

ISSUE BRIEF

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**Proposed Changes to  
Medicaid State Directed Payments  
and Targeted Practitioner Payments**  
May 2026 Proposed Rule

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## INTRODUCTION

On May 22, 2026, the Centers for Medicare & Medicaid Services (CMS) released the Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments Proposed Rule. This rule outlined changes to Medicaid provider reimbursement addressing the directives in P.L. 119-21 (now known as the Working Families Tax Cut legislation) enacted July 4, 2025, and extending those payment limitations to additional providers under Medicaid managed care and fee-for-service (FFS).

The proposed changes to the regulations are comprehensive and complex. Health Management Associates (HMA) colleagues have spent considerable time analyzing the regulation and stand ready to help organizations interpret the regulation, evaluate the impact, and strategize on possible next steps. To facilitate your review of the proposed rule and its implications, they have created the following summary of key elements. The complete proposed rule can be found [here](#).

### Overview

Through the proposed rule, CMS seeks to address the directives included in P.L. 119-21 (now known as the Working Families Tax Cut [WFTC] legislation) enacted July 4, 2025, to limit Medicaid provider reimbursement under managed care state directed payments (SDPs). The proposed rule, however, goes beyond the WFTC to propose limits to FFS targeted practitioner payments and modifications of other requirements related to SDPs.

Section 71116 of the WFTC legislation calls for reducing the payment ceiling from the average commercial rate to a percentage of Medicare payment levels for all new SDPs for services provided in hospitals, nursing facilities, academic medical centers. Existing SDPs were grandfathered in at current levels and provided a transition period to phase down to the new lower limit. The proposed rule extends that lower ceiling to SDPs for all provider types and analogously lowers the payment ceiling to Medicare levels for targeted practitioner payments under FFS.

### Proposed Rule Changes Discussed in this Issue Brief

1. Lowering the payment ceiling for all SDPs to either 100% of Medicare for states administering Affordable Care Act (ACA) expansion programs or 110% of Medicare for states without an ACA expansion program
2. Grandfathering certain SDPs in at levels above Medicare and providing a transition period with an annual 10% reduction until the payments are reduced to Medicare levels
3. Limiting the types of SDPs to be allowed prospectively
4. Capping targeted Medicaid FFS practitioner payments at 100% of Medicare for expansion states and 110% of Medicare for non-expansion states

## 1. PAYMENT LIMIT FOR SDPS

In the 2024 Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule, CMS finalized the SDP payment limit as the average commercial rate (ACR) for the following four provider categories: inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services delivered at an academic medical center.

### Summary of Proposed Rule

Citing significant growth in SDP spending over the past several years, CMS, at the direction of the WFTC legislation, proposes to reduce the payment ceiling for all SDPs to a percentage of the service level total published Medicare payment rates.

### Key Components

- **Total published Medicare payment rate:** The Medicare payment ceiling would be calculated at the service or discharge-specific level. The published Medicare payment rate is defined as the amounts calculated as payment by service that have been developed under title XVIII Part A and Part B of the Social Security Act, including all reimbursement components in the rate developed by CMS for Medicare, such as disproportionate share hospital adjustments and adjustments related to medical education, geography, and quality.
  - If no Medicare rate has been published for a specific service, the limit for that service would be equal to the Medicaid state plan's approved rate or under a waiver of such plan. The Medicaid state plan approved rate is exclusive of supplemental payments.
  - Providers that are reimbursed based on a percentage of costs, such as critical access and freestanding children's hospitals, would use their most recent and complete Medicare cost reports to establish the prospective SDP payment limit on a per service or discharge basis.
- **Expansion vs. non-expansion limit:** States that have expanded Medicaid eligibility, as authorized in the ACA, are limited to 100% of the total Medicare payment ceiling. States that have not expanded Medicaid eligibility are limited to 110% of the total Medicare payment ceiling.
  - For services with no published Medicare rate, both expansion states and non-expansion states are limited to 100% of the Medicaid state plan approved rate.
  - The expansion state limit applies to the first rating period after a state Medicaid program expands. If a state opts out of expansion, the non-expansion state limit applies for the first rate-setting period after the state ends expansion.

