July 21, 2026
The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2449-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2449-P. Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Dear Administrator Oz,

As organizations dedicated to promoting the health of our nation's children, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments." Medicaid serves as a critical lifeline, ensuring children—especially those from families with low incomes, those in rural areas, those with disabilities, and those with chronic health conditions—have access to the physical and mental health care they need to grow, thrive, and lead healthy lives. We are concerned that the proposed changes to state directed payments (SDPs) could undermine access to care for all children and families. **We urge CMS to reconsider the proposed changes to Medicaid payment policy and preserve the funding and flexibility necessary to ensure children across the country continue to have access to high-quality, specialized care.**

Medicaid and the Children's Health Insurance Program (CHIP) provide essential health care coverage to approximately 35 million children in the United States.[1] This includes coverage for 42% of all U.S. children with special health care needs[2] and approximately 37% of children with cancer.[3] In 2023, 40.6% of children in small towns and rural areas were enrolled in Medicaid and CHIP.[4] Medicaid is an essential resource that nearly 3 million children in military-connected families are eligible for or covered by.[5] Medicaid provides children with access to a comprehensive set of services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This benefit ensures Medicaid covers a wide array of services all kids need including immunizations, well-child checkups, and vision and dental services. Medicaid is also the nation's largest payer for behavioral health services.

Given the central role Medicaid plays in children's health coverage and access to care, any changes to Medicaid payment policy should be evaluated through the lens of their impact on children and the providers who serve them. Children have unique health care needs that require timely access to pediatric specialists, behavioral health services, preventive care, and

[1] "February 2026: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot," U.S. Centers for Medicare and Medicaid Services, May 2026.
[2] "5 Key Facts About Children with Special Health Care Needs and Medicaid," Kaiser Family Foundation, April 2025.
[3] 3 Ji, Xu, et al., "Narrowing Insurance Disparities Among Children and Adolescents With Cancer Following the Affordable Care Act," JNCI Cancer Spectrum: Vol. 6, No. 1, 2022.
[4] "Medicaid's Role in Small Towns and Rural Areas," Georgetown University McCourt School of Public Policy Center for Children and Families, January 2025.
[5] "Medicaid: A Vital Resource for Nearly 3 Million Military-Connected Children," FTI Consulting, 2023.

community-based supports. Policies that weaken provider capacity or reduce states' ability to sustain pediatric care networks risk undermining access to essential services for millions of children, particularly those with complex medical needs and those living in underserved communities. **To protect children from the unintended and potentially harmful consequences of these proposals, we strongly urge CMS to exempt pediatric services from the proposed Medicaid payment changes.** Should CMS proceed with these policies, we recommend that CMS work closely with pediatric experts and stakeholders to ensure that children's access to essential health care services is not diminished or disrupted.

Our detailed comments are outlined below.

SDPs Support Children's Access to Care

SDPs are not merely helpful—they are foundational to ensuring children can access the care they need. These payments help pediatric providers deliver a full continuum of services, from primary and preventive care to specialized and highly complex treatment, while also supporting pediatric workforce development, research, and community-based initiatives that improve child health outcomes. By giving states flexibility to strategically direct Medicaid funding, SDPs help sustain the providers and care networks that millions of children and families rely on. This support is particularly important for preserving specialized pediatric services that are often unavailable elsewhere and ensuring access to high-quality care regardless of a child's geographic location, medical complexity, or ability to pay. Any policy changes that restrict states' ability to use SDPs to support pediatric care risk weakening the nation's pediatric care infrastructure and creating barriers to care for children.

H.R. 1 imposes sweeping new limits on the use of SDPs that would have significant consequences for children's access to care. A recent analysis of 64 children's hospitals across 27 states found that SDPs account for 38% of their total Medicaid funding and 13% of their overall operating resources, underscoring the critical role these payments play in supporting pediatric services.[6] Under H.R. 1, children's hospitals in states pursuing a new SDP arrangement would receive SDP funding that is 44% lower than current combined Medicaid base and SDP payment levels.[7] Such reductions would make it more difficult for pediatric providers to maintain specialized service lines, invest in workforce capacity, and meet the growing needs of children and families. Ultimately, the new SDP restrictions would reduce access to specialized, high-quality pediatric care and threaten the stability of the health care infrastructure that serves children nationwide.

