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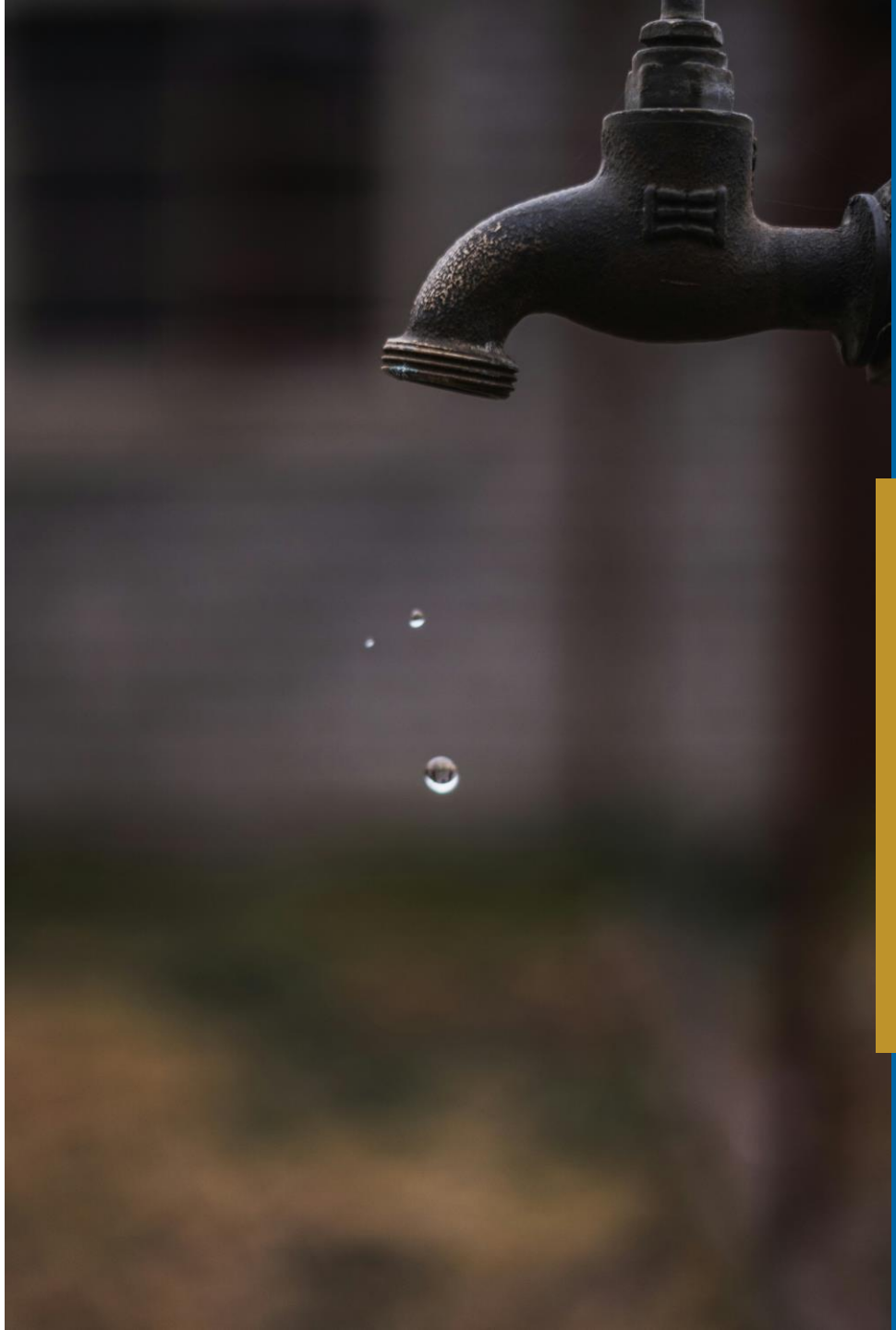
A Summer Webinar Series:

