prospectively could later be shown, bill code by bill code, to have funded payments above the limit once updated Medicare rates or reconciled cost reports become available — a structurally retrospective test bolted onto a prospective certification, and one that compounds for every rating period in which Medicare's annual rule cycle does not align with the state's Medicaid rating period.

B. PMPM Rate Development vs. Per-Bill Code Level Compliance

Section 438.5's entire rate-build methodology — base data, trend, adjustments — operates at the population and aggregate level. CMS's 2026–2027 Medicaid Managed Care Rate Development Guide[35], confirms this directly: its SDP documentation section instructs a state's actuary to demonstrate how an SDP's expected cost impact — developed from the utilization and delivery of services under the managed care contract — is loaded into the composite PMPM alongside base data, trend, non-benefit costs, and risk adjustment. The RDG's entire SDP framework is built around demonstrating that an SDP's aggregate cost impact on the composite PMPM is reasonable, appropriate, and attainable, consistent with the current, aggregate "total payment rate" test. The RDG does not, as of this writing, contain any methodology for testing per-bill code or per-line-item discharge compliance against a Medicare benchmark, because no such test has previously existed.

This is not a documentation oversight that a future update could quickly fix; it reflects the absence of any established actuarial methodology, anywhere in the current regulatory, sub-regulatory, or actuarial-standards framework, for translating a per-code or per-discharge pass/fail result into a population-level PMPM adjustment. A capitation rate is not simply a sum of its constituent per-bill code prices — it reflects

[34] 91 Fed. Reg. 30400, at 30414.

[35] Centers for Medicare & Medicaid Services, 2026–2027 Medicaid Managed Care Rate Development Guide (Feb. 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/2026-2027-medicaid-rate-guide-022026.pdf

utilization, case mix, trend, and risk adjustment applied at the population level. There is no established bridge between "this HCPCS code exceeded the Medicare-based limit for this provider class in this rating period" and "the composite PMPM rate should therefore be adjusted by this amount." Until such a bridge exists, a per-bill code level compliance determination and a PMPM rate certification are, in a meaningful actuarial sense, answering two different questions in two different units of measurement.

A related but distinct problem is statistical credibility. Population-level PMPM rate development pools utilization and cost data across an entire rate cell specifically so that random claims fluctuation washes out — the foundational premise behind ASOP No. 25's credibility-procedures guidance, which § 438.5 rate development already relies on for base-data adjustments. Testing compliance at the individual HCPCS code or MS-DRG level necessarily shrinks the underlying data pool for many services: a lower-volume code, a smaller provider class, or a less common discharge type may have too few claims in a given rating period to produce a statistically credible per-bill code average, even where the same underlying data is perfectly adequate at the aggregate PMPM level. ASOP No. 25 would ordinarily direct an actuary in this situation to blend limited experience with other relevant data, or to apply an explicit credibility weighting; the proposed per-bill code/per-line-item discharge limit does not appear to contemplate any such adjustment — a service either falls under the Medicare-based limit or it does not, based on whatever per-bill code data happens to exist, however thin. This compounds the reconciliation problem above: not only is there no established method for translating a per-bill code level test back into the PMPM, but the per-bill code level test itself may, in a material number of cases, be applied to samples too small to be actuarially credible in the first place.

1. Claims-Payment Structures That Cannot Be Repriced to Medicare at All

A further, and in some respects more basic, implementation problem is that a meaningful share of Medicaid payment arrangements are not structured in a way that can be repriced against a per-bill code level Medicare rate. Sub-capitated behavioral health, dental, and vision arrangements pay a downstream entity a fixed PMPM to assume risk for an entire category of service. While states typically require the downstream entity to submit bill code-level encounter data with an associated shadow-priced or estimated value under § 438.5, that valuation is not an actual payment—the real transaction is the capitated PMPM, which is not directly tied to any individual bill code's price. Nursing facility and ICF/IID per diem rates, similarly, are single, all-inclusive daily rates that bundle room and board, nursing, therapy, and ancillary services into one number; Medicare's skilled nursing facility per diem, where one exists at all, is built on an entirely different case-mix methodology (the Patient-Driven Payment Model) designed around a post-acute, time-limited population, not the long-stay custodial population Medicaid nursing facility rates are built to cover. Global budget and delegated capitation arrangements with federally qualified health centers and rural health clinics raise a related problem in the opposite direction: CMS has separately confirmed that the statutorily-required prospective payment system ("PPS") rates paid to FQHCs and RHCs are not considered SDPs at all[36], meaning a meaningful share of Medicaid provider payment already sits entirely outside the SDP framework this rule amends, using CMS's statutorily-mandated payment methodology that was never designed to be, and cannot readily be, expressed as a percentage of a Medicare per-bill code level rate. In each of these cases, the inability to effectuate a per-bill code level Medicare comparison is not a data problem to be solved with better reporting; it is a mismatch between the unit CMS proposes to measure (the individual bill code or line-item discharge) and the unit the payment arrangement is actually built around (the capitated life, the resident-day, or the statutorily fixed encounter rate).

