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Summary of CMS Proposed Rule (CMS-2449):

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

Released May 20, 2026

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

Highlights

- CMS released the proposed rule "Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments" on May 20, 2026, proposing changes to Medicaid managed care state directed payment (SDP) limits and new limits for certain targeted FFS provider payments.
- The proposal would formally implement section 71116 of H.R.1, referred to as the Working Families Tax Cut legislation, and further clarify SDP payment limits, grandfathering, and phase-down policies.
- CMS is accepting public comments on the proposed rule for 60 days following publication in the Federal Register before issuing a final rule (period estimated to close on July 21).

Overview of Key Provisions

Provision	Proposed Rule
10% Annual SDP Phasedown	CMS proposes a fixed annual reduction based on the original grandfathered total SDP dollar amount. **Effective Date:** First rating period beginning on or after January 2028
Expansion of SDP Caps to Services not specified in HR1	CMS proposes extending Medicare-based caps (100% for expansion states/110% for non-expansion states) to all non-grandfathered SDPs. **Effective Date:** First rating period on or after January 1, 2029
Medicare Equivalent Rate/ Medicare Limit	CMS proposes setting SDP payment limits at the full published Medicare rate, including all applicable adjustments. Where applicable, states must confirm the Medicare limit is being met at the claim and encounter level rather than in the aggregate. When no Medicare rate exists, CMS would instead set the limit at 100% of the State plan rate, the State plan waiver rate, or use cost-based methodologies validated through cost reports.
Payment Limit on Select FFS payments	CMS proposes a Medicare-based cap on select FFS Medicaid payments that target subsets of providers that are not statewide or within a specific geographic region. The cap is applied at the service level and provider level, with limited exceptions for statutory payment systems, lack of Medicare equivalents, or cost-based reconciliation. **Effective Date:** For states with targeted FFS payments above the payment limit, states must come into compliance by the start of the first State fiscal year that begins on or after January 1, 2029.
SDP Grandfathering Rules	Largely in line with the February 2026 guidance. The Sellers Dorsey summary can be found here. **Effective Date:** As of July 4, 2025.
Prohibition on Separate Payment Terms	CMS proposes continuing use of separate payment terms for SDPs until the Medicare-based payment limit is reached, after which States must transition programs to rate adjustments. Non-grandfathered SDPs must follow the existing timeline in the 2024 Medicaid Managed Care Final rule for eliminating use of separate payment terms. **Effective Date:** Grandfathered SDPs: the first rating period after the Medicare-based payment limit is reached. Non-grandfathered SDPs: the first rating period after July 9, 2027.
Prohibition of Uniform Rate Increases	CMS proposes prohibiting uniform rate increases over the coming years. **Effective Date:** For non-grandfathered SDPs, the prohibition takes effect the first rating period on or after January 1, 2028. For grandfathered SDPs, the prohibition takes effect when the Medicare-based payment limit is reached.

Key **Provisions**

In addition to the statutory provisions included in H.R.1 and related CMS guidance issued to date, the proposed rule also reflects broader CMS policy priorities and interpretations. The following summarizes key provisions proposed through this rulemaking.

10% Annual SDP Phase-Down

Background

Under Section 71116 of HR1, beginning on the first rating period on or after January 1, 2028, total SDP payment rates are set to be reduced by 10% annually until the total payment rate is equal to 100-110% of the Medicare rate respective to expansion status.

CMS Proposal

CMS proposes phasing down SDPs by applying a fixed annual reduction equal to 10 percentage points of the original grandfathered SDP dollar amount, as documented in question 4 of the grandfathered preprint. This fixed reduction amount is held constant over time and applied against the SDP until the payment reaches the Medicare-based cap (100% or 110%).

Expansion of SDP Caps to Services Not Specified in H.R. 1

Background

H.R. 1 imposes SDP caps on four services: Inpatient hospital, Outpatient hospital, Nursing Facility, and Physician Services at an Academic Medical Center. Since H.R 1's passage, there has been ambiguity regarding the treatment of SDPs for services not explicitly included in the H.R. 1 SDP caps, including behavioral health, emergency medical, and dental services.

CMS Proposal

CMS proposes to extend the Medicare-based payment limit to all non-grandfathered SDPs for rating periods beginning on or after January 1, 2029.

This approach forces faster compliance for non-grandfathered arrangements, which must meet the cap by 2029. By contrast, grandfathered SDPs benefit from a gradual transition, phasing down at 10% annually until they reach the same limit.

Medicare Equivalent Rate

Background

Under Section 71116 of H.R.1, new programs are capped at 110% of the published Medicare rate in non-expansion states and 100% of the Medicare rate in expansion states, or the state plan waiver rate if no published Medicare rate exists.