- **Service-specific requirement:** SDP payment ceilings currently are calculated at the aggregate level by class of providers eligible for payment. This rule proposes that SDPs would be limited to the total published Medicare payment rate at the service level—a departure even from Medicaid FFS upper payment limits (UPLs), which are limited to a reasonable estimate of what Medicare would pay but are calculated at the aggregate level by ownership class (i.e., private, non-state government, or state-owned).
- **Value-based payments (VBP) SDPs:** VBP SDPs, even those designed as prospective population-based payments, would be expected to be added to base payments and reconciled to the total Medicare ceiling based on actual utilization to ensure a provider does not receive payments in excess of the total Medicare ceiling for any given service.
- **All provider types and US territories:** The WFTC legislation called for the reduced payment ceiling to be applied to the specified four classes of providers. This rule proposes that **all providers** be limited to the same ceiling and that the revised limits also apply to US territories. Because these additional providers in the 50 states and the District of Columbia and all providers in the US territories were not included in the WFTC legislation, the total published Medicare payment rate ceiling applies starting January 1, 2029—a year later than the four specified provider classes but with no phase down period.

#### Key Implications and Potential Concerns

- Providers receiving SDPs set to equal the total Medicare ceiling would no longer be able to negotiate rates beyond the established rate floor/fee schedule.
- Medicare rates for some services currently fall below the costs of providing them. Limiting reimbursement to a level below cost may lead to reductions in access to care for Medicaid enrollees.
  - For some services, such as inpatient and outpatient hospital services, total statewide payments under FFS are limited to a reasonable estimate of what Medicare would have paid for those sets of services or the Medicare allowable costs. States may implement policies that allow certain services to be reimbursed at a higher amount, as long as the aggregate payment levels remain at or below the aggregate allowable Medicare limits. Reimbursement for the same service provided under Medicaid managed care would not have that same flexibility.
- Providers that have historically received base payments plus SDPs at a level that exceeds the average for their class will now be limited at the service level to their total Medicare ceiling.
- State base reimbursement methodologies may differ from Medicare's formula. Cross-walking the different structures to calculate the new Medicaid payment limits will pose a **substantial administrative burden**.

- Limiting VBP SDPs to a reconciled total Medicare payment ceiling restricts the level of incentives states can provide to high-performing providers.
- Historically, CMS has allowed states to direct Medicaid managed care plans to pay based on the Medicaid FFS fee schedule without requiring prior written approval. Under the new limits, if a state pays a higher rate for a service under the Medicaid approved fee schedule than the published Medicare rate, that service would be limited to the Medicare managed care rate.
- For SDPs to provider classes not included in the WFTC legislation and are currently approved at levels above Medicare, no transition period is provided. The payment ceiling will drop straight to Medicare levels beginning January 1, 2029.
- States will need to submit a total Medicare payment rate comparison certified by an actuary beginning with the first rating period **on or after January 1, 2027**, giving them little time to prepare this complex calculation.

## 2. GRANDFATHERING OF SDPS

To allow for a transition period between current SDP spending and the new limitations, the WFTC legislation defined criteria under which an SDP could be grandfathered and subject to a gradual phase down. Grandfathering eligibility is limited to the four classes of providers identified in the WFTC legislation and applies only to SDPs that cover a period within 180 days of enactment and for which a completed preprint was submitted to CMS prior to July 4, 2025.

### Summary of Proposed Rule

The proposed rule provides definitions and clarifications related to the grandfathering provisions in the WFTC legislation. In addition, it provided additional flexibility related to the 2024 final rule for states within their SDP phase down periods.

### Key Components

- **180 days criterion:** Defined as 180 business days, which will capture any rating periods for calendar year (CY) 2024, state fiscal year (SFY) 2025, CY 2025, SFY 2026, and CY 2026.
- **Submission criteria:** The WFTC legislation included other submission dates and criteria for grandfathering eligibility; however, CMS has determined that completed preprints submitted prior to July 4, 2025, would include any preprint that met any of the other WFTC criteria.
- **Pause on some 2024 final rule components:** To ensure states stay in compliance with their grandfathered limits during the phase down, CMS is proposing a time-limited exemption to the prohibition on separate payment terms and retrospective changes to preprint submissions. This pause would continue until the SDP is no longer considered “grandfathered” because it has been reduced to the Medicare ceiling.

- **ACR demonstration:** Submission of ACR demonstrations for grandfathered SDPs would only be required until the first rating period beginning on or after January 1, 2029.
- **10 percent annual reduction:** CMS has defined the 10% annual reduction to grandfathered SDPs to be equal to **10% of the total grandfathered SDP amount**. For example, if the grandfathered limit of an SDP is \$1.5 billion, then the state would need to reduce payments by \$150 million annually starting with rating periods beginning in 2028 until the total payments reach the Medicare ceiling.

