national partnership for women & families

July 21, 2026

Administrator Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Oz,

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments Proposed Rule ("Proposed Rule").

The National Partnership for Women & Families (National Partnership) is a national, non-profit, non-partisan organization with a mission to improve the lives of women and families by achieving equality for all women, especially for individuals and communities that face structural oppression and barriers to opportunity. Among our core areas of focus are improving access to affordable, high-quality health care; reducing inequities in health care and outcomes, and promoting health system transformation efforts that eliminate bias and foster equitable care for patients and consumers.

State-directed payments (SDPs) play a pivotal role in delivering equitable access to affordable, comprehensive healthcare for women and families across the country. **The National Partnership strongly opposes the Proposed Rule's extreme restrictions and constraints on SDPs. The National Partnership believes that CMS should rescind the Proposed Rule for its drastic expansion of the application of The Working Families Tax Cut (WFTC). If the Proposed Rule is implemented, we offer feedback on the following sections:**

I. Payment limits on SDPs (Section II.A.1)
II. Types of Permissible SDPs and Provider Classes (Section II.A.3)

The Proposed Rule Threatens Women's and Families' Health

In 2016, CMS established SDPs to allow states to direct manage care organization payments to providers. In the 2016 Final Rule, CMS highlighted the importance for states to have flexibility in using their Medicaid managed care programs to "improve quality, [assist in] better care coordination, and reduce[] costs." States use SDPs as a vital policy tool to supplement historically low Medicaid reimbursement rates in order to increase provider participation, expand healthcare access, and improve quality of care. SDPs are

particularly useful to bolster women's health services, including maternity care and primary care. The Proposed Rule will place restrictions on states' use of SDPs, which will impact the financing of these services and ultimately worsen women's health access and outcomes.

CMS's proposed cuts to SDPs must be understood in the context of the maternal health crisis in the United States. The United States has higher rates of pregnancy-related deaths than any other high-income country, and more than 80 percent of these deaths are preventable. The maternal health crisis has been exacerbated by the closures of women's health facilities. Since 2020, 130 hospitals' labor and delivery units have closed. Medicaid is a lifeline for women and pregnant people giving them access to essential healthcare. There are 74.9 million people enrolled in Medicaid. Medicaid covers nearly 1 in 4 of women ages 19-44 in rural communities, and finances more than 40 percent of all births in the United States. Many states have depended on SDPs to support hospital finances that keep safety-net hospitals afloat, to increase the number of physicians who accept patients enrolled in Medicaid, and to offset low Medicaid reimbursement rates with SDPs to expand access to care.

I. *The Proposed Rule will exacerbate hospital closures.*

Restrictions on SDPs will put hospitals that serve a high percentage of Medicaid patients at greater risk of closing, particularly those that have relatively little commercial revenue. Many of these hospitals at risk of closing are in rural areas, and their closures would force patients to travel far distances to the nearest hospital or possibly forgo care. Since the enactment of WFTC in July 2025, 14 hospitals have closed. There are more than 700 rural hospitals (one-third of all rural hospitals in the country) are at risk of closing, and almost 300 of these hospitals are at immediate risk of closing.

The survival of rural hospitals in Georgia and Kansas are examples of the importance of SDPs. In Georgia, due to SDPs, the state has been able to redirect disproportionate share hospital (DSH) funding originally intended for safety net and teaching hospitals to small rural hospitals. Nearly 39% of hospitals are in rural areas, and these hospitals serve 19% of the state's population. Restrictions to SDPs would lead to a loss of $89.1 million in annual DSH funding for these rural hospitals. In Kansas, 42% of the general hospitals are classified as rural. Even with receiving SDPs, 87% of Kansas' rural hospitals are still operating in the red. Restrictions to SDPs will inevitably lead to elimination of some services at these hospitals and possibly even closures of entire rural health facilities. Georgia and Kansas are just two examples of states that rely on SDPs to maintain and keep open health facilities in rural areas.

Without SDPs, rural communities will lose access to critical and life-saving services like emergency care, primary care, pediatric care, obstetrics care, and more. Rural hospital closures not only hurt patients but are also associated with long-term declines in the number of physicians in rural counties and adverse effects on local economic outcomes. SDPs play an important role in ensuring patients have access to timely care and in supporting the local economy by helping rural hospitals remain open.

II. *The Proposed Rule will diminish access to maternity care.*

Medicaid is the largest source of coverage for pregnancy, birth, and postpartum care nationwide. The loss of funding from the proposed restrictions on SDPs will threaten access to essential maternity care and discourage states from expanding pregnancy-related services in their Medicaid programs. Medicaid finances 41 percent of births nationally and almost half of births in rural areas. WFTC cuts to Medicaid funding have already resulted in the closure of 65 labor and delivery units, emergency departments, women's health clinics, and freestanding birth centers. With 35 percent of United States counties already classified as maternity care deserts (meaning that 1,104 counties lack a single birthing facility or obstetric clinician), the Proposed Rule risks further reducing access to maternity care services by forcing additional funding cuts. These reductions are likely to worsen maternal and infant health outcomes, including preventable deaths, exacerbating the ongoing maternal health crisis.