[36] 42 CFR § 438.6(a) (defining "pass-through payment" to exclude GME payments and FQHC or RHC wrap-around payments, and separately excluding payments to FQHCs and RHCs from the base data used to develop a State directed payment); Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 Fed. Reg. 41002 at 41045 (May 10, 2024), https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf

2. Data Collection Burden

Independent of whether a Medicare-comparable benchmark exists, the proposed § 438.6(c)(8) compliance framework would require states to compile and submit, for every SDP, an NPI-level list of every eligible provider together with the specific per-bill code or per-line-item discharge Medicare or state-plan rate basis used to test compliance. For an SDP that reaches a broad provider class across hundreds of HCPCS codes or MS-DRGs — which describes the large majority of SDPs currently in effect — this is a materially larger and more granular data-assembly exercise than anything the current aggregate total-payment-rate demonstration requires, which tests a single class-average figure against a single benchmark rather than testing every code, for every provider, individually. States and their actuaries would need to build and maintain crosswalks between whatever grouper or code set the state's payment methodology uses (which, as discussed above, is frequently APR-DRG rather than MS-DRG, or a state-specific fee schedule with no direct Medicare code equivalent) and the Medicare code set the rule requires for compliance testing. This is a recurring, rating-period-by-rating-period burden, not a one-time build, because both the state's payment methodology and Medicare's fee schedules and DRG weights update on independent annual cycles.

C. The Medicare Comparison Problem in the SDP Compliance Context

Section 4.B above documents, in granular and code-level detail, why a Medicare benchmark frequently does not exist. The actuarial soundness implication of that gap is explained here. CMS states directly in the CMS-2449-P preamble that "many Medicaid benefits continue to lack a corresponding total published Medicare payment rate," specifically citing behavioral health and substance use disorder treatment and LTSS, including HCBS, and identifying the state plan approved rate as the fallback payment limit in those cases[37]. Supporting population-level data from KFF underscore the scale of the gap: roughly 5.6 million Medicaid enrollees used LTSS in 2020, with 72 percent using HCBS exclusively[38], and Medicaid — not Medicare — pays 61 percent of the $459 billion spent nationally on long-term care[39]. Medicare's LTSS-adjacent coverage is a post-acute, time-limited benefit, not a benefit for ongoing custodial or habilitative need, meaning there is generally no Medicare rate functionally comparable to an ongoing HCBS personal-care or waiver service, even where a superficially similar CPT or HCPCS code exists on paper.

CMS's proposed fallback — 100 percent of the state plan approved rate where no Medicare rate exists — does not resolve the actuarial soundness question; it relocates it. The issue is not merely that a Medicare rate is unavailable for a given code. It is tying the SDP limit, bill code by bill code, to whichever benchmark happens to exist — Medicare where available, the state plan rate where not — is difficult to reconcile with a rate-development process under § 438.5 that is built around population-level trend and utilization for a defined, aggregate set of covered benefits. A single plan's PMPM blends Medicare-comparable and non-comparable services in proportions that vary by rate cell, by population, and by year; the per-bill code level test, by design, has no aggregate or PMPM analog to reconcile that blend back to.

D. Value-Based Payment Incompatibility

By design, value-based payment ("VBP") arrangements — population-based payment, performance-based payment, shared savings and shared risk arrangements — decouple payment from individual service units. That decoupling is the entire premise of the model: it rewards outcomes and total cost of care rather than the

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[37] 91 Fed. Reg. 30400, at 30407.