The Future of Medicaid State Directed Payments

June 10, 2026



Summer Webinar Series

Understanding Work and Community Engagement Requirements | July 15

How New Program Integrity Expectations Affect Medicaid Payments| August 12

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CMS Proposed SDP Rule

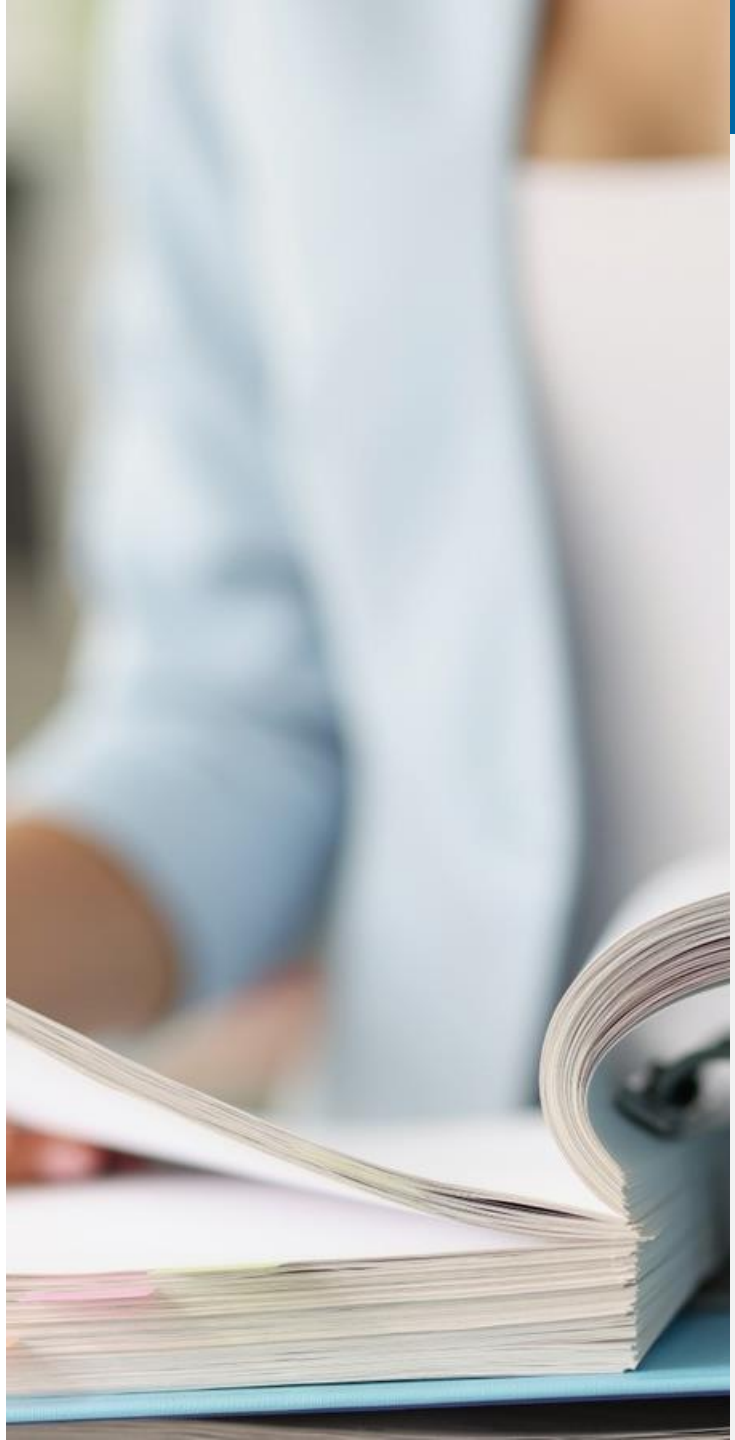
PUBLISHED MAY 22, 2026

Implements State Directed Payment (SDP) Mandates from Working Families Tax Cut Act (WFTC)

- Restricts value of most payments to a percentage of Medicare equivalent rates
- Freezes existing payments above the new limits and provides a mechanism for states to transition payments into compliance

Establishes New Restrictions on Medicaid Payments

- Creates new requirements for SDP spending and design
- Proposes additional reductions to spending limits on some fee-for-service (FFS) provider payments



Rule Proposes Broad SDP Constraints

CMS PROJECTS SIGNIFICANTLY GREATER FEDERAL SAVINGS, DRIVEN BY BROADER RESTRICTIONS ON SDPS AND SUPPLEMENTAL PAYMENTS

- CMS estimates **substantially greater federal savings** from the proposed rule than from the SDP-related provisions in the WFTC ($510B vs. $149B).
- The difference suggests the proposed rule may have a **broader impact than the statutory SDP changes** alone, although differing scoring methodologies may also contribute.
- Key drivers of the additional fiscal impact include:
  - Expansion of **Medicare-based payment limits** beyond hospital, nursing facility, and academic medical center practitioner services to all state-directed payments.
  - **New restrictions** on other forms of Medicaid supplemental payments.

