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Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments

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Background & Key Takeaways

On May 20, 2026 the Centers for Medicare & Medicaid Services (CMS) issued a Proposed Rule on the Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments (hereinafter, "Proposed Rule"). The Proposed Rule implements statutory changes from Section 71116 of the One Big Beautiful Bill Act (OBBBA), enacted into law on July 4, 2025 by setting updated limits on Medicaid state-directed payments (SDPs) and providing additional information regarding a grandfathering period for certain SDPs.[1,2] The Proposed Rule also includes changes that appear to exceed the OBBBA's statutory requirements, including proposals to change Medicaid payment limits for Medicaid fee-for-service (FFS) delivery systems and to stop the use of average commercial rate (ACR)-based supplemental payments.

A CMS fact sheet on the Proposed Rule is available here. Comments are due **on July 21, 2026**. Vizient looks forward to working with our provider clients to help inform our letter to CMS.

Medicare-Based Payment Limits for SDPs

To implement Section 71116 of OBBBA, for rating periods beginning on or after July 4, 2025, CMS proposes to reduce the maximum payment rate for non-grandfathered SDPs for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioner services at academic medical centers (AMCs) to 100% of the total published Medicare payment rate in Medicaid expansion states and 110% of the total published Medicare payment rate in non-expansion states.[3] To implement this policy, CMS proposes a new definition for "payment limit"[4], among other definitions.

In addition, CMS proposes policy that goes beyond the requirements of Section 71116 of OBBBA by extending the payment limit to all SDP service types for rating periods beginning on or after January 1, 2029 rather than applying the payment limits to the four service types included in the statute. Similarly, CMS proposes to apply the Medicare-based payment limit to all fifty states, Washington, D.C. and the United States (U.S.) Territories, even though Section 71116 of the OBBBA does not apply to U.S. Territories. CMS proposes a January 1, 2029 effective date to provide states with sufficient time to redesign SDPs, work with interested parties and legislative bodies and engage in technical consultation with CMS.

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[1] Section 71116 of OBBBA directed the Department of Health and Human Services (HHS) 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 academic medical center (AMC). Section 71116 also included a provision allowing a temporary grandfathering period for certain SDPs until the rating period beginning on or after January 1, 2028, at which point such SDPs would be required to gradually transition down to the new payment limit. https://www.congress.gov/bill/119th-congress/house-bill/1/text

[2] SDPs are a type of supplemental payment states use to increase Medicaid base rates and support programs such as quality incentives.

[3] This pertains to rating periods beginning on or after July 4, 2025, the date of passage of OBBBA.

[4] CMS proposes to add a new definition for "payment limit" that codifies the payment limits in Section 71116 of OBBBA, defined as 100 percent of the total published Medicare payment rate for a Medicaid expansion state and 110 percent for a non-expansion state, with 100 percent of the state plan approved rate when no Medicare rate exists.

Total Published Medicare Payment Rate

CMS proposes to update the definition of "total published Medicare payment rate"[5] to clarify that SDP payment limits should be applied at the level of each specific service or discharge, either at the Healthcare Common Procedure Coding System (HCPCS) code level or the Medicare Severity Diagnosis-Related Groups (MS-DRGs), at the Medicare-calculated payment amount for each discharge or service. CMS proposes to use the most recent complete Medicare cost report and cost-based methodology payment approach as the Medicare rate for purposes of the limit for providers paid on a cost basis. Further, CMS expects states to use CMS validated tools (e.g., web pricers or the Medicare Physician Fee Schedule (PFS)) when calculating the applicable payment limit for provider payments under an SDP. CMS clarifies that when there is no total published Medicare payment rate for a covered service, the total payment limit is set at 100% of the Medicaid state plan-approved rate for all services covered under SDPs for all fifty states, Washington, D.C. and the U.S. territories.

