



**AMERICAN
PSYCHOLOGICAL
ASSOCIATION**
SERVICES, INC.

July 17, 2026

Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

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

Submitted electronically via Regulations.gov

Dear Administrator Oz:

On behalf of American Psychological Association Services Inc. (APA Services), please accept the following comments in response to your Proposed Rule concerning State-Directed Payments under managed Medicaid plans and Targeted Practitioner Payments under fee-for-service Medicaid systems (CMS-2449-P), published in the [Federal Register](#) on May 22, 2026. APA Services is the companion organization of the American Psychological Association (APA), which is the largest scientific and professional organization representing the discipline and profession of psychology, as well as over 190,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

State-Directed Payments (SDPs) and Targeted Payments are key strategies that states can deploy to incentivize greater provider participation in managed and fee-for-service Medicaid alike, thereby increasing access to care among underserved communities. Augmenting the workforce of mental health and substance use providers is among the most common goals of these arrangements.¹ Three out of four clinical psychologists cite low reimbursement rates² as a major barrier to participation in public and private insurance plans and experts consistently recommend that CMS strengthen support mechanisms for behavioral health providers in a way that both addresses the actual cost of care and adjusts for undervaluation of their services.³

¹ Medicaid and CHIP Payment and Access Commission (June 2022), Directed Payments in Medicaid Managed Care, <https://www.macpac.gov/wp-content/uploads/2022/06/Chapter-2-Oversight-of-Managed-Care-Directed-Payments-1.pdf>.

² American Psychological Association (2025). AI in the Therapist's Office: 2025 Practitioner Pulse Survey, <https://www.apa.org/pubs/reports/practitioner/2025/full-report.pdf>.

³ National Academies of Sciences, Engineering, and Medicine. 2024. Expanding behavioral health care workforce participation in Medicare, Medicaid, and Marketplace plans. Washington, DC: The National Academies Press. <https://doi.org/10.17226/27759>.



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Given the ongoing challenges that Medicaid managed care programs face in building sufficient networks of behavioral health providers⁴, it is unsurprising that so many states would turn to SDPs as a remedial strategy. However, under last year's "One Big Beautiful Bill Act" (H.R. 1)⁵, Congress made targeted changes to SDPs in the name of protecting the Medicaid program from alleged fraud, waste, and abuse. This proposed rule far exceeds the scope of regulatory authority laid out in H.R. 1, cuts more than three times the amount of federal funding from SDP arrangements than Congress intended,⁶ and would virtually eliminate these arrangements altogether. APA Services urges the Administration to reconsider this proposed rule and return it to the clear parameters outlined in federal law.

Significance of SDPs to Behavioral Health Care Access

Medicaid remains the single-largest payor of behavioral healthcare services⁷, and Medicaid also remains a significant source of coverage for individuals in need of treatment for mild, moderate, and severe substance use disorders.⁸ For enrollees in need of treatment, Medicaid can cover an array of behavioral health services in a multitude of settings, from short-term immediate crisis services to certified community behavioral health clinics to outpatient services such as school-based clinics.⁹

Most Medicaid programs cover the majority of—if not all—their behavioral health service offerings through managed care plans.¹⁰ Through these plans, however, beneficiaries' ability to access behavioral health services has not kept pace with their demand, with many managed Medicaid plans having networks with few to zero active providers in the county, particularly among rural counties.¹¹ Without citing evidence, this proposed rule implies an association of *all*

⁴ HHS Office of Inspector General (October 2025), Many Medicare Advantage and Medicaid Managed Care Plans Have Limited Behavioral Health Provider Networks and Inactive Providers, <https://oig.hhs.gov/documents/evaluation/11233/OEI-02-23-00540.pdf>.

⁵ Pub. L. 119-21 (Jul. 4, 2025) § 71116, <https://www.congress.gov/bill/119th-congress/house-bill/1/text#d3245e38064-intro-1>.

⁶ Congressional Budget Office (July 21, 2025), Estimated Budgetary Effects of Budget Law 119-21, <https://www.cbo.gov/publication/61570>.

