Submitted via Regulations.gov

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 Administrator Oz:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to comment on the Department of Health and Human Services' ("HHS" or "the Department") proposed rule, *Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments* ("Proposed Rule")[1].

The Proposed Rule aims to implement a vision of Medicaid financing that is far more restrictive than any passed by Congress. Not only does HHS seek to implement a draconian version of the payment limits specified for certain state directed payments (SDPs) under § 71116 of the so-called "One Big, Beautiful Bill Act" (OBBBA), it proposes sweeping cuts to provider payments for services, geographic locations, and delivery systems far beyond what is required or authorized under the statute.

As a result, the Proposed Rule would reduce federal Medicaid spending by over $510 billion dollars by 2035, more than triple the Congressional Budget Office (CBO) estimate of the effects

of § 71116 of OBBBA. When combined with state funding cuts, the Proposed Rule would slash overall Medicaid funding by a staggering $774.8 billion.[2] If finalized as proposed, the Proposed Rule would exacerbate existing systemic barriers to accessing high-quality care in Medicaid, with foreseeable and harmful consequences for beneficiaries.[3]

SDPs and supplemental payments in fee-for-service (FFS) Medicaid allow states to target provider payments to support beneficiary needs, particularly in settings where base Medicaid payments are not sufficient to cover the cost of providing care.[4] These payment mechanisms are fundamental to the stability of state health care budgets, and ensure that hospitals, nursing facilities, emergency medical services, and community-based settings remain viable.

NHeLP supports thoughtful guardrails on SDPs and FFS supplemental payments. We agree with the Department that states and HHS share an obligation to ensure that payments that flow through these pathways are fiscally sound, transparent to the public, and consistent with existing statutory and regulatory obligations. Specifically, we have repeatedly urged HHS to acknowledge its obligations to enforce requirements under § 1902(a)(30)(A) of the Social Security Act governing the adequacy of rates; and to take steps to ensure that Medicaid beneficiaries and the general public have access to detailed information regarding Medicaid payment rates, including SDPs.[5] The Proposed Rule rejects

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[1] HHS, *Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments*, 91 Fed. Reg. 34000 (May 22, 2026).

[2] Proposed Rule at 30451-30452; CBO, *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] *See, e.g.,* Jane Zhu, et al., *"Ghost" Physicians: More Than One-Quarter Of Physicians Enrolled In Medicaid Delivered No Care To Beneficiaries In 2021,"* HEALTH AFF., Vol. 45, No. 2 (Feb. 2, 2026), https://doi.org/10.1377/hlthaff.2025.00703; Allen M. Chen, *Re-Evaluating Access in Healthcare: Focus on Quality of Care,* PUBLIC HEALTH CHALLENGE (Nov. 11, 2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC12604675; Howard H. Goldman, *How Phantom Networks And Other Barriers Impede Progress On Mental Health Insurance Reform*, HEALTH AFF., Vol. 41, No. 7 (July 5, 2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00541; Jane Zhu, et al., *Phantom networks: discrepancies between reported and realized mental health access in Medicaid*, HEALTH AFF., Vol. 41, No. 7 (July 5, 2022), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00052.

[4] Alice Burns, et al., KFF, *Spending on Medicaid State Directed Payments Before New Limits Take Effect* (June 15, 2026), https://www.kff.org/medicaid/spending-on-medicaid-state-directed-payments-before-new-limits-take-effect; MACPAC, *Directed Payments in Medicaid Managed Care* (October 2024), https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf ("MACPAC 2024"); Justin H. Markowski, et al., *Variation in Medicaid and Medicare Payment Rates to Community Health Centers, 2023,* HEALTH AFF., Vol 45, No. 4 (April 6, 2026), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2025.00949; HHS, Office of the Assistance Sec'y for Planning and Evaluation, *Assessing Medicaid Payment Rates and Costs of Caring for the Medicaid Population Residing in Nursing Homes: Final Report* (Oct. 11, 2024), https://aspe.hhs.gov/reports/assessing-medicaid-payments-costs-nursing-homes.

[5] *See* Nat'l Health Law Prog., *Comments on CMS-2442-P, Ensuring Access to Medicaid Services* (June 30, 2023), https://healthlaw.org/resource/comments-on-proposed-medicaid-managed-care-

this type of measured approach, however. Instead, the Department's proposals would override statutory requirements under OBBBA and the Medicaid Act to pursue the Administration's primary goal: reducing federal support for Medicaid.

We are also concerned by repeated implications throughout the Proposed Rule that a state's use of lawful and highly-regulated payment mechanisms and funding sources, such as intergovernmental transfers and provider taxes, automatically triggers program integrity concerns. This rhetoric is deeply troubling in the context of the Administration's demonstrated willingness to inflate and weaponize unsupported fraud allegations against states and health care providers.[6]

For these reasons and others articulated in these comments, we urge HHS to withdraw the Proposed Rule. 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.

I. HHS Fails to Address the Impact of the Proposed Rule on Medicaid Beneficiaries

As HHS acknowledged in 2024:

> provider payment influences access [to care], with low rates of payment limiting the network of providers willing to accept Medicaid patients, capacity of those providers who do participate in Medicaid, and investments in emerging technology among providers that serve large numbers of Medicaid beneficiaries.[7]

Indeed, the research on the relationship between provider payments and beneficiary access to care is settled: higher provider reimbursement improves access to and quality of care.[8] SDPs and FFS supplemental payments offer states tools to increase provider

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access-rule; *Comments on CMS-2439-P, Medicaid and CHIP Managed Care Access, Finance, and Quality (June 30, 2023)*, https://healthlaw.org/resource/comments-on-proposed-medicaid-access-rule; *Comments on CMS-2393, Medicaid Fiscal Accountability Regulation* (Feb. 1, 2020), https://www.regulations.gov/comment/CMS-2019-0169-2922; *Comments on CMS-2408-P, Proposed Rule on Medicaid and CHIP Managed Care* (Jan 18, 2019), https://www.regulations.gov/comment/CMS-2018-0140-0211.

[6] *See*, *e.g.,* Nat'l Health Law Prog., *NHeLP Condemns Weaponization of Medicaid Data to Justify $1 Trillion in Cuts* (Feb. 15, 2026), https://healthlaw.org/news/nhelp-condemns-weaponization-of-medicaid-data-to-justify-1-trillion-in-cuts; Ctr. on Budget and Pol'y Priorities, *Federal Government's Attacks on Medicaid Are a Pretext to Weaken the Program and Punish Particular States* (March 4, 2026), https://www.cbpp.org/blog/federal-governments-attacks-on-medicaid-are-a-pretext-to-weaken-the-program-and-punish.

