VIA ELECTRONIC TRANSMISSION

July 21, 2026

CMS Administrator Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2499-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Opposition to CMS-2499-P Proposed Rule "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments" (RIN 0938-AV69)

Dear Administrator Oz,

The Center for Reproductive Rights ("The Center") submits this comment in opposition to the Centers for Medicare & Medicaid Services ("CMS") Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments Proposed Rule ("proposed rule").[1]

Since 1992, the Center has used the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past thirty-four years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetric care, contraception, safe abortion services, and comprehensive sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where every person is free to decide whether or when to have children and whether or when to get married; where access to quality reproductive health care is guaranteed; and where everyone can make these decisions free from coercion or discrimination. As an organization committed to advancing policies that uphold reproductive rights, including the right to available, high quality, accessible, acceptable maternal health care, as fundamental human rights,[2] the Center opposes

[1] Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments, 91 Fed. Reg. 30,400 (proposed May, 22, 2026) (to be codified at 42 C.F.R. § 438, and § 447) [hereinafter "Proposed Rule"].

[2] Committee on Economic, Social and Cultural Rights (ESCR Committee), General Comment No. 14: The right to the highest attainable standard of health (Art. 12), (22nd Sess., 2000), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 80, para.12 (a)-(d), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); ESCR Committee, General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social, and Cultural Rights), U.N. Doc. E/C.12/GC/22 (2016).

this rule on the grounds that it exceeds what Congress mandated in the One Big Beautiful Bill Act ("OBBBA") by imposing new limits to all State Directed Payments ("SDPs") and some fee-for-service ("FFS") payments.[3] This proposal, if finalized, will significantly deepen existing barriers to maternal health care and constrain states' abilities to address and improve maternal health outcomes.

I. The proposed rule will have harmful effects on the provision of maternal health care.

The United States is experiencing an ongoing maternal health crisis, with Black, Indigenous, and Hispanic birthing people facing unacceptably high rates of maternal mortality and severe maternal morbidity.[4] Medicaid plays a central role in financing maternal health care, covering an average of 41 percent of births nationwide, and up to 60 percent of births in some states.[5] States have increasingly relied on Medicaid payment innovations, such as SDPs, to strengthen provider participation, preserve access to obstetric services, improve quality, and reduce longstanding inequities in maternal health outcomes.[6] SDPs and other payment strategies have become vital to maintaining obstetric provider participation in Medicaid and have helped hospitals struggling to preserve labor and delivery services, particularly in rural and underserved communities where a larger proportion of the population utilizes Medicaid.[7]

A. The proposed rule will exacerbate labor and delivery unit closures and further expand maternity care deserts by reducing SDPs.

Over one-third of U.S. counties are considered "maternity care deserts" defined as counties that lack maternity care resources, such as birthing hospitals, birth centers offering obstetric care, and obstetric providers.[8] As a result of these shortages and especially in the face of the devastating funding cuts included in OBBBA challenges in accessing and maintaining maternal health care

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[3] One Big Beautiful Bill Act, P.L. 119-21, at §71116 [hereinafter OBBBA]; Anne Karl and Avi Herring, *CMS Releases State Directed Payment Proposed Rule*, STATE HEALTH AND VALUES STRATEGIES (May 27, 2026) https://shvs.org/cms-releases-state-directed-payment-proposed-rule/.

[4] Donna Hoyert, *Health E-Stat 113: Maternal Mortality Rates in the United States, 2024*, NAT'L CTR. FOR HEALTH STAT., (Mar. 2026) https://www.cdc.gov/nchs/data/hestat/hestat113.pdf.

[5] MEDICAID AND CHIP 2025 SCORECARD: BIRTHS COVERED BY MEDICAID, CTRS. FOR MEDICARE & MEDICAID SERVS (last visited July 14, 2025), https://www.medicaid.gov/state-overviews/scorecard/measure/Births-Covered-by-Medicaid?measure=EE.2&dataset=2025&measureView=state&dataView=pointInTime&chart=map

[6] Geraldine Doetzer, *Medicaid Financing After OBBBA: Changes to State Directed Payments and Provider Taxes*, NAT'L HEALTH L. PROGRAM (Sep. 18, 2025) https://healthlaw.org/resource/medicaid-financing-after-obbba-state-directed-payments-and-provider-taxes/; Leonardo Cuello, *CMS Triples Harmful Impact of HR 1 Medicaid Provider Cuts in State Directed Payment Proposed Rule,* GEORGETOWN CTR. FOR CHILDREN & FAMILIES (May 28, 2026) https://ccf.georgetown.edu/2026/05/28/cms-triples-harmful-impact-of-hr-1-medicaid-provider-cuts-in-state-directed-payment-proposed-rule/.

