

The Disability and Aging Collaborative &



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July 21, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, Maryland 21244-8016

Re: RIN 0938-AV69; CMS-2449-P
Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service
Targeted Medicaid Practitioner Payments

Dear Dr. Oz:

The undersigned members of the Long Term Services and Supports Task Force of the Consortium for Constituents with Disabilities (CCD) and the Disability and Aging Collaborative (DAC) appreciate the opportunity to comment on the Proposed Rule “Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments” (“Proposed Rule”).

CCD is the largest coalition of national organizations advocating for federal public policy that ensures self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. DAC is a coalition of national and state organizations that work together to advance long-term services and supports policy at the federal level. DAC and CCD have a longstanding history of advocating for people with disabilities and aging adults to access needed care in their communities, and supporting the family caregivers and care workers who provide that care.

We write to express our concern regarding the impact of the Proposed Rule on access to services for individuals with disabilities, and particularly on home and community-based services (HCBS). For people with disabilities and aging adults, access to HCBS is often what makes it possible to remain in the community and avoid unnecessary institutionalization.

The Proposed Rule extends beyond the requirements of section § 71116 of the “One Big Beautiful Bill Act” (OBBBA). It proposes much deeper cuts than those estimated by the Congressional Budget Office (CBO) and does so by using restrictions on funding not contemplated in OBBBA’s statutory language.

OBBBA limits the use of state-directed payments (SDPs) for four specific services: inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center. OBBBA states that such services must be reduced, effective January 1, 2028, by 10% per year until they reach 100% of the Medicare rate in expansion states, or 110% of the Medicare rate in non-expansion states. The Proposed Rule goes far beyond the requirements of OBBBA, applying § 71116(a) payment limits to SDPs for all services, including HCBS; applying these requirements to U.S. territories; applying payment limits on a per-service rather than an aggregate basis; prohibiting the use of a uniform rate or percentage increase SDPs; narrowing the pathway for current SDPs to become “grandfathered SDPs”; and extending OBBBA payment limits at a per-service level to certain fee-for-service (FFS) supplemental payments.¹

The Proposed Rule risks harming access to HCBS in three ways. First, the Proposed Rule will result in steep federal funding reductions to states, threatening access to HCBS. Second, by extending restrictions on State Directed Payments (SDPs) beyond the four categories that are statutorily mandated, the Proposed Rule hamstring states’ ability to target payments to address direct care workforce shortages and long-term underinvestment in HCBS. Third, the Proposed Rule will place a significant burden on states, requiring them to convert the majority of state directed payments from uniform dollar or percent increases to a maximum fee schedule.

¹ Addressing each way the Proposed Rule exceeds the requirements of statute is beyond the scope of these comments. However, CMS’ proposed mechanisms, when taken together, will result in massive restrictions on states’ ability to obtain funding for essential services, as discussed below.

1. Drastically Reducing Funding Available for HCBS

The Proposed Rule would reduce federal Medicaid spending by \$510.1 billion dollars by 2035, **more than triple** the CBO estimate of the effects of § 71116 of OBBBA. When combined with state funding cuts, CMS estimates the Proposed Rule would slash overall Medicaid funding by a staggering \$774.8 billion.²

Even if these funding cuts are not targeted specifically at community-based services, reductions in Medicaid funding resulting from this proposed rule may have a devastating impact on access to services for people with disabilities. When states face budgetary constraints due to reduced federal funding, cuts to HCBS consistently follow.³ As noted above, the Proposed Rule would cut federal Medicaid spending by a whopping \$510.1 billion by 2035, compared to the \$149 billion federal funding reduction estimated by CBO for § 71116 of OBBBA.⁴ Restrictions on states' ability to narrowly tailor rate structures to best support people with disabilities and the complexities of their needs, coupled with forthcoming massive cuts, risks serious harm.