[7] U.S. Dep't of Health & Human Svcs., *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality,* 88 Fed. Reg. 28092, 28014 (May 3, 2023).

[8] Edward Alan Miller, et al., *The Effects of Medicaid Payment and Payment-to-Cost Ratio on Nursing Home Five-Star Quality Ratings*, J. OF THE POST-ACUTE AND LONG-TERM CARE MEDICAL ASS'N, Vol. 27, Issue 2 (Feb. 2026), https://www.jamda.com/article/S1525-8610(25)00559-6; Diane Alexander and Molly Schnell, NBER Working Paper No. 26095, *The Impacts of Physician*

payments when base rates are inadequate to ensure beneficiary access to care as required by the Medicaid Act.[9]

Because SDPs and FFS supplemental payments are used to increase provider reimbursement, the Proposed Rule would mandate a nationwide pay cut for providers that serve Medicaid beneficiaries. And yet, HHS offers no meaningful assessment of the effects of the Proposed Rule on beneficiaries' access to care, acknowledging only that "there may be adverse impacts on providers and consequently beneficiaries."[10]

Cuts of the magnitude proposed by the Department would almost certainly restrict access to covered services for Medicaid beneficiaries. Providers that are unable or unwilling to accept permanent, deep rate reductions will limit the number of Medicaid patients they serve or simply drop out of Medicaid entirely. Providers that rely heavily on Medicaid payments, such as safety net hospitals, will face severe financial distress. Many will reduce services or even close their doors.[11] Ignoring the effects of such significant changes on those the Medicaid program is designed to serve is an unacceptable omission. The Proposed Rule's failure to address the effects of its proposed cuts on beneficiaries deprives the public of the opportunity to understand the impact of the rule and comment accordingly.

II. The Proposed Rule Exceeds HHS' Statutory Authority

As HHS acknowledges in the Proposed Rule, "there are circumstances under which requiring managed care plans to make specified payments to health care providers is an

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Payments on Patient Access, Use, and Health (July 2019), https://www.nber.org/system/files/working_papers/w26095/w26095.pdf and summarized at National Bureau of Economic Research, *Increased Medicaid Reimbursement Rates Expand Access to Care* (October 2019), https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care; Kayla Holgash and Martha Heberlein, *Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't*, HEALTH AFF. FOREFRONT (April 10, 2019), https://www.healthaffairs.org/content/forefront/physician-acceptance-new-medicaid-patients-matters-and-doesn-t; Michael Barnett, et al., *State policies and enrollees' experiences in Medicaid: Evidence from a new national survey,* HEALTH AFF., Vol. 27, No. 10 (Oct. 1, 2018), https://doi.org/10.1377/hlthaff.2018.0505; Joanna Bisgaier, et al., *Factors associated with increased specialty care access in an urban area: the roles of local workforce capacity and practice location*, J. OF HEALTH POLITICS, POL'Y AND L., Vol. 39, No. 6 (Sep. 23, 2014), https://pubmed.ncbi.nlm.nih.gov/25248959.

[9] § 1902(a)(30)(A); § 1903(m)(2)(A)(iii); § 1932(b)(5).

[10] Proposed Rule at 30447.

[11] American Association of Pediatrics, *AAP leaders: Proposed Medicaid rule changes could have 'devastating' impact* (May 22, 2026), https://publications.aap.org/aapnews/news/35249/AAP-leaders-Proposed-Medicaid-rule-changes-could; Jesse Pines, *Trump's Beautiful Bill Puts 400 Hospitals At Risk of Closing. Here's the Full List*, FORBES (April 30, 2026), https://www.forbes.com/sites/jessepines/2026/04/30/trumps-beautiful-bill-puts-400-hospitals-at-risk-of-closing-heres-the-full-list; Anne O'Hagen Karl, et al., Manatt, *How States Can Ensure Safety Net Hospitals Benefit from the New Medicaid Access Rule* (July 24, 2024), https://www.manatt.com/insights/newsletters/health-highlights/how-states-can-ensure-safety-net-hospitals-benefit.

important tool in furthering the State's overall Medicaid program goals and objectives."[12] States have used SDPs to pay for services and promote state health priorities in settings ranging from hospitals[13] and nursing facilities[14] to community-based clinics.[15]

Since the first Trump Administration, HHS has used the average commercial rate (ACR) as the payment limit for SDPs, codifying the limit for certain services in 2024.[16] § 71116 of OBBBA requires the Secretary to amend 42 C.F.R. § 438.6(c)(2)(iii) to reduce certain SDP payment limits. This subparagraph of the SDP regulations applies to a group of SDPs that both require prior CMS approval and provide payments for four categories of services: inpatient hospital services, outpatient hospital services, nursing facility services, and professional services in an academic medical center (the "four OBBBA services").[17] Under OBBBA, payment limits for these SDPs must be limited to 100% of the Medicare rate in states that have expanded Medicaid to low-income adults; 110% of the Medicare rate in other states; or, in the absence of a published Medicare rate, the Medicaid state plan rate (or waiver rate) for a given service. Section 71116(b) of OBBBA establishes grandfathering criteria that would permit some SDPs to phase down to the new payment limits gradually. Because the ACR is generally much higher than Medicare or Medicaid rates for the same

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[12] Proposed Rule at 30411.

[13] North Carolina's primary hospital services SDP "will support the financial sustainability of hospitals that serve large proportions of Medicaid-covered individuals…ensure a sufficient number of hospitals engage in each managed care plan's network to provide timely access to services…and will support provider efforts to improve performance." North Carolina also leverages the SDP to promote state medical debt relief priorities for Medicaid beneficiaries and other low-income residents. North Carolina SDP Preprint Approval (January 17, 2025), https://www.medicaid.gov/medicaid/managed-care/downloads/NC_Fee_IPH.OPH.BHI.BHO_Renewal_20250701-20260630.pdf; NCDHHS, *CMS Approves North Carolina's Medical Debt Relief Incentive Program* (July 29, 2024), https://www.ncdhhs.gov/news/press-releases/2024/07/29/cms-approves-north-carolinas-medical-debt-relief-incentive-program.

[14] Citing the ongoing effects of COVID-19 on nursing facility services in the state, a Tennessee SDP provides a 3.6% payment increase for nursing facilities "in order to preserve access for TennCare members to high quality and appropriate care." Tennessee SDP Preprint Approval (April 2, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/TN_Fee_NF_Renewal_20260101-20261231.pdf.