⁷ Medicaid and CHIP Payment and Access Commission (June 2015), Behavioral Health in the Medicaid Program—People, use, and Expenditures, <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures-1.pdf>.

⁸ H. Saunders and R. Rudowitz (June 6, 2022), Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020, <https://www.kff.org/mental-health/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/>.

⁹ Association for Behavioral Health and Wellness, Preserving Medicaid and the Children's Health Insurance Program is Critical for Behavioral Health, <https://abhw.org/wp-content/uploads/2025/04/ABHW-Medicaid-Brief.pdf>.

¹⁰ Kaiser Family Foundation (Dec. 9, 2021), State Policies Expanding Access to Behavioral Health Care in Medicaid, <https://www.kff.org/medicaid/issue-brief/state-policies-expanding-access-to-behavioral-health-care-in-medicaid/>.

¹¹ HHS Office of Inspector General (March 2024), A Lack of Behavioral Health Providers in Medicare and



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SDP arrangements with fraud, waste, and abuse. As a result, it forecloses any possibility that SDPs could have a positive impact on a limited and overtaxed workforce.

Expansion of Payment Limits Beyond H.R. 1

H.R. 1 directed the Secretary of the U.S. Department of Health and Human Services (HHS) to impose payment limits only on four types of services described in the existing regulations—inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers.¹² In this proposed rule, however, CMS claims the authority to impose limits on SDP payments on *all* service types. CMS also seeks to impose similar payment caps on Targeted Payments in fee-for-service Medicaid programs without clear authorization from Congress to do so.

Should CMS finalize this proposed rule as written, any state-directed payments to any type of provider—including small and independent practitioners—would be subject to arbitrary payment limits, regardless of the degree of the workforce shortage or the urgency of the need for access to their services. On average, Medicaid programs reimburse psychologists for common mental health services only at 74% of the Medicare fee-for-service rates¹³, while on average commercial insurance plans reimburse at nearly twice the Medicare fee-for-service rates.¹⁴ Imposing an across-the-board SDP cap would leave states with fewer workable options to remedy or mitigate dire provider shortages they may be facing in a critical specialty such as mental health or substance use treatment.

Limitation of Services Covered Under SDPs

The proposed rule's expansion into a much broader array of services in settings beyond those laid out in H.R. 1 also has troubling implications for the calculation of the new payment caps specified in H.R. 1. Both H.R. 1 and this proposed rule specify that for Medicaid expansion states, the limit is set at 100% of the Medicare rate for such service; for non-Medicaid expansion states, the limit is set at 110% of the Medicare rate for such service.¹⁵ Where there is no set Medicare rate for such service, the limit is defined as the payment under the state Medicaid plan.

Because the scope of this rule expands well beyond H.R. 1's clear parameters, it fails to consider that many services are used by populations who are not typical Medicare beneficiaries and therefore would not have a published Medicare rate. These include home and community-based services for people with disabilities, pediatric services, maternal health services, and evidence-

Medicaid Impedes Enrollees' Access to Care, <https://oig.hhs.gov/documents/evaluation/9844/OEI-02-22-00050.pdf>.

¹² Pub. L. 119-21 § 71116(a); 42 C.F.R. § 438.6(c)(2)(iii).

¹³ Jane M. Zhu, Aine Huntington, Emily Mitchell, and Briana Last, Estimating Medicaid Reimbursement For Psychological Services. *Health Affairs* 2025 44:12, 1530-1536 10.1377/hlthaff.2025.00563

¹⁴ Spencer Marshall, Danjie Zhou, and Charlie Mills (July 24, 2025). White Paper: Commercial reimbursement Benchmarking 2025, <https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-medicare-ffs-rates-2025>.

¹⁵ Pub. L. 119-21 § 71116(a)



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based behavioral health services; under this proposed rule, any SDP affecting these services are automatically capped at a presumably lower amount.