### Key Implications and Potential Concerns

- Grandfathered programs that use separate payment terms or make retrospective adjustments would be able to maintain that structure until payment levels phase down to the new Medicare limit, rather than needing to redesign the programs beginning in 2027, as originally required in the 2024 Medicaid managed care rule. This would allow states more transparency and predictability while minimizing risk during the transition period when payments would be reduced.
  - The timing of the finalization of this proposed rule creates some uncertainty related to these provisions. The prohibition on retroactive adjustments to SDP submissions in the 2024 Medicaid managed care rule goes into effect for rating periods beginning on or after July 9, 2026. States with rating periods beginning shortly after (e.g., states with October 1 rating period starts) will likely need to submit their annual preprint before knowing whether the proposed pause on these rule components is finalized.
- For the 10% reduction, CMS does allow states to reduce payments by more than 10% in one year and prorate a future year. For example, if the grandfathered limit of an SDP is \$1 billion and the state reduces spending to \$850 million in 2028, the state could then spend \$800 million in 2029 as long as spending continued to exceed Medicare levels.
- It is unclear how CMS will treat programs that contain SDPs for multiple classes of services at varying levels of Medicare. For example, if a program that meets the grandfathering criteria includes inpatient payments above Medicare payment levels but outpatient payments below Medicare payment levels, would the 10% reduction be equal to 10% of the full preprint spending amount or would it be equal to 10% of the inpatient payment only?

### 3. LIMITATIONS ON TYPES OF SDPS

Current regulations state that SDPs may be structured as any of the following:

- Value-based purchasing models
- Delivery system reform or performance improvement initiatives
- Minimum fee schedule (defined as the state plan approved rates, 100% of Medicare rates in effect no more than three years prior, or something else)
- Maximum fee schedule
- Uniform dollar or percentage increases

These regulations also allow flexibility in defining the class(es) or providers to which these structures apply.

#### Summary of Proposed Rule

The proposed rule calls for revising the language related to minimum and maximum fee schedule SDPs and removing uniform dollar or percentage increases as an allowable structure.

#### Key Components

- **Minimum fee schedule:** For minimum fee schedule SDPs, CMS proposes to establish only one allowable payment structure—a minimum fee schedule that is within the payment limit.
- **Tying payments to state plan approved rates:** Under current regulations, states are allowed to structure SDPs to pay minimum fee schedules tied to the Medicaid state plan approved rates without prior written approval to minimize the administrative burden on CMS, given that the agency has already reviewed and approved the rates as reasonable under Medicaid FFS. This rule proposes that because SDPs are explicitly limited to the total published Medicare rates, states will no longer be allowed to tie SDPs to Medicaid FFS rates without providing a total payment rate analysis proving that the rates per service do not exceed Medicare's.
- **Removal of uniform increases:** Starting with rating periods beginning on or after January 1, 2028, CMS proposes to remove states' ability to create uniform dollar or percentage increase SDPs. This provision will apply only to new SDPs and renewals of non-grandfathered uniform increase SDPs.
- **Classes of providers:** Although CMS does not propose additional limitations on how states define provider classes within the preprint, they do request comment as to whether they should and what limitations they should apply.

### Key Implications and Potential Concerns

- Removing language that allows states to set minimum fee schedules as the approved Medicaid state plan rates without prior written approval creates additional administrative burden for states and could result in a situation in which the allowable payment ceiling for a service under Medicaid FFS exceeds the allowable payment ceiling under Medicaid managed care.
- Removing the ability to make uniform increases for new SDPs and SDPs either non-grandfathered or past their grandfathering period will require significant structural changes to increases now tied to days, discharges, or claim counts. States will have the option to increase payments for services under a minimum fee schedule, allowing SDPs to pay at the gap between Medicaid base payments and the full Medicare rate for each service.
  - While this may have a similar aggregate payment impact as a uniform percentage add-on, requiring states to limit payments at the service level could alter distribution shares by provider and likely would prohibit a uniform increase across all services.
- CMS also warns that any attempt to encourage managed care plans to pay providers in a certain way is considered a directed payment and must comply with these restrictions. Examples would include incentive or withhold arrangements made under § 438.6(b). States are prohibited from requiring that some or all of the funding in the incentive or withhold arrangement be paid to providers.
- Although not proposed in the rule and only mentioned as a topic for comment, removing the flexibility for states to define their provider classes in ways that, for example, do not align with groups of providers defined in the Medicaid state plan, would significantly limit a state's ability to target certain groups of providers in need of enhanced payments to preserve access to care.