CMS considered the following two alternatives to update the definition of "total published Medicare payment rate": (1) exclude Medicare cost-based reimbursements from the "total published Medicare payment rate", which would make SDP limits for cost-based providers default to the state plan rate; and (2) require only Medicare rates established through rulemaking to serve as the benchmark for all providers, including those paid on a Medicare cost basis. CMS chose to not propose these alternative definitions for "total published Medicare payment rate" because states and providers indicated that Medicare or state plan rates are often substantially lower than payments under Medicare's cost-based methodology. **CMS requests comment on the proposed definitions and the alternatives considered, and any additional considerations or mechanisms for determining compliance with the applicable payment limit for providers paid outside of the published Medicare fee schedules or Medicare Prospective Payment System (PPS).**

Payment Limit Monitoring and Compliance

To assess and monitor compliance with the new payment limit, CMS proposes to require states to submit a list of all providers eligible for the SDP, each provider's National Provider Identifier (NPI), the total published Medicare payment rate or state plan approved rate, and the total published Medicare payment rate or, if no such Medicare rate exists, the state plan-approved rate used as the payment limit basis. CMS also proposes requiring a detailed description of how the state would ensure that payment to each provider for each furnished service would not exceed the payment limit, including information about the processes, systems or technology. To help states comply with this new requirement, CMS will issue guidance, as needed, on federal SDP standards, the documentation needed to demonstrate compliance with SDP payment limits, updates to the CMS review process and considerations for state monitoring, oversight and evaluation of SDP payment limits.

Further, CMS proposes the agency can request additional documentation to assess compliance with the payment limit beginning with the first rating period on or after January 1, 2029 to all fifty states, Washington D.C. and the U.S. territories. For example, as indicated in the Proposed Rule, CMS or another reviewer could use the provider NPI list to extract relevant Transformed Medicaid Statistical Information System (T-MSIS) claims and payment data for the rating period and compare each payment to the Medicare rate for that service to check whether payments stayed within the limit.

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[5] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6

For value-based payment (VBP) SDPs, CMS proposes to require states to provide a detailed validation methodology to ensure that payments from VBP SDPs do not exceed the payment limit on a per service basis. CMS considered an alternative for VBP SDPs that would require states to have their actuaries design population- or condition-based SDP payments and certify that total provider payments, including performance payments and shared savings, would not exceed the per-service payment limit. **CMS asks for feedback on these proposals, including the alternative option, and any other operational or oversight methods to protect fiscal integrity in VBP SDPs.**

Grandfathering Period for Existing SDPs

Temporary Grandfathering Period

Section 71116 of the OBBBA provides for a temporary grandfathering period for certain SDPs and requires a phase down beginning with the first rating period that starts on or after January 1, 2028. In the Proposed Rule, CMS provides the following criteria for an SDP to qualify for the temporary grandfathering period:

- The SDP received written prior approval and is for inpatient hospital services, outpatient hospital services, nursing facility services or qualified practitioner services at an AMC
- The SDPs are for a rating period that includes at least 1 business day between either October 11, 2024 - July 3, 2025 or July 5, 2025 - March 27, 2026.
- The SDP was described in a completed preprint[6,7] with an eligible rating period and documented total dollar amount that was submitted to CMS on or before July 4, 2025.
- Exceeds the payment limit set forth in regulation.[8]

CMS proposes to utilize the total dollar amount documented in Item 4[9] of the CMS approved preprint for each grandfathered SDP as the maximum allowable expenditure for that SDP during the temporary grandfathering period prior to the phase down. To ensure the limit for a grandfathered SDP is not exceeded, CMS would require that any renewal or amendment covering rating periods beginning on or after July 4, 2025 and before January 1, 2028 may not exceed the Item 4 total dollar amount for the applicable rating period.

CMS also proposes that states would not be permitted to revise a preprint submission after July 4, 2025 to change the rating period to qualify as a grandfathered SDP, or to increase the total dollar amount of a grandfathered SDP.