Components of the Proposed Rule

- SDP payment limit reductions
- Grandfathering of SDPs
- Limitation on types of SDPs
- Targeted Medicaid payment limits under fee-for-service

SDP Payment Limitations

CEILING CALCULATION

New ceiling calculation for all SDPs must equal a percentage of Medicare

- 100% of Medicare for states that have expanded Medicaid
- 110% of Medicare for states that have not expanded Medicaid

The Medicare ceiling must be applied at the service-specific level

- **Medicare rates define the ceiling.** Ceiling calculated by re-pricing Medicaid claims/ discharges at Medicare-equivalent rate. Medicare rate includes add-on components (uncompensated care, medical education, geography, and quality)
- **No Medicare rate = state plan rate ceiling.** If no published Medicare rate, reimbursement is capped at Medicaid state plan approved rate. Unlike Medicare ceiling calculation, Medicaid state plan rate is not inclusive of supplemental payments
- **Cost-based providers use cost reports.** Providers with reimbursement set as a percentage of costs (like critical access hospitals) would use their most recent Medicare cost report to identify their ceiling

SDP Payment Limitations

NEW RESTRICTIONS ON STATE MEDICAID REIMBURSEMENT

Impacted services extends beyond those identified in WFTC legislation

- WFTC identified four services (inpatient & outpatient hospital, professional services, nursing facility) for new limit – rule extends to SDPs for all providers

Medicare ceiling per service extends to value-based payments (VBP)

- VBPs, even those designed as prospective population-based, also cannot exceed the total Medicare payment rate by service

Concerns with Medicare Limit Calculation

Increases the administrative burden of SDP programs

- State Medicaid reimbursement design often significantly deviates from Medicare.
- Repricing each individual service at Medicare rates will require a complex crosswalk—especially for outpatient hospital services where Medicare pays based on bundles of services

Limits the ability to target payments to ensure access

- Currently, states can set higher payments for services critical to the needs of their residents.
- Limiting all services to Medicare takes away this flexibility, and services that are critical under Medicaid but not as prevalent under Medicare (e.g., maternal health) could see decreases to reimbursement
- Also, limits health plans' ability to negotiate higher rates to ensure adequate networks

Deviates from payment limit for same services under Medicaid fee-for-service (FFS)

- FFS upper payment limit calculations are performed at the aggregate level and are based on a "reasonable estimate" of what Medicare would have paid.
- This includes the option to define the Medicare limit as the cost of services.

Medicaid vs. Medicare Reimbursement

EXAMPLES OF MISALIGNMENT IN METHODS AND COVERED SERVICES

Inpatient care

- Medicare reimburses for most inpatient care based on Medicare Severity-Diagnosis Related Groups (MS-DRGs)
  - Developed for adult patients and related to resource intensity by procedure
- Many states also use DRGs to reimburse under Medicaid but utilize the All-Patient Refined Diagnosis Related Groups (APR-DRGs)
  - Includes all age groups and also accounts for severity of illness and risk of mortality
  - States have historically chosen this methodology to better align with their Medicaid population

Cost-reimbursed providers

- States may choose to use cost as a basis for reimbursement for Medicaid payments—this is especially common with government-owned providers
- If Medicare pays for services for that provider type under a different methodology, any directed payment would instead be limited to Medicare reimbursement at the service level

Uncovered services

- Medicaid provides coverage for services excluded under Medicare FFS such as pediatric, long-term care, and dental
- States would be limited to Medicaid FFS state plan approved rates excluding supplemental payments

Administrative Burden Example

Example of current IP average commercial rate (ACR) payment limit demonstration:

Hospital	% of Medicaid Discharges	Medicaid Payments	ACR Ceiling	Gap Available for SDPs
Hospital A	20%	$1,000	$2,500	$1,500
Hospital B	50%	$5,000	$10,000	$5,000
Hospital C	30%	$4,000	$8,250	$4,250
Total	**100%**	**$10,000**	**$20,750**	**$10,750**

Hospitals may receive their share of the $10,750 available based on their % of total Medicaid discharges, regardless of their individual ACR gap.