[15] This Oklahoma SDP leverages a state-funded managed care provider incentive fund created by legislators to address concerns with network adequacy in managed care including; for example, by providing a $25 uniform increase for specific high-value preventive services furnished by certain non-physician providers, including after-hours care visits, well visits, and SBIRT screenings. Oklahoma SDP Preprint Approval (March 19, 2024), https://www.medicaid.gov/medicaid/managed-care/downloads/OK_Fee_Oth2_New_20240401-20250630.pdf.

[16] U.S. Dep't of Health and Human Svcs., *Ensuring Access to Medicaid Services,* 89 Fed. Reg. 40542, 41067 (May 10, 2024). *See also* Proposed Rule at 30405; 42 C.F.R. § 438.6(c)(2)(iii).

[17] SDPs that use minimum fee schedules based on state plan rates or 100% of the Medicare rate are generally exempt from written prior approval requirements. 42 C.F.R. § 438.6(c)(2)(i).

service, NHeLP and other stakeholders raised concerns about the impact of the law's SDP cuts to Medicaid beneficiary access to care following its enactment.[18]

Despite these warnings of beneficiary harm based on the statute's already-severe funding cuts, the Proposed Rule would impose an even more expansive restriction on Medicaid provider payments than those passed by Congress. The Proposed Rule would significantly exceed the changes required under OBBBA, including:

- Applying payment limits under § 71116(a) of OBBBA to **all** services and **all** types of SDPs (not just the four OBBBA services);
- Applying the requirements of the Proposed Rule to U.S. territories, which were excluded from OBBBA's changes to SDPs under § 71116(d)(3);
- Mandating that states apply payment limits on a per-service rather than an aggregate basis;
- Eliminating 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 FFS supplemental payments.

These changes are not authorized under OBBBA or the Medicaid Act. If finalized, they would undermine access to care in both managed care and FFS Medicaid, in violation of the statutory requirements to maintain actuarially sound rates in managed care and ensure equal access to coverage for all Medicaid beneficiaries.[19]

A. Provisions of the Proposed Rule Directly Conflict § 71116 of OBBBA

Certain provisions of the Proposed Rule conflict directly with the text of § 71116 of OBBBA. For example, § 71116(b) creates three distinct pathways for SDPs to be eligible for grandfathering rules. The Proposed Rule combines two of the pathways into a single, combined requirement and effectively erases the third, rewriting the statutory text and replacing it with more stringent criteria.[20] This misinterpretation is not only legally

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[18] Nat'l Health L. Prog., *Medicaid Financing After OBBBA: State Directed Payments and Provider Taxes* (Sept. 17, 2025), https://healthlaw.org/resource/medicaid-financing-after-obbba-state-directed-payments-and-provider-taxes; Nat'l Assn. for Behavioral Healthcare, *H.R. 1: Reduced State-Directed Payments*, https://www.nabh.org/wp-content/uploads/2025/09/State-Directed-Payments.pdf; Edwin Park, Geo. Ctr. for Children and Families, *New CMS Guidance on H.R. 1's Restriction of State Directed Payments* (Feb. 4, 2026), https://ccf.georgetown.edu/2026/02/04/new-cms-guidance-on-h-r-1s-restrictions-of-state-directed-payments.

[19] § 1902(a)(30)(A); § 1903(m)(2)(A)(iii).

[20] The statutory pathways are: 1) Receipt of written prior approval of a preprint; 2) submission of a completed preprint; or 3) a "good faith effort" to receive such approval. The Proposed Rule would collapse the "good faith effort" pathway into the distinct "submission of a completed preprint" pathway, despite acknowledging that states "often request extensive technical assistance on SDP policies and regulatory requirements," which suggests that there are ample opportunities prior to final approval during which the Department could determine whether a state has made a "good faith effort" to achieve approval. *See* Proposed Rule at 30418.

insupportable but would have significant consequences for states, providers, and beneficiaries. Given that the average ACR for inpatient hospital services is more than 200% of the Medicare rate—and exceeds 300% in some states—an SDP that cannot be grandfathered due to the Proposed Rule's stricter interpretation of OBBBA could face immediate cuts amounting in certain circumstances to hundreds of millions of dollars or more.[21]

Additionally, Congress directed the Department to amend payment limits under 42 C.F.R. § 438.6(c)(2)(A) with respect to SDPs in "states," defined at § 71116(d)(3) as "1 of the 50 States or the District of Columbia." Lawmakers excluded U.S. territories from the definition and therefore from the new payment limits. Notably, Medicaid programs in U.S. territories are funded through annual block grants and temporary supplemental funds that already cap federal spending, reducing any perceived risk that territorial SDPs might drive unnecessary federal spending.[22] However, the Proposed Rule would extend OBBBA's payment limits to the territories, apparently on the basis of HHS' own determination that doing so is "prudent and necessary." This would immediately affect Medicaid providers and beneficiaries in Puerto Rico, which is the only territory with current approved SDPs. For example, CMS recently renewed an SDP for payments up to $123,350,308 to "sustain access to inpatient hospital services" and "support payment and delivery system transformation activities". [23] Although Congress would have excluded this SDP from new payment limits, HHS has substituted its own judgment and would require the territory come into compliance not only with new payment limits, but with the extensive additional changes in the Proposed Rule discussed elsewhere in these comments.

B. The Proposed Rule Would Reduce Access to Care in Conflict with Statutory Requirements

Most of the changes in the Proposed Rule are outside of the scope of, and not authorized by, OBBBA. While the Department is authorized to regulate SDPs and FFS supplemental payments to the extent its interpretation is aligned with the text and purpose of the Medicaid Act, the Proposed Rule is out of step with both the letter and intent of the law. If finalized as proposed, the Proposed Rule would almost certainly reduce beneficiary access

[21] *See* Christopher Whaley, et al., RAND, *Prices Paid to Hospitals by Private Health Plans* (May 17, 2022), https://www.rand.org/pubs/research_reports/RRA1144-1.html; Preethi Rao, et al., *State-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act* (June 18, 2026), https://www.rand.org/pubs/research_reports/RRA4098-1-v2.html.

[22] MACPAC, *Medicaid and CHIP in the Territories* (Feb. 2021), https://www.macpac.gov/wp-content/uploads/2019/07/Medicaid-and-CHIP-in-the-Territories.pdf. Note that Puerto Rico's effective matching rate will be reduced from 76% to 55% beginning in fiscal year 2028. *See* Akash Pillai, et al., KFF, *Recent Changes in Medicaid Financing in Puerto Rico and Other U.S. Territories* (Oct. 28, 2024), https://www.kff.org/elections/recent-changes-in-medicaid-financing-in-puerto-rico-and-other-u-s-territories.