[7] Sarah Klein and Molly Castle Work, *Positive Outliers: How Some Rural Communities Maintain Access to Labor and Delivery Services*, THE COMMONWEALTH FUND (Oct. 24, 2025), https://www.commonwealthfund.org/publications/2025/oct/positive-outliers-how-rural-communities-maintain-access-labor-delivery.

[8] NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE US 2024 REPORT, MARCH OF DIMES (last visited Jul. 14, 2024) https://www.marchofdimes.org/maternity-care-deserts-report.

varies considerably across states and communities.[9] Some states have experienced widespread obstetric unit closures, while others face severe shortages of obstetrician-gynecologists, certified nurse-midwives, maternal-fetal medicine specialists, or maternal mental and behavioral health providers.[10] States have increasingly used directed payments to address these localized workforce shortages by increasing reimbursement rates for providers serving Medicaid beneficiaries, encouraging provider participation in Medicaid managed care networks, supporting quality improvement initiatives, and sustaining access to essential obstetric services.[11]

As of this year, 40 states and the District of Columbia receive nearly $100 billion in annual federal Medicaid spending through SDPs, showing a nationwide need to maintain this funding flexibility or risk devastating consequences in access to vital care, including maternal health care.[12] The proposed rule's limitation on these payment arrangements will reduce states' ability to target investments and allow for competitive provider reimbursement rates where they are most needed. This will ultimately discourage providers from participating in Medicaid or force hospitals to cut labor and delivery services, particularly in communities already experiencing limited access to maternity care. The result will only serve to increase maternity care deserts.[13]

B. The proposed rule will disproportionately harm hospitals and health care systems serving large numbers of Medicaid beneficiaries.

The proposed rule is also likely to have significant consequences for hospitals, and especially hospitals that provide obstetric care.[14] Hospital maternity units frequently operate with narrow or negative financial margins due to the need to maintain 24-hour staffing, emergency readiness, specialized equipment, neonatal services, and other fixed costs regardless of patient volume.[15] Medicaid reimbursement has historically fallen below the cost of providing care, making supplemental payment arrangements an important mechanism for helping hospitals sustain labor

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[9] Annaliese Johnson et al., *Medicaid Cuts Threaten Pregnancy And Postpartum Coverage, Access To Care, And Health*, HEALTH AFF. (Oct. 25, 2025) https://www.healthaffairs.org/content/forefront/medicaid-cuts-threaten-pregnancy-and-postpartum-coverage-access-care-and-health.

[10] *Id.*

[11] Tammie Smith, *Federal Medicaid Spending Through State Directed Payments Nears $100 Billion Annually Across 41 States, With New Limits Set to Reduce Funding to States*, KFF (Jun. 15, 2026) https://www.kff.org/medicaid/federal-medicaid-spending-through-state-directed-payments-nears-100-billion-annually-across-41-states-with-new-limits-set-to-reduce-funding-to-states/.

[12] *Id*.

[13] Nathaniel Weixel, *Hospitals across nation brace for Medicaid cuts under 'big, beautiful' law*, THE HILL (Jul. 13, 2025), https://thehill.com/policy/healthcare/5397653-hospitals-medicaid-cuts-rural-areas/ "Restrictions on state directed payments and provider taxes cut off critical financial lifelines for hospitals… State directed payments are a critical source of support for hospitals, particularly in rural areas, and provider taxes help reduce the gap between Medicaid and other payers, ensuring that physicians can take Medicaid patients and hospitals can be adequately staffed. Cutting these lifelines is not sustainable, and it will harm patients.").

[14] Anne Karl et al., *How Medicaid State-Directed Payments Support Critical Health Care Providers,* THE COMMONWEALTH FUND (Jul. 3, 2025) https://www.commonwealthfund.org/blog/2025/how-medicaid-state-directed-payments-support-critical-health-care-providers.

[15] *Stopping the Loss of Rural Maternity Care*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM (Jun. 2026) https://ruralhospitals.chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf.

and delivery services.[16] SDPs have allowed states to narrow the gap between Medicaid reimbursement and the actual costs of providing high-quality care, particularly in managed care delivery systems.[17] Reducing these supplemental payments will weaken hospitals' financial capacity to maintain obstetric services.

