REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

July 21, 2026

Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Parts 438 and 447
Attn: CMS-2449-P
RIN 0938-AV69

Submitted via regulations.gov

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

On behalf of the Rehabilitation & Community Providers Association of Pennsylvania (RCPA), thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) interim final rule addressing the Medicaid Program; Medicaid Managed Care State-Directed Payments (SDPs) and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments.

RCPA is a statewide association representing more than 400 human services providers in Pennsylvania. Our provider network includes thousands of licensed programs and facilities, and serves more than two million vulnerable Pennsylvanians annually. The RCPA comments to the CMS Medicaid Managed Care State-Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments reflect the position of our membership, whose visions, missions, and operational footprints will be deeply impacted by the implementation of this and several of the proposed changes as a result of the H.R. 1 Bill.

We respectfully submit our comments below:

The rule was anticipated to limit state-directed payments for four core services (inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center) to Medicare (or 110% of Medicare for non-expansion states) as required under section 71116 of H.R. 1. However, the rule goes much further than H.R. 1 by:

The application of the Medicaid payment limits to Medicare in H.R. 1 beyond the four core services to all services under Medicaid state-directed payments disregards the Medicare payment limits in the aggregate elsewhere in the Medicaid program and instead implements Medicare limits on Medicaid state-directed payments on a per-service and per-provider basis.

In Pennsylvania, Medicaid provider rates have fallen critically short compared to the cost of delivering care. In areas such as mental health and substance use disorder treatment services, organizations have seen limited rate increases after the unwinding of Medicaid post public health emergency. The failure of the state, and its actuarial entity Mercer, to develop actuarially sound and sustainable rates has contributed to the current state, and the implementation of these SDPs will yield catastrophic results in future service access. The growing landscape of financially vulnerable providers already has forced providers to close or curtail services with less revenue from Medicaid, particularly with revenue losses from increases in the number of people without health insurance coming from Medicaid work requirements and reductions to Affordable Care Act premium subsidies.

The rates included in the capitation today do not have a floor or ceiling except for PAS services. The Community HealthChoices managed care organizations (CHC-MCO) contracts require the MCOs to pay

agencies a minimum of the PAS rate paid by Medicaid (OBRA waiver in this case). In addition to the chaos this could cause, and the MCOs' 1915(c) waiver authority to select their own networks, this could cause an MCO to choke out providers for any reason, or no reason at all. There is concern that a strict interpretation of the SDP rules would eliminate this "floor" and the MCOs would be free to establish significantly disparate rates for no reason at all. There are several such situations in Florida and Tennessee, among others, where the individual agencies negotiate their rates with each MCO.

While some providers may be able to absorb reduced payments with nominal changes to quality or access, many providers have found that average commercial rates are much higher than Medicaid and Medicare, and are fleeing this space to remain sustainable to their missions. However, providers that serve primarily Medicaid enrollees often have lower operating margins and may be more financially vulnerable than other providers, suggesting that safety net providers may be especially affected by the reduced revenues.

An additional area of impact will be the state's platform of Value-Based Programming (VBP) in HealthChoices, Behavioral HealthChoices, and Community HealthChoices that are required in the MCO contracts; with specific direction as to the percentage of total spend that must be in VBP, as well as the type of risk and shared savings that can be included. All VBP programs in PA must be approved by the appropriate office overseeing the program (OMAP, OMHSAS, OLTL). A strict interpretation of the SDP rules could lead to the MCOs electing not to use any VBP program, or more critically, issuing VBP programs that are unattainable and end up requiring participating providers, and to invest resources in an attempt to receive the additional payments.

Because Pennsylvania has invested heavily in keeping children with developmental disabilities and medical complexity in their homes and communities rather than institutional settings, maintaining a financially stable pediatric provider network is essential. Any reduction in Medicaid funding that weakens this network risks undermining the state's ability to provide timely, high-quality Early Intervention services and may ultimately increase long-term educational, healthcare, and social service costs by delaying access to evidence-based interventions. Applying broad payment caps without accounting for the unique economics of pediatric care could unintentionally jeopardize access to specialized services for some of Pennsylvania's most vulnerable children.

The additional risk is that funding for programs to improve service quality, quality of life, and improved outcomes will be focused exclusively on cost reductions. The proposed implementation of these realigned SDPs removes the current flexibility to structure state-directed payments as a percent or amount addition to negotiated rates; and to extend the Medicaid managed care state-directed payment limitations to some fee-for-service programs that today can make payments in excess of Medicare.

Specifically, as it relates to CMS' proposed application of Medicare limits to Medicaid state-directed payments on a per-service and per-provider basis, the proposed rule fails to consider the population differences between the two programs when applying Medicare payment limits to Medicaid payments for various cohorts.

While Pennsylvania continues its efforts to expand and sustain Medicaid provider value-based payments, making those payments subject to Medicare limits is counter to arrangements that aim to grow innovation, quality, and positive health outcomes. State-directed payments are an important part of the financial reimbursement for services to Medicaid enrollees, allowing providers to invest in quality and for Pennsylvania to ensure access to care.

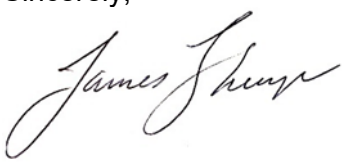
RCPA has long advocated for relief from the PA Department of Human Services to create more effective and efficient regulatory standards and practice for providers. The implementation of these changes to the SDP will not only increase administrative burden to the state and contracted MCOs to maintain various Medicare fee schedules and reimbursement rates, but will also be layered upon the providers who

already operate under the burden of multiple HealthChoices managed care entities for physical, community, and behavioral health, who all have the autonomy to regulate and implement at their choosing. One provider could be contracted with five or more MCOs, all with a different operational practice from the other.

Conclusion

In closing, RCPA appreciates the opportunity to provide these comments. We welcome any questions or further discussion about our comments outlined above. Please contact RCPA COO and Mental Health Division Director Jim Sharp for further clarification. Thank you for your time and consideration.

Sincerely,



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RCPA