[23] Puerto Rico SDP Preprint Approval (April 26, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/PR_Fee_IPH_Renewal_20251001-20260930.pdf.

to care, undermining the very statutory requirements the Department claims would authorize its actions.

1. § 438.6 — SDP Proposals Beyond Those Required Under OBBBA

With respect to SDP-related proposals that go beyond OBBBA, HHS relies on its authority under § 1903(m)(2)(A)(iii) of the Medicaid Act to regulate the actuarial soundness of risk-based contracts between states and MCOs. Under 42 C.F.R. § 438.4, actuarially sound capitation rates are defined as those that are

> projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract [between the state and an MCO] for the time period and the population covered under the terms of the contract.

In other words, "actuarial soundness" is intended to ensure that capitated payments are sufficient to provide enrollees with access to required services. States ensure actuarial soundness during contract negotiations with MCOs through a number of mechanisms; for example, adhering to federal requirements for network adequacy and quality standards.[24] But the Proposed Rule would sharply restrict SDPs by lowering payment limits across the board and imposing new administrative burdens on states, making it more challenging and costly for states to develop SDPs and more difficult for plans to attract and retain high-quality providers. These outcomes are in direct conflict with the goals of actuarial soundness.

The Proposed Rule would extend OBBBA payment limits to all services and all SDPs. 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. Such rates are not necessarily appropriate benchmarks for the specific needs of the Medicaid population. Medicaid is specifically designed to meet the needs of low-income individuals, who have disproportionate and more complex medical needs and health challenges.[25] Moreover, while Medicare is primarily designed to cover the needs of people over age 64, Medicaid covers people of all ages, including low-income babies, children, adolescents, adults, and older adults.

Medicaid rates must reflect not only the diverse care needs of its beneficiaries, but the program's unique coverage and enrollment guarantees. For example, people who are eligible for Medicaid must be permitted to enroll quickly at any point of the year and remain eligible for a period of retroactive coverage, albeit shortened following OBBBA enactment.[26]

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[24] *See, e.g.,* 42 C.F.R. Part 438, Subpart E; § 438.68.

[25] Benjamin D. Sommers, The Commonwealth Fund, *Low-Income Americans and Health Reform: Unmet Needs, Significant Opportunities* (Oct. 8, 2014), https://www.commonwealthfund.org/blog/2014/low-income-americans-and-health-reform-unmet-needs-significant-opportunities.

[26] § 71112(a) of OBBBA.

Moreover, Medicaid provides coverage for some services that are not covered by most other payers, including home and community based services (HCBS) and other long-term services and supports (LTSS); and is the primary payer for services that are covered less frequently or less comprehensively by Medicare and private payers, such as maternity care, family planning, and behavioral health care services.[27] In cases where a published Medicare rate exists, states would be required to use that rate as the basis for a cap under the Proposed Rule, regardless of the appropriateness of the Medicare for Medicaid beneficiaries that require a given service.

Finally, while Medicaid is a jointly-funded program, states and not the federal government are responsible for administering Medicaid programs, which therefore reflect the differing needs of residents of and within the states. By extending OBBBA payment limits to all SDPs and all services, the Proposed Rule ignores the specific needs of Medicaid beneficiaries and the discretion that state Medicaid agencies have to develop appropriate provider payments, including for services that Congress did not include in its statutory changes under § 71116 of OBBBA.

HHS does not adequately justify its proposals to extend OBBBA payment limits on SDPs for services other than those listed in § 71116 of OBBBA. The Department does not explain how its general concerns related to SDPs apply to non-OBBBA SDPs, which account for just 1 to 2 percent of total SDPs.[28] First, throughout the Proposed Rule, the Department

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[27] As NHeLP noted in its comments on the 2023 Medicaid Access Proposed Rule, "While we think that the vast majority of these services subject to the comparative analysis will have a counterpart in Medicare, certain reproductive and sexual health services and behavioral health services may not. For behavioral health services, Medicare does not cover services that are essential for individuals with serious mental illness, such as … assertive community treatment. . . .. For reproductive and sexual health services, Medicare generally only covers contraception for non-contraceptive purposes. For example, Medicare does not cover Long-Acting Reversible Contraception (LARCs) but it is covered by Medicaid. Moreover, many reproductive health providers who serve Medicaid enrollees are not Medicare providers. Because there is a lack of coverage in Medicare for these specific behavioral and reproductive health services, there will be a gap in the analysis when it comes to ensuring that payment rates meet accessibility standards." *See* Nat'l Health Law Prog., *Comments on CMS-2439-P, Medicaid and CHIP Managed Care Access, Finance, and Quality (June 30, 2023)*, https://healthlaw.org/resource/comments-on-proposed-medicaid-access-rule; Wayne Turner, Nat'l Health L. Prog., *What Makes Medicaid, Medicaid? Five Reasons Why Medicaid is Essential to Low-Income People* (April 17, 2023), https://healthlaw.org/resource/what-makes-medicaid-medicaid; Children's Hospital Association, *7 Ways Pediatric Care is Different from Adult Care* (June 16, 2026), https://www.childrenshospitals.org/news/cha-blog/2026/06/7-ways-pediatric-care-is-different-from-adult-care. *See also* ASPE, Office of Behavioral Health, Disability, and Aging Pol'y, *Behavioral Health Crisis Services Billed to Commercial Insurance, Medicaid, and Medicare* (Jan. 14, 2025), https://aspe.hhs.gov/sites/default/files/documents/aa5c107a6537dacaa8d0e411d0856675/crisis-services-billed-insurance-medicaid-medicare-brief.pdf (noting that states have flexibility to use a variety of Medicaid codes to accurately reflect types of providers and different methods of delivery for crisis services (*e.g.* hotline services, peer support, bundled payment models) but absent additional rulemaking, Medicare is limited to providing psychotherapy for crisis services)).

[28] Proposed Rule at 30453.

professes concern that states are using intergovernmental transfers and provider taxes to pay for their share of SDPs. Although these are both lawful sources of state funding that are already subject to significant federal oversight, HHS clearly aims to discourage their use in order to further slash federal support for Medicaid.[29] Setting aside this broad vilification of valid types of non-federal funding, HHS does not demonstrate that SDPs other than those identified under § 71116 of OBBBA widely rely on either intergovernmental transfers or provider taxes. Indeed, a review of current SDP preprints indicate that SDPs that pay for many services not identified under OBBBA, such as primary care services, dental services, community-based behavioral health services, and HCBS simply do not rely on intergovernmental transfers or provider taxes to fund these services.[30] Therefore, extending OBBBA payment limits beyond the four OBBBA services does little to address HHS' purported concerns related to these types of state funding sources.