Hospitals serving large Medicaid populations, including safety-net hospitals, rural hospitals, teaching hospitals, and other facilities that disproportionately care for low-income patients, will face difficult decisions in the coming years regarding staffing levels, investments in quality improvement, and the continued operation of labor and delivery units.[18] Across the country, hospitals have already made the difficult decision to shutter obstetric units due to financial constraints, resulting in increased travel times for prenatal care and delivery and reducing timely access to emergency obstetric services.[19] The proposed payment reductions will further strain these hospitals and providers, and risks accelerating these trends.

C. The proposed rule impedes states' efforts to address racial disparities in maternal health outcomes.

The proposed rule impedes state efforts to reduce persistent racial inequities in maternal health outcomes. Many states have designed Medicaid payment initiatives to encourage evidence-based practices, strengthen quality improvement collaboratives, expand access to culturally responsive maternity care, and support hospitals serving populations with the greatest maternal health needs.[20] Restricting states' authority to direct enhanced payments toward these objectives would undercut an important policy tool for addressing longstanding inequities in maternal health care.[21]

Additionally, the proposed rule will slow efforts to strengthen the maternal health workforce. States have increasingly sought to use Medicaid payment policy to improve recruitment and retention of obstetric clinicians, certified nurse-midwives, labor and delivery nurses, behavioral health providers, and other professionals who provide pregnancy-related care.[22] Payment reforms have also supported implementation of team-based maternity care models and expanded access

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[16] *Id*.
[17] Sarah Klein and Molly Castle Work, *supra* note 7.
[18] *Id*.
[19] *OBBBA is Threatening Women's Health Care Access*, NAT'L P'SHIP FOR WOMEN & FAMILIES (Jun. 2026) https://nationalpartnership.org/report/obbba-is-threatening-womens-health-care-access/.
[20] Akash Pillai et al., *Medicaid Efforts to Address Racial Health Disparities*, KFF (Jul. 1, 2024) https://www.kff.org/medicaid/medicaid-efforts-to-address-racial-health-disparities/; Cameron Santoro, Medicaid Budget Survey Highlights Postpandemic Challenges and Priorities, AM. J. OF MANAGED CARE (Oct. 24, 2024) https://www.ajmc.com/view/medicaid-budget-survey-highlights-postpandemic-challenges-and-priorities.
[21] States' efforts to reduce well-documented disparities in maternal health outcomes are consistent with Medicaid's objective of ensuring access to high-quality care for beneficiaries and may include facially neutral payment, and quality improvement, workforce, and access initiatives. These efforts should not be misconstrued as advocating for unlawful discrimination or race-based preferences. *See,* 42 U.S.C. §1936-1, §1396a(a)(30)(A), and §42 U.S.C. § 1396u-2.
[22] Anne Karl et al., *supra* note 14.

to specialized maternal health services.[23] By limiting states' flexibility to increase reimbursement for providers serving Medicaid populations, the proposed rule will make it more difficult to address workforce shortages that contribute directly to gaps in access and quality.

At a time when many states are working to implement recommendations from experts to address maternal health disparities, like taking steps to expand postpartum coverage, strengthening perinatal quality improvement initiatives, and investing in evidence-based maternity care models, federal policy should preserve, not restrict, the tools available to support these efforts. Finalizing the proposed rule as drafted would limit states' ability to respond to their maternal health crises, reduce critical financial support for hospitals providing obstetric care, and jeopardize ongoing efforts to improve maternal health outcomes for Medicaid beneficiaries. We encourage CMS to withdraw this proposed rule.

II. The proposed rule goes beyond Congressional mandate and violates the Administrative Procedure Act ("APA").

Under the APA, "agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" shall be set aside.[24] The proposed rule violates the APA because it exceeds the Congressional mandate explicitly laid out in OBBBA and is therefore not in accordance with law. Additionally, it is arbitrary and capricious in violation of the APA because of its insufficient reasoning and impact analysis.[25]

When enacting OBBBA, Congress directly addressed the subject of SDPs in Section 71116, which instructed the Secretary to implement payment limits for four specified SDPs. CMS, for the purposes of "alignment with Medicare payment rates,"[26] proposes to expand these limitations, beyond what Congress specified, to all SDPs and to certain targeted FFS payments.[27] To justify this change, CMS repeatedly invokes the Presidential Memorandum on "Eliminating

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[23] BAILIT HEALTH, *STATE STRATEGIES TO PROMOTE VALUE-BASED PAYMENT THROUGH MEDICAID MANAGED CARE FINAL REPORT*, MEDICAID AND CHIP ACCESS COMMISSION (Mar. 13, 2020) https://www.macpac.gov/wp-content/uploads/2020/03/Final-Report-on-State-Strategies-to-Promote-Value-Based-Payment-through-Medicaid-Mananged-Care-Final-Report.pdf.