Medicare is Not an Appropriate Payment Benchmark for Pediatric Care

Medicare is not an appropriate benchmark for pediatric care because it fails to adequately reflect the unique complexity, resource intensity, and family-centered nature of services provided to children. As CMS is aware, Medicare covers only a very limited pediatric population, and its service definitions and payment methodologies were not designed to account for the clinical needs of children. In the proposed rule, CMS recognizes that certain services are not covered under Medicare and allows states to rely on Medicaid fee-for-service rates in those instances. However, the broader concern is that while Medicare rates may exist for pediatric

[6] Children's Hospital Association. Implications of Budget Reconciliation Legislation on Children's Hospitals. August 2025.
[7] *Ibid.*

services, those rates often do not capture the additional time and resources required to deliver pediatric care. As a result, reliance on Medicare rates as a benchmark risks systematically undervaluing pediatric services and undermining access to care for children.

Generally, Medicare payment rates are based on standardized methodologies that utilize Medicare Severity Diagnosis-Related Groups (MS-DRGs) for inpatient hospital services and a Resource-Based Relative Value Scale (RBRVS) for physician and outpatient services. However, these methodologies are designed for individuals age 65 and older and individuals with disabilities and do not reflect the services—and resource intensity—provided to children. Pediatric services and procedures require more face-to-face time with patients and families, more patient and family education and counseling, and more emotional support and communication, which can all increase the amount of time a physician and other clinical staff spend with each pediatric patient. The cost of pediatric services can be higher than for adult care due to the need for more direct hands-on time by clinical staff, more case management, higher telephone call volume, and other factors (e.g., cost of supplies in multiple sizes for inpatient pediatric units).[8]

Current Medicaid base rates do not cover the cost of providing pediatric care, making supplemental payments such as SDPs essential to maintaining children's access to needed services. As CMS implements the new SDP limits, it is critical that these longstanding funding shortfalls and the unique economics of pediatric care are taken into account. Without such consideration, pediatric providers may face inadequate payment, further widening the gap between the cost of care and available funding and ultimately diminishing access to care for children.

Proposed Policies Beyond the Scope of H.R. 1

Applying the Medicare-based Limit to All SDPs

CMS proposes applying the Medicare-based payment limit to all SDPs, rather than only to the four service categories specified in H.R. 1. **We urge CMS to align its policy with the statute and apply the Medicare-based limit only to those four service types (inpatient services, outpatient services, nursing facility services, and qualified practitioner services at academic medical centers).**

The proposed expanded SDP restrictions would affect providers and services that are critical to children's health and well-being, including pediatric behavioral health services, home- and community-based services (HCBS), dental care, specialty pediatric care, and services for children with medical complexity. In addition, existing SDPs supporting services outside the four categories covered by H.R. 1 would be subject to the new payment limits without the transition periods provided for those four categories. These targeted payments help states strengthen pediatric provider networks, address workforce shortages, and ensure children can receive needed care in their homes and communities.

This broad expansion of SDP caps would significantly limit states' flexibility to use Medicaid payment strategies to support pediatric providers and address persistent access challenges. In practice, it would replace state discretion with federally established payment benchmarks that were developed to reflect the costs of treating Medicare beneficiaries, not children. This

[8] National Academies of Sciences, Engineering, and Medicine. The Future Pediatric Subspecialty Physician Workforce: Meeting the Needs of Infants, Children, and Adolescents. September 2023.

mismatch is particularly problematic because many pediatric services and HCBS have no meaningful Medicare equivalent. In those cases, states could be forced either to limit the use of SDPs for these services or effectively default to state plan or fee-for-service payment levels, even when those rates are inadequate to support access to care. As a result, states would be significantly constrained in their ability to use SDPs to improve payments for services that are essential to children's health and well-being, undermining efforts to address provider shortages, expand capacity, and meet the unique needs of pediatric populations.

