State of California
Office of the Attorney General

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Via Federal eRulemaking Portal at www.regulations.gov

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 801
Baltimore, MD 21244–8016

RE: Comments on Proposed Rule: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments. 91 Fed. Reg. 30,400 (May 22, 2026), RIN 0938–AV69

Dear Secretary Kennedy and Administrator Oz:

We, the undersigned Attorneys General of California, Arizona, Colorado, Delaware, Hawai'i, Illinois, Massachusetts, Michigan, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington submit this letter in response to the U.S. Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services's (CMS) Notice of Proposed Rulemaking "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments" (the Proposed Rule).[1] State-Directed Payments (SDPs) and supplemental payments under fee-for-service Medicaid (FFS) (collectively, Healthcare Affordability Payments) have proven to be invaluable tools to fund hospital and healthcare access for rural, urban, and otherwise vulnerable communities and address the healthcare affordability crisis. As State Attorneys General, we have a duty to protect our residents, safeguard their health and safety, and defend state programs. The Proposed Rule

[1] 91 Fed. Reg. 30,400 (May 22, 2026).

oversteps by giving CMS authority to cut this crucial funding beyond what Congress authorized and fails to consider the devastating harms to patients and providers that will flow from further Medicaid cuts.

The Proposed Rule does not exist in a vacuum—rather, CMS issued it during a time of great strain for our healthcare system due to the enactment of the One Big Beautiful Bill Act (or OBBBA, also known as H.R. 1). The Congressional Budget Office estimate that 10.9 million Americans will lose health insurance by 2034 because of H.R. 1.[2] The Center on Budget and Policy Priorities estimates that Medicaid alone will lose between 9.9 million and 14.9 million enrollees because of other OBBBA provisions.[3] In California, experts project that OBBBA's many harmful provisions, together, will double the state's uninsured rate to 14.7 percent.[4] The loss of insurance coverage will be devastating to our hospitals. When people lack insurance coverage, they still experience health emergencies. Treating patients without insurance will increase a hospital's uncompensated care costs. Hospitals may have to raise prices on other consumers to recover from these funding losses and some may be forced to reduce services, merge, or shutter completely. Our hospitals are already under strain, with 146 rural hospitals having closed or terminated services between 2005 to 2023.[5] This has accelerated the growth of hospital and healthcare service deserts, which means that people will need to travel farther and longer to obtain healthcare. And in a medical emergency, access to a nearby hospital affects health outcomes and could even be the difference between life and death.

With that in mind, CMS should be implementing the One Big Beautiful Bill Act to maximize access to healthcare, not going out of its way to increase its harmful effects. While the States recognize that OBBBA requires some reduction to state-directed payments for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center, Pub. L. No. 119-21, § 71116(a), 139 Stat. 303 (2025) (citing 42 C.F.R. § 438.6(c)(2)(iii)), but the Proposed Rule would compound the harms caused by the OBBBA by extending—without statutory authority—the same cuts to FFS supplemental payments and to SDPs for other critical services, including rehabilitation and psychiatric care. Such overreach is inexcusable at a time when rural hospitals have already been devastated by

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[2] Letter from Philip L. Swagel., Dir. Cong. Budget Office, to Ron Wyden, Ranking Member, S. Comm. on Fin. 2 (June 4, 2025), https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf.
[3] Elizabeth Zhang & Gideon Lukens, *Medicaid Work Requirements Will Take Away Coverage From Millions: State and Congressional District Estimates*, Ctr. on Budget & Policy Priorities (July 22, 2025), https://www.cbpp.org/research/health/medicaid-work-requirements-will-take-away-coverage-from-millions-state-and.
[4] Miranda Dietz et al., Univ. of Cal. Los Angeles Ctr. for Health Policy Research, Over Two Million More Californians Projected to Lack Health Insurance by 2030 at 1 (2026), https://laborcenter.berkeley.edu/wp-content/uploads/2023/05/Over-2-million-more-Californians-projected-to-lack-health-insurance-by-2030-1.pdf.
[5] U.S. Department of Agriculture, Economic Research Services, 146 rural hospitals closed or stopped providing inpatient services from 2005 to 2023 in the United States, https://ers.usda.gov/data-products/charts-of-note/110927. Although the number of rural hospital closures and conversions slowed in 2010, 2015, 2017, and 2021, it started to rise again after 2022.

Medicaid cuts and millions of Americans are struggling to pay for healthcare and other basic necessities.