#### 4. TARGETED MEDICAID PAYMENT LIMIT IN AN FFS DELIVERY SYSTEM

Currently, payments for practitioner services under Medicaid FFS may be paid up to the ACR.

##### Summary of Proposed Rule

CMS is proposing to better align the limitations on practitioner payments under FFS with the new limitations on SDPs. If a state makes payments to a subset of targeted practitioners, the new proposed limit would be actual Medicare payment rates applicable to the practitioner or provider for the same time period as the Medicaid state plan rate year.

##### Key Components

- **Medicare limit:** The proposed limit applies to both base and supplemental payments. States would be unable to raise base rates above Medicare levels for a targeted group of practitioners. The payment limit for expansion states will be equal to 100% of the actual Medicare payment rates; the payment limit for non-expansion states will be equal to 110%.
- **Practitioner definition:** This limit applies to 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.
- **UPL-limited services:** This limit does not apply to a service currently subject to a UPL such as inpatient and outpatient hospital services.
- **Targeted definition:** 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. The proposed rule does allow for payments to be considered uniform and **not subject to the limit** in instances in which different practitioners within a benefit category are paid differently for the same service and the payment differential is tied to provider qualifications.
- **Examples of targeted payments:**
  - A fee schedule specifically developed for applied to certain practitioners that exceeds the fee schedule available to other like practitioners. This excludes instances where there is a statutory requirement for a specific payment rate or methodology such as for Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs)
  - Supplemental payments for which the eligibility includes qualifications or requirements that favor certain providers
  - Quality incentive payments or VBPs that exclude certain practitioners from participation

- **Geographic eligibility:** Payments may be considered uniform and targeted if they apply to a specific geographic region defined by a county, parish, borough, or other municipality, but a state cannot define a separate special purpose district solely for rate-setting purposes.
- **Limit demonstration:** A state would only need to submit a demonstration showing payments below the defined limits with their initial proposal and not annually as is required for UPL demonstrations. The state plan amendment (SPA) authorizing these targeted payments would need to make clear how the applicable payment level will not exceed Medicare payment rates for the duration of its existence.
- **Applicable payment percentages:** If Medicare pays a mid-level practitioner a percentage lower than 100 percent of the Medicare published rate, then targeted payments to these same practitioners will need to be limited to the same percentage.
- **Non-facility rate:** The applicable Medicare payment rates will be the non-facility rate rather than the facility payment rate.
- **No Medicare payment rate:** For services that do not have an exact Medicare equivalent payment rate, CMS proposes that a state develop a methodology for identifying a comparable Medicare payment rate. The SPA would need to include language explaining how the comparable rate was determined.
- **Bundled payments:** If a service is part of a bundled payment under Medicaid but not Medicare, the state would be expected to unbundle the services and crosswalk them to the applicable Medicare payment rate.
- **State plan rate year:** The targeted payment rates would need to align with the Medicare payment rates for the Medicare payment year (either a federal fiscal year or a calendar year) in which the state plan rate year begins.
- **Transition period:** States with existing state plan payments that exceed the new limit would have until the first SFY beginning on or after January 1, 2029, to comply with the new limit. To qualify, a state would need to submit a SPA to remove or update these payments with an effective date no later than the start of that first SFY.

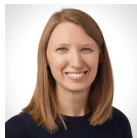
#### Key Implications and Potential Concerns

- The design of targeted practitioner payments would be significantly limited because states would need to ensure that for each year the targeted payments remain within the applicable percentage of updated Medicare payment rates. Consequently, payments would likely need to be defined as a percentage of the current Medicare payment rates so they can dynamically adjust without requiring a new SPA submission.

- The crosswalk of Medicaid payment rates to Medicare will likely be administratively burdensome—especially for states that set Medicaid rates using an entirely different methodology than Medicare’s.
- Applying the Medicare payment limit at the service level will limit states’ ability to incentivize certain service types that may need enhanced reimbursement amounts to preserve access to care (e.g., primary care, neonatal, etc.).
- Although CMS is proposing that these limits will not apply to currently approved programs until January 1, 2029, practitioners in states paying approximately or up to the ACR, will see their Medicaid payment rates drop significantly in 2029.

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