Children with medical complexity, for example, often depend on home care services—including private duty nursing, personal care services, and paid family caregiving—to live safely at home and avoid institutional care. Because Medicare does not meaningfully cover pediatric private duty nursing, the proposed policy would severely limit states' ability to use SDPs to improve payment rates for these services. This would further exacerbate existing nursing shortages, delay hospital discharge for medically complex children, increase avoidable hospitalizations, and ultimately drive higher health care costs. Similarly, respite care—a core HCBS benefit that provides critical support for family caregivers—has no Medicare equivalent, leaving states with far less flexibility to enhance payments and sustain access. Other services commonly used by children, including applied behavior analysis, behavioral supports, and certain therapy services delivered through HCBS waivers or state plans, also have limited or no Medicare payment counterparts.

Restricting states' ability to direct additional resources to these child-serving providers and services, the proposal would worsen existing workforce shortages and reduce access to care for children enrolled in Medicaid. Pediatric specialists, behavioral health providers, dentists, home health agencies, and other providers may face greater financial challenges in serving Medicaid patients, particularly in rural and underserved communities. Ultimately, the proposal risks reducing children's access to timely, high-quality care and weakening the pediatric care infrastructure that children and families rely on across the country.

Medicare-Based Payment Limit for "Targeted" Services in Medicaid Fee-for-service (FFS)

We recommend CMS withdraw its proposal to establish a new Medicare-based limit for targeted Medicaid fee-for-service payments, as this policy exceeds the requirements of H.R. 1 and further jeopardizes access to care for children. Compounding these concerns, the proposal would apply to existing targeted fee-for-service supplemental payments without allowing any transition or phase-out period, creating the potential for significant and immediate funding disruptions for providers that rely on these payments. Because Medicaid payment rates consistently fall below the cost of providing care, supplemental payment programs play a critical role in preserving children's access to care. These funding mechanisms help states support pediatric providers that serve a large share of Medicaid-covered children and address longstanding gaps between Medicaid payments and the actual cost of delivering pediatric services. Supplemental payments help sustain provider capacity, workforce, and infrastructure necessary to ensure children can access preventive, primary, specialty, behavioral health, dental, and other essential services. Without these payments, many pediatric providers would face significant financial challenges that would limit their ability to serve children and families.

Congress has long recognized that base Medicaid payment rates alone are often insufficient to ensure adequate provider participation and beneficiary access to care. Supplemental payment programs have therefore become an essential component of Medicaid financing, helping states maintain strong pediatric provider networks and ensuring children can obtain timely access to needed services. The proposal to establish a new Medicare-based limit would undermine these

longstanding investments by restricting states' ability to direct additional resources to providers serving large numbers of Medicaid beneficiaries, despite no clear statutory requirement in H.R. 1 to do so. By further constraining Medicaid payment capacity at the same time that states and providers are adapting to other significant Medicaid financing changes enacted through H.R. 1, the proposal would compound financial pressures across the pediatric health care system.

Pediatric providers are particularly vulnerable to these changes because Medicaid is the largest insurer of children and accounts for a substantial share of pediatric health care financing. Many pediatric providers already operate within narrow financial margins due to chronic Medicaid underpayment and the unique costs associated with caring for children. The proposed limits on targeted fee-for-service payments, combined with other Medicaid financing restrictions included in H.R. 1, would further widen the gap between payment and the cost of care, making it more difficult for pediatric providers to maintain services and meet the needs of children and families. Over time, these pressures would contribute to reduced provider participation in Medicaid and diminished access to care for children.

By imposing restrictions that are not required under H.R. 1, the proposal would unnecessarily curtail state flexibility and weaken an important tool that states use to strengthen pediatric provider networks and address access challenges. Preserving state flexibility to make targeted provider payment enhancements is essential to ensuring that children can access the care they need when and where they need it. Reductions in these payments could exacerbate existing shortages of pediatric specialists, behavioral health providers, dentists, and other clinicians who care for children, particularly in underserved and rural communities. Most importantly, the proposed policy risks shifting the burden onto children and families through longer wait times, fewer participating providers, reduced service availability, and diminished access to high-quality pediatric care. Therefore, we recommend that CMS withdraw its proposal to establish a new Medicare-based limit for targeted Medicaid fee-for-service payments.