The States disagree with CMS's conclusion that Healthcare Affordability Payments are a problem to be solved. Healthcare Affordability Payments provide federal matching funds when states pay to fix healthcare access problems for their residents. This funding maintains healthcare access in rural areas, strengthens rural and neighborhood hospitals, expands key services like primary care and mental healthcare, funds children's hospitals and childbirth care, and more.[6] Indeed, CMS's data produced in support of the Proposed Rule show that the majority of Healthcare Affordability Payments benefit hospitals. *See id.* at 30,406 (Table 2). And CMS concedes that the Proposed Rule's cuts will total half a trillion dollars between 2026 and 2035. *Id.* at 30,451. CMS would need to replicate OBBBA's Rural Health Transformation grant program ten times to make up for these losses.[7]

Fundamentally, Healthcare Affordability Payments are working well in the States and should be protected, not undermined. The Proposed Rule is particularly concerning because it extends beyond the reductions required by the OBBBA to arbitrarily cut Healthcare Affordability Payments for services Congress spared, like mental healthcare, rehabilitation care, as well as extending to reach fee-for-service supplemental payments. These cuts needlessly endanger access to critical services. Further, the States are concerned that policies announced in the Proposed Rule's preamble would undermine Medicaid expansion under the Affordable Care Act (ACA)—contrary to the will of voters in 41 states. Finally, the States identify other problems with the Proposed Rule, including that the proposed definition of "geographic area" arbitrarily penalizes large, dynamic urban regions and CMS's document production mandate is overbroad.

We urge CMS to withdraw this Proposed Rule.

Healthcare Affordability Payments are Working Well in the States.

Medicaid is a federal program that helps states provide health insurance and long-term care for about 80 million hardworking Americans.[8] This is about 1 in 5 people in the United States.[9] In California, Medi-Cal covers over one-third of the state's residents.[10] In general, individual states run their Medicaid programs, like Medi-Cal, and the federal government

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[6] *See, e.g.*, California Hospital Association, Medicaid State-Directed Payments Help Ensure Patient Access to Care 2 (2026), https://calhospital.org/file/medicaid-state-directed-payments-help-ensure-patient-access-to-care.
[7] *See Rural Health Transformation Program*, CMS.gov (April 10, 2026), https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview (describing $50 billion grant program).
[8] *E.g.*, Robin Rudowitz et al., *Medicaid 101*, KFF (Oct. 8, 2025), https://www.kff.org/medicaid/health-policy-101-medicaid.
[9] *Id.* (Figure 2).
[10] *E.g.*, *Medi-Cal Enrollment and Renewal*, Cal. Dept. of Healthcare Serv. https://www.dhcs.ca.gov/data-statistics/medi-cal-enrollment-and-renewal (last visited July 13, 2026).

provides matching funds between 50 and 90 percent. States deliver Medicaid through direct payments to providers under the fee-for-service program and through managed care organizations (MCOs). MCOs contract with the states to deliver healthcare services to their beneficiaries in exchange for a set Medicaid payment per member each month for these services.[11]

In general, CMS regulations prohibit states from directing what MCOs may spend their money on. *See* 42 C.F.R. § 438.6(c)(1). However, existing regulation allows states to require "uniform dollar or percentage" payment rate "increase for providers that provide a particular service under the contract" if they meet specific standards and obtain agency approval, essentially letting states send additional funding to needed services. *Id.* § 438.6(c)(1)(iii)(D); *see also id.* § 438.6(c)(2) (standards and approval process). For example, a state that meets the standards and follows the process may direct higher payments for rural hospital emergency rooms that provide critical healthcare services to their communities, thereby keeping them open and ensuring access.[12] Indeed, about 84 percent of federal dollars spent through SDPs that require CMS approval pay for hospital services.[13] FFS supplemental payments serve a similar function.

Healthcare Affordability Payments are supporting important work, both in the signatory states and around the country. For example:

- California created a Healthcare Affordability Payment for district and municipal public hospitals in 2023.[14] The money largely funds rural district hospitals to protect and improve access to care for members in these areas.[15]