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[6] In the Proposed Rule, CMS elaborates on the terms "good faith effort" and "completed preprint" as related to this criterion. For "good faith effort", CMS interprets a State's submission of a completed SDP preprint prior to the applicable statutory date to constitute a good faith effort to receive CMS approval. Therefore, CMS believes the term ''good faith effort'' in status ''2'' and status ''4'' to mean submission of a completed preprint CMS Statuses that could qualify for the grandfathering provision are:

- SDPs (other than for rural hospitals) for which written prior approval was made by CMS before May 1, 2025 (Status 1);
- SDPs (other than for rural hospitals) for which a good faith effort to receive CMS approval was made before May 1, 2025 (Status 2);
- SDPs for rural hospitals for which written prior approval was made by CMS before July 4, 2025 (Status 3);
- SDPs for rural hospitals for which a good faith effort to receive our approval was made before July 4, 2025 (Status 4); and
- SDPs for which a completed preprint was submitted to CMS prior to July 4, 2025 (Status 5).

[7] CMS proposes that a "completed preprint" means an SDP preprint with all relevant sections of the preprint filled out, and all information provided only in the fillable sections of the preprint and the published addendum tables, as applicable.

[8] Specifically, exceeds the payment limit set forth in paragraph 42 CFR Part 438.6(c)(8) which is included in the Proposed Rule (pg. 65)

[9] Item 4 of the current SDP preprint captures the State's estimated total dollar amount associated with the SDP to provide transparency regarding the fiscal impact (Federal and non-Federal share) of the State's proposal and to aid the review for written prior approval required under § 438.6(c)(2)(i), including CMS's assessment of whether the SDP complies with standards outlined in § 438.6(c)(2).

Phase Down of Grandfathered SDPs

To align with Section 71116 of OBBBA, CMS proposes that grandfathered SDPs are subject to a 10 percentage point phase down each year beginning with the first rating period on or after January 1, 2028 until the until the total payment rate equals the statutory payment limit (e.g.,100% of the total published Medicare payment rate for a Medicaid expansion state and 110% for a non-expansion state, with 100% of the state plan approved rate when no Medicare rate exists). CMS proposes that the 10 percentage point phase down is based on the original grandfathered total dollar amount rather than an annually compounding reduction.[10] CMS notes that states must coordinate annually with their managed care plans to track projected and actual SDP spending and ensure the total dollar amount paid by plans to providers for each rating period does not exceed the applicable payment limit throughout the temporary grandfathering and phase-down periods.

CMS proposes that both the agency and states must monitor compliance and track progress toward the payment limit, requiring states to submit annual documentation for each grandfathered SDP beginning with the first rating period on or after January 1, 2027. CMS selected January 1, 2027 as the start for the documentation requirement so states can collect baseline information before beginning the required phase down beginning with the first rating period on or after January 1, 2028.

Minimum and Maximum Fee Schedule SDPs

CMS proposes to align allowable minimum fee schedules more closely with the proposed Medicare-based payment limit. Beginning with the first rating period on or after January 1, 2028, CMS proposes to allow states to adopt minimum fee schedules that do not exceed the payment-rate limit without obtaining written prior approval.[11,12] CMS also proposes to revise the existing maximum-fee-schedule regulation[13] to allow states to require managed care plans to adopt maximum fee schedules capped at the Medicare-based payment limit, provided the Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP) still can reasonably manage risk and retain discretion to meet contract goals. The revised provision would take effect for rating periods on or after January 1, 2029 if finalized.

Uniform Increase SDPs

CMS proposes, beginning with the first rating period on or after January 1, 2028, that states would be prohibited from establishing new “uniform increase” SDPs and from renewing any non-grandfathered uniform increase SDPs. CMS also proposes a limited exception allowing grandfathered SDPs, including many previously approved uniform increase SDPs, to continue temporarily (i.e., until the first rating period the payment limit is met).

