July 21, 2026

The Honorable Robert Kennedy, Jr.
Secretary Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Dr. Mehmet Oz
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P). The undersigned 40 members of the Coalition for Whole Health and allies, a group of leading national organizations advocating for policies to increase access to quality mental health and substance use care, offer the following comments.

We respectfully urge CMS not to finalize these rules as proposed. We believe CMS has far exceeded its statutory authority to interpret and implement Public Law 119-21 (H.R. 1) and the Social Security Act, and has failed to act within the bounds of reasoned decision-making in this proposed rule.

A. Medicaid Managed Care State Directed Payments

We urge CMS not to finalize the proposed changes to Medicaid managed care state directed payments (SDPs) as CMS has exceeded its statutory authority and failed to act within the bounds of reasoned decision-making in extending SDP limits to all Medicaid services. Section 71116(a) of Public Law 119-21 granted CMS authority to revise 42 C.F.R. § 438.6(c)(2)(iii) "such that, *with respect to a payment described in such section* . . . the total payment rate for *such service* is limited to" 100% of the Medicare payment rate in expansion states, and 110% of the Medicare payment rate in non-expansion states (emphasis added). However, § 438.6(c)(2)(iii) only speaks to SDPs for "inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center." Even this proposed rule acknowledges that Public Law 119-21 was limited to these services: "Section 71116 of the WFTC legislation directed the Secretary to reduce the total payment rate limit for certain SDPs for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an AMC." Clearly, the statutory language in Public Law 119-21 only contemplated the services described in this section, and Congress did not authorize SDP caps for other types of services or settings.

Yet, CMS exceeded its statutory authority in this proposed rule by extending these caps to *all* services

under a vague assertion that it has the authority to interpret and implement sections 1902(a)(4) and 1903(m)(2)(A)(iii) of the Social Security Act. However, CMS did not demonstrate that these proposed payment rates are "actuarially sound" and that these methods of administering Medicaid are "necessary for the proper and efficient operation of the State plan." Instead, the agency simply contends that imposing the same limit on all SDPs would be "a reasonable and appropriate approach" because it would prevent states from cost-shifting payments to other providers and services that "could be used to obscure fraud, waste and abuse." However, the agency offers no facts or evidence to support this claim.

Importantly, increased utilization of services is **not** the same as fraud, waste, and/or abuse. In the case of substance use disorder and mental health treatment, U.S. national spending has increased because of the number of people receiving the treatment they need.[1] And increasing the number of people who receive treatment must continue to be a top priority, including through sufficient reimbursement rates in Medicaid and in all financing systems. Approximately 18.2% of people in the U.S. aged 12 or older in 2024 needed substance use disorder treatment in the past year, yet less than 1 in 5 of those individuals received it.[2] While the number of overdose deaths has been declining over the past few years, we are still losing nearly 70,000 lives annually in this country to this preventable cause of death.[3] Additionally, there are 61.5 million adults in the U.S. aged 18 or older in 2024 who had a mental health condition, yet only about half (52.1%) received mental health treatment that year.[4] Suicide remains one of the leading causes of death in this country as well, with nearly 50,000 lives lost annually.[5] Taken together, the U.S. is losing 1 person to overdose or suicide approximately every 4 minutes.

Medicaid is one of our country's best tools for preventing and treating these conditions. Medicaid remains the single largest payer of substance use and mental health care,[6] and has higher rates of access to quality treatment for these conditions than other types of health insurance.[7] When states do leverage SDPs for substance use disorder and mental health care, especially because of years of underfunding these professionals, it leads to more Medicaid members receiving these services.[8] But states cannot continue to do so, or continue to improve access and outcomes, if they do not have access to the funding and financing options they need. Preserving Medicaid funding and financing options are necessary for the proper and efficient operation of state plans.

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[1] Tami L. Mark et al., "US National Spending on Mental Health and Substance Use Disorder Treatment Driven by Case Growth, 2000-21," Health Affairs (Mar. 18, 2026), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.01351.

[2] "Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health," SAMHSA 42-43 (July 2025), https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduhannual-national-report.pdf.

[3] "Provisional Drug Overdose Death Counts," U.S. Centers for Disease Control and Prevention, National Center for Health Statistics (Updated June 7, 2026), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

[4] *See* "Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health," *supra* note 2, at 50.

[5] "Suicide Data and Statistics," U.S. Centers for Disease Control and Prevention (Updated May 20, 2026), https://www.cdc.gov/suicide/data/index.html.