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[11] *Managed Care*, Medicaid.gov, https://www.medicaid.gov/medicaid/managed-care (last visited July 5, 2026). This arrangement resembles a traditional Health Maintenance Organization (HMO).
[12] The American Hospital Association reports that nearly half of all rural hospitals operated at a financial loss in 2023, underscoring the need for investment. *See* American Hospital Association, Rural Hospitals at Risk: Cuts to Medicaid Would Further Threaten Access 1 (2025), https://www.aha.org/system/files/media/file/2025/06/Rural-Hospitals-at-Risk-Cuts-to-Medicaid-Would-Further-Threaten-Access.pdf. Medicaid covers about half of all rural births, for example, but Medicaid paid rural hospitals approximately 63 cents on the dollar for inpatient obstetrics care in 2024. *Id.*
[13] Alice Burns et al., *Spending on Medicaid State Directed Payments Before New Limits Take Effect*, KFF (June 15, 2026), https://www.kff.org/medicaid/spending-on-medicaid-state-directed-payments-before-new-limits-take-effect.
[14] *District and Municipal Public Hospital Directed Payment*, Cal. Dept. of Healthcare Serv., https://www.dhcs.ca.gov/services/district-and-municipal-public-hospital-directed-payment (last visited July 5, 2026).
[15] *See* Letter from Alexis Gibson, Acting Dir., Div. of Managed Care Policy, Ctr. for Medicaid & CHIP Serv., to Jacey Cooper, Chief Deputy Dir., Health Care Programs, Cal. Dep't of Health Care Serv. at 7 (June 13, 2023), https://www.dhcs.ca.gov/wp-content/uploads/2025/10/CA-Fee-IPH-OPH-NF-New-20230101-20231231-Approval-Package.pdf.

- Another California program, the Quality Incentive Pool, funds value-based payments for public health care systems that are tied to performance on a set of quality measures in multiple areas of care, supporting the State's overall quality strategy.[16]

- North Carolina projects that its largest Healthcare Affordability Payment will direct close to $6.5 billion to providers between July 1, 2025 and June 30, 2026 to increase reimbursement rates for hospital services.[17] CMS approved this payment, funded partly by provider taxes, to bring Medicaid payments for inpatient and outpatient hospital services closer to commercial rates, attracting more providers to participate in Medicaid.[18]

- In New Mexico, a $90 million Healthcare Affordability Payment funds a uniform payment increase for nursing facilities and a quality payment program that provides additional pay-for-performance incentives to facilities that meet requirements based on state-selected quality metrics including prevalence of falls, infection control, and patient experience.[19]

- In Washington, a $3 million Healthcare Affordability Payment requires providers to increase payment rates for publicly funded sexual and reproductive health providers, as designated by the State Department of Health, to maintain and improve enrollee access to care.[20] The rate increase is necessary to ensure that these providers remain financially viable and, in turn, can maintain network adequacy for enrollees.[21] Without the SDP, these providers are reimbursed at only 39 percent of the rates available under the insurance plan for the state's public sector workforce.[22]

- In Kansas, Healthcare Affordability Payments are a critical tool to close the gap between Medicaid base payments for rural hospitals and the resources those hospitals need to stay open.[23] Even after receiving Healthcare Affordability Payments, 87 percent of hospitals in Kansas's rural communities are operating at a loss, with 47 vulnerable to closure.[24] If

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[16] Quality Incentive Pool (QIP) 2022: Fact Sheet, California Association of Public Hospitals and Health Systems, https://caph.org/wp-content/uploads/2022/05/caph_qip_2022_final.pdf (last visited July 20, 2026).
[17] Geraldine Doetzer, Nat'l Health Law Program, Medicaid Financing after OBBBA: Changes to State Directed Payments and Provider Taxes 5 (Sept. 18, 2025), https://healthlaw.org/wp-content/uploads/2025/09/Doetzer_NHELP_SDPs-and-PTs-after-OBBBA_091725.pdf.
[18] *Id.*
[19] *Id.*
[20] *Id.* at 6.
[21] *Id.*
[22] *Id.*
[23] *See* Anne Karl et al., *How Medicaid State-Directed Payments Support Critical Health Care Provider*s, Commonwealth Fund (July 3, 2025), https://www.commonwealthfund.org/blog/2025/how-medicaid-state-directed-payments-support-critical-health-care-providers.
[24] *Id.*

SDPs in Kansas were reduced to 100 percent of Medicare rates, hospitals would see up to a 21-percent decline in Medicaid payments, threatening the sustainability of rural hospitals and the services they provide.[25]

- Georgia's largest provider of Medicaid services, Grady Memorial Hospital in Atlanta, has used Healthcare Affordability Payments to expand home visits, increase cancer screenings, and open new outpatient clinics.[26] Healthcare Affordability Payments have also freed up funding for small rural and critical access hospitals.[27] The Georgia Hospital Association estimates that cuts would lead to a loss of $89.1 million in annual funding for these rural hospitals.[28]

- In Arizona, a Healthcare Affordability Payment program for Phoenix Children's Hospital provides 60 percent of specialized care to pediatric patients covered by Medicaid statewide.[29] If payments were capped at Medicare rates, Phoenix Children's would lose up to 85 percent of the Healthcare Affordability Payment it receives, potentially as much as $172 million.[30]

The Proposed Rule exacerbates the already dire state of America's healthcare system. Already seven in 10 Californians feel that healthcare expenses place a financial strain on their household.[31] Rather than implement OBBBA in the interest of hardworking Americans' healthcare access, CMS appears instead to be seeking to reduce healthcare services even beyond what Congress and President Trump chose to do.

