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New Restrictions Limiting Medicaid State Directed Payments: H.R. 1's Limitations and Centers for Medicare and Medicaid Services' Proposed Rule

H.R. 1 Implementation Explainer: June 2026

Among the many provisions in the 2025 budget reconciliation law (H.R. 1) that gut Medicaid, one of the most consequential is the imposition of new limits on state directed payments (SDPs), which many states use to boost reimbursements to providers who serve Medicaid patients. On May 20, 2026, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule dictating how the agency will implement these new restrictions, including proposing to extend H.R. 1's policies to more provider types. This explainer provides background on the SDP mechanism, discusses H.R. 1's changes and examines CMS' new proposed rule. A companion explainer examines the impact on providers, Medicaid beneficiaries and state health care systems, and offers next steps for advocates.

State directed payments: Strengthening access to care for Medicaid patients

State directed payments (SDPs) are one mechanism used by states to increase reimbursement for Medicaid providers and promote quality and access in Medicaid managed care.[1] Through SDPs, 41 states and the District of Columbia require managed care organizations to increase Medicaid payment rates in targeted ways that align provider pay with overarching state-defined health care goals, including:

- **Increasing access to care.** Medicaid historically reimburses providers at lower rates than Medicare and commercial payers.[2] This lower reimbursement is a major reason providers turn Medicaid beneficiaries away; SDPs can help reduce these payment disparities. Research shows that increasing Medicaid rates, even through small rate increases, translates to more providers participating in Medicaid and increased access to care for patients.[3]
- **Addressing workforce shortages.** Compared to patients with other insurance types, Medicaid patients have far greater difficulty accessing needed care, often due to provider shortages and lack of available appointments.[4] SDPs are one tool states use to address these problems. **Utah**, for example, increases payment rates to help mitigate behavioral health provider shortages that threaten access to care.[5]

- **Supporting rural providers.** SDPs offer a critical financial bridge to rural hospitals and other safety-net providers that disproportionately serve Medicaid patients.[6] For example, an SDP in **New Mexico** supplements payment for the twenty smallest rural hospitals in the state, which is intended to bolster the financial resources and capacity of these hospitals to serve the wider community.[7]
- **Incentivizing specialists to treat Medicaid patients.** Lower Medicaid reimbursement creates a strong disincentive for specialty providers to treat Medicaid patients.[8] Raising Medicaid payment rates through SDPs helps to tackle this problem. For example, an SDP in **Florida** is aimed at reducing wait times for patients seeking care at cancer treatment centers.[9]
- **Shifting care to lower-cost community settings.** SDPs that financially incentive the delivery of services away from hospitals to community-based settings are a cost-effective way to support quality patient care and improve care coordination.[10] **New Hampshire**[11] and **Louisiana**[12] use SDPs to incentivize timely follow-up after emergency department visits to connect patients to community-based providers and prevent future unnecessary hospital encounters.
- **Incentivizing primary and preventive care, including for pregnant women and children.** **Georgia** offers an enhanced payment to increase the number of pregnant women receiving prenatal services within 30 days of Medicaid enrollment.[13] Since 2018, **Tennessee** has offered an enhanced fee to primary care providers to encourage them to complete well-child visits, significantly increasing access to these important screenings. (In 2024, the rate of well-child visits reached a historical high of 75%, up from below 60% in 2020).[14]

Provider payments and patient access are put at risk by H.R. 1 and new proposed rules

Prior to H.R. 1, CMS allowed states to pay Medicaid providers through the SDP mechanism up to the average reimbursement rate paid by commercial insurers for the same service ("average commercial rate").[15] While this policy did not translate to every or even most Medicaid providers receiving payment at this higher level,[16] having this option meant that states could pay select providers on par with average commercial rates, helping states attract and retain providers in their Medicaid programs. H.R. 1 and new proposed rules put these types of payments at risk and would mean that states can no longer pay Medicaid providers above the *Medicare* rate, which is often far below commercial payment rates.[17] **If CMS finalizes its proposed rule, CMS estimates an 18.2% reduction in Medicaid provider pay nationwide in 2026, growing to a 54.5% cut by 2035.**