2. Restricting States' Ability to Appropriately Ensure Access to HCBS

The Proposed Rule would extend OBBBA payment limits to all services, including HCBS. This broad-brush approach largely replaces state discretion to set Medicaid payments with federally established rates that were developed to cover the costs of serving Medicare beneficiaries. For those services without a Medicare equivalent, states will be forced to cap SDPs at the even lower rate (generally) of the state plan Medicaid rate. These federally imposed rates are not necessarily appropriate benchmarks for the specific needs of the Medicaid enrollees with disabilities and long term care needs, including people with behavioral health needs.⁵ We are concerned that this may hamper

² Proposed Rule at 30451-30452; Congressional Budget Office, *Estimated Budgetary Effects of P.L. 119-21, to Provide 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>.

³ Jessica Schubel et al., *History Repeats? Faced with Medicaid Cuts, States Reduced Support for Older Adults and Disabled People*, HEALTH AFF. (Apr. 16, 2025), <https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled>.

⁴ Proposed Rule at 30451-30452; Congressional Budget Office, *Estimated Budgetary Effects of P.L. 119-21, to Provide 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>.

⁵ U.S. Department of Health & Human Services, Office of Inspector General, *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollee's Access to*

states' abilities to effectively respond to the access challenges that already plague HCBS.

CMS posits that SDPs should be limited to state plan rates because the state plan review process ensures that rates “are sufficient to enlist enough providers so that care and services are available.”⁶ CMS similarly asserts that HCBS waiver services “review process ... ensure[s] consistency with section 1902(a)(30)(A) of this Act.”⁷ The reality is very different. Historically, direct care work, such as personal care and habilitation services, has been undervalued and undercompensated. Medicaid’s typically low reimbursement rates for these services suppress wages and benefits and impede recruitment and retention.⁸ The median hourly wage for a direct care worker is just \$16.77 nationally, lower than the median wages for similar low-entry level occupations, such as customer service representatives, food preparation workers, and retail salespersons.⁹ Meanwhile, demand for HCBS continues to grow as our population ages, and as more people with disabilities and older adults are able to choose to live in the community.¹⁰ The result is what has been commonly referred to as the “direct-care

Care 11 (March 2024) (noting that “a significant number of providers in the existing behavioral health workforce did not provide services to Medicaid and Medicare enrollees,” and recommending, among other strategies, that CMS “should take steps to more accurately value and pay for behavioral health services” and take steps to increase payments.

⁶ Proposed Rule at 30407.

⁷ *Id.* at 30415.

⁸ President’s Comm. For People with Intellectual Disabilities, *Report to the President 2017: America’s Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy* 20 (2017), https://acl.gov/sites/default/files/programs/2018-02/2017%20PCPID%20Full%20Report_0.PDF; Medicaid & CHIP Payment & Access Comm’n, *Issue Brief: State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages* 1 (March 2022), <https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf>.

⁹ Jiyeon Kim, PHI, *Competitive Disadvantage: Direct Care Wages Lag Behind—2024 Update* (2024), <https://www.phinational.org/resource/competitive-disadvantage-direct-care-wages-are-lagging-behind-2024-update/>.

¹⁰ Amanda R. Krieder & Rachel M. Werner, *The Home Care Workforce Has Not Kept Pace with Growth in Home and Community-Based Services* (April 19, 2023) 42 HEALTH AFFAIRS 650, https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01351?utm_medium=social&utm_source=twitter&utm_campaign=may+2023+issue&utm_content=aop&utm_term=kreiderhttps://bipartisanpolicy.org/wp-content/uploads/2023/11/BPC-Direct-Care-Workforce-Report-Final.pdf; Bipartisan Policy Center, *Addressing the Direct Care Workforce Shortage: A Bipartisan Call to Action* (Dec. 2023), <https://bipartisanpolicy.org/wp-content/uploads/2023/11/BPC-Direct-Care-Workforce-Report-Final.pdf>.

workforce crisis,” meaning that many people who have been determined eligible for HCBS simply cannot find providers to deliver the service. The Proposed Rule risks worsening this crisis by limiting state flexibility to target payments to fill known gaps in service availability. When states cannot target payments to address workforce shortages, the practical result may be missed shifts, reduced service availability, longer waits for providers, and greater risk that people cannot remain safely in their homes and communities.