The Proposed Rule's Failure to Consider or Quantify Harm to Patients and Their Providers is Arbitrary and Capricious.

CMS admits that the Proposed Rule will cause "adverse impacts on providers and consequently on beneficiaries." 91 Fed. Reg. at 30,447. This results in "transfers from providers and other affected entities and individuals," i.e., hardworking American families who get their health insurance through Medicaid, "to States and the Federal government." *Id.* at 30,450. CMS estimates that these "transfers" will total over half a trillion dollars between 2026 and 2035. *Id.* at 30,451.

Nothing in the Proposed Rule quantifies, evaluates, or fairly considers the impact that demolishing half a trillion dollars of healthcare funding will have on access to care, quality of care, or the number of providers willing to accept Medicaid. CMS asserts, without explanation,

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[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *See* Jen Joynt et al., *The 2026 CHCF California Health Policy Survey*, Cal. Health Care Found. (Feb. 25, 2026), https://www.chcf.org/resource/2026-california-health-policy-survey (Key Finding 1).

that "[w]e are not able to quantify these costs." *Id.* at 30,447. Moving forward on extending cuts to Healthcare Affordability Payments without considering the harms to patients, providers, hospitals, and the States is arbitrary and capricious. The States urge CMS to withdraw the Proposed Rule accordingly.

The Proposed Rule Exceeds Statutory Authority by Targeting Services Congress Exempted

OBBBA Exempts Most Types of Healthcare Services from Healthcare Affordability Payment Cuts.

OBBBA directs CMS to cut SDPs for only four categories of healthcare services: those "described in" the current section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations that are "furnished" during a rating period beginning on or after the effective date of OBBBA. Pub. L. No. 119-21, § 71116(a), 139 Stat. 303 (2025). These are inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center. 42 C.F.R. § 438.6(c)(2)(iii). If Congress had wanted other cuts, it could have clearly said so. The Proposed Rule elects to expand these cuts to *all* SDPs for *all* services effective January 1, 2029. 91 Fed. Reg. 30,464 (to be codified at 42 C.F.R. § 438.6(c)(8)(iii)). This is contrary to the statute. Further, the Proposed Rule eliminates uniform SDP increases effective January 1, 2028. 91 Fed. Reg. 30,427. This elimination is not directed by statute. Rather, section 71116(a) of the One Big Beautiful Bill Act directed the Secretary to "revise section 438.6(c)(2)(iii)," which is the payment limit provision. But the Proposed Rule instead rewrites § 438.6(c)(1)(iii), a different subsection governing permissible SDP forms.

CMS's stated reason for cutting additional Healthcare Affordability Payments is to "improve the fiscal integrity . . . of the Medicaid program," "align with" the presidential memorandum seeking to eliminate waste, fraud, and abuse, and prevent unspecified "cost shifting" that could otherwise mitigate the impact of cutting Healthcare Affordability payments for hospitals. 91 Fed. Reg. 30,415, 30,416, 30,446. These justifications are insufficient to authorize the expansion of cuts.

The cited memorandum, which seeks to address waste, fraud, and abuse in Medicaid, merely directs CMS to "ensur[e] Medicaid payments rates are not higher than Medicare, to the extent permitted by applicable law."[32] OBBBA is the "applicable law" and that law is limited to inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center. Pub. L. No. 119-21, § 71116(a), 139 Stat. 303 (2025) (citing 42 C.F.R. § 438.6(c)(2)(iii)). So is the ACA, which forbids the HHS Secretary from promulgating "any regulation" that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care" or "impedes timely access to health care services." 42 U.S.C. § 18114(1)–(2). CMS makes no finding or showing that state-directed payments for programs protected by Congress in OBBBA are wasteful or fraudulent.

[32] Memorandum on Eliminating Waste, Fraud, and Abuse in Medicaid, 2025 Daily Comp. Pres. Doc. 671 (June 6, 2025), https://www.govinfo.gov/content/pkg/DCPD-202500671/pdf/DCPD-202500671.pdf.

