Insights

CMS Proposes New Limits on Medicaid State Directed Payments and Fee-for-Service Practitioner Payments: How the Rule Builds on the One Big Beautiful Bill

June 15, 2026

By: Meghan M. Linvill McNab, Grant M. Achenbach, and Brandon W. Shirley

On May 22, 2026, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule (the "Proposed Rule") that would implement, and in several respects expand beyond, the Medicaid state directed payment ("SDP") provisions enacted in the One Big Beautiful Bill ("OBBB"). If finalized, the Proposed Rule would have a wide-spread impact on States' SDPs, including not only SDPs for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers, as required by the OBBB, but also SDPs for other service types, as well as targeted practitioner payments in Medicaid fee-for-service.

Given the potential impact of the Proposed Rule, including CMS's proposed expansion of the payment limits beyond those required by the OBBB, stakeholders are encouraged to submit comments to CMS by the July 21, 2026 deadline.

Background: OBBB's Medicaid Reimbursement Changes

As we discussed in our prior article, *One Big Beautiful Bill, But More*, the OBBB made significant Medicaid reimbursement changes, including changes aimed at SDP programs, which are additional payments made through Medicaid managed care programs and often used to increase reimbursement for targeted provider types. That article explained that SDP programs have been subject to CMS approval, evaluation, and renewal requirements, while also drawing increased federal scrutiny because some arrangements paid providers at levels above Medicare.

Section 71116 of the OBBB directed CMS to revise federal Medicaid managed care regulations to limit the total payment rate for certain SDPs. For the statutory service categories—inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers—the OBBB replaced the prior average commercial rate framework with a Medicare-based limit. The statutory limit is generally 100% of the total published Medicare payment rate in Medicaid expansion states and 110% of that rate in non-expansion states, with special rules where no Medicare rate exists.

Key Elements of the Proposed Rule

Notably, the Proposed Rule goes beyond the requirements of the OBBB, implementing additional limits and parameters such as the following.

1. Grandfathering: Protection Lasts Only While Payments Remain Above the Applicable Limit

The Proposed Rule would implement OBBB's temporary grandfathering protection for eligible SDP arrangements, but CMS's proposed interpretation is narrower than some states and providers may have expected. Under the Proposed Rule, a grandfathered SDP is protected only for the period during which the grandfathered total payment rate remains above the applicable Medicare-based payment limit. Once the required phase-down brings the arrangement to, or below, the applicable limit, the arrangement would no longer receive grandfathered treatment. At that point, CMS explains that, beginning with the first rating period in which the payment limit is met, the State would have to comply with the general SDP requirements that do not apply to grandfathered SDPs, including the prohibition on separate payment terms and the requirement to submit any required preprint prospectively. The State also would have to incorporate the SDP as an adjustment to capitation rates and, for rating periods beginning on or after January 1, 2028, ensure that the SDP fits within one of the permissible SDP structures: a minimum fee schedule, a maximum fee schedule, or a value-based payment arrangement. See 91 Fed. Reg. at 30421.

This distinction matters because grandfathering is not a permanent status attached to a program. Rather, it functions as a temporary transition mechanism for payments that exceed the new cap. Beginning January 1, 2028, CMS proposes to apply a mandatory annual reduction to grandfathered arrangements until the payment rate no longer exceeds the applicable limit. For some programs, that may mean only a short transition period if the amount above the limit is modest.

2. Expansion of the SDP Limit After January 1, 2029

The OBBB's statutory SDP limit applies to specified categories of services. The Proposed Rule would go further. For rating periods beginning on or after January 1, 2029, CMS proposes to extend Medicare-based payment limits to all SDPs, all service types, all states, the District of Columbia, and U.S. territories. This expansion would bring SDP arrangements outside the OBBB's four statutory categories into the same general Medicare-based cap structure.

CMS frames this broader expansion as a program-integrity and anti-circumvention measure. In CMS's view, limiting only the statutory categories could encourage states and providers to restructure payments or shift reimbursement into other service categories not expressly covered by the OBBB. The Proposed Rule would therefore align all SDP arrangements under a broader federal payment ceiling beginning in 2029.

3. New Fee-for-Service Limit for Targeted Practitioner Payments

The Proposed Rule also would create a new limit for certain Medicaid fee-for-service ("FFS") *targeted* practitioner payments beginning January 1, 2029. This proposal is notable because the OBBB's SDP provisions focus on managed care SDPs; CMS is proposing to extend a similar payment-limit concept into targeted FFS practitioner payments based on its authority under section 1902(a)(30)(A) of the Social Security Act.

CMS proposes to apply the new FFS limit to practitioner service types that are not already subject to an upper payment limit ("UPL"). In other words, where existing Medicaid rules already impose a UPL framework, that existing framework would continue to control. But for targeted FFS practitioner payments that fall outside an existing UPL, CMS would establish a Medicare-based ceiling intended to align FFS supplemental or targeted payments with the limits applicable in managed care.

Importantly, the Proposed Rule does not create a broad aggregate UPL for these targeted FFS practitioner payments. Instead, CMS proposes a service-specific limit. That means compliance would be measured by reference to the applicable service type, rather than by allowing a state to offset payments above the limit for one service with payments below the limit for another. This service-specific approach could significantly affect how states design, document, and defend targeted FFS payment methodologies.

The proposed FFS limit would apply only to *targeted practitioner payments*, not to all Medicaid FFS practitioner reimbursement. CMS describes these payments as Medicaid FFS payments that are directed to a defined subset of practitioners or services, rather than generally applicable base payment rates available across the program. In practice, a targeted practitioner payment would include an enhanced, supplemental, or otherwise specially designated payment methodology that increases reimbursement for particular practitioner service types, provider classes, geographic areas, or delivery-system objectives. As a result, states should distinguish between broadly applicable FFS rate methodologies and payment arrangements that target selected practitioner payments for additional reimbursement, because only the latter would be subject to the new service-specific limit.

Practical Implications for States and Providers

If finalized, the Proposed Rule would require states and providers to reassess both managed care and FFS Medicaid payment strategies. States with grandfathered SDPs should evaluate how long each arrangement would remain above the applicable payment limit and model the impact of the required phase-down. Providers that rely on SDP revenue should likewise consider whether the grandfathering period may be shorter than expected.

States and providers should also review arrangements outside the OBBB's original statutory categories, because CMS's proposed January 1, 2029 expansion could bring currently unaffected SDP structures under a Medicare-based cap. Finally, states using targeted FFS practitioner payment methodologies should determine whether those payments are already subject to a UPL and, if not, how a new service-specific Medicare-based limit would affect payment levels and state plan design.

Comment Opportunity

CMS is accepting comments on the Proposed Rule through July 21, 2026. Stakeholders may wish to comment on the scope of CMS's authority to extend the OBBB's SDP limits beyond the statutory categories, the operational impact of the grandfathering methodology, the application of Medicare-based limits to territories and additional SDP types, and the consequences of imposing a service-specific limit on targeted FFS practitioner payments.

For questions regarding the new Proposed Rule and its impact on state Medicaid programs, please contact Meghan M. Linvill McNab, Grant M. Achenbach, or Brandon W. Shirley.