Congress enacted a policy concerning SDPs it clearly drafted with narrow subsets of services in mind, and therefore never intended to set payment limits on these services at all, much less impose a lower payment limit on them. By adopting an expanded view of the services subjected to payment limits, the proposed regulation effectively removes any incentive to create SDPs for any service for which a Medicare rate is not currently available, which in turn limits the ability of states to address serious workforce issues they may be experiencing concerning, for example, maternal mental health or child and adolescent mental health.

Compounding State Burden in Administering SDPs

This proposed rule also purports to eliminate, without any basis in H.R. 1, the most common form of SDP arrangement.¹⁶ Should this proposed rule become final as written, SDPs that require managed care plans to pay a fixed amount or percentage in addition to the base rate to targeted providers would need to either terminate such SDP arrangement or move to a different form of SDP before the rating periods beginning on or after January 1, 2028. As a result, states would be left in the position of quickly completing a massive array of complex administrative tasks by the deadline. These include, but are not limited to, drafting and filing new preprints for CMS' consideration, re-drafting managed care agreements, and assessing new capitated rates for managed care entities. This may not be a feasible option for many states, and as a result, many existing SDPs may simply disappear. The proposed rule cites a need to prevent “retrospectively rewarding providers with higher payments on a per-service basis for furnishing fewer services to Medicaid beneficiaries.” However, this understanding mischaracterizes the very purpose of this payment mechanism—to provide an added incentive to attract and retain additional Medicaid providers offering services deemed to be experiencing a dire shortage.

Narrowed Criteria for Grandfathering Existing SDP Arrangements

Finally, this proposed rule places SDPs that are currently in place on a shorter timeframe to come into compliance than authorized under H.R. 1. H.R. 1 specifies that states that already have payments above the new SDP caps can retain them until the first rating period beginning on or after January 1, 2028, after which point they must slowly reduce these “grandfathered SDPs” by ten percentage points every year until they comply with the new payment limit. H.R. 1 also specifies that existing SDP arrangements can be “grandfathered” into this longer compliance period if they meet *any* one of three criteria: (1) written prior approval, or a good faith effort to receive such approval, was made before May 1st, 2025; (2) a payment to a rural hospital was made under an approved SDP arrangement (or a good-faith effort to receive such approval was made) for the rating period occurring within 180 days of the date of H.R. 1's enactment; or (3) a payment was made for which a completed preprint was submitted to HHS prior to the enactment of H.R. 1.

¹⁶ Medicaid and CHIP Payment and Access Commission (June 2023), Directed Payments in Medicaid Managed Care, Table 1. <https://www.macpac.gov/wp-content/uploads/2023/06/Directed-Payments-in-Medicaid-Managed-Care.pdf>.



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Instead of abiding by these clear parameters outlined by Congress, this proposed rule eliminates the ability of states that were making a good-faith effort to implement an SDP before the payment caps were in place to qualify for “grandfathered” status and also requires states to meet *both* of the other two criteria, effective immediately. The proposed regulations also add several burdensome reporting requirements for states operating SDPs that are granted grandfathered status. The combined impact of these regulations, unmoored from the text and goals of H.R. 1, will make it more difficult for states to operate their existing SDPs, making it more likely that many of these arrangements will simply be reduced or eliminated immediately upon finalization of these proposed rules.

Thank you for the opportunity to weigh in on this proposed rule. APA Services urges the Administration to reconsider this proposed rule and return it to the clear parameters outlined in federal law. APA Services understands the Administration’s goal to maintain fiscal integrity of the Medicaid program and would be happy to participate in a conversation with HHS leadership on the development of more targeted and efficient means of detecting and eliminating fraud, waste, and abuse in federal health care programs. To the extent that APA and psychologists can serve as a resource to the Administration in any way, please feel free to reach out to Stephen R. Gillaspy, PhD, Deputy Chief of Health Policy and Healthcare Financing, at sgillaspy@apa.org, or Andrew Strickland, Senior Legislative and Regulatory Officer, at astrickland@apa.org.

Sincerely,

Katherine B. McGuire
Chief Advocacy Officer
American Psychological Association Services, Inc.