[38] How Many People Use Medicaid Long-Term Services and Supports and How Much Does Medicaid Spend on Those People?, KFF, https://www.kff.org/medicaid/how-many-people-use-medicaid-long-term-services-and-supports-and-how-much-does-medicaid-spend-on-those-people/

[39] Medicaid 101, KFF, https://www.kff.org/medicaid/health-policy-101-medicaid/

volume or unit price of any single service. A hard per-bill code or per-line-item discharge cap tied to a fixed percentage of Medicare leaves no headroom to pay a quality bonus, a shared-savings distribution, or any other outcomes-based payment above the Medicare-equivalent rate for any individual underlying service, even where the aggregate VBP arrangement remains actuarially sound, and reasonable, appropriate, and attainable, in total. Myers and Stauffer's client alert on the proposed rule[40]— written by a firm that performs this actuarial work for states — flags this as an open, unresolved implementation question: "How are value-based payment SDPs (population-based payment, performance-based payment) to be reconciled to a per-service limit?", noting that "CMS's proposed validation methodology requirement is conceptually clear, but actuaries and state staff will need detailed sub-regulatory guidance on what acceptable validation looks like".

A related problem arises independent of VBP structure. Capitation rate development routinely varies payment within a single code or DRG based on legitimate case-mix and severity differences — a higher-acuity patient can appropriately generate a higher payment for the same billing code without any actuarial soundness concern, since § 438.5's rate-build methodology is specifically designed to price that variation at the population level. A flat per-bill code level Medicare-equivalent ceiling does not distinguish between a payment that is too high because it reflects inefficiency and one that is higher because it reflects appropriate acuity-based variation; both would appear identical under a per-bill code level test. This is the same problem VBP arrangements face, applied to case-mix rather than outcomes.

Medicare's mandatory episode-based payment models illustrate exactly how opaque this reconciliation problem becomes once bundled or total-cost-of-care payment is layered onto a fee-for-service chassis. Medicare's current mandatory bundled payment model, the Transforming Episode Accountability Model ("TEAM"), effective January 1, 2026, holds participating hospitals accountable for a 30-day episode spanning a surgical procedure and all related post-acute care, with a target price reconciled retrospectively against actual episode spending[41]. TEAM's predecessor, the Comprehensive Care for Joint Replacement ("CJR") model, which TEAM replaces, used a 90-day post-discharge episode window on the same basic design. In both models, the individual services rendered during the episode — the inpatient DRG, the post-acute skilled nursing stay, the follow-up visits — continue to be billed and initially paid through ordinary fee-for-service and DRG mechanisms, but the net economic payment to the hospital is only known after a retrospective reconciliation against a target price that is not itself published as a per-bill code or per-line-item discharge rate anywhere in Medicare's public fee schedules. A Medicaid SDP built around an analogous total-cost-of-care or episode arrangement faces the identical problem CMS's payment models create for themselves: there is no single, clean, publicly published "total published Medicare payment rate" to test an episode-based Medicaid payment against, because Medicare's comparable arrangement does not price the episode that way either. The separate payment terms embedded in the reconciliation formula — the target price methodology, the risk adjustment, the quality-score adjustment to the reconciliation amount — are, from the outside, opaque in exactly the way a simple HCPCS or DRG fee schedule is not.

1. Enhanced Fee Schedule vs. Core Code Splits

A further wrinkle specific to VBP and quality-incentive SDPs is that many states pay providers using a split structure: a base, or "core," Medicaid fee schedule amount for a given code, plus a separate enhanced or supplemental add-on layered on top through the SDP. New Jersey's approved outpatient hospital SDP, for example, pays a base Medicaid outpatient rate plus a separate SDP add-on averaging approximately $956.80 per visit at public facilities and $212.55 per visit at private facilities[42]. CMS's existing FFS supplemental

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[40] CMS Proposes Major Changes to Medicaid Managed Care State Directed Payments, Myers and Stauffer, https://myersandstauffer.com/insights/cms-proposes-major-changes-to-medicaid-managed-care-state-directed-payments-and-medicaid-fee-for-service-targeted-medicaid-practitioner-payments/

[41] TEAM (Transforming Episode Accountability Model), CMS, https://www.cms.gov/priorities/innovation/innovation-models/team-model