Grey Area Payments and Other Prohibited Practices

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[10] In the Proposed Rule, CMS gives the following as an example: the grandfathered total dollar amount for CY 2025 is $1 billion. Under the proposal, the state would be permitted to submit SDP renewals to maintain or reduce the Grandfathered total dollar amount ($1 billion) for each of the two subsequent rating periods (CY 2026 and CY 2027). Beginning with the CY 2028 rating period (that is, the first rating period beginning on or after January 1, 2028), the state would be required to phase down the grandfathered total dollar amount by at least 10 percentage points annually (that is, $100 million) until the applicable payment limit is reached. Under the proposal, that annual reduction amount would be at least $100 million, which is 10 percent of the Grandfathered total dollar amount of $1 billion.

[11] g § 438.6(c)(1)(iii)(A), eCFR :: 42 CFR 438.6 -- Special contract provisions related to payment.

[12] CMS notes concerns that under current rules, some SDPs use Medicare rates up to three years old or State plan rates when a Medicare rate exists and does not require prior CMS approval, so they could exceed the payment limit and only be found through audits.

[13] § 438.6(c)(1)(iii)(E), eCFR :: 42 CFR 438.6 -- Special contract provisions related to payment.

As indicated in the Proposed Rule, current rules do not allow states to direct managed-care plan spending except through a valid SDP,[14] a permissible pass-through payment[15] or if there is a Medicaid law or regulation that allows payments to providers for services covered under the contract between the state and a managed care plan. CMS is concerned that some states may attempt to circumvent the proposed or existing requirements by including general or vague contract requirements for provider payments, known as "grey area payments", which are not subject to approval as an SDP or pass-through payment. The agency explains these arrangements are not permissible and, in the Proposed Rule (pg. 89-91), outlines several examples that would be rejected. **CMS requests comment on the examples of "grey area payments."**

CMS also explains that it considers impermissible any practice where states direct managed-care plans to participate in SDPs or condition SDP participation on providers diverting SDP funds to third parties (e.g., private consultants, provider associations, entities that collect provider taxes or the plans themselves) because SDPs must be based solely on the utilization and delivery of services, advance the state's quality goals and align with the SDP evaluation plan. CMS proposes revising regulations to specify that SDPs must be based only on the utilization and delivery of services furnished by a provider.[16]

Provider Classes

Under current SDP standards, states must define an eligible provider class and treat all providers in that class equally with respect to payment and performance under the SDP.[17,18] Another current SDP standard is that the state must provide documentation demonstrating the total payment rate for each service and provider class.[19] In the Proposed Rule, CMS expresses concern that some states may define provider classes too narrowly and in ways that are not closely aligned with their Medicaid managed-care quality strategy. To better understand whether additional guardrails may be warranted, **CMS seeks comment on whether and how to define "provider class" to inform future rulemaking**.[20]

Targeted Medicaid Payment Limit in a FFS Delivery System

In the absence of federal upper payment limits (UPL) for practitioner services, CMS has allowed supplemental payments based on Medicare or the Average Commercial Rate (ACR). However, CMS is concerned that certain ACR-based payments are much greater than comparable Medicare amounts. As a result, CMS proposes to replace ACR-based limits on targeted payments to align with current law capping SDPs at either 100% or 110% of the specified total published Medicare payment rate. In addition, CMS proposes creating a practitioner- or provider-specific limit on total

[14] Under §438.6(c), eCFR :: 42 CFR 438.6 -- Special contract provisions related to payment.
[15] Under §438.6(d), eCFR :: 42 CFR 438.6 -- Special contract provisions related to payment.
[16] § 438.6(c)(2)(ii)(A), eCFR :: 42 CFR 438.6 -- Special contract provisions related to payment.
[17] § 438.6(c)(2)(ii)(B), eCFR :: 42 CFR 438.6 -- Special contract provisions related to payment.
[18] For example, if a State directs their managed care plans to pay two classes of dental providers, such as urban and rural, a minimum fee schedule for certain dental services, the State might direct that each provider in Provider Class A (urban dental provider) would receive a minimum payment of $100 for a pediatric dental cleaning, while each provider in Provider Class B (rural dental provider) would receive a minimum payment of $200 for a pediatric dental cleaning.
[19] in § 438.6(c)(2)(ii)(I), eCFR :: 42 CFR 438.6 -- Special contract provisions related to payment.
[20] CMS notes the agency considered alternative options such as defining provider class is to mean a group of providers as defined in the approved Medicaid State plan or under which the criteria for defining the provider class for an SDP would be required to be directly tied to the goals and objectives of the State's Medicaid managed care quality strategy and to be specific to the services and enrollees to which the SDP applies.