Second, the Department states that applying OBBBA payment limits universally "would help ensure that States do not engage in cost shifting, such as attempting to increase payments to providers for services other than the four [OBBBA] services."[31] This justification is both speculative and counter to meaningful, long-term cost reduction. The Department offers no evidence that states have used SDPs to engage in inappropriate cost-shifting behavior, specifically how states would do so in the future, or why it would be unable to address these concerns when evaluating individual SDP preprints for approval, particularly given the relatively low volume of SDPs that do not involve one of the four OBBBA services. However, HHS' proposed extension of OBBBA payment caps to all services would remove a tool that states can use to encourage the provision of care in less-costly settings when appropriate. Ultimately, the Department fails to provide sufficient evidence that the benefits of applying OBBBA payment limits and additional administrative burdens on SDPs for non-OBBBA services outweighs the likely effects on Medicaid beneficiaries of reducing access to providers by limiting payments.

The Proposed Rule would also dramatically increase state and MCO administrative burdens at a time when state budgets are already stretched past their breaking points as a result of OBBBA's cuts to taxes and health and nutrition programs.[32] For example, the Proposed Rule would require states to calculate all SDPs for all services on a per-claim or per-discharge basis, rather than on the current SDP-wide basis or an aggregate provider-

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[29] § 1903(w)(6), 42 C.F.R. § 433.51 (IGTs); §1903(w)(3)(A), 43 C.F.R. § 433.68 (provider taxes).
[30] CMS, "Approved State Directed Payment Preprints," https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.
[31] *Id.* at 30415-30416.
[32] Leighton Ku, et al., Commonwealth Fund, *H.R. 1 Funding Cuts Will Overshadow Gains from the New Rural Health Transformation Program* (June 9, 2026), https://www.commonwealthfund.org/publications/issue-briefs/2026/jun/hr-1-funding-cuts-rural-health-transformation; Jade Little and Adriana Kohler, Geo. Ctr. for Children and Families, *How H.R. 1 Cuts and Changes to Medicaid Played out in 2026 State Legislative Sessions (Part 2)*, https://ccf.georgetown.edu/2026/07/02/how-h-r-1-cuts-and-changes-to-medicaid-played-out-in-2026-state-legislative-sessions-part-2.

type basis as is typical in many FFS supplemental payments.[33] For a single SDP involving hospital rates, this could require a state to demonstrate that tens of thousands or more provider-specific discharge claims are aligned with Medicare rates, and guarantee that providers—with whom the state has no contractual relationship in the managed care context—are held to the Medicare- or Medicaid-specific payment limits for each claim.[34]

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.[35] This requirement would impact two-thirds of approved SDPs, regardless of whether they are already under proposed new payment limits.[36] Although 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, entirely prohibiting uniform increase SDPs is a clear overreaction to concerns related to specific SDPs. 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. HHS suggests that states could simply convert uniform increase SDPs to a maximum fee schedule set at the applicable payment limit. But this recommendation not only disregards the administrative burden of redesigning SDPs en masse but reduces state flexibility to design and implement appropriate payment increases.

Vastly increasing the administrative burden to develop and monitor SDPs that provide much lower payments 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. These outcomes are counter to the requirement to maintain actuarially sound rates that ensure access to sufficient, high-quality managed care

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[33] Proposed Rule at 30413. States would also be required to submit to CMS a list of Medicare or Medicaid rates, a list of each provider that may be eligible for the SDP along with individual National Provider Identifiers (NPIs), and a "detailed description of how the State would ensure that payment to each provider for each furnished service would not exceed the applicable payment limit." *Id.*

[34] Anne Karl and Avi Herring, State Health & Value Strategies, *CMS Releases State Directed Payment Proposed Rule* (May 27, 2026), https://shvs.org/cms-releases-state-directed-payment-proposed-rule (estimating that a state with 235 hospitals would need to submit 181,655 unique rates for inpatient hospital services alone).

[35] MACPAC 2024 at 4, Fig. 1, "Directed Payment Types and Projected Payment Amounts, 2024," https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf.

[36] States have used uniform increase SDPs to support access to a broad array of Medicaid services, including inpatient hospital services, 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/managedcare/downloads/CO_Fee_IPH.OPH.BHI.BHO_New_20250701-20260630.pdf (behavioral health); Nebraska SDP Preprint Approval (March 12, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/NE_Fee_D_Renewal_20260101-20261231.pdf (dental services).

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.

2. § 438.6(a) — Comment Solicitation: "Provider Classes"

HHS solicits comments regarding possible approaches to defining "provider class" to inform future notice-and-comment rulemaking.

We urge the Department to refrain from defining "provider class" in a way that would curtail state flexibility to design and implement SDPs to meet the needs of their beneficiary populations.[37] Requiring states to adhere to an artificially broad or rigid provider class definition would reduce the effectiveness of SDPs as a tool for promoting specific policies that may only apply to certain providers, such as rural providers, or specific quality initiatives, such as participation in a learning collaborative.[38]

The Department expresses concerns that states are defining "provider class" narrowly to achieve aims that are insufficiently correlated with its quality strategy or designed to hold specific providers harmless from non-federal funding sources.[39] But CMS already has "authority to request additional information from States regarding provider classes identified in SDP preprints" as part of the preprint review under 42 C.F.R. § 438.6(c)(2)(1); and to withhold or disallow approval of a preprint if a specific SDP does not meet all regulatory requirements.

Finally, NHeLP disputes the Department's characterization of policies concerning medical debt or uncompensated care as "not directly tied to Medicaid managed care delivery."[40] One hundred million Americans carry medical debt, with 44% of these owing $2,500 or more.[41] Medical debt increases financial instability for individuals, decreasing access to care and making Americans poorer and sicker on a population level.[42] The consequences

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[37] "For example, a State may direct managed care plan expenditures to ensure that certain minimum payments are made to safety net providers to ensure access to care, to enhance provider payment as mandated by State legislative directives, or to make quality payments to ensure providers are appropriately rewarded for meeting certain program goals." Proposed Rule at 30403.

[38] *Id*. at 30429.

[39] 42 C.F.R. § 438.6(c)(2)(ii)(C).

[40] Proposed Rule at 30430.

[41] Lunna Lopes, et al., KFF, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (June 16, 2022), https://www.kff.org/health-costs/kff-health-care-debt-survey/#c7f7c77b-dec4-4baf-bed1-78e3522b4f46 ("Uninsured adults, women, Black and Hispanic adults, parents, and those with lower incomes are especially likely to say they have health care-related debt.")