[24] 5 U.S.C.A. § 706(2)(A).

[25] Encino Motorcars, LLC v. Navarro, 136 S. Ct. 2117, 2125 (June 20, 2016) (citing Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co., 463 U.S. 29, 103 (1983)). Typically, a court will find an agency action to be arbitrary and capricious if the agency "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983) (internal citations omitted); Envtl. Def. Fund, Inc. v. Costle, 657 F.2d 275, 283 (D.C. Cir. 1981) ("While we are admonished from rubber stamping agency decisions as correct, our task is complete when we find that the agency has engaged in reasoned decisionmaking within the scope of its Congressional mandate.") (internal citations and quotations omitted).

[26] Proposed Rule, *supra* note 1 at 30411.

[27] OBBBA *supra* note 3, at § 71116.

Waste, Fraud, and Abuse in Medicaid" ("Presidential Memorandum")[28] as a basis for expanding Medicare-based payment limitations beyond the statutory requirements.[29] While the Presidential Memorandum reflects the Trump Administration's policy priorities, it does not grant CMS the authority to "sua sponte" enact restrictions on SDPs.

A. The proposed rule further violates the APA for failure to engage in reasoned decision making.

Furthermore, the APA mandates that an agency must provide "adequate reasons" for its rulemaking, in part by "examin[ing] the relevant data and articulat[ing] a satisfactory explanation for its action including a rational connection between the fact found and the choice made."[30] In addition, an agency can only change an existing policy if it provides a "reasoned explanation" for disregarding or overriding the basis for the prior policy.[31] CMS has not provided a satisfactory explanation for why the current payment arrangements, which the agency had previously approved, should now be treated as "waste" or "abuse." Additionally, CMS has not analyzed the consequences that this policy choice will have on the financial stability of hospitals, including their ability to maintain an adequate maternal health workforce.[32] Because CMS has failed to provide a reasoned explanation for such a significant departure from prior policy and has not adequately considered or addressed the significant consequences of this proposal for Medicaid beneficiaries, providers, and states' efforts to improve maternal health outcomes, we urge CMS to withdraw this proposed rule.

III. Conclusion

On its own, OBBBA's impact on the health care landscape has been and will continue to be devastating.[33] These additional proposed restrictions would substantially reduce state flexibility to design payment strategies tailored to local health care needs. The proposed rule would also undermine ongoing efforts to improve the provision of maternal health care and address inequities in maternal health outcomes.[34] Additionally, the rule violates the APA because it exceeds Congress's statutory mandate, lacks a reasoned basis for departing from prior policy, and

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[28] Memorandum on Eliminating Waste, Fraud, and Abuse in Medicaid, Daily Comp. Pres. Doc. 202500671 (Jun. 6, 2025) https://www.whitehouse.gov/presidential-actions/2025/06/eliminating-waste-fraud-and-abuse-in-medicaid/ [hereinafter Presidential Memorandum].
[29] Proposed rule, *supra* note 1 at 30401, 30406, 30410, 30412-13, 30415, 30420, 30426, and 30437.
[30] Encino Motorcars, LLC v. Navarro, *supra* note 25.
[31] *Id*.
[32] Anne Karl et al., *supra* note 14.
[33] Annaliese Johnson et al., *supra* note 9.
[34] *OBBBA is Threatening Women's Health Care Access*, Nat'l Partnership for Women & Families (Jun. 2026) https://nationalpartnership.org/report/obbba-is-threatening-womens-health-care-access/; HOUSE ENERGY AND COMMERCE COMMITTEE DEMOCRATS, PALLONE & WYDEN RELEASE REPORT ON MATERNAL HEALTH ONE YEAR AFTER TRUMP'S BIG UGLY BILL (Jul. 6, 2026) https://democrats-energycommerce.house.gov/media/press-releases/pallone-wyden-release-report-maternal-health-one-year-after-trumps-big-ugly

fails to adequately consider the significant consequences of its proposed changes. For these reasons, we urge CMS to withdraw this proposed rule.

If you have any questions, please contact Vandana Ranjan, (vranjan@reprorights.org).

Sincerely,

Daria Neal
Senior Director, U.S. Policy and Advocacy