CMS Proposal

CMS proposes defining the Medicare equivalent for the purpose of determining the Medicare-based caps tying SDP payment limits to the full Medicare payment rate by individual service and provider (for example using HCPCS codes or DRGs), rather than using aggregate, UPL-style limits. The limit would reflect the total published Medicare rate—including all adjustments, for example, geographic quality add-ons or modifiers. States would be expected to use CMS Medicare pricing tools and fee schedules to calculate and validate these service-level payment limits.

If no Medicare rate exists for a service, CMS proposes using 100% of the State plan-approved rate as the payment limit.

For providers reimbursed by Medicare on a cost basis, such as critical access hospitals, children's hospitals, and cancer hospitals, there is no standard fee schedule benchmark. For these providers, CMS proposes using Medicare cost reports to derive service-level payment limits, applying cost allocation methods to translate costs into per-service or per-discharge amounts. CMS indicates it will issue future guidance specifying allowable cost reporting and allocation methodologies, building on existing Medicare- and Medicaid-based cost reporting frameworks.

Payment Limit on Select Fee-for-Service Payments

Background

H.R. 1 did not impose limits on fee-for-service (FFS) Medicaid payments. However, the June 2025 Presidential Memorandum, *"Eliminating Waste, Fraud, and Abuse in Medicaid,"* directs HHS to ensure Medicaid payment rates do not exceed Medicare levels, to the extent permitted by law.

CMS Proposal

In response, CMS proposes a Medicare-based cap on targeted FFS Medicaid payments, limiting total payments to 100% of Medicare in expansion states and 110% in non-expansion states. Targeted programs are defined as those that apply to a subset of practitioners and that are not statewide or within a specific geographic region of the state. The cap would apply broadly to targeted practitioner and provider payments. There are limited exceptions for statutorily required payment methodologies, such as FQHCs, rural health clinics, and hospice, where federal law may require payment levels above Medicare. Additionally, exceptions apply when no reasonable Medicare equivalent exists, or when payments are reconciled to actual provider costs, with CMS requiring supporting justification in both cases.

CMS would implement this cap by embedding it directly in state plan payment methodologies rather than relying on UPL-style demonstrations. Unlike traditional UPLs, which operate as aggregate ceilings, this policy applies at the individual service and provider level.

For states with targeted FFS payment above the payment limit, states must come into compliance by the start of the first State fiscal year that begins on or after January 1, 2029.

Separate Payment Terms

Background

The 2024 Managed Care Final Rule imposed a prohibition on separate payment terms effective for rating periods beginning on or after July 9, 2027.

CMS Proposal

For grandfathered SDPs, CMS proposes delaying the prohibition on separate payment terms until the point at which the Medicare-based payment limit is met, after which States must transition from separate payment terms to rate adjustments. For non-grandfathered SDPs, CMS proposes continuing to apply the timeline for prohibiting separate payment terms included in the 2024 Medicaid Managed Care Rule.

Uniform Rate Increases Prohibited

Background

Uniform rate increases are the most common payment method for SDPs. Under uniform rate increases, states require managed care plans to pay providers a fixed additional amount or fixed percentage on top of their existing negotiated rates for each service.

CMS Proposal

CMS proposes that for non-grandfathered SDPs, beginning with the first rating period on or after January 1, 2028, uniform rate increases will no longer be permitted. For grandfathered SDPs, uniform rate increases will continue to be permitted until the payment limit of 100% of Medicare or 110% of Medicare is reached.

SDP Grandfathering Rules

The SDP grandfathering rules codifies CMS's February 2026 guidance and the interpretations CMS previewed following recission of the September 9, 2025 guidance. Notably, prior guidance included CMS's revised interpretation of "180 days" as 180 business days rather than calendar days, creating a broader range of eligible rating periods for grandfathering under Section 71116.

Prior guidance also reinforced CMS' position that states may not revise rating periods or preprints *solely* to newly qualify for grandfathering protections and reiterates that broader interpretations of "good faith effort" do not expand eligibility beyond submission of a completed pre-print. The Sellers Dorsey summary can be found here.

Other Areas to Note

Grey Area Payments

CMS makes clear that incentive and withhold arrangements are payments to managed care plans and cannot be structured in a way where states direct expenditures by requiring the funding in the incentive or withhold arrangement to be paid to providers.

Preprint Form, Prospective Preprint Submission, and Reporting the Medicare Equivalent

CMS proposes requiring states to annually provide in the preprint a comparison of SDPs to the Medicare equivalent or State plan-approved rates in the preprint, beginning with the first rating period on or after January 1, 2027. CMS anticipates revising the SDP preprint at a later date to address needed revisions under a final rule. Finally, the proposed rule delays compliance with the provision from the 2024 Medicaid Managed Care Rule requiring prospective preprint submissions. The proposed rule delays the provision's implementation until the Medicare payment limit is reached.