[42] Xuesang Han, *Associations of Medical Debt With Health Status, Premature Death, and Mortality in the US*, JAMA NETWORK OPEN (March 4, 2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC10912961; Sara R. Collins, et al., *Paying for It: How Health Care Costs and Medical Debt are Making Americans Sicker and Poorer* (Oct. 26, 2023), https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey.

of medical debt on households is profound and far-reaching, with more than 6 in 10 people with medical debt reporting that they cut back spending on food, clothing, and other basic necessities and nearly half spending all or nearly all of their savings to pay down medical debt.[43] Medical debt, which is largely involuntary and unavoidable, is not an accurate predictor of creditworthiness, yet a medical debt flag on a credit report can limit access to housing and employment.[44] Beyond the impacts to individuals, medical debt reduces access to care and increases costs to the entire health care system. Hospitals that provide a greater amount of uncompensated care are more likely to operate close to or at a financial loss, threatening their ability to keep their doors open to the community, particularly in rural areas.[45] Moreover, hospitals and other providers incorporate costs related to uncompensated care into the rates they charge across the board, increasing costs for everyone who uses health care services, regardless of payer.[46]

Research shows that financial assistance can counteract these effects, clearing the burden of past medical debt and increasing future access to low-cost, high-impact care, such as treatment for high cholesterol, diabetes, and depression.[47] While individuals who are currently enrolled in a Medicaid managed care plan may be insulated from care denials while they are actively enrolled, a significant number of people who are eligible for Medicaid experience coverage gaps, reflecting high rates of churn in the program.[48] Interruptions in Medicaid coverage lead former enrollees to defer care, driving medical debt during periods of uninsurance and increasing costs to the risk-based managed care system upon an

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[43] *See supra* n. 43.

[44] State Health & Value Strategies, *State Spotlight: North Carolina's Comprehensive Medical Debt Relief and Reform Incentive Program* (Nov. 2024), https://www.shvs.org/wp-content/uploads/2024/11/SHVS_State-Spotlight_North-Carolina_Final.pdf.

[45] *See, e.g.,* Va. Commonwealth Univ., Dep't of Health Behavior and Pol'y, *Hospital Uncompensated Care Costs in Virginia* (Sept. 2015), https://healthpolicy.vcu.edu/media/school-of-population-health/hbp-2023/policyBrief0915_ACC.pdf ("Among hospitals with uncompensated care costs of 10 percent or more of total costs, about half experienced financial losses from patient care in 2013. On average, these hospitals had operating margins near zero…[H]ospitals with a low burden of uncompensated care—less than 4 percent of total costs—performed much better financially, with average operating margins of 7.8 percent.")

[46] *See* Cheryl Fish-Parcham, Families USA, *If Millions Lose Health Insurance, We'll All Pay for It in Our Premiums* (June 20, 2017), https://www.familiesusa.org/resources/if-millions-lose-health-insurance-well-all-pay-for-it-in-our-premiums.

[47] Alyce Adams, et al., "The Impact of Financial Assistance Programs on Health Care Utilization: Evidence from Kaiser Permanente," Am. Econ. Rev. Insights, Vol. 4, No. 3 (Sept. 2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9634821; Rebekah Gee, *Medicaid Eligibility Expansion Is Also Associated With Improved Fiscal Health of Families*, Am. J. Pub. Health, Vol. 111, No. 8 (Aug. 31, 2021), https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2021.306387.

[48] Alex Olgin, NPR, *How North Carolina erased medical debt for 2.5 million people* (Jan. 21, 2028), https://www.npr.org/2026/01/21/nx-s1-5678541/north-carolina-undue-medical-debt-erased; Bradley Corallo, et al., KFF, "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies" (Dec. 14, 2021), https:www.kff.org/medicaid/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies.

individual's return to coverage.[49] Coverage loss and churn will be exacerbated by OBBBA implementation; in particular, work requirements and more frequent redeterminations could drive up to 10.1 million people to lose coverage in 2028.[50] Efforts to reduce medical debt and defray the costs of uncompensated care are closely linked to costs and access to care within the Medicaid managed care system. Such initiatives are therefore an appropriate element of an SDP that otherwise meets applicable requirements.

3. § 447.381 — FFS Targeted Payment Proposals

The Department's approach to FFS supplemental payments is similarly misaligned with its cited statutory authority. The Proposed Rule would graft the OBBBA payment limits onto the FFS system by reducing "targeted payments" to certain practitioners from the current ACR cap to 100% of the Medicare limit in an expansion state or 110% in a non-expansion state (or, in the absence of a published Medicare rate, the state plan limit). Like the SDP payment limits, these caps would be imposed on a service level, rather than the aggregate level that applies to other FFS supplemental payments subject to upper payment limits (UPLs).[51] These FFS changes are not authorized or even referenced under § 71116 of OBBBA, which deals exclusively with the subset of SDPs governed under 45 C.F.R. § 438.6(c)(2)(iii). Rather, the Department relies primarily on § 1902(a)(30)(A) to justify new FFS supplemental payment limits. This provision of the Medicaid Act, known as the "equal access provision," requires that state Medicaid programs "ensure payments are consistent with efficiency, economy, and quality, and are sufficient to enlist enough providers so that care is available to enrollees to the same extent as it is to the general population in the same geographic area". But as with the proposed changes to SDPs, HHS's proposals would sharply reduce provider payments, replace state flexibility to direct Medicaid-specific payments with payments based on Medicare rates, and greatly increase state administrative burdens with respect to design, implementation, and reporting. This will reduce the willingness of states to develop supplemental payments and discourage providers from participating in Medicaid, in conflict with the requirements of the equal access provision.

III. The Proposed Rule Would Harm Beneficiaries by Reducing Access to Critical Services and Undermining Value-Based Purchasing Models

In the absence of any meaningful assessment by HHS of the effects of the Proposed Rule on beneficiaries, NHeLP offers the following analysis of how the proposals would cause harm to people with Medicaid by reducing access to critical services, including HCBS and

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[49] Eric T. Roberts and Craig Evan Pollack, *Does Churning in Medicaid Affect Health Care Use?,* MED. CARE, Vol. 54, No. 5 (May 2016), https://pmc.ncbi.nlm.nih.gov/articles/PMC5548183.

[50] Matthew Buettgens, et al., Urban Institute and Robert Wood Johnson Fdn., *Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations:* (March 2026), https://www.rwjf.org/en/insights/our-research/2026/03/millions-could-lose-health-coverage-due-to-new-rules.html.

[51] *See, e.g.*, 42 C.F.R. §§ 447.271, 447.272, 447.321.

maternity care services, and by undermining incentives for states to develop value-based purchasing (VBP) SDPs.