CMS's attempts to justify its proposal by citing "fiscal integrity" and "cost shifting" are equally insufficient. 91 Fed. Reg. 30.416. For example, CMS speculates that the States could "attempt[] to increase payments to providers for services other than the four services specified in section 71116 of" OBBBA to "offset the loss of revenue reductions resulting from the payment limit on the four services." *Id.* at 30,415. Hospitals "could consolidat[e] with other healthcare provider entities, such as independent provider practices and clinics," according to CMS, or "shift[] certain" unspecified "services from an outpatient hospital setting to a clinic setting" to circumvent OBBBA. *Id.* The Proposed Rule cites no evidence to support this potential response, nor does CMS acknowledge that state-directed payments require approval of CMS prior to deployment in any event. Again, CMS does not consider any of the above detailed harms from additional cuts to Healthcare Affordability Payments when evaluating how to address this speculative response.

With regard to the elimination of uniform SDP increases, CMS created this increase category in 2016 and has approved hundreds since. The Proposed Rule fails to explain the reversal and includes no reliance analysis. The Proposed Rule also does not consider a less restrictive alternative—subjecting uniform increases to the new payment limits rather than abolishing the category, and fails to explain why this alternative is insufficient to address its stated redistribution concern.

The federal government already has abundant tools to prevent healthcare consolidation where it is harmful.[33] So do the States.[34] KFF notes that "[t]here has been a large amount of consolidation in provider markets over the past 30 years."[35] As such, it is illogical for CMS to assume that future consolidation is an effort to evade OBBBA's caps on Medicaid rates for certain services and not the continuation of an existing trend.

The States remind CMS that they have broad experience regulating the practice of medicine, including any inappropriate shifting of services from outpatient hospital settings to clinical settings. The States exercise the general police power, including public health, under our federal system. Nothing in the Proposed Rule supports a conclusion otherwise. It is arbitrary and capricious for CMS to cut Healthcare Affordability Payments for critical services like psychiatric care and rehabilitation based on this remote possibility.

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[33] *See, e.g.,* FTC Sues to Block Novant Health's Acquisition of Two Hospitals from Community Health Systems, Federal Trade Commission (Jan. 25, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/01/ftc-sues-block-novant-healths-acquisition-two-hospitals-community-health-systems.
[34] *E.g.*, Cal. Gov't Code § 5914 et seq. (authorizes review of nonprofit health facility transactions by the Attorney General); Cal. Code Regs. Tit. 11 § 9995 subd. (f)(9) ("Attorney General shall consider whether the effect of the agreement or transaction may be substantially to lessen competition or tend to create a monopoly" when reviewing transaction).
[35] Zachary Levinson et al., Ten Things to Know About Consolidation in Health Care Provider Markets, KFF(April 14, 2024), https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets.

The Proposed Rule Lacks Reasoned Decision-making

With its across-the-board reductions and broad reliance on Medicare rates, CMS does not consider that the Medicaid program serves a different population from Medicare. Thus, Medicare rates may not provide a reasonable proxy for state-directed payments for certain services, such as obstetric care or pediatric specialties. Further, provider shortages in Medicaid affect the population in ways that may require states to use higher SDPs where this would not be required in the Medicare program. States are required to ensure that Medicaid enrollees have adequate access to providers, and these payments are an important tool in meeting this access standard.

Access to Mental Healthcare and Rehabilitation Care is Already Limited for Medicaid Patients and the Proposed Rule will Make the Problem Worse.

The Proposed Rule's overreach will have real consequences for hardworking Americans. Nearly 40 percent of the nonelderly adult Medicaid population (13.9 million enrollees) had a mental health or substance use disorder diagnosis in 2020.[36] Yet HHS reports that, as of December 2, 2025, 40 percent of the U.S. population lives in a Mental Health Professional Shortage Area.[37] Forty-five percent of rural counties lack a psychologist.[38] The American Hospital Association reports that Medicaid payments covered just 70 percent of costs for behavioral health services in hospital settings, which include substance use disorder treatment, as of 2025.[39] In 2017, only 45.5 percent of psychiatrists accepted Medicaid payments from new patients.[40] Less than 20 percent of psychiatrists are available to see new patients at all, according to a recent study, and median wait times for in-person and telepsychiatry appointments were 67 days and 43 days respectively and these problems were consistently worse in rural areas.[41]

Cutting Healthcare Affordability Payments for rehabilitation care and physical therapy will similarly threaten Medicaid patients' ability to access these important services. Doctors and surgeons already report difficulty finding physical therapy and rehabilitation care providers for their Medicaid patients. One study of 157 physical therapy providers in Massachusetts found that

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[36] Guth et al., Medicaid Coverage of Behavioral Health Services in 2022: Findings from a Survey of State Medicaid Programs, KFF (March 17, 2023), https://www.kff.org/mental-health/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs.
[37] National Center for Health Workforce Analysis, State of the Behavioral Health Workforce, 2025, at 1 (2025), https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf.
[38] *Id.* at 5.
[39] American Hospital Association, *supra* n.12, at 1.
[40] Medicaid and CHIP Payment and Access Commission, Physician Acceptance of New Medicaid Patients: Findings From the National Electronic Health Records Survey 3 (2021), https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf.
[41] Ching-Fang Sung et al., *Low Availability, Long Wait Times, and High Geographic Disparity of Psychiatric Outpatient Care in the US*, 84 General Hospital Psychiatry 12 (2023), https://www.sciencedirect.com/science/article/abs/pii/S0163834323000877.