The most common strategies states use to address the workforce crisis and increase availability of services include raising provider rates, investing in worker education and training, and incentive payments to combat workforce shortages.¹¹ States may target rates to ensure individual beneficiary needs are met, adjusting rates dependent on qualities of beneficiaries, such as acuity, level of care, or risk of high utilization.¹² States may choose to incentivize providers to obtain additional training, or to encourage retention of staff. States can also choose to make retainer payments of up to 30 days to HCBS providers during temporary disruptions in care, similar to a bed hold for a nursing facility.¹³ Retention payments can be particularly important for small agencies

¹¹ Alice Burns et al, KFF, *Payment Rates for Medicaid Home Care: States’ Responses to Workforce Challenges* (Feb. 18, 2025), <https://www.kff.org/medicaid/payment-rates-for-medicaid-home-care-states-responses-to-workforce-challenges/>; CMCS, *Medicaid Managed Care Options in Responding to COVID-19* (May 14, 2020), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051420.pdf> (explaining options under managed care authorities to help states mitigate the harsh impact of Covid-19 on people with disabilities, including ensuing gaps in care).

¹² CMS, 1915(c) *HCBS Waiver Payments and Financing Trends* 25 (Nov. 12, 2025), <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-hcbs-waiver-pay-financing-trends-mar2026.pdf> (noting that 12 states across 36 waivers use FFS supplemental payments beyond base payments, and that states may use these supplemental payments to incentive providers based on service quality and participant satisfaction; to promote training and continuing education; to expand access to care; and to address operational costs); CMS, *Capitated Rate Setting for MLTSS Programs* (June 2017), <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/rate-setting-mltss-prgrms.pdf> 31-33 (explaining payment strategies available to support policy goals, including strategies in addition to capitation rates).

¹³ CMS, Dear State Medicaid Director (July 25, 2000) (Olmstead Update #3), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd072500b.pdf>; CMS, Dear State Medicaid Director 11 (May 13, 2021) (SMD # 21-003) (Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the Covid-19 Emergency), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>.

supporting individuals with high needs, and prevent major disruptions in care.¹⁴ SDPs and supplement payments are two important tools states have to implement these strategies.

While most HCBS-related SDPs are modest adjustments to Medicaid state plan rates and thus would not be limited by this Proposed Rule, states need flexibility to exceed Medicare rates (or state plan rates when no Medicare rate exists) for HCBS to meet specific unmet needs. For example, Louisiana offers bonuses to certain private duty nurses, noting that the state “reviewed bonus offerings by local hospitals and other institutions that employ nurses to determine what an approximate bonus structure would be needed to attract nurses to these home health agencies.”¹⁵ Louisiana then ensures that the total Medicaid payment is less than the average commercial rate.¹⁶ Louisiana does this to help children remain safe and healthy in their own homes, with their families, and to help support families by letting them access regular, predictable nursing services. This is exactly the type of state-specific access strategy CMS should preserve, rather than discourage. Such arrangements may be at serious risk under the Proposed Rule.

We are concerned that the Proposed Rule may limit states’ ability to target payments using SDPs for services that do not have an associated Medicare rate. Many services provided in HCBS have no Medicare-associated rate, including personal care services.¹⁷ SDPs for these services may require a uniform increase above FFS rates. If FFS supplemental rates for HCBS are excluded, states could be in a position where they are able to make FFS supplemental rate increases to address HCBS shortages, but will not be able to direct similar targeted rate increases for managed care. We seek clarification that where the SDP is limited to 100% of the Medicaid fee for service rate in 1915(c) waivers and equivalent HCBS waivers, such base rates include supplemental payments approved via those waivers.

¹⁴ Medicaid & CHIP Payment & Access Comm’n, *Use of Medicaid Retainer Payments During the COVID-19 Pandemic* (May 2021), <https://www.macpac.gov/wp-content/uploads/2021/04/Use-of-Medicaid-Retainer-Payments-during-the-COVID-19-Pandemic.pdf>; CMCS, *Medicaid Managed Care Options in Responding to COVID-19* (May 14, 2020), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051420.pdf>

¹⁵ Louisiana SDP Preprint Approval (Nov. 19, 2025), https://www.medicaid.gov/medicaid/managed-care/downloads/LA_Fee_HCBS2_Amend_20250701-20260630.pdf.