A. Home and Community-Based Services

Historically, direct care work such as personal care services has been undervalued and undercompensated. Medicaid's typically low reimbursement rates for these services suppress wages and benefits and impedes recruitment and retention.[52] The median hourly wage for a home care worker is just $16.77 nationally, lower than the median wages than similar low-entry level occupations, such as customer service representatives, food preparation workers, and retail salespersons.[53] Meanwhile, demand for HCBS continues to grow as our population ages, and as more people with disabilities are able to choose to live in the community.[54] The result is what has been commonly referred to as the "direct workforce crisis," meaning that many people who have been determined to need HCBS and are entitled to it simply cannot find providers to deliver the service. The Proposed Rule risks worsening this crisis by limiting state flexibility to target payments in ways that ensure that gaps in need are accurately addressed.

The most common strategies states use to address the workforce crisis and increase availability of workers include raising provider rates, investing in worker education and training, and incentive payments to combat workforce shortages.[55] States may target rates to ensure individual beneficiary needs are met, adjusting rates dependent on qualities of

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[52] 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%20Short%20Report.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.

[53] 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.

[54] 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; 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.

[55] 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; CMS, *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 impact of COVID-19 on people with disabilities, including ensuing gaps in care).

beneficiaries, such as acuity, level of care, or risk of high utilization.[56] 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.[57] Retention payments can be particularly important for small agencies supporting individuals with high needs and prevent major disruptions in care.[58] 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 (when such rates exist) or state plan rates for HCBS to meet specific unmet needs. For example, Louisiana offers bonuses to certain private duty nurses, noting that they "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."[59] Louisiana then ensures that the total Medicaid payment does not exceed the average commercial rate.[60] 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. Such arrangements may be at serious risk under the Proposed Rule.

We are concerned that the 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

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[56] 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 at 31-33 (explaining payment strategies available to support policy goals, including strategies in additional to capitation rates).

[57] 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.

[58] 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; CMS, *Medicaid Managed Care Options in Responding to COVID-19* (May 14, 2020), https://www.medicaid.gov/federal-policy-guidance/downloads/cib051420.pdf.

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

[60] *Id.*

have no Medicare associated rate, including personal care services.[61] The proposed definition of "state plan approved rates" excludes any FFS supplemental rates. If FFS supplemental rates for HCBS are excluded, it may be that states will 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.

Last, when states face budgetary constraints, states have historically cut funding for HCBS.[62] As noted above, the Proposed Rule would cut federal Medicaid spending by a whopping $510.1 billion dollars by 2035, compared to the $149 billion federal funding reduction estimated by CBO for § 71116 of OBBBA.[63] While HCBS may not be specifically targeted by the Proposed Rule, when federal funding for Medicaid is reduced and states are left with difficult choices, rate cuts for HCBS are a predictable outcome. 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.

B. Maternity Care

SDPs and FFS supplemental payments are essential financing mechanisms that enable states to sustain maternity care providers serving Medicaid beneficiaries, particularly in rural and underserved communities. The proposed reductions and limitations to these payment authorities would significantly undermine states' ability to address longstanding maternal health challenges at a time when the United States is experiencing both a maternal mortality crisis and unprecedented losses of gynecological and obstetric services.[64]

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[61] Proposed Rule at 30442.

[62] 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.

[63] 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.

[64] U.S. Dep't of Health & Human Servs., Office of the Assist. Sec'y for Health, *Report on Addressing the Maternal Health Crisis in the United States: An Update from the U.S. Department of Health and Human Services* (July 2024), https://aspe.hhs.gov/sites/default/files/documents/688063d3176311f3b2ee6c14f02bf4e4/rtc-maternal-health.pdf; Munira Z. Gunja, et al., Commonwealth Fund, *Insights into the U.S. Maternal Mortality Crisis: An International Comparison* (June 4, 2024), https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison; Katy B. Kozhimannil, et al., *Obstetric Care Access Continues to Decline at Rural and Urban Hospitals across U.S. States, 2010–2022*, HEALTH AFF., Vol. 44, No. 7 (July 7, 2025), https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01552.

Medicaid finances more than 40% of births nationwide and nearly half of births in rural communities.[65] Maternity care remains one of the most resource-intensive services hospitals provide, while Medicaid reimbursement has historically fallen well below the cost of care.[66] As a result, states increasingly rely on SDPs and FFS supplemental payments to preserve obstetric workforce capacity, maintain labor and delivery services, and expand access to prenatal, delivery, and postpartum care.

These mechanisms are especially critical as 35% of U.S. counties now lack maternity care services, more than 2.3 million women of reproductive age live in maternity care shortage areas, and nearly 300 rural hospitals discontinued obstetric services between 2011 and 2023.[67] As of 2022, more than half of all rural hospitals (52.4%) no longer offered obstetric care.[68] Since the enactment of OBBBA, the National Partnership for Women & Families found that 65 Labor and Delivery units, 17 reproductive health clinics, and 7 freestanding birth centers have closed nationwide.[69]

One of the most common types of SDPs states use to improve maternity care is a uniform payment or percentage increase. In the Proposed Rule, HHS contends that uniform payment or percentage increases "are not, in practice, being used to enhance services and ensure access for Medicaid beneficiaries, but rather to reward providers based on their ability to provide non-Federal share."[70] However, numerous states have used the uniform increase SDPs to preserve obstetric services, enhance maternal health quality, and expand access to care in rural communities.

For example, Georgia used a uniform increase SDP to provide additional funding to private rural hospitals that maintain and expand maternity and obstetric services. As Georgia explained in its approved preprint, the payment arrangement recognizes the need to support rural hospitals, and the additional funding "will allow participants to… grow the

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[65] KFF, *Births Financed by Medicaid by Metropolitan Status*, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid.

[66] Mary B. Baker et al., *Medicaid Cost and Reimbursement for Low-Risk Prenatal Care in the United States*, J. MIDWIFERY & WOMEN'S HEALTH, Vol. 66 Issue 5 (Sept./Oct. 2021), https://onlinelibrary.wiley.com/doi/10.1111/jmwh.13271.

[67] Rolonda Donelson, et al., Nat'l Partnership for Women & Families, *Republican's New Health Care Law Will Impact Over 130 Rural Labor and Delivery Units* (June 2025), https://nationalpartnership.org/report/republican-budget-bill-could-close-over-140-rural-labor-and-delivery-units; March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the US (2024)*, https://www.marchofdimes.org/maternity-care-deserts-report; Yasmeen Abutaleb, WASH. POST, *Medicaid cuts threaten rural hospitals — and access to maternity care* (Sept. 2025), https://www.washingtonpost.com/politics/2025/09/01/medicaid-cuts-rural-maternity-care.