Other Provisions Beyond the Scope of H.R. 1

In addition to the policies outlined above, CMS proposes additional harmful provisions that go beyond the requirements of H.R. 1. These proposals include the following:

- Applying Medicare-based SDP limits to the territories, rather than only to the states and the District of Columbia as specified in H.R. 1. The rule would also apply SDP limits to SDPs that do not require prior approval, which is not required by H.R. 1.
- Prohibiting the use of “uniform” SDPs, which would require states to completely restructure most of their existing SDPs (even if grandfathered) or, as is likely, eliminate many of them.
- Restricting the availability of grandfathering protections under H.R. 1. For example, the proposed rule eliminates one criterion for grandfathering—a good-faith exception—which is specifically provided under H.R. 1. CMS further proposes requiring states to satisfy *both* of the other two H.R. 1 criteria (rather than only having to satisfy one or the other). The proposed rule would also effectively shorten the grandfathering period by reducing total SDPs by 10 percent each year, irrespective of how much SDPs currently exceed the Medicare-based limits.

By proposing restrictions that exceed those enacted by Congress in H.R. 1, CMS would further limit states’ ability to use Medicaid financing tools to support providers that furnish critical services to children and families. These additional restrictions, combined with other H.R. 1

payment limitations, would significantly reduce states' flexibility to sustain investments in pediatric providers and children's health systems across the country, forcing states to make difficult decisions about how to absorb funding reductions. As a result, states may be compelled to reduce provider payments, scale back investments in pediatric workforce capacity and care delivery infrastructure, or accept reduced provider participation in Medicaid and diminished service availability. Given that pediatric providers already operate under payment structures that often fail to cover the full cost of care, further reductions in Medicaid funding could threaten access to preventive services, specialty care, behavioral health treatment, and services for children with complex medical needs. Children in rural and underserved communities would be particularly vulnerable to provider shortages, longer wait times, and increased travel distances for care. Collectively, these policies would undermine states' ability to maintain robust pediatric provider networks and could ultimately reduce access to timely, high-quality care for the millions of children who rely on Medicaid.

Therefore, we recommend that CMS withdraw these provisions that go beyond the scope of H.R. 1.

Proposed New Medicare Limits on SDPs

Value-based Payment (VBP) SDPs

We recommend CMS withdraw its proposal to apply the Medicare-based limit to VBP SDPs. VBP approaches are an important tool for improving children's access to care and advancing better health outcomes. These arrangements give states and providers the flexibility to invest in care models that address children's needs more effectively, including care coordination, preventive services, population health initiatives, and interventions that address drivers of poor health before they result in more serious and costly health conditions. By aligning payment with quality and outcomes rather than volume alone, VBP SDPs help support a more accessible, integrated, and child-centered system of care. They also enable states to address persistent barriers to care, particularly for children with complex medical needs, behavioral health conditions, developmental disabilities, and those living in rural and underserved communities.

Promoting improved health outcomes and strengthening access to care for children should remain a central policy objective. CMS has long recognized the importance of testing and advancing value-based payment models in Medicare to improve outcomes, enhance care coordination, and promote more efficient care for seniors. Given that Medicaid is the nation's largest insurer of children, it is equally important that states and providers have the flexibility to pursue value-based approaches that improve child health outcomes and generate long-term value. However, the rule's proposal to require states to implement a "detailed validation methodology" ensuring that value-based SDPs do not exceed the Medicare-based limit on a service-code basis may introduce significant administrative and operational constraints. The proposed retrospective reconciliation approach would mean that providers who successfully reduce utilization and improve outcomes may be required to return a portion of their payments, effectively penalizing investments in care management, care coordination, and other value-enhancing activities.