96.4 percent would provide rehabilitation care for a knee reconstruction patient with private insurance but only 51.8 percent would do so for a patient with Medicaid.[42] Out of 71 randomly selected orthopedic surgery practices in North Carolina, only 72 percent offered an appointment for a fictitious 42-year-old man on Medicaid with a shoulder injury while 96 percent were willing to treat the same patient with private insurance.[43] Results were similar for a fictitious boy with a broken arm seeking orthopedic care in California, with only one of 50 offices willing to schedule the Medicaid patient but all 50 being willing to schedule the same pediatric patient with private insurance.[44]

The Proposed Rule will exacerbate these access problems. Mental health providers already cite low reimbursement rates and administrative burdens as the main reasons they choose not to participate in insurance plans.[45] So do rehabilitation care and physical therapy providers.[46] And beyond the general public health benefits for greater access to mental health care, the Medicaid program is required to comply with federal mental health parity requirements.[47] CMS's proposed cuts will make compliance more difficult. Indeed, improving reimbursement rates is one potential state strategy to address lack of access to care and parity issues.[48] Yet the Proposed Rule directly undermines this strategy by cutting and capping the same rates.

The Proposed Rule Exceeds Statutory Authority by Targeting Fee-For-Service Healthcare Affordability Payments for Cuts Without Direction from Congress and is Arbitrary and Capricious.

As discussed above, OBBBA only directs CMS to cut SDPs for four categories of healthcare services. Pub. L. No. 119-21, § 71116(a), 139 Stat. 303 (2025) (citing 42 C.F.R. § 438.6(c)(2)(iii)). The Proposed Rule elects to expand these cuts to *all* Healthcare Affordability Payments, including FFS supplemental payments that have nothing to do with the specific SDPs Congress targeted. 91 Fed. Reg. 30,465 (proposed 42 C.F.R. § 447.381(c)). Lacking a

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[42] Miranda J. Rogers et al., Medicaid Health Insurance Status Limits Patient Accessibility to Rehabilitation Services Following ACL Reconstruction Surgery, 6 Orthapaedic J. of Sports Med. (2018), https://journals.sagepub.com/doi/epub/10.1177/2325967118763353.
[43] Brendan M. Patters et al., Access to Outpatient Care for Adult Rotator Cuff Patients With Private Insurance Versus Medicaid In North Carolina, 12 J. Shoulder & Elbow Surgery 1623 (2013), https://pubmed.ncbi.nlm.nih.gov/24135415.
[44] David L. Skaggs et al., Access to Orthopedic Care for Children With Medicaid Versus Private Insurance in California 107 Pediatrics 1405 (2001), https://pubmed.ncbi.nlm.nih.gov/11389265.
[45] National Center for Health Workforce Analysis, *supra* n.37, at 7.
[46] For example, Rogers, *supra* n.42 found that although 34.9 percent of providers who declined Medicaid did not give a reason, 39.4 percent stated "no contract" was the reason and another 13.6 percent directly cited low reimbursement rates.
[47] *See, e.g.*, 42 CFR §§ 438.3(n), *id*. at §§ 438.900-438.930; *id*. at § 457.496(d).
[48] *E.g.*, Heather Saunders et al., A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs, KFF (Jan. 10, 2023), https://www.kff.org/mental-health/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs.

Congressional mandate, CMS cites 42 U.S.C. § 1396a(a)(30)(A), which requires Medicaid payments to be "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers," for authority without further explanation. *See, e.g.*, 91 Fed. Reg. 30,407. But nothing in this statute even hints at the roaming authority to cap rates at will and without evidence. Courts are skeptical and rightly so.[49]

CMS's stated reason for cutting these Healthcare Affordability Payments fails to rationally connect the facts found and the choice made. *Contra Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.,* 463 U.S. 29, 43 (1983). For example, CMS does not explain why "lowering the limit from … [Average Commercial Rate] to a Medicare-based benchmark" would be a more "prudent" option. *Contra* 91 Fed. Reg. 30,437. CMS merely asserts that "Medicare rates are generally lower than commercial rates for physician and hospital services." *See id.* But reasonable agency decision-making would evaluate the *impact* of lowering the supplemental payment limit. Rather than undertake that analysis, CMS asserts, without evidence or elaboration, that "we believe that the Medicare FFS payment rates are likely to serve as a reliable balance between the requirement that rates be economic and efficient … as well as the ability for States to maintain a level of payment sufficient to enlist providers to furnish the relevant services to beneficiaries at high quality." 91 Fed. Reg. 30.437. Agency "belief" untethered from facts or evidence is not rational rulemaking *See* 5 U.S.C. § 706(2)(A).