[42] New Jersey Medicaid Fee Schedule 2026, citing CMS Approval Letter for NJ State Directed Payments, https://checkmedicaid.com/new-jersey-medicaid-fee-schedule/

payment demonstration guidance separately recognizes this split-structure problem, requiring states to specify whether "supplemental/enhanced payment is made on a per code payment ceiling basis or is based on the aggregate"[43]. A per-bill code level Medicare comparison test does not, on its face, indicate whether the "total payment rate" to be tested is the core code payment alone, the enhanced add-on alone, or the sum of the two — and the answer may matter considerably, since a core-plus-enhanced structure that is entirely reasonable in the aggregate could appear to breach a per-bill code limit if only one of the two components is tested, or could mask a genuine problem if the two are simply summed without regard to how each component is actually triggered and paid.

E. Overpayment, Recoupment, and IBNR Distortion

As described in Section 3, the retroactive-adjustment mechanism in § 438.7(c)(5)–(6) is the operative pathway for unwinding an SDP later found to have exceeded the per-bill code limit. Claims are paid by MCOs in good faith against a certified PMPM rate; a later determination — whether on audit, or once updated Medicare rates or reconciled cost reports become available, often two to three years down the road, — that certain per-bill code level payments breached the limit does not necessarily change the total plan liability already incurred, but it does implicate the "material error" correction pathway and future rate certifications, notwithstanding that the original rate certification was actuarially sound as certified at the time, using the best information available. ASOP No. 5's guidance on incurred-but-not-reported and incomplete claims adjustments is the relevant actuarial mechanism for how this kind of retrospective correction would need to be reserved for and reflected in subsequent rate certifications — but ASOP 5, like ASOP 49, was not written with a per-bill code, per-line-item discharge compliance test of this kind in view, and provides no specific methodology for how large or how far back such a correction should reach once a state's or a plan's per-bill code level compliance is retested against updated Medicare data years after the original claims were paid.

F. Why the Existing Aggregate Approach Aligns with Actuarial Soundness, and the Per-Bill Code Level Approach Does Not

Every conflict identified in this section traces back to the same root cause: CMS has proposed to replace an aggregate, class-based compliance test with a per-bill code, per-line-item discharge test, without reconciling that change to the population-based, prospective architecture the rest of Medicaid managed care actuarial soundness regulation is built on. The existing regulatory architecture that CMS-2449-P amends was built around class-average, aggregate testing, and CMS has previously defended that design choice on the merits, for reasons that remain sound today.

First, the existing "total payment rate" definition at § 438.6(a) is already an aggregate construct — the average rate paid across all providers in a specified provider class for a specified service. This aligns naturally with § 438.4's population-based, PMPM actuarial soundness standard, because both operate at the same level of aggregation, making reconciliation between the SDP compliance test and the composite capitation rate straightforward in a way the proposed per-bill code level test is not. Second, CMS's FFS UPL framework is the model for what an aggregate approach looks like, and CMS has explained why it is appropriate there: UPLs apply an aggregate payment ceiling based on an estimate of what Medicare would pay in total for a broad service category, while allowing facility-specific payments within that broad service category to vary "sometimes widely," so long as the aggregate service-wide total does not exceed the aggregate ceiling. This preserves the flexibility that individual facility-level variation often requires — for accurate cost-based reimbursement, for safety-net targeting, or for quality incentives — while still constraining total program spending. Third, and most directly on point, CMS has previously and explicitly reasoned that SDP compliance testing should be more flexible than the FFS UPL's aggregate ownership-class structure, not tied to a more

[43] Methodologies for Enhanced Payment Made to Physicians and Other Practitioners, CMS, https://www.medicaid.gov/medicaid/downloads/upl-instructions-qualified-practitioner-services-replacement-new.pdf

granular test: in the 2024 final rule, CMS explained that § 438.6(c)(2)(ii)(B) gives states broader flexibility than FFS UPL requirements specifically because SDP provider classes are not required to track the FFS UPL's ownership-based classes, since CMS "could face challenges applying a similar UPL standard across provider classes under an SDP without some alignment between State-defined classes and the FFS UPL framework." This is CMS's, relatively recent, articulated rationale for why an aggregate, class-based test — not a more granular one — is the appropriate way to measure SDP compliance with the reasonable, appropriate, and attainable standard.