The Proposed Rule's restrictions on SDPs and consequent loss of funding will make it more difficult for states to maintain or expand optional pregnancy-related services. States have discretion to cover services such as doula support, fertility services, and breastfeeding support, which can improve birth outcomes and experiences. By reducing the Medicaid funding available to states and providers, the Proposed Rule places these optional benefits at greater risk of reduction or elimination.

III. *The Proposed Rule will limit people's access to primary care.*

Limitations to SDPs will create more barriers to women's and families' access to primary care services. Primary care is most people's first point of contact with the health care system and is responsible for a range of health care services, from prevention and wellness to diagnosis and treatment.

Primary care physicians across the country have expressed concerns that cuts to Medicaid funding will push them out of practice and constrain people's access to care. A 2025 survey of 561 U.S. primary care clinicians found that more than one-third of respondents were worried their practice would lose financial viability. Furthermore, the Association of American Medical Colleges projects a shortage of 20,200 to 40,400 primary care doctors by 2036.

Access to primary care saves lives, and the Proposed Rule's cuts to SDPs will threaten people's health. Studies found that people who have a regular primary care provider are more likely to have better outcomes, receive preventive care, and have a better care experience. And experts estimate that 130,000 U.S. deaths per year could be prevented by improving primary health care access. People need more access to primary care, which requires increased investment in these services.

Feedback on Sections II.A.1 and II.A.3

Sections II.A.1 and II.A.3 of the Proposed Rule create unnecessary and extremely broad restrictions on states' ability to use SDPs, which harm the health of women and families.

I. *Payment limits on SDPs (Section II.A.1)*

The National Partnership opposes the proposal to expand the scope of services affected by payment limits. WFTC imposed SDP limits on inpatient/outpatient hospitals, nursing facilities, and qualified practitioner services at academic medical centers. WFTC limited SDPs for these four services to 100% of the total Medicare published payment rate for an expansion state and 110% of the total Medicare published payment rate for a non-expansion state. The proposed rule drastically expands these payment limits to all services. This will include setting payment limits for primary care services, pediatric services, maternity care, and behavioral health, potentially impacting millions of patients and providers across dozens of states.

Additionally, CMS's expansion of payment limits to all services is inconsistent with Congress's intent in passing WFTC. Congress defined only four services it intended to impose payment limits on and intentionally excluded other services from the payment limits, including primary care, pediatric services, and maternity care.

Therefore, we object to the Proposed Rule's changes to SDP payment limits given the devastating impacts on women's and families' health and the deviation from Congress's explicit language and intent.

II. *Types of Permissible SDPs and Provider Classes (Section II.A.3)*

The National Partnership opposes the elimination of uniform rate increases. Uniform increase SDPs are the most common type of SDP. Eliminating uniform rate increases will threaten coverage for the women and families who live in the 40 states and DC that currently receive $93 billion in annual federal Medicaid spending through SDPs.

Based on the approved SDP preprints, three different states, New Mexico, New York, and Oregon, are using uniform rate SDPs to enhance maternal and obstetric programs. New Mexico and Oregon's uniform rate increase SDPs are for ensuring maternal health services are accessible in rural communities in their respective states. There are also 67 approved uniform increase SDPs for enhancing primary care services and eight approved for pediatric care services.

CMS justifies its restrictions to uniform increase SDPs based on alleged concern that states are inappropriately using these types of SDPs. However, eliminating the most common type of SDP will only limit, deny, and delay healthcare to women and families. Therefore, we strongly oppose the Proposed Rule's elimination of uniform increase SDPs.

The Proposed Rule Violates the Administrative Procedures Act (APA)

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The Proposed Rule is arbitrary and capricious because CMS failed to consider states' and Medicaid beneficiaries' reliance interests on SDPs and the devastating health consequences of restricting SDPs. The Administrative Procedures Act requires courts to "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). The Supreme Court held it is arbitrary and capricious for agencies to ignore "serious reliance interests." *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009); *see Dep't of Homeland Sec. v. Regents of the Univ. of California*, 591 U.S. 1, 30 (2020).

Here, CMS estimates that the Proposed Rule would reduce reimbursement to Medicaid providers by more than $775 billion over 10 years. States rely on SDPs to expand high-quality healthcare services; Medicaid beneficiaries, especially those living in rural areas, rely on SDPs to access emergency, primary, maternity, and pediatric care. When an agency changes course, such as restricting SDPs by $775 billion over 10 years, it must consider the reliance interests. *Dep't of Homeland Sec.*, 591 U.S. at 30.

Because CMS has not considered the serious reliance interests of Medicaid beneficiaries and states in the Proposed Rule's restrictions on SDPs, the Proposed Rule is arbitrary and capricious.

Overall, the National Partnership strongly opposes the Proposed Rule's limitations on SDPs. Restrictions on SDPs will lead to constraints on critical healthcare, ultimately further devastating the health of women and families and worsening this country's maternal health crisis.

We strongly urge CMS to rescind the Proposed Rule to increase and strengthen access to coverage and services, instead of diminishing care, and making care less available.

If you have further questions, please contact Rosann Mariappuram, Director of Reproductive Health & Rights, at rmariappuram@nationalpartnership.org.

Sincerely,

Nima Sheth, MD, MPH
Vice President of Health Justice