Example of Medicare payment limit demonstration for just three IP DRGs at one hospital:

Hospital	DRG	Medicaid Payments	Medicare Rate	Service SDP Limit
Hospital A	##1	$800	$950	$150
Hospital A	##2	$900	$1,000	$100
Hospital A	##3	$12,000	$11,500	$0

Hospitals may only receive an SDP for a service if Medicaid pays less than Medicare. The state would need to perform this calculation for the 700+ MS-DRGs for every hospital. In this example, 3 x 700 = 2,100+ lines.

SDP Payment Limitations

MAJOR IMPACTS TIED TO THE CHANGE

Providers

- Diminished ability to negotiate rates above Medicare
- Redistribution of benefit within SDP programs
- Reduced revenue from SDP programs in many states (especially those with payments at or near ACR)

Medicaid Health Plans

- Impacts to provider network development / maintenance
- Potential infrastructure redevelopment to better align Medicaid reimbursement with Medicare

State Medicaid Agencies

- Administrative complexity in re-pricing all Medicaid claims to Medicare.
- Impacts to Medicaid enrollee access
- Greater influence of Medicare policy in Medicaid reimbursement

Grandfathered SDPs

Eligibility:

- Apply to one of the following rating periods: calendar year (CY) 2024, state fiscal year (SFY) 2025, CY 2025, SFY 2026, and CY 2026.
- Payment for inpatient or outpatient hospital services, nursing facility services, or qualified practitioner services delivered at an academic medical center.
- Based on a preprint that was submitted in a complete form prior to July 4, 2025.

Annual 10% Reduction:

- Defined as 10% of the total grandfathered SDP amount. The 10% reduction amount will be constant until payment levels hit the Medicare payment ceiling.
- Will start with rating periods beginning on or after January 1, 2028.

10% Annual Reduction

Phasedown period

- Not a uniform timeline for all SDPs
- Will vary by state and SDP program depending on the difference between the grandfathered amount and the Medicare ceiling

Varied interpretations

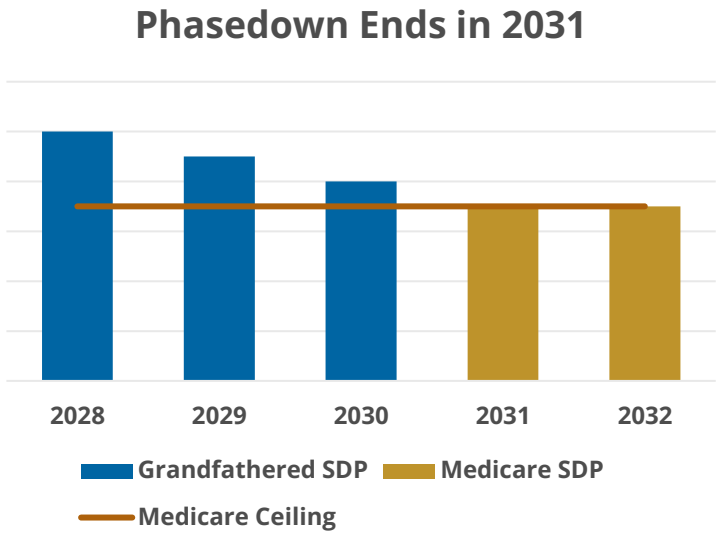
- The WFTC legislation called for a 10% annual reduction but there was some ambiguity as to 10% of what
- Other interpretations (e.g., reducing the percentage above Medicare by 10 percentage points annually) could have extended the transition timeline

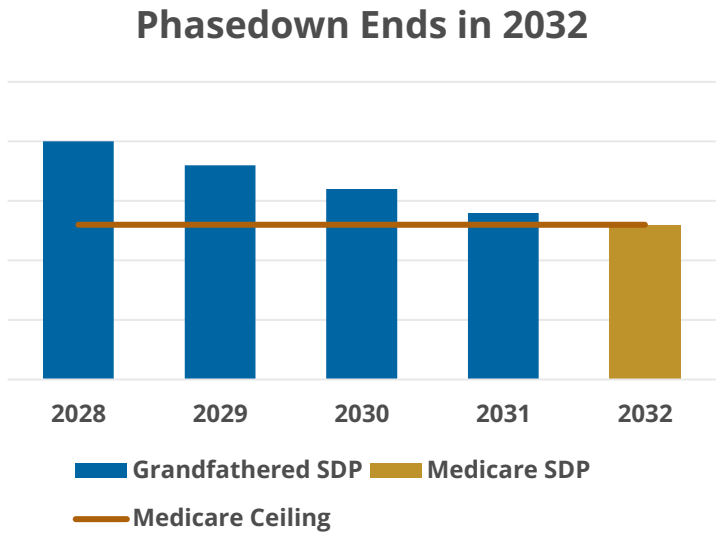
Other services

- Services beyond the main four will not have a phasedown period and will need to drop to the Medicare ceiling for rating periods beginning on or after January 1, 2029