[6] "Behavioral Health," Medicaid and CHIP Payment and Access Commission (accessed June 23, 2026), https://www.macpac.gov/topic/behavioral-health/.

[7] Tami L. Mark et al., "The Quality of Opioid Use Disorder Treatment in Medicare is Low and Lags Behind Medicaid," Health Affairs (Sept. 2025), https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00207; Heather Saunders et al., "5 Key Facts About Medicaid Coverage for Adults with Mental Illness," KFF (Feb. 21, 2025), https://www.kff.org/mental-health/5-key-facts-about-medicaid-coverage-for-adults-with-mental-illness/.

[8] *See, e.g.*, "Coordinated care organizations had mixed financial results, creating a nearly break-even year," Oregon Health Authority (Sept. 19, 2025), https://www.oregon.gov/oha/erd/pages/increased-health-care-usage-grew-2024-expenses-for-oregon-medicaid-insurers.aspx.

CMS offers no evidence in this proposed rule that the Medicare payment rates meet the Social Security Act requirements for the full range of services to which it now proposes to extend these SDP limits, which suggests the agency has failed to act within the bounds of reasoned decision-making. For example, CMS failed to address how the Medicare rates for substance use disorder and mental health services are either actuarially sound or necessary for the proper and efficient operation of the State plan, while simultaneously acknowledging that Medicare rates do not exist for all services because the program fails to cover the full range of treatment for these conditions. As discussed further in the next section, Medicare is not subject to the Mental Health Parity and Addiction Equity Act, although Medicaid managed care plans are subject to this law. As such, there is an inherent conflict in CMS's claim that capping Medicaid SDPs to Medicare payment rates – at least for substance use disorder and mental health services – would be necessary for the proper operation of the state Medicaid plan. CMS did not address this issue at all, which is especially concerning amidst the ongoing overdose public health emergency and mental health crisis, for which states may properly and efficiently wish to direct payments, as many SDPs currently do.[9] Instead, the agency claims that the mere potential for obscuring fraud is sufficient to make this sweeping change to the Medicaid program, without any discussion of the potential implications for access to substance use disorder and mental health care, or any of the other services or settings for which SDP caps are not authorized by statute.

Furthermore, we are concerned with CMS's proposed methodology for payment limits for services not covered by Medicare. Medicare fails to cover many critical mental health and substance use disorder benefits that keep people out of hospitals and emergency rooms, and allow them to live in their homes and communities, such as residential treatment, mobile crisis teams, assertive community treatment, and others. Congress did not authorize CMS to set payment limits on these services in Medicaid, and states and managed care organizations need the flexibility to ensure that when they do cover these benefits, they can set reimbursement rates that meet statutory requirements and ensure meaningful access.

Accordingly, we strongly urge CMS not to extend the SDP payment limits to the additional services and facilities beyond those expressly authorized by Public Law 119-21.

B. Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

We urge CMS not to finalize the proposed changes to Medicaid fee-for-service (FFS) targeted Medicaid practitioner payments. While CMS was granted authority to make changes to certain state directed payments in Public Law 119-21, Congress did not include any provisions that authorized CMS to set caps on FFS payments. As CMS notes, the Social Security Act requires a Medicaid state plan "to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30). However, we strongly disagree with CMS's assertion that the Medicare FFS payment rates serve as a reliable rate to ensure economy and sufficiency for Medicaid, particularly for substance use disorder and mental health services. CMS has exceeded its statutory authority in proposing these

[9] MACPAC, "Directed Payments in Medicaid Managed Care," Medicaid and CHIP Payment and Access Commission (Oct. 2024), https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf; 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/.

changes, and has failed to engage in reasoned decision-making in this proposal. Accordingly, CMS should not finalize these rules.

First, research suggests that Medicare is not consistent with quality of care for substance use disorders. A study published last year in Health Affairs examined nationally recognized quality measures for opioid use disorder (OUD) treatment in Medicare and Medicaid, and found that Medicaid surpassed Medicare on all measures examining the quality of care for OUD:[10]

- Only 36% of Medicare FFS beneficiaries initiated treatment (started OUD treatment within 14 days of a new OUD diagnosis), compared to 55% of Medicaid enrollees.
- Only 15% of Medicare FFS beneficiaries with OUD engaged in treatment (received two or more additional OUD services or medications within 34 days of their initiation visit), compared to 30% of Medicaid enrollees.
- Only 21% of Medicare FFS beneficiaries with OUD were treated with medications for opioid use disorder (MOUD), the gold standard of treatment for this condition, compared to 57% of Medicaid enrollees.
    - Notably, more recent data suggests that the rate of access to MOUD has continued to increase in Medicaid such that it is now nearly 70%,[11] whereas the Medicare rate has stayed relatively constant at around one in five enrollees.[12]