In reality, the Proposed Rule would further impede a fee-for-service Medicaid system that already faces challenges. Indeed, the preamble acknowledges that states have used targeted supplemental payments to increase enrollee access to physicians and dentists in safety net hospitals. 91 Fed. Reg. 30,407. And physicians already cite low Medicaid payment rates, delays in Medicaid reimbursement, and challenges with Medicaid provider enrollment as barriers to participating in Medicaid.[50] Limiting the states' ability to address lack of providers in certain geographical or service areas will exacerbate these issues. And the problems identified in the prior section with using Medicare rates for types of services that are rarely funded by Medicare apply to these supplemental payments as well. CMS's failure to consider these concerns is unreasonable.

The Proposed Rule Contains Additional Unnecessary Attacks on Healthcare

The Polices Announced in the Proposed Rule's Preamble Undermines Medicaid Expansion Under the Affordable Care Act and Its Promise that No American Should Go Without Health Insurance.

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[49] *Cf. Christ the King Manor, Inc. v. Sec'y of Health & Human Serv.*, 730 F.3d 291, 299–300 (3d Cir. 2013) (arbitrary and capricious to approve state plan that capped Medicaid payments for certain nursing facilities at "amount [state] could afford to pay" under 42 U.S.C. § 1396a(a)(30)(A) without taking any steps to ensure that payments would still be consistent with quality of care and adequate access).

[50] *E.g.*, Medicaid and CHIP Payment and Access Commission, Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services 1 (2025), https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf.

Medicaid expansion, pioneered by the Affordable Care Act, is a crucial tool to counter the cost-of-living crisis.[51] The States are particularly troubled by language in the Proposed Rule's preamble that appears intended to coerce states into abandoning Medicaid expansion. 91 Fed. Reg. 30,418. The Proposed Rule declares that "if a State were to transition from an Expansion State to a Non-Expansion State, that State's SDPs would then be subject to the applicable payment limit for Non-Expansion States." *Id.* CMS declares this "necessary to implement the proposed payment limit equitably among States and with clarity for enforcement." *Id.*

To date, 41 states have expanded Medicaid under the ACA.[52] This includes six states that approved Medicaid expansion by referendum between 2019 and 2021.[53] One study found that ACA Medicaid expansion was associated with a significant increase in the likelihood of having any source of full-year insurance coverage of 29.6 percentage points among adults with disabilities and 6.7 percentage points among adults without disabilities.[54] This saved adults with disabilities $457 in out-of-pocket healthcare costs and saved $191 for adults without disabilities.[55] Efforts by CMS to undermine the Affordable Care Act are inappropriate.

The Proposed Rule's Definition of "Geographic Area" Arbitrarily Penalizes Large, Dynamic Urban Areas within the States.

The Proposed Rule would exempt fee-for-service supplemental payments that are "uniform for all Medicaid practitioners or providers furnishing the applicable Medicaid-covered services … within a geographic region of the State" from newly imposed payment limits for Healthcare Affordability Payments. 91 Fed. Reg. at 30,435, 30,465 (explaining and proposing new 42 C.F.R. § 447.381(b)(1). Generally speaking, the States support exemptions from the cuts to Healthcare Affordability Payments, including allowing counties and other similar governmental regions to demonstrate "uniform[ity]." However, the Proposed Rule restricts "geographic region[s] of the State" to a "county, parish, borough, or municipality." CMS indicates that the express purpose of this language is to ensure that a state "could not define a special purpose district solely for rate-setting purposes (or utilize a pre-existing district such as one associated with tax rates)." 91 Fed. Reg. at 30,435.

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[51] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (Medicaid coverage for individuals with income that does not exceed 133 percent of the poverty line; *id.* § 1396d(y)(1)(E) (federal matching funds at 90 percent for states that expand Medicaid). *See also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 542 (2012) (explaining relevant provisions of ACA); *id.* at 585 (explaining voluntary nature of state Medicaid expansion).

[52] *Status of State Medicaid Expansion Decisions*, KFF (May 21, 2026), https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions.

