

## Overview of CMS' Proposed Rulemaking Regarding State Directed Payments

May 21, 2026

On May 20, the Centers for Medicare and Medicaid Services (CMS) released its proposed rule, "[Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments](#)," implementing provisions of H.R.1 to establish new limits on certain Medicaid managed care State directed payments (SDPs). Additional information on the proposal can be found in the [press release](#) and [fact sheet](#). Comments on proposed rule are due July 21, 2026.

In alignment with H.R.1, total SDP rates are capped at 100% of Medicare in expansion states and 110% in non-expansion states for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center.

Where a Medicare benchmark is unavailable, the payment limit would be 100% of the state-plan-approved rate (or under a waiver of such a plan).

The proposed rule would further extend the SDP limits beyond the four original services under H.R.1 (listed above) to all SDPs, regardless of service type, in all states, Washington, D.C., and territories beginning Jan. 1, 2029. The payment limits for all SDPs will be capped at 100% of the total published Medicare payment rate for expansion states and 110% of the total published Medicare payment rate for non-expansion states.

The proposed rule would also apply new, similar limits to certain targeted Medicaid fee-for-service payments for all services not subject to an existing upper payment limit. Targeted payments, both base and supplemental, would be limited to a percentage of Medicare rates in alignment with the managed care proposal above; 100% of Medicare payment rates for expansion states and 110% for non-expansion states.

This proposal would include behavioral health SDPs and could lead to significant disruption in 2029.

Additional provisions in the proposed rule include proposals to:

- Establish new claims-level compliance and reporting requirements, including submission of provider-specific (NPI-level) data, identification of applicable benchmark rates, and documentation of controls to ensure that each individual service payment does not exceed the cap.
- Eliminate uniform increase SDPs as a permissible type of SDP for rating periods beginning on or after Jan. 1, 2028, with a limited exception for grandfathered SDPs.

- Permit states to adopt minimum or maximum fee schedules that are no greater than the applicable payment rate limit without CMS prior approval for rating periods beginning on or after Jan. 1, 2028.
- Introduce new reconciliation requirements for value-based payment SDPs, requiring states to demonstrate post-period compliance with the cap at the service level.
- The rule specifies that payments exceeding the cap constitute Medicaid overpayments subject to recovery and reporting requirements, explicitly linking SDP limits to existing overpayment regulations.