Medicaid FFS payments when all or part of a payment is targeted to a subset of practitioners or providers rather than made available to everyone who furnishes the same Medicaid service.[21,22]

CMS proposes limited exceptions to the targeted payment limits, under which payments would be reviewed using an alternative standard. States must submit, in the form and manner specified by CMS, sufficient documentation demonstrating that the payments qualify as an exception. CMS proposes to allow an exception when a state cannot identify a reasonably comparable Medicare rate for some or all services in a targeted payment, most often for broad service categories not covered by Medicare. CMS also proposes an exemption for payments that are reconciled to a provider's actual, allowable costs from the Medicare-based payment limits, provided the cost-reconciliation follows Office of Management and Budget (OMB) cost principles.

CMS proposes that if a state's current targeted Medicaid payments exceed the proposed Medicare payment limit, the state must submit a State Plan Amendment (SPA) to remove or lower those payments, so they take effect by the start of the first state fiscal year on or after January 1, 2029. CMS is not proposing to consider any exceptions to the transition period timeline. **CMS requests comment on shorter or longer transition periods from the effective date of the final rule, including 6 months, 1 year and 2 years, or another date before or after January 1, 2029**. **CMS also requests comment on two alternative phase down transition approaches including establishing an interim limit, such as 200% of Medicare rates, midway through the transition period leading to January 1, 2029. Under the second alternative approach, CMS would require an annual percentage reduction, such as 10%, of the total payment amount that exceeds Medicare over the course of a 10-year transition period from the effective date of the final rule.**

Scope of Proposal

CMS proposes that the limit would not apply when a state's FFS payment methods are uniform for all participating practitioners or providers within the state, or within a geographic region of the state (e.g., a county, parish, borough, or other municipality) that is referenced under a payment methodology specified in the state plan. CMS expects states to use geographic boundaries such as counties to identify rural regions and set separate but uniform rates for those areas. **CMS asks for comment on this proposal and on whether additional guidance would be helpful for states seeking to preserve or increase the supply of providers in rural areas**.

Targeted Medicaid Payment Limit

CMS proposes limiting targeted FFS Medicaid payments at a percentage of the corresponding Medicare FFS rate in effect for the state plan rate year (e.g., 100% for expansion states and 110% for non-expansion states) to align the FFS limits with the SDP limits under the OBBBA. States would use the published Medicare rate as the benchmark and limit the targeted Medicaid payment to the applicable percentage of that Medicare amount.

CMS proposes that if the Proposed Rule is finalized, states must use the specific Medicare rate that matches the provider type, site of service and geographic locality when checking that a targeted

[21] A payment is considered targeted when it is not available to all practitioners or providers furnishing the same Medicaid-covered service
[22] CMS proposes "Practitioner," to include physicians, dentists and other dental practitioners, and other licensed practitioners (such as nurse practitioners). "Provider" would include providers such as GEMT providers, air ambulance providers, and NEMT providers (referred to collectively as transportation providers in this proposed rule), as well as other providers such as clinics.

Medicaid FFS payment stays within the proposed payment limits. Further, CMS expects states to rely primarily on the PFS non-facility rates as the appropriate benchmark for targeted payments because the proposed limits generally do not apply to services already subject to facility-based UPLs or statutory limits.[23] When a state proposes a targeted Medicaid payment for a service with no direct Medicare equivalent, CMS proposes to require the state to develop a methodology for identifying a reasonably comparable Medicare payment for a similar Medicare-covered service and to provide a clear explanation of the rationale and steps used to construct the Medicare rate used for comparison. States that use unique, state-specific bundled Medicaid payment codes must identify the services included within the bundled payment rate and cross-walk those constituent services to corresponding Medicare payment rates where feasible.