[53] Fredric Blavin et al., *Medicaid Expansion Through Ballot Initiatives Increased Medicaid Enrollment And Reduced Uninsurance Among Adults*, Health Affairs (2026), https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.01102.

[54] Creedon et al., *Effects of Medicaid Expansion on Insurance Coverage and Health Services Use Among Adults With Disabilities Newly Eligible for Medicaid,* 57 Health Serv. Res. 183, 189 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9660429/pdf/HESR-57-183.pdf.

[55] *Id.* at 190, 191.

The States are concerned that defining geographic regions so narrowly will unfairly penalize commuters and large, complex urban areas that are legitimately a single healthcare market. Many Americans split their time between different jurisdictions and some do so daily. Consider the phenomenon of New Hampshire residents who commute to work in Boston, Massachusetts or New Jersey residents who work in New York City, New York. Or consider California's San Francisco Bay Area, which includes nine separate counties that regularly coordinate on regional issues, like the San Francisco Bay Area Rapid Transit District, the Bay Area Housing Finance Authority, and the Bay Area Air Quality Management District.

It is reasonable for the States to plan healthcare delivery around the reality that millions of Americans may live, work, and access healthcare across governmental boundaries. It is irrational to wholly exclude complex, dynamic urban regions from consideration as a "geographic region" under the Proposed Rule. If CMS insists on cutting FFS Healthcare Affordability Payments, it should at least allow a process for recognizing "geographic regions" larger than an individual county, parish, borough, or municipality. The existence under state law of multi-county government bodies to resolve regional problems is strong evidence of a "geographic region."

The States are also concerned that the Proposed Rule's ambiguous definition of "geographic region" excludes and has the potential to needlessly burden major urban areas organized as consolidated local governments. For example, the City and County of San Francisco has existed within California as a consolidated city and county since 1856. *See* 1856 Cal. Stat. 145–46. Other examples of consolidated local governments include the City and County of Denver and the City and County of Honolulu. *See* 1901 Colo. Sess. Laws 97–98 (Denver). The language proposed by CMS is unclear whether such jurisdictions benefit from the proposed exemption. If CMS insists on cutting FFS Healthcare Affordability Payments, it should at minimum, amend the list of qualifying geographic regions to expressly include a "city and county" and other consolidated local governments.

Expansion of CMS's Audit Authority Under the Proposed Rule Should Be Explicitly Limited.

The Proposed Rule would allow CMS to compel states to produce "[a]ny additional documentation requested … to demonstrate compliance with the limit." 91 Fed. Reg. 30,464 (proposed 42 C.F.R. § 438.6(c)(8)). This unusually broad information collection authority is justified, according to CMS, to "fully understand how a State would verify regulatory compliance" and to allow "other oversight bodies," which are not specified, "to engage in robust post-implementation monitoring and oversight." *Id.* at 30,416. The States are concerned this language is not sufficiently tailored to limit document requests to matters that are germane to the Medicaid program. Further, any document requests should comply with applicable privacy laws.

The States' concerns are amply justified by the recent mishandling of state Medicaid information, as discovered in *State of California et al. v. U.S. Dep't of Health & Human*

Services,[56] or the Administration's repeated, failed efforts to invade teenagers' medical privacy simply because they are transgender.[57] At minimum, CMS should amend the proposed section 42 C.F.R. § 438.6(c)(8) to clarify that the Proposed Rule only requires production of documents related to the healthcare service payment limit at issue and complies with existing privacy laws.

In conclusion, Healthcare Affordability Payments are working well in the States and should be protected, not undermined. The Proposed Rule is particularly concerning in that it exceeds statutory authority to arbitrarily cut Healthcare Affordability Payments for services Congress spared, like mental healthcare, rehabilitation care, and FFS supplemental payments. This needlessly endangers access to these critical services without proper evaluation and consideration of harms—which is also arbitrary and capricious.

For all these reasons, the States urge CMS to change course. We are available to assist you with designing Healthcare Affordability Payment regulations that protect funding for key healthcare services while complying with OBBBA's narrow direction.

Sincerely,

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[56] *State of Cal. v. U.S. Dep't of Health & Human Serv.*, No. 25-cv-05536-VC (N.D. Cal. Dec. 29, 2025).
[57] *E.g.*, Selena Simmons-Duffin, *Trump's DOJ Can't Get Names and Medical Files of Trans Youth in California, for Now*, KQED (June 22, 2026), https://www.kqed.org/news/12088110/trumps-doj-cant-get-names-and-medical-files-of-trans-youth-in-california-for-now.

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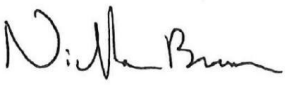

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