States across the country are already using SDP-supported value-based models to improve children's access to care and strengthen pediatric delivery systems. In Colorado, SDP funding supports comprehensive, team-based care for children through investments in rural subspecialty outreach, care coordination, family navigation, integrated behavioral health

services, and support for primary care providers caring for children with autism. In New York, SDPs support several value-based and access-focused initiatives, including maternity and neonatal care models that reward high-quality NICU care, pediatric ambulatory surgery programs that help ensure adequate payment for pediatric anesthesia services, and patient-centered medical homes that improve care coordination and access for children. In Ohio, SDP-funded quality initiatives support adolescent well-child visits, quality improvement efforts aimed at reducing premature births, and innovative partnerships that connect children in rural Appalachian communities to scarce pediatric specialty services.

The proposal would also undermine innovative pediatric payment models that states have developed to address local access challenges. For example, South Carolina uses SDP-supported programs to support physician training programs and critical pediatric services, including therapies and home-based care, helping address existing shortages and lengthy wait times for services such as speech therapy. In Virginia, value-based arrangements through the Cardinal Care program have provided critical support to pediatric practices and quality improvement efforts, but these models would become significantly more difficult to sustain under a Medicare-based payment cap. Texas similarly relies on large SDP programs to support pediatric and hospital services across the state, and reductions in allowable payments could significantly weaken providers' ability to maintain access to care for children, particularly for services that have no meaningful Medicare equivalent.

Ultimately, applying a Medicare-based limit to VBP SDPs is particularly problematic because the costs of many pediatric services, community-based services, and innovative care interventions are not readily captured by Medicare payment methodologies. A rigid service-code-based payment ceiling fails to account for the value of investments in care coordination, behavioral health integration, family support services, rural outreach, and other activities that improve access and outcomes for children. Rather than promoting value, the proposal could discourage innovation, limit states' ability to address pediatric workforce shortages and access gaps, and weaken successful models that help children receive care earlier, closer to home, and in the most appropriate setting.

For these reasons, we recommend that CMS withdraw its proposal to apply the Medicare-based limit to VBP SDPs. Preserving state flexibility to design and implement pediatric-focused value-based payment arrangements is essential to improving children's access to care, supporting provider participation, and advancing better long-term health outcomes for children and families.

The undersigned organizations appreciate the opportunity to comment on the proposed rule. Please contact Milena Berhane at milena.berhane@childrenshospitals.org or (202) 753-5521 with any questions or if you need any additional information.

Sincerely,

National Organizations

American Academy of Pediatrics
Children's Hospital Association
Academic Pediatric Association
American Academy of Family Physicians
American Pediatric Society

American Thoracic Society
Association of Medical School Pediatric Department Chairs
Catholic Health Association of the United States
Family Voices National
First Focus on Children
Georgetown University Center for Children and Families
March of Dimes
National Association of Pediatric Nurse Practitioners
North American Society for Pediatric Gastroenterology, Hepatology and Nutrition
Pediatric Policy Council
Society for Pediatric Research
The National Alliance to Advance Adolescent Health

State Organizations

AAP Colorado
American Academy of Pediatrics New York Chapter 1
American Academy of Pediatrics, CA Chapter 3
American Academy of Pediatrics, DC Chapter
American Academy of Pediatrics, Hawaii Chapter
American Academy of Pediatrics, Virginia Chapter
Arizona Chapter of the American Academy of Pediatrics
Children's Community Pediatrics
Florida Chapter of American Academy of Pediatrics, Inc.
Georgia Chapter, American Academy of Pediatrics
Idaho Chapter of the AAP
Illinois Chapter, American Academy of Pediatrics
Iowa Chapter of the American Academy of Pediatrics
Kansas Chapter, American Academy of Pediatrics
KY AAP
Maine Chapter, American Academy of Pediatrics
Maryland Chapter, American Academy of Pediatrics
Massachusetts Chapter of the American Academy of Pediatrics
Michigan Chapter American Academy of Pediatrics
Minnesota Chapter, American Academy of Pediatrics
Mississippi Chapter of the American Academy of Pediatrics
Montana Chapter of the American Academy of Pediatrics
NC Pediatric Society
Nevada Chapter, American Academy of Pediatrics
NHAAP
Ohio Chapter, American Academy of Pediatrics
Oregon Pediatric Society
PA Chapter, American Academy of Pediatrics
Tennessee Chapter of the America Academy of Pediatrics
Wisconsin Chapter of the American Academy of Pediatrics (WIAAP)