Insights

One Big Beautiful Bill, But More

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On July 4, 2025, President Trump signed into law H.R. 1, known as the One Big Beautiful Bill ("OBBB"). While the OBBB is massive and the sections that address Medicaid topics are vast, this series of articles will select specific areas of Medicaid impacted by the Bill and drill down into the full weight and effect of not only the OBBB, but also recent Federal rules, guidance, and policies on these topics.

Our first topic is Medicaid reimbursement, specifically state directed payment programs ("SDPP"), which are additional payments made in Medicaid managed care programs that often target certain provider types and increase reimbursement beyond levels that state appropriations can generally cover.

State Directed Payment Programs ("SDPP")

As part of the 2016 Mega-Managed Care Final Rule, CMS set forth an explicit mechanism for States to establish programs directing Medicaid managed care entities ("MCEs") to pay providers at a certain level or amount, similar to how States have historically paid providers supplemental payments in Medicaid fee-for-service program. These payment programs, known as SDPPs, are subject to a laundry list of standards and requirements that the State must abide by. In addition, they are subject to oversight ad nauseam via the prior written approval (pre-print) process, annual evaluation plan process, and renewal process (which must occur every 1 to 3 years). Regardless of their permissibility and oversight, the administration still has concerns over their use (or, as some would say, abuse).

On June 6, 2025, President Trump issued a Memorandum for the Secretary of Health and Human Services ("HHS") the Administrators of the Centers for Medicare and Medicaid Service ("CMS") regarding the subject "Eliminating Waste, Fraud, and Abuse in Medicaid" ("Presidential Memo"). The Presidential Memo sets the landscape giving the history of the Biden Administration and how it permitted States and providers to "game the system" – covering States' use of provider taxes to allegedly avoid contributing money toward Medicaid services, thereby increasing provider rates to almost 3x the Medicare amount. After attesting to the fiscal impact of these mechanisms, President Trump pledged to protect and improve the Medicaid and Medicare program, ultimately directing the Secretary of HHS to "take appropriate action to eliminate waste, fraud, and abuse in Medicaid, including by ensuring Medicaid payments rates are not higher than Medicare, to the extent permitted by applicable law." Curiously, at the time of that Memo the applicable law permitted CMS to approve payments (SDPPs) that were indeed higher than Medicare.[1] Right after the Presidential Memo, the OMB Regulatory Review website reflected a proposed rule titled "Medicaid Managed Care-State Directed Payments (CMS-2449)," which was received by the OMB on June 9, 2025 and under review at the OMB.

While the regulatory actions are being buttoned up, the OBBB took a more definitive step toward limiting SDPPs. Section 71116 of the OBBB directs the Secretary of HHS to revise 42 CFR 438.6(c)(2)(iii)2 (or a successor regulation) to limit payment described in such section to either 100% or 110% of the published Medicare rate (depending on the state's coverage of the adult population) or, in the absence of a Medicare rate, the Medicaid state plan rate. The language itself is interesting in a few ways.

First, it only refers to "total published Medicare payment rate", raising questions of which Medicare rate *period applies* (prior fiscal year, current, etc.) or what Medicare rate applies (facility, non-facility).

Second, instead of defining "expansion state" for purposes of determining whether 100% or 110% of the Medicare rate applies, as was done in OBBB Sec. 71115 (which amends the provider tax law), the OBBB spells out the factors for expansion state differently than Sec. 71115's formal definition of Expansion State.

OBBB Sec. 71116 (SDPP)	OBBB Sec. 71115 (Provider Taxes)
Refers to "a State that provides coverage to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) that is equivalent to minimum essential coverage (as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and determined in accordance with standards prescribed by the Secretary in regulations) under the State plan (or waiver of such plan) of such State under title XIX of such Act"	"EXPANSION STATE.—The term 'expansion State' means a State that, beginning on January 1, 2014, or on any date thereafter, elects to provide medical assistance to all individuals described in section 1902(a)(10)(A)(i)(VIII) under the State plan under this title or under a waiver of such plan."

The differences in how Sec. 71116 describes "expansion state" for purposes of SDPP versus Sec. 71115 for purposes of provider taxes raises questions in several areas:

1) Sec. 71116's reference to coverage as opposed to medical assistance in the provider tax language.
2) Sec. 71116's threshold of minimum essential coverage.
3) Sec. 71115's reference to a state's election to provide medical assistance on Jan. 1, 2014 and anytime thereafter, and how that translates if a state decides to discontinue medical assistance to the adult population.

The OBBB directive on payment levels for SDPPs also contains a grandfathering provision for:

a) a payment described in 42 CFR 438.6(c)(2)(iii) (or a successor regulation) for which written prior approval (or a good faith effort to receive such approval, as determined by the Secretary) was made before May 1, 2025, or
b) a payment described in 42 CFR 438.6(c)(2)(iii) for a *rural hospital* (as defined in subsection OBBB Sec 71116(d)(2)) for which written prior approval (or a good faith effort to receive such approval, as determined by the Secretary) was made by July 4, 2025, for the rating period occurring within 180 days of July 4, 2025, or
c) a payment so described for such rating period for which a completed preprint was submitted to the Secretary prior to July 4, 2025

It appears that for each of these grandfathered payments, beginning with the rating period on or after January 1, 2028, the total amount of such payment shall be reduced by 10 percentage points each year until the total payment rate for such service is equal to 100% or 110% of the Medicare rate, as applicable. This

grandfathering language also raises numerous question regarding several areas:

> **1)** For b. above, the language refers to "for a rating period occurring within 180 days of July 4, 2025". A rating period is just that—a period of time—and is usually 12 months long, so an entire rating period will likely not occur within 180 days. Therefore, the question is whether the rating period must simply commence within 180 days of July 4, 2025 (presumably within 180 days after July 4, albeit unclear).
> **2)** For c. above, the language refers to "payment so described" and "for such rating period," although it isn't clear whether that refers to a payment described in a. or b., and whether the rating period looks at the same occurrence within 180 days of July 4, 2025 or simply the rating period for which the pre-print related (which could have been any rating period and did not have to occur within 180 days of July 4th).

While the grandfathered payments delay the implementation date of any SDPP rate cuts, for all other SDPPs that are subject to the rate cuts and not so grandfathered, such rate cuts are to commence with the rating period beginning on or after July 4, 2025. Standing between the OBBB and implementation of the limit on SDPPs is the federal rulemaking process, which can take some time between the proposed rule publication, public comment process, final rule publication, and effective date. This leaves open the question of whether CMS can continue to approve SDPPs between the Medicare rate and ACR and what happens with any such approved SDPPs once the final rule goes into effect.

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

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[1]See 42 CFR 438.6(c)(2)(iii) which states "The total payment rate for each State directed payment for which written prior approval is required under paragraph (c)(2)(i) of this section for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center must not exceed the average commercial rate." The ACR is generally higher than Medicare, so under the regulations as they existed at the time of the Memo, the Secretary was allowed to approve SDPP up to the average commercial rate ("ACR"). While this express permission to approve SDPPs up to the ACR was promulgated in a 2024 final Rule (89 Fed. Reg 41267 (May 10, 2024)), CMS had approved SDPPs up to the ACR throughout President Trump's first term (2017 to 2021)

[2]Which currently states, in part, ""[t]he total payment rate for each State directed payment for which written prior approval is required under paragraph (c)(2)(i) of this section for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center must not exceed the average commercial rate."