This is more than just an inconsistency with the Medicaid statute, though. In the midst of the ongoing overdose epidemic, renewed by the Secretary on June 4, 2026,[13] it would be a threat to public health to reduce access to OUD treatment by capping FFS payments based on the Medicare payment rates, particularly because of Medicaid's key role as the main source of coverage for adults with OUD and among those receiving treatment.[14]

Second, research by your Department suggests that reimbursement rates in Medicare (as well as in Medicaid, for that matter) are not currently sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. In 2024, the U.S. Department of Health & Human Services Office of Inspector General (OIG) released a report highlighting how the lack of behavioral health providers in Medicare and Medicaid impedes enrollees' access to care.[15] Key findings include:

- Few behavioral health providers actively serve Medicare and Medicaid enrollees: on average,

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[10] Tami L. Mark et al., "The Quality of Opioid Use Disorder Treatment in Medicare is Low and Lags Behind Medicaid," Health Affairs (Sept. 2, 2025), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00207.

[11] Thanh T. Lu et al., "Cascade of Care for Opioid Use Disorder Among Medicaid Beneficiaries," JAMA Network (Apr. 22, 2026), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2848015.

[12] U.S. Department of Health & Human Services, Office of Inspector General, "Fewer than One in Five Medicare Enrollees Received Medication to Treat Their Opioid Use Disorder," U.S. Department of Health & Human Services, OEI-02-24-00430 (Apr. 2025), https://oig.hhs.gov/documents/evaluation/10253/OEI-02-24-00430.pdf.

[13] U.S. Department of Health & Human Services, Administration for Strategic Preparedness & Response, "Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of the Opioid Crisis," U.S. Department of Health & Human Services (June 4, 2026), https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-4Jun2026.aspx.

[14] Heather Saunders & Robin Rudowitz, "Implications of Potential Medicaid Reductions for Addressing the Opioid Epidemic," KFF (May 14, 2025), https://www.kff.org/medicaid/implications-of-potential-federal-medicaid-reductions-for-addressing-the-opioid-epidemic/.

[15] U.S. Department of Health & Human Services, Office of Inspector General, "A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care," U.S. Department of Health & Human Services, OEI-02-22-00050 (Mar. 2024), https://oig.hhs.gov/documents/evaluation/9844/OEI-02-22-00050.pdf.

there are 2.9 active behavioral health providers per 1,000 Medicare FFS enrollees, and 3.1 active behavioral health providers per 1,000 Medicaid enrollees.
    - A quarter of the counties OIG studied had fewer than one active behavioral health provider per 1,000 Medicare FFS enrollees or Medicaid enrollees.
    - Rural counties had about one-third the number of active behavioral health providers compared to urban counties.
    - Even fewer providers could prescribe medication to Medicare and Medicaid enrollees: there were 0.8 active behavioral health providers per 1,000 Medicare FFS enrollees, and 0.5 active behavioral health providers per 1,000 Medicaid enrollees.
- Active providers in Medicare and Medicaid represented only about one-third of the total behavioral health provider workforce. Notably though, Medicaid was higher than Medicare FFS: 38% of behavioral health providers actively participated in Medicaid, compared to only 29% in Medicare FFS.
    - The report specifically pointed to low payment rates as one of the reasons for this limited participation.
- Only 8% of Medicaid enrollees received treatment from a behavioral health provider, but the rate was half that (4%) in Medicare FFS.
    - Importantly, Medicaid enrollees most often saw counselors and social workers, who are reimbursed at a lower rate in Medicare than other non-physician practitioners, as discussed further below.

Furthermore, research based on SAMHSA's N-SUMHSS data shows that only 47% of substance use disorder treatment facilities participate in Medicare, compared to 75% in Medicaid and 78% in private insurance.[16] This disparity in Medicare, not just as compared to Medicaid but especially as compared to private insurance, shows that substance use disorder services are not available to Medicare beneficiaries to the same extent as the general population, suggesting that Medicare payment rates would conflict with Medicaid's statutory requirements.