Compliance with the Targeted Medicaid Payment Limit

CMS proposes that if, after the rule takes effect, a state submits a SPA that proposes payments above the limit, CMS will notify the state and ask for an amendment. If the state does not amend the SPA, CMS will issue a Request for Additional Information and may disapprove the SPA. States that fail to fix existing over-limit payments by the transition deadline may face reduced grant awards, deferral or disallowance of the federal share for the excess payments and other compliance actions.[24] Further, if a state submits an SPA that proposes payments above the limit and no exception applies, CMS will disapprove the SPA and require the state continue to pay under its already approved rate methodology.

Regulatory Impact Analysis

In the Proposed Rule, CMS estimates providers would lose revenue from reduced SDPs, but the net loss could be much smaller because many providers pay provider taxes or intergovernmental transfers (IGTs) that fund the non-federal share.[25] CMS explains that due to limited provider-level data and wide variation across states and provider types, CMS cannot estimate these provider impacts in detail. Further, CMS expects significant interactions with other OBBBA provisions (e.g., Sections 71115 (Provider Taxes) and 71117 (Requirements Regarding Waiver of the Uniform Tax Requirement for Medicaid Provider Tax)) are likely to reduce provider tax collections, which states commonly use to finance the non-federal share of SDPs. As a result, SDPs could decline even without Section 71116's SDP-specific changes, creating overlapping effects that make it difficult to attribute impacts to any single provision. CMS indicates that the agency plans to analyze the interactions between these proposals in future rulemaking. **CMS requests feedback on the estimated impact to providers.**

In the Proposed Rule, CMS attempts to calculate the impact of the SDP proposals but was limited in comparing total payment rates across benchmarks because SDP data is not standardized or aggregated across provider types and may be incomplete. In the Proposed Rule, CMS modeled low and high price scenarios for savings. In the low scenario, where Medicaid, Medicare and ACR rates are assumed to be relatively similar, CMS projects $408.4 billion in Medicaid spending reductions

[23] In the Proposed Rule, CMS indicates Part A rates would only be used in limited situations (e.g., hospice or certain home-health services) and many Part A services (like inpatient hospital care) are already subject to other Medicaid limits and generally fall outside the proposed rule.
[24] In estimating the amount subject to deferral or disallowance, CMS would review the State-submitted information about the payment in question, such as the most recent SPA establishing or amending the payment, and would assess the extent to which Medicare payment rates are available for the associated services and the degree to which the applicable limit has been exceeded.
[25] CMS states that because many providers already send money back to the state through provider taxes or IGTs those funds are used by the state as the non-federal share to draw federal matching dollars.

from 2026–2035 (in 2026 dollars), with $272.1 billion of that as federal savings and $136.3 billion as state savings. In the high scenario, CMS assumes Medicaid, Medicare and the ACR rates are relatively further apart and projects that Medicaid spending would be reduced by $989.7 billion over 2026 through 2035 (in real 2026 dollars), where federal Medicaid spending would be $649.7 billion lower, and state Medicaid spending would be $339.6 billion lower. These projections are outlined in Tables 22 and 23 in the Proposed Rule (pg. 160).

CMS also explains that estimating effects on FFS supplemental payments is difficult because payment rates vary widely across payers, services and states, and supplemental payment data are less detailed than SDP data. Similar to the SDP analysis, CMS developed a range of estimates with different relative prices between Medicaid, Medicare and the ACR which are summarized in the Proposed Rule (pg. 162-167). **CMS welcomes comments on the proposed scenarios and savings estimates.**

What's Next?

Comments on the Proposed Rule are due on July 21, 2026. Vizient's Office of Public Policy and Government Relations looks forward to hearing continued client feedback on this Proposed Rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or comments regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. Please direct your feedback to Randi Gold, Director, Hospital Payment Policy and Regulatory Affairs in Vizient's Washington, D.C. office.