The case against the per-bill code level alternative, correspondingly, has four independent legs, each developed at length above:

- **Level-of-aggregation mismatch**. § 438.4's standard is defined and measured at the PMPM level while a per-bill code level test is defined and measured at the individual-claim level, with no established methodology anywhere in the CFR, CMS's sub-regulatory guidance, or ASOP 49 (in either its current or exposure-draft form) for translating one into the other;
- **Timing mismatch.** Capitation rates are certified prospectively while a per-bill code level test measured against annually updating Medicare fee schedules and inherently retrospective cost reports can only be fully evaluated after the fact;
- **Heterogeneity-of-benchmark problem.** Some bill codes have a Medicare rate and others do not, forcing two different types of benchmarks into a single capitation rate that is otherwise built and tested as one coherent, population-level unit;
- **Loss of headroom for value-based arrangements.** A hard per-bill code level ceiling removes the flexibility VBP arrangements need to reward quality and outcomes above a fixed unit-price benchmark, even where the aggregate arrangement remains reasonable, appropriate, and attainable.

The actuarial profession's forward-looking guidance — the ASOP 49 exposure draft's new qualified-opinion provision discussed in Section 4.C — contemplates that a mandate that cannot be reconciled through a standard rate-development adjustment may simply not be certifiable as fully actuarially sound using the tools available to actuaries today. Taken together, these four problems are not incidental implementation friction; they are the direct and foreseeable consequence of abandoning the aggregate architecture that made SDP compliance testing compatible with actuarial soundness certification in the first place.

Section 6: Identified Areas for CMS to Address

The conflicts identified in Section 5 do not require CMS to abandon its underlying policy objective of constraining SDP spending relative to Medicare. They do require CMS to resolve a specific set of methodological and operational questions before a per-bill code or per-line-item discharge compliance framework can be implemented in a manner consistent with the actuarial soundness standard. This section identifies those items.

Absent this foundational work, states and their actuaries would be left to develop divergent, ad hoc approaches to each of these questions independently, undermining the very consistency and fiscal integrity goals the proposed rule is intended to advance.

A. Medicare Benchmark Definition

CMS's preamble addresses part of this question: the "total published Medicare payment rate" at § 438.6(a) "may include applicable Medicare payment adjustments, including but not limited to geographic and quality adjustments," and is "inclusive of all components included in the rate developed by CMS for Medicare payment"[44]. In practice, this means that Medicare's inpatient prospective payment system rate — which already embeds indirect medical education and disproportionate share hospital adjustments as components of the per-discharge payment — would flow through as part of the benchmark. What the preamble does not address is how Medicaid-specific supplemental payment streams that exist entirely outside the Medicare rate structure — Medicaid DSH, Medicaid GME paid outside of any Medicare-linked calculation, and FQHC/RHC wraparound payments — are meant to interact with the new per-bill code level SDP limit.

Identified area for CMS to address: Clarification on whether these payments are additive to, netted against, or wholly independent of the per-bill code level benchmark, since they already exist alongside SDPs under separate regulatory authority and are not addressed by this rulemaking at all.

A related definitional gap arises in the grandfathering phase-down. A grandfathered SDP program may span multiple service classes with different relationships to the Medicare benchmark — for example, inpatient payments above the applicable Medicare limit and outpatient payments below it — raising a question of how the phase-down should be applied across those classes.

Identified area for CMS to address: Clarification on whether the required 10-percent annual reduction applies to the program's total grandfathered amount or separately to each service class within it.

This ambiguity is a direct extension of the benchmark-definition question above: a single, program-wide phase-down percentage assumes a level of aggregation that the per-bill code level compliance test elsewhere in the rule does not otherwise permit.

B. Methodology for Services with No Medicare Equivalent

As documented at length in Sections 4.B and 5.C, CMS's proposed fallback — 100 percent of the state plan approved rate where no Medicare rate exists — answers the question of which number to use, but not the deeper actuarial soundness question of whether a blended, bill code-by-bill code benchmark test, alternating between a Medicare rate and a state plan rate depending on the bill code, is compatible with population-level PMPM rate development under § 438.5.

Identified area for CMS to address: Propose methodology for how an actuary should treat a capitation rate that blends Medicare-comparable and non-comparable services under this dual-benchmark structure, and propose methodology for handling the DRG-grouper divergence (MS-DRG versus APR-

[44] 91 Fed. Reg. 30400, at 30413 (citing 89 Fed. Reg. 41002, 41049 (May 10, 2024)).

