Re: Docket No. CMS–2025–1823 — Proposed Changes Affecting Medicaid and CHIP Financing Mechanisms

I submit this comment to express serious concern regarding CMS's proposed rulemaking affecting Medicaid and CHIP financing mechanisms, including provider taxes and related funding structures. While CMS characterizes this proposal as a clarification or program integrity measure, it operates in practice as a deregulatory or retrenchment action that risks weakening statutory safeguards, destabilizing state Medicaid programs, and reducing access to care for vulnerable populations.

I. Statutory Structure and Congressional Intent

Medicaid is a cooperative federal–state program designed to ensure broad access

to medical care for low-income individuals. Congress deliberately afforded states flexibility in financing mechanisms—within defined guardrails—to sustain coverage and provider participation.

Changes that restrict, narrow, or indirectly invalidate long-standing provider tax structures risk undermining that cooperative balance without congressional authorization, contrary to the intent of Title XIX of the Social Security Act.

Supporting Authority and Statutory Citations

Social Security Act, Title XIX, 42 U.S.C. §§ 1396–1396w-6

42 U.S.C. § 1396a(a) (state plan requirements and federal-state structure)

42 U.S.C. § 1396b(w) (provider tax provisions and permissible financing

mechanisms)
NFIB v. Sebelius, 567 U.S. 519, 575–85 (2012) (Medicaid as cooperative federal–state program; limits on coercive federal action)
II. Deregulatory Effect and Programmatic Risk
Although framed as technical or corrective, the proposal appears to:
Reduce state flexibility in structuring lawful financing mechanisms
Increase administrative uncertainty and compliance risk
Create incentives for states to reduce benefits, eligibility, or provider reimbursement
These effects function as de facto deregulation of federal responsibility by shifting fiscal pressure downward to states and beneficiaries.
III. Arbitrary and Capricious Concerns

(APA)
CMS has not adequately demonstrated that the proposed changes are supported by evidence of widespread abuse or misuse sufficient to justify their scope.
An agency may not rely on generalized concerns to justify policy shifts that:
Disrupt settled reliance interests
Increase risk of coverage loss
Alter the federal–state balance without clear statutory mandate
See Motor Vehicle Mfrs. Ass'n v. State Farm, 463 U.S. 29, 43 (1983).
APA AND RELIANCE INTERESTS
Administrative Procedure Act, 5 U.S.C. § 706(2)(A)
Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983)
FCC v. Fox Television Stations, Inc., 556 U.S. 502, 515–16 (2009) (policy reversals and reliance interests)

Encino Motorcars, LLC v. Navarro, 579 U.S. 211, 221–22 (2016) (failure to consider reliance interests renders rule arbitrary and capricious)

IV. Public Health and Equity Implications

Any regulatory change that destabilizes Medicaid financing foreseeably:

Reduces provider participation

Increases care deserts

Disproportionately harms disabled individuals, children, and communities of color

CMS has an affirmative obligation to assess and mitigate these impacts, not merely acknowledge them.

HEALTH ACCESS AND EQUITY

Olmstead v. L.C., 527 U.S. 581 (1999) (unjustified isolation and access to care)

Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid Financing and Provider Participation

(annual reports)
CMS, Medicaid Managed Care Final Rule findings on access and provider participation
V. Request
CMS should withdraw or substantially revise this proposal to:
Preserve lawful state financing flexibility
Avoid indirect benefit or access reductions
Ensure compliance with statutory purpose and administrative-law requirements
At minimum, CMS should delay finalization pending a more robust impact analysis.
Respectfully submitted,
[Your Name]
Concerned Member of the Public