Remaining questions on applicability

- How will CMS treat SDP programs that include services from both the list of four and others?
- If a state has multiple SDP programs for the same universe of providers (e.g., a uniform rate increase and a VBP) do each need to be reduced by 10% annually or is there flexibility in how the reduction can be spread?





SDP Grandfather Requirement

MEDICAID MANAGED CARE RULE IMPLEMENTATION CHANGE

During an SDP's phasedown, the grandfathered SDPs would be exempt from requirements established in the 2024 Medicaid Managed Care Rule:

- Prohibition on retrospective changes to preprint submissions
- Prohibition on separate payment terms

The term "separate payment term" refers to the ability for states to separately pay SDPs outside of capitation rate payments to health plans

- These are typically used to pay out fixed pools of dollars and/or fixed uniform add-ons

States utilize separate payment terms and the ability to make retroactive adjustments today to better track SDP spending—ensuring that payments get to the providers in full—and to adjust for actual utilization which can only be estimated prospectively

- Allowing states to continue with these mechanisms will provide CMS greater transparency to track spending and better ability to enforce the grandfathered limits

SDP Grandfather Requirements

MAJOR IMPACTS TIED TO THE CHANGE

Providers

- CMS interpretation of 10% amount is simplest but most impactful in terms of reduction amount / year
- Adjustment from ACR to Medicare standard will significantly reduce Medicaid reimbursement for many providers.

Medicaid Health Plans

- Exemption from managed care rule changes may reduce complexity of implementing other SDP changes

State Medicaid Agencies

- Calculation of 10% reduction amount is administratively simple and predictable after year one.

Limitations on Types of SDPs

These limitations will only apply to non-grandfathered SDPs (starting with January 1, 2028) and grandfathered SDPs after their phasedown is complete.

Uniform Add-ons

- SDPs will no longer have the option to be structured as uniform add-ons to claims
- Only allowable types:
  - VBPs or delivery system reform or performance improvement initiatives
  - Minimum or maximum fee schedule adjustments

State Plan Approved Rates

- **Current Policy:** States can direct health plans to pay no less than the Medicaid FFS approved fee schedule without receiving prior written approval from CMS
- **Proposed Rule:** States would need to demonstrate that the approved Medicaid FFS rates do not exceed Medicare rates by service

Prohibition on Separate Payment Terms

- All payments will need to be structured as capitation rate adjustments
- Will introduce risk to health plans and providers as enrollment and utilization deviate from projections

Comparison of Payment Structures

EXAMPLE OF SDP FOR ONE SPECIFIC SERVICE

Uniform Add-on Distribution

Provider	Base Medicaid Payments for Service	ACR Gap for Service	Current Uniform SDP Distribution	% of Total SDP Received
Provider A	$3,000	$4,500	$4,250	25%
Provider B	$5,000	$7,000	$7,083	42%
Provider C	$4,000	$5,500	$5,667	33%
Total	**$12,000**	**$17,000**	**$17,000**	**10%**

The top chart represents an SDP paid as a uniform % add-on to base payments.

All providers receive the same percentage increase over base negotiated rates.

Minimum Fee Schedule Distribution

Provider	Base Medicaid Payments for Service	Minimum Fee Schedule Set to Medicare	Adjustment to Fill Medicare Gap	% of Total SDP Received
Provider A	$3,000	$5,000	$2,000	67%
Provider B	$5,000	$5,000	$0	0%
Provider C	$4,000	$5,000	$1,000	33%
Total	**$12,000**	**$15,000**	**$3,000**	**100%**

The bottom chart shows how payments would change based on a minimum fee schedule approach.

Providers only receive the gap between their payments for the service and Medicare rates.

This results in a different distribution of payments across providers.