DRG) documented in Section 4.B, which affects roughly half of state Medicaid hospital payment systems.

C. How Per-Bill Code Level Limits Interact with Prospective PMPM Rate Certification

CMS has proposed a technical workaround only for the narrow case of cost-based, non-PPS providers, using the most recent complete, CMS-validated Medicare cost report to derive a prospective per-bill code level equivalent. Even the timing of the benchmark is unsettled: the proposed rule does not clearly state whether the applicable Medicare rate is the one in effect when a state submits its SDP preprint or the one in effect during the actual year of service — a distinction that matters given CMS's emphasis on rates being set in advance of the rating period. More broadly, the proposed per-bill code or per-line-item discharge payment limit is fundamentally a retrospective test - a compliance determination that may not be fully knowable until after a Medicare rate update or a cost-report reconciliation, which usually doesn't happen until two to three years down the road - while Medicaid managed care capitation rates must be certified as actuarially sound prospectively. This is not solely a hospital-sector problem — it recurs anywhere a state's payment methodology, Medicare's corresponding fee schedule, and the Medicaid rating period do not share a common effective date or finalization timeline, which describes most of the Medicaid managed care landscape.

Identified area for CMS to address: Propose general framework for resolving a timing mismatch. A comprehensive resolution would need to address, at minimum:

- **Whether the applicable Medicare rate for a per-bill code level compliance determination is the rate in effect at SDP preprint submission or the rate in effect during the actual year of service;**
- **How a per-bill code level compliance determination that cannot be finalized until after a Medicare rate update or cost-report reconciliation is to be treated for purposes of a capitation rate that must be certified before the rating period begins;**
- **Whether and how a state's rating period could be aligned, or a grace period built in, to accommodate Medicare's independent annual rulemaking cycle; and**
- **Whether retrospective per-bill code level findings should ever reopen a capitation rate that was actuarially sound as certified, given the "material error" limitation on retroactive adjustments under § 438.7(c)(5) discussed in Section 3 and Section 5.E.**

Absent such a framework, the narrow cost-report workaround CMS has proposed addresses one symptom of the timing conflict without resolving its cause.

One way to resolve this issue would be for CMS to adopt the UPL estimate at point in time standard instead of requiring reconciliation to a fully audited Medicare rate. The Medicaid upper payment limit (UPL) for institutional FFS providers is defined at 42 CFR §§ 447.321 as "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles," calculated from the most recent available data at the time of each demonstration, with no requirement that the estimate later be reconciled to actual, finalized Medicare payment data[45] . Adapting this point-in-time estimate standard to the per-bill code level SDP limit would let CMS test compliance against the best available data at the time of certification, consistent with how Medicaid FFS already treats the same underlying Medicare-comparison problem, rather than requiring the kind of ongoing reconciliation to updated or audited Medicare rates that creates the timing conflict described above.

[45] 42 CFR § 447.321(b); see also MACPAC, Upper Payment Limit Supplemental Payments (Nov. 2021), https://www.macpac.gov/wp-content/uploads/2021/11/Upper-Payment-Limit-Supplemental-Payments.pdf (states submit UPL demonstrations using available data prospectively, with no subsequent reconciliation to actual Medicare payment data).

D. Whether the Rate Development Guide Needs Updating

CMS's 2025–2026 Rate Development Guide has not been updated to address per-bill code or per-line-item discharge SDP compliance testing at all; its SDP documentation section is built entirely around the current aggregate total-payment-rate test. If CMS-2449-P is finalized as proposed, the RDG's SDP documentation section would need substantial revision to instruct actuaries how a bill code- or line-item discharge-level compliance test interacts with, or is reconciled to, the composite PMPM rate-development methodology the rest of the RDG describes. This is a concrete, verifiable gap in CMS's existing sub-regulatory guidance, not a speculative one, and it would need to be resolved — through notice-and-comment rulemaking or through a subsequent RDG update — before states' actuaries would have any CMS-sanctioned methodology to follow.

Identified area for CMS to address: Substantial revision to the Medicaid Managed Care Rate Development Guide's SDP documentation section instructing actuaries how a bill code- or line-item discharge-level compliance test interacts with, and is reconciled to, the composite PMPM rate-development methodology the rest of the RDG describes. This revision should occur with enough time for states to implement ahead of the new rule's effective date.

