July 21, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2449-P
Submitted electronically to regulations.gov

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

Dear Administrator Oz:

The National Association of Accountable Care Organizations (NAACOS) appreciates the opportunity to submit comments in response to the Medicaid State Directed Payments and Targeted Practitioner Payments proposed rule. NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) and value-based care entities in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve the quality of care for patients and reduce health care cost. Collectively, our members are accountable for the care of more than 10 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model.

We aim to grow accountable care across all payers as it has demonstrated to provide higher quality care at lower costs by shifting care upstream and focusing on health outcomes rather than volume of services. While there has been steady growth of accountable care in Medicare, Medicaid adoption has lagged with just 20.6 percent of payments through risk-bearing alternative payment models (APMs) compared to 45.2 percent of payments in risk-bearing traditional Medicare APMs[1]. **We are concerned that proposed policies for value-based payment (VBP) arrangements may further hinder the growth of Medicaid APMs and result in higher overall spending and poorer health outcomes.**

First, we do not support requiring States to provide a detailed validation methodology to ensure that payments from value-based payment (VBP) state directed payments (SDPs) do not exceed the payment limit on a per service basis or the alternative proposal for States' actuaries to develop and certify that population or condition-based SDPs would not exceed the permissible applicable payment limits. These policies ignore core, evidence-based approaches that have proven to be successful in Medicare models, including paying higher for certain services that improve health outcomes while lowering payment for other services. With the reduced costs, all ACOs redistribute their earned shared savings to practices, resulting in higher payments to primary care. While this approach recognizes and corrects how

[1] https://hcp-lan.org/apm-measurement-effort-2/

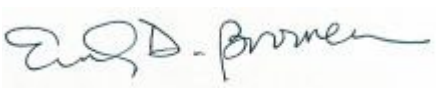
undervalued these services are, it would result in certain services exceeding payment limits. Similarly, the proposal would prohibit states from implementing incentives that drive adoption of APMs. In traditional Medicare, the MACRA statute requires CMS to provide a higher payment update for clinicians in risk-bearing arrangements. CMS has also proposed a policy that would pay clinicians in APMs a higher payment for complex evaluation and management services. As currently proposed, the requirements of VBP SDPs would counterintuitively prohibit implementing similar incentives. Additionally, we concur with CMS' assertion that "a per service payment limit may pose operational and logistical complexities, particularly in the context of population and condition-based SDP arrangements."

Second, we do not support considering VBP payments "targeted payments", and thus subject to limits, if they are part of a VBP methodology where participation is limited to only a select group of practitioners or providers. Adoption of APMs requires upfront costs and infrastructure that may not be available to all providers. This requirement would have the unintended effect of limiting all VBP arrangements to mandatory approaches and prohibiting innovative and novel approaches for more advanced providers.

We appreciate that CMS is seeking ideas to "operationalize alternative value-based arrangements in Medicaid, given that value-based care is a tool to support CMS priorities including holding providers accountable for health outcomes and reducing wasteful spending." **CMS should not implement any of the proposed approaches but rather develop alternative approaches that recognize inherent principles of value-based care, including lowering total overall costs rather than focusing on unit, shifting costs and placing higher value on services tied to strong outcomes, and incenting providers and clinicians to join APMs**. For example, in the nation's most successful value-based payment initiative, MSSP, successful groups of providers typically receive payments well in excess of the payments they would have received on a unit rate basis. This feature has made the program a success and we hope it will be replicated in Medicaid programs. Accordingly, CMS should retain its current approach of reviewing and approving VBP approaches for SDPs and VBP targeted payments and require States to work with their actuaries to ensure approaches will lower total costs while maintaining or improving the quality of care.

Thank you for the opportunity to provide feedback on Medicaid State Directed Payments and Targeted Medicaid Practitioner Payments proposed rule. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to continued engagement on scaling APMs in Medicaid. If you have any questions, please contact Aisha Pittman, senior vice president of government affairs at NAACOS at aisha_pittman@naacos.com.

Sincerely,



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