[68] Katy B. Kozhimannil, et al., *Obstetric Care Access at Rural and Urban Hospitals in the United States*, JAMA, Vol. 333, No. 2 (Dec. 2024), https://jamanetwork.com/journals/jama/fullarticle/2827543.

[69] Nat'l Partnership for Women & Families, *OBBBA is Threatening Women's Health Care Access* (June 2026), https://nationalpartnership.org/report/obbba-is-threatening-womens-health-care-access.

[70] Proposed Rule at 30426.

neonatal workforce in Georgia's rural counties."[71] Similarly, Louisiana—where Medicaid finances approximately 64% of births, including 70% of births in nonmetropolitan areas—used a uniform increase SDP for inpatient and outpatient hospitals, including the Women's Hospital.[72] The Women's Hospital is Louisiana's largest maternity care provider and operates several maternal-fetal medicine satellite clinics serving the most rural communities across the state.[73]

States have also used uniform increase SDPs to improve postpartum care, one of the most effective strategies for reducing maternal mortality, as nearly two-thirds of pregnancy-related deaths occur during the postpartum period. New Mexico's uniform payment increase supports rural safety-net providers while tying payments to quality measures such as timely postpartum visits and postpartum depression screening.[74] Likewise, New York requires participating providers to attest that Medicaid beneficiaries received a comprehensive postpartum visit, including a postpartum depression screening within 12 weeks after delivery.[75]

As described further below, the rule also proposes to add administrative burdens that will undermine states' use of VBP SDPs to improve maternal health outcomes. For example, New Jersey's recent VBP SDP rewarded hospitals for achieving evidence-based maternal health quality measures, participating in statewide quality improvement initiatives, reducing racial disparities in maternal outcomes, and implementing systems that promote equitable, high-quality maternity care. The SDP was one part of a state program with the overarching goal to reduce preventable maternal morbidity and cut the state's maternal mortality rate by 50%.[76]

The Proposed Rule's restrictions would increase financial pressure on maternity care providers already operating on narrow margins, accelerate labor and delivery unit closures, reduce obstetric workforce capacity, and thereby further diminish access to maternity care. The resulting harms would fall most heavily on rural communities, low-income families, and communities of color.

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[71] Georgia Preprint Approval (March 2, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/GA_Fee_IPH.OPH5_New_20250701-20260630.pdf.
[72] Louisiana Preprint Approval (November 19, 2025), https://www.medicaid.gov/medicaid/managed-care/downloads/LA_Fee_IPH.OPH_Renewal_20250701-20260630.pdf.
[73] Women's Hospital, *A Labor of Love Celebration Woman's Hospital Awaits the Delivery of Its 400,000th Baby* (Feb 2025), https://www.womans.org/news/2025/labor-love-celebration.
[74] New Mexico Preprint Approval (July 26, 2024), https://www.medicaid.gov/medicaid/managed-care/downloads/NM_Fee_IPH.OPH6_New_20240101-20240630.pdf.
[75] New York Preprint Approval (Nov. 7, 2024), https://www.medicaid.gov/medicaid/managed-care/downloads/NY_Fee_OPH.PC.SP_New_20240401-20250331.pdf.
[76] New Jersey Preprint Approval (April 11, 2025), https://www.medicaid.gov/medicaid/managed-care/downloads/NJ_VBP_IPH.OPH_Renewal_20250701-20260630.pdf. This payment arrangement is part of the QIP-NJ program, designed to be a multi-year effort. This preprint addresses Measurement Year 5 of the effort. The first application was approved for the period July 1, 2020 to December 31, 2020.

C. Value-Based Purchasing SDPs

VBP SDPs link provider payment to quality of care, rather than the volume of submitted claims.[77] HHS has taken steps to encourage states to leverage SDPs to encourage providers to participate in VBP models.[78] States have designed and implemented VBP SDPs that implement pay-for-performance initiatives, population-based payments, and performance improvement initiatives.[79]

But the Proposed Rule undermines efforts to align payment with value by requiring states to reconcile SDPs on a per-service level to OBBBA's Medicare- or Medicaid-based payment limits. In doing so, the rule would eliminate "upside risk" above the applicable Medicare or Medicaid rate for providers that achieve quality or cost targets, and require the state to claw back any payments that exceed what Medicare or Medicaid would have paid for provision of the same service.

Such an approach is fundamentally at odds with the goals of VBPs to decouple payment from claims volume and promote accountability for health outcomes. Providers have little incentive to participate in value-based initiatives, including those that reduce aggregate costs, if their performance is rewarded at the same Medicare- or Medicaid-based rate regardless. The prospect of reconciliation and claw-back would discourage participation in innovative VBP SDPs, including those that use prospective payments to encourage providers to invest in cost-saving services that may not be billable under Medicare.[80] Moreover, the Proposed Rule would require states with VBP SDPs to adhere to onerous reporting requirements, presenting another disincentive for states to develop and implement VBP SDPs, particularly innovative bundled or population-based payments that are designed to incentivize volume over value.

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[77] Max Yates, et al., *Value-Based State Directed Payments in Medicaid Managed Care*, JAMA HEALTH FORUM (June 20, 2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2835284.

[78] *See,* U.S. Dep't of Health & Human Svcs., *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality,* 89 Fed. Reg. 41002, 41261 (May 10, 2024).

[79] Missouri SDP Preprint Approval (April 23, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/MO_VBP_IPH.OPH3_New_20250701-20260630_0.pdf (authorizing payments to hospitals that meet or exceed the benchmark for follow-up to emergency department visits for mental illness); Rhode Island SDP Preprint Approval (May 20, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/RI_VBP_Oth_Renewal_20250701-20260630.pdf (authorizing payments to support the state's Total Cost of Care payment arrangement); Massachusetts SDP Preprint Approval (May 21, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/MA_VBP_BHO_Renewal_20250101-20271231.pdf (authorizing payments for Community Behavioral Health Centers that meet benchmarks such as serving new members and providing outpatient behavioral health services).

[80] Proposed Rule at 30417.

HHS' proposals related to VBP SDPs are both short-sighted and misaligned with other efforts by the Administration to promote value-based care.[81] While we recommend HHS withdraw the proposal to require states to calculate and enforce payment limits at the service or discharge code level, it is particularly inappropriate in the VBP context.

IV. Conclusion

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for your attention to our comments. If you have any questions or need further information, please contact Geraldine Doetzer at doetzer@healthlaw.org.

Sincerely,

Geraldine M. Doetzer
Senior Attorney

[81] CMS, Value-Based Care, https://cms.gov/priorities/innovation/key-concepts/value-based-care.