E. Who Validates Per-Bill Code Level Compliance, and Under What Standard

The proposed rule specifies actuarial certification in some places and not others. Beginning with the first rating period on or after January 1, 2027, states must submit a total payment rate comparison for grandfathered SDPs, expressed as a percentage of the total Medicare payment rate, certified by an actuary — consistent with the existing model, under which the current "final State directed payment cost percentage" at § 438.6(c)(7)(iii) is likewise actuary-certified. The new, general § 438.6(c)(8) compliance mechanism, by contrast, requires an NPI-level provider list, the per-bill code level Medicare or state-plan rate basis, and, for VBP-structured SDPs, a validation methodology — but nowhere assigns this validation to an actuary or ties it to any stated professional standard. Myers and Stauffer's client alert states that "actuaries and state staff will need detailed sub-regulatory guidance on what acceptable validation looks like"[46] — a statement that only makes sense if the rule has not yet designated who performs or certifies this validation. The existing actuarial soundness architecture is internally consistent about assigning this kind of responsibility to a credentialed actuary operating under ASOP 49 (with ASOPs 23, 25, and 41 by cross-reference); the new per-bill code level validation mechanism sits entirely outside that architecture, and CMS would need to resolve, at minimum, whether this validation is intended to be actuarial work at all, and if so, how it reconciles to the actuary's existing aggregate PMPM certification under §§ 438.4 and 438.7. It is telling that CMS did not attempt to fold per-bill code level compliance into the existing § 438.7 capitation rate certification that every other actuarial soundness determination runs through. Instead, CMS proposed an entirely separate, parallel actuary-certified comparison — the grandfathered-SDP total payment rate comparison under § 438.6(c)(2)(iii)(D) — bolted onto, rather than integrated with, the existing rate-certification framework. CMS's decision to create a separate mechanism for the grandfathered SDP comparison, rather than incorporate per-bill code level testing into the existing rate certification process suggests that the existing framework was not designed to perform per-bill code level equivalence testing.

Identified area for CMS to address: An explicit determination of whether per-bill code level validation under § 438.6(c)(8) is intended to be actuarial work governed by ASOP 49, and if so, how it reconciles to the actuary's existing aggregate PMPM certification under §§ 438.4 and 438.7.

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[46] CMS Proposes Major Changes to Medicaid Managed Care State Directed Payments, Myers and Stauffer, https://myersandstauffer.com/insights/cms-proposes-major-changes-to-medicaid-managed-care-state-directed-payments-and-medicaid-fee-for-service-targeted-medicaid-practitioner-payments/

F. SDP Preprint Locked Base Payment Clarification

The SDP preprint's total payment rate comparison — the mechanism through which a state demonstrates that base payment plus the SDP effect will not exceed the applicable payment limit — is prepared and submitted as of a specific point in time, tied to the SDP preprint's submission, renewal, or amendment[47]. Base payment, for this purpose, is the rate a managed care plan and a provider negotiate directly, independent of any SDP; it is not itself subject to preprint review or approval, and it can change through ordinary contracting between preprint submissions, particularly for SDPs approved for multi-year terms that may span more than a single rating period.

The proposed rule does not address what happens when that renegotiation occurs after a state's total payment rate comparison has been submitted and approved. If a plan's base payment for a covered bill code increases after the point at which the comparison was locked in, the combined base-plus-SDP payment could exceed the applicable Medicare-based limit without triggering any required re-demonstration, since compliance testing under the proposed rule is tied to preprint submission and renewal rather than to continuous monitoring of the underlying base payment.

Identified area for CMS to address: Clarification on whether, and how, a state is expected to monitor or account for changes to the negotiated base payment that occur after the total payment rate comparison has been submitted, and whether a base payment increase occurring between preprint submissions that pushes combined payment above the applicable Medicare-based limit constitutes a compliance failure under the proposed rule.