SDP Limitations

MAJOR IMPACTS TIED TO THE CHANGE

Providers

- Removing the ability to structure payments using uniform add-ons will lead to redistribution of SDP benefit
- Prohibiting separate payment terms will add risk to payment structure and its associated financing

Medicaid Health Plans

- Health plans will need to align provider payment structure with fee schedules rather than paying supplemental add-ons
- Prohibiting separate payment terms will add risk to payment structure

State Medicaid Agencies

- Developing and enforcing minimum fee schedules at no greater than Medicare levels will require additional administrative burden
- Prohibiting separate payment terms will add risk and remove a level of transparency

FFS Medicaid Targeted Practitioner Payments

ADDITIONAL REDUCTIONS AND RESTRICTIONS INCLUDED IN SDP PROPOSED RULE

Practitioner Definition

- Physicians; dentists and other dental practitioners; other licensed practitioners; transportation providers, including ground emergency medical transportation, air ambulance providers, and nonemergency medical transportation providers; as well as other providers such as clinics and Certified Community Behavioral Health Clinics.
- Does not apply to services already limited by FFS upper payment limits (UPLs)

Medicare Levels

- Like the limits proposed for SDPs, CMS proposed to limit "targeted" practitioner payments to Medicare levels - 100% of Medicare in expansion states, 110% of Medicare in non-expansion states
- Unlike with SDPs, there would be no phasedown period, though the change would not be required until the state fiscal year beginning on or after January 1, 2029

Applicable "Targeted" Payments

- A payment is considered targeted to a subset of practitioners when it is available to only some practitioners who furnish the same Medicaid-covered service
- Rates could continue to be above Medicare levels for certain services if those rates applied to all providers

What Comes Next?

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Key Dates

July 21, 2026

Comments on the proposed rule due to CMS

July 9, 2027

2024 rule states that for rating periods beginning on or after this date, **states can no longer make SDPs using separate payment terms** *(rule proposes this does not apply during phasedown)*

Jan. 1, 2029

SDPs for rating periods beginning on or after this date for services beyond inpatient, outpatient, nursing facility, and qualified practitioner at an academic medical center and must be reduced to the 100%/110% Medicare ceiling.

Targeted FFS practitioner service payments must also be reduced to at or below 100%/110% of Medicare levels for state fiscal years beginning on or after this date

2026 | 2027 | 2028 | 2029

July 9, 2026

2024 Medicaid managed care rule states that for rating periods beginning on or after this date**, states can no longer make retroactive adjustments to preprint** *(rule proposes this does not apply during phasedown)*

Jan. 1, 2027

States must submit a Medicare payment limit demonstration starting with rating periods beginning on or after this date

Jan. 1, 2028

WFTC SDP phasedown begins with rating periods beginning on or after this date. New limitations on SDPs begin to apply

Regulatory Landscape Continues to Evolve

UPCOMING COMMENT OPPORTUNITIES AND RELATED RULEMAKING COULD FURTHER SHAPE THE MEDICAID FINANCING LANDSCAPE

Federal Comment Period

- CMS is accepting comments on this proposed rule until July 21, 2026
  - Some aspects of the proposed rule appear to extend beyond the direction provided in the WFTC legislation, potentially creating opportunities for stakeholder input during final rule development.

Other Relevant Rulemaking

- Community engagement (work requirements) interim final rule published June 1, 2026
- Pending proposed provider tax rule implementing WFTC requirements could be released at any time
- Pending proposed “Strengthening the Integrity of Medicaid and CHIP Managed Care, Financing, and Access to Care” rule could be released at any time
  - Short description includes reference to SDPs

What should you be doing next?

PAYMENT LIMITS AND PHASE-DOWN REQUIREMENTS WILL RESHAPE PROVIDER FINANCING, CREATING NEW CHALLENGES FOR PROVIDER SUSTAINABILITY AND ACCESS TO CARE.

Stakeholder	Understand Impact	Modeling and Analysis	Strategize Next Steps
States	Assess how SDP changes could reshape provider financing and access across the state	Quantify impacts on provider funding, safety-net sustainability, and access to care	Determine how to balance fiscal constraints with provider sustainability and access goals
Payers	Assess implications for provider payments, contracts, and reporting requirements	Analyze impacts on provider reimbursement, and administrative burden	Evaluate potential contract, operational, and compliance changes as state approaches emerge
Providers	Identify SDP revenue exposure and program dependencies	Model reimbursement and margin impacts under alternative scenarios	Align advocacy, operational, and financial strategies

Questions?

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