¹⁶ *Id.*

¹⁷ Proposed rule at 30442.

3. Eliminating the Use of Uniform Increases

The Proposed Rule would also require states to fundamentally reconfigure a significant majority of all SDPs, representing tens of billions of Medicaid dollars, by eliminating uniform increase SDPs entirely.¹⁸ This new requirement would impact two-thirds of approved SDPs, including the majority of HCBS-related SDPs, regardless of whether they are already under proposed new payment limits.¹⁹

The Department justifies its proposal on the basis of concerns that some states may have retroactively amended certain uniform increase SDPs to maximize payments to providers. Even accepting the Department's premise, the proposed approach is an overcorrection at best. It is unclear why the Department could not simply address concerns with problematic uniform increase SDPs through the existing SDP preprint approval and renewal processes. CMS suggests that states could simply convert uniform increase SDPs to a maximum fee schedule set at the applicable payment limit. This recommendation not only disregards the administrative burden of redesigning SDPs en masse, but it also reduces state flexibility to design and implement appropriate payment increases.

Vastly increasing the administrative burden to develop and monitor less flexible SDPs will almost certainly discourage states from developing or renewing some SDPs at all, fueling the massive Medicaid cuts the Department estimates will result if the Proposed Rule is finalized. Administrative burden on states can translate into access barriers for beneficiaries when states delay, narrow, or abandon payment arrangements that support provider participation and service availability. These outcomes are counter to the requirement to maintain actuarially sound rates that ensure access to sufficient, high-quality managed care services, and will have severe consequences for Medicaid beneficiaries who will struggle to locate providers willing or able to accept significant reimbursement reductions for furnishing covered services.

¹⁸ Medicaid & CHIP Payment & Access Comm'n, *Directed Payments in Medicaid Managed Care* 4, Fig. 1 (Oct. 2024), <https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf>.

¹⁹ States have used uniform increase SDPs to support access to a broad array of Medicaid services, ranging from inpatient hospital services to HCBS, community-based behavioral health, and dental care. See, e.g., Wisconsin SDP Preprint Approval (March 30, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/WI_Fee_HCBS3_Renewal_20260101-20261231.pdf (HCBS); Colorado SDP Preprint Approval (April 24, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/CO_Fee_IPH.OPH.BHI.BHO_New_20250701-20260630.pdf (behavioral health).

Conclusion

We urge CMS to withdraw the Proposed Rule. The Department states that “[r]eforming SDP requirements would allow CMS and States to refocus on the original purpose of these arrangements, which is to permit States to direct certain managed care plan expenditures within specified parameters to improve access and ultimately, quality of beneficiary care.” Yet the changes imposed through this proposed rule would have the opposite effect – they would reduce access to critical HCBS and undermine state efforts to support people with disabilities and aging adults in their homes and communities. To the extent that OBBBA requires the Secretary to amend existing regulations related to certain SDPs, the Department should release a new notice of proposed rulemaking that is narrowly tailored to implement the statutory requirements.

Thank you for your attention to this. Please feel free to reach out to Jennifer Lav at lav@healthlaw.org or John Poulos at jpoulos@autisticadvocacy.org with any questions or concerns.

Sincerely,

Access Ready Inc.

American Association on Health and Disability

American Network of Community Options and Resources (ANCOR)

American Speech-Language-Hearing Association

American Therapeutic Recreation Association

Association of People Supporting Employment First (APSE)

Autistic Self Advocacy Network

Autistic Women & Nonbinary Network

Bazelon Center for Mental Health Law

Care in Action

Caring Across Generations

Disability Belongs

Easterseals, Inc.

Family Voices NJ @ SPAN

Justice in Aging

Lakeshore Foundation

Medicare Rights Center

Muscular Dystrophy Association

National Academy of Elder Law Attorneys (NAELA)

National Association of Councils on Developmental Disabilities

National Disability Rights Network (NDRN)

National Domestic Workers Alliance
National Health Law Program
National Respite Coalition
New Disabled South
SPAN Parent Advocacy Network
The Arc of the US
Well Spouse Association