G. Administrative Burden and Operational Feasibility

Every item above carries an administrative burden that the current, aggregate methodology does not impose, and that burden falls on states, MCOs, and CMS's review staff. The current total-payment-rate test requires a state to demonstrate a single class-average figure against a single benchmark for each SDP The proposed per-bill code level framework would require, for every SDP, an NPI-level provider list, a per-bill code or per-line-item discharge rate basis, and — where the state's payment methodology does not natively use Medicare's code set or DRG grouper — a constructed crosswalk between the two, refreshed every rating period as both systems update independently.

For a large SDP reaching a broad provider class across hundreds of codes, this is not an incremental increase in documentation; it is a categorically different scale of data assembly, actuarial judgment, and CMS review capacity than the current framework requires. CMS's preprint review process for SDPs already takes considerable time under the current, single-benchmark methodology; a compliance framework requiring per-bill code level validation would, absent a significant expansion of review capacity and a clearly defined validation methodology, risk materially slowing SDP approvals — with corresponding effects on providers awaiting approved rate increases and on states' ability to implement time-sensitive delivery-system reforms.

It is worth stating plainly that the current aggregate methodology has operated for years without imposing this burden and does so while still constraining SDP spending relative to a defined benchmark — the average commercial rate limit that already applies to the four largest SDP-spending service categories.

Identified area for CMS to address: A reasoned justification for why the incremental fiscal benefit of a per-bill code, per-line-item discharge test justifies its incremental and significant cost in data burden, review capacity, and actuarial uncertainty, relative to a more granular but still aggregate refinement of the existing average-commercial-rate methodology. CMS has not, in this proposed rule, articulated a case that the current aggregate approach is failing to achieve its fiscal integrity purpose in a way that would justify this categorically different, and categorically more burdensome, replacement.

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[47] 91 Fed. Reg. 30400, at 30405

H. Validation Methodology for Value-Based Payment and Episode-Based SDPs

Section 5.D documents that value-based payment and episode-based SDPs — including Medicaid arrangements modeled on Medicare's own mandatory bundled-payment models — decouple payment from individual service units by design, and that the proposed rule does not explain how a bundled or total-cost-of-care arrangement is to be tested against a limit defined at the individual bill code or discharge level. The proposed rule's general validation methodology requirement under § 438.6(c)(8) does not address this case specifically, leaving states and their actuaries without a defined path for demonstrating compliance for exactly the payment arrangements the rule is intended to encourage.

Identified area for CMS to address: A defined validation methodology for VBP and episode-based SDPs, addressing how a bundled or total-cost-of-care arrangement is to be tested against a per-bill code level limit at all.

Section 7: Conclusion

This report has evaluated CMS-2449-P's proposed per-bill code and per-line-item discharge payment limit against the actuarial soundness standard that has governed Medicaid managed care capitation rates since 2003. That standard was built, and has consistently been applied by CMS itself, as a population-level, aggregate, prospective test. The per-bill code and per-line-item discharge compliance mechanism CMS-2449-P proposes departs from that architecture in ways this report has documented in detail:

- it relies on Medicare benchmarks that do not exist for a substantial share of Medicaid-covered bill codes and provider types;
- it is fundamentally a retrospective compliance test layered onto a rate-setting process that must be certified prospectively, and in some cases, may not be reconciled with prospective PMPM rate certification in a straight-forward manner using established actuarial methodology;
- it removes the flexibility value-based payment arrangements depend on, pushing states back toward fee-for-service reimbursement;
- it leaves open basic questions about who is responsible for validating compliance and under what professional standard; and
- It would impose a substantial administrative burden on states, health plans, and CMS, in practice requiring capitation rates to be certified twice.

None of this means CMS's underlying objective — constraining SDP spending relative to a defined, Medicare-anchored benchmark — is unachievable. The existing aggregate, total-payment-rate framework already does that, and this report has identified specific, addressable steps CMS could take to refine it further without abandoning the population-level architecture that actuarial soundness certification depends upon.

This report explains that the per-bill code and per-line-item discharge approach, as proposed, is not ready to be finalized in its current form. The timeline for finalizing this rule also does not appear to leave CMS enough time to resolve the items identified in Section 6, or leave states, health plans, and their actuaries enough time to implement a final rule in an actuarially sound manner. Addressing the items identified in Section 6, and providing the additional sub-regulatory guidance, methodology, and lead time necessary for actuarially sound implementation, could require more time than the current timeline for finalizing this rule appears to allow. One possible path forward would be for CMS to consider delaying the rule's effective date until that work is complete.