Together, these studies show that Medicare FFS payment rates are in fact not "consistent with efficiency, economy, and quality of care," nor are they "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

This is not surprising, though. Medicare is not subject to the Mental Health Parity and Addiction Equity Act (MHPAEA), the anti-discrimination law that requires reimbursement rates – among other non-quantitative treatment limitations – to be designed and applied in a way that is comparable for mental health and substance use disorder providers as for medical and surgical providers. Moreover, payments under the Medicare Physician Fee Schedule are generally higher for clinical procedures such as surgeries and diagnostic tests,[17] and lower for non-procedural services that mental health and substance use disorder providers deliver like counseling and psychotherapy. By contrast, states currently have the flexibility in Medicaid to set rates that are sufficient to enlist counselors and other mental health and

[16] Heather Saunders & Rhiannon Euhus, "A Look at Substance Use and Mental Health Treatment Facilities Across the U.S." KFF (Feb. 2, 2024), https://www.kff.org/mental-health/a-look-at-substance-use-and-mental-health-treatment-facilities-across-the-u-s/.
[17] Alex Cottrill, Juliette Cubanski, & Tricia Neuman, "What to Know About How Medicare Pays Physicians," KFF (Oct. 7, 2025), https://www.kff.org/medicare/what-to-know-about-how-medicare-pays-physicians/.

substance use disorder providers, and they are required to comply with MHPAEA for managed care plans (and FFS when some benefits are delivered via managed care), alternative benefit plans, and the Children's Health Insurance Program (CHIP).

Even more alarmingly, CMS has proposed that States would have to further limit targeted Medicaid payments for providers who are not reimbursed at the full Medicare FFS rate. The proposed rule highlights how certain non-physician practitioners – nurse practitioners, physician assistants, and clinical nurse specialists – are reimbursed at 85% of the physician rate in Medicare. The proposed rule does not even acknowledge that non-physician behavioral health practitioners – clinical social workers, mental health and addiction counselors, and marriage and family therapists – are only reimbursed at 75% of the physician rate in Medicare. This amount, and even the proposed 10% bump in reimbursement rates for providers in non-expansion states, would be woefully inconsistent with "quality of care," and certainly insufficient "to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

However, CMS did not even acknowledge the impact on mental health or substance use disorder providers – or access to such providers – in this proposed rule, which reinforces the degree to which the agency failed to act within the bounds of reasoned decision-making. In fact, the only time "mental health" or "substance use disorder" even appear in this proposed rule is when CMS acknowledges that Medicaid covers a broader array of services than Medicare, such that there would be no comparable payment rate under Medicare. Notably, this was not even in the section on FFS payment limits, but on the section on SDPs. Nonetheless, this suggests CMS is well aware that Medicare is an inadequate benchmark for comparison to Medicaid, and yet elected to proceed with this proposal anyway without discussing the differences in reimbursement rates for behavioral health providers or the current access challenges that exist.

In summary, CMS has exceeded its statutory authority by proposing to cap Medicaid FFS targeted Medicaid practitioner payments using a Medicare benchmark for substance use disorder and mental health services. Moreover, CMS failed to engage in reasoned decision-making with respect to the impact of this proposal on substance use disorder and mental health services. We urge CMS to rescind this proposal.

* * *

CMS has an opportunity to put meaningful action behind this Administration's Great American Recovery Initiative. You can ensure people continue to have access to the substance use disorder and mental health care they need and save lives.

Thank you for considering our comments. We would be happy to work with you to identify alternative ways CMS can support states in continuing to improve access to substance use disorder and mental health care. Please do not hesitate to contact Deborah Steinberg at dsteinberg@lac.org to discuss further.

Sincerely,

Legal Action Center

American Association of Psychiatric Pharmacists
American Association on Health and Disability
American Foundation for Suicide Prevention
American Nurses Association
American Society of Addiction Medicine
Bazelon Center for Mental Health Law
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Concerted Care Group Baltimore
Crisis Text Line
Destination Tomorrow
Easterseals, Inc.
Faces & Voices of Recovery
Fountain House
Friends of Recovery – New York
IBR Reach Health Services
IC&RC
Inseparable
International Society of Psychiatric-Mental Health Nurses
Kolmac Integrated Behavioral Health
Lakeshore Foundation
Man Alive Inc.
Maryland Association for the Treatment of Opioid Dependence (MATOD)
MedMark Treatment Centers
NAATP
National Alliance on Mental Illness
National Alliance to End Homelessness
National Association for Behavioral Healthcare
National Association for Rural Mental Health (NARMH)
National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)
National Behavioral Health Association of Providers
National Eating Disorders Association
NCADD Maryland
Partnership to End Addiction
Policy Center for Maternal Mental Health
Psychotherapy Action Network (PsiAN)
Pyramid Healthcare
The American Counseling Association
The National Alliance to Advance Adolescent Health
Treatment Communities of America