New H.R. 1 restrictions on state directed payments for hospitals and nursing facilities

Under H.R. 1, Congress capped SDP payments related to four types of providers — *inpatient hospitals, outpatient hospitals, nursing facilities and academic medical centers* — at 100% of the Medicare rate (in states that have expanded Medicaid coverage under the Affordable Care Act's Medicaid expansion[18]) or 110% of Medicare (for the 10 nonexpansion states).[19] This cap applies immediately to new SDPs, but the law grants a temporary "grandfathering" period, allowing certain existing SDPs to remain in place even if they are above Medicare rates (see discussion below). Starting January 1, 2028, the law mandates all grandfathered SDPs go through a multi-year phase-down by 10 percentage points per year until payment rates fall to the state's applicable Medicare rate. Eventually, all SDPs for these provider types will fall at or below Medicare rates, with substantial impact to Medicaid providers:

- Because Medicare rates are often below commercial payment rates,[20] the Congressional Budget Office estimates that H.R. 1's SDP provision will reduce federal Medicaid spending by $149 billion over 10 years (2025–2034).[21]
- Adding in the corresponding additional cuts from state spending, researchers estimate that, nationally, **H.R. 1's statutory SDP limitation alone (not including any additional cuts proposed by CMS) will reduce total state and federal Medicaid payment to hospitals and nursing facilities by $241 billion by 2034.**[22]
- As 80% of SDPs are designated for inpatient and outpatient hospital services,[23] these cuts are expected to deeply impact hospitals that have a high Medicaid patient volume and depend on SDPs to remain financially stable and serving the wider community.[24]

CMS' H.R. 1 implementation guidance, February 2026: Grandfathering period criteria

Under H.R. 1, certain existing hospital and nursing facility SDPs can remain in place and unchanged until January 1, 2028, even if above Medicare rates, if they qualify for the law's temporary "grandfathering" period. Per H.R. 1, SDPs qualify for grandfathering if: (1) they fall in a rating period[25] occurring within 180 days of the law's enactment (July 4, 2025); and (2) the state received written prior approval from CMS or made a "good faith effort" to receive such approval before statutory deadlines.[26]

Determining which SDPs qualify for grandfathering is significant, not only for providers to understand whether increased payments survive until 2028 but for states to plan for whether they can depend on these payments in the short term or will need to determine alternative approaches to financially incentivize quality and access in Medicaid managed care in the absence of higher payment rates.

- In February 2026, CMS issued preliminary guidance to clarify which SDPs meet the temporary grandfathering period.[27] The February guidance replaced prior guidance,[28] reinterpreting definitions in ways that grant grandfathering status to a much wider range of SDPs — for example by clarifying that 180 "days" in the statute should be interpreted as 180 *business* days, rather than *calendar* days.[29] This change is consequential, given that one or more SDPs in 30 states would have failed to meet grandfathering status under CMS' initial guidance.[30]
- CMS' May 2026 proposed rule (see below) would finalize the February guidance, but it would not extend grandfathering status to SDPs for other provider types or to any current SDP that does not exceed the Medicare limit (with consequences for the continued status of many hospital and nursing facility payments as discussed below).

CMS' proposed rule, May 2026: Extending H.R. 1's SDP restrictions to all Medicaid providers

On May 20, 2026, CMS released a notice of proposed rulemaking (NPRM) which proposes extending H.R. 1's SDP restrictions to *all* Medicaid providers in all states and territories, along with restrictions on the types of payments states can make going forward.[31] This proposal goes far beyond Congress' already monumental Medicaid cuts: CMS estimates that these **additional regulatory SDP cuts would reduce reimbursement to Medicaid providers by more than $780 billion over 10 years** (2026–2035). CMS proposes to achieve this level of cut to Medicaid providers in four primary ways:

1. **Extending SDP cuts to all provider types, including primary care and behavioral health:** CMS proposes to cap all SDPs (beyond the initial four hospital and nursing facility provider types identified in H.R. 1) at the Medicare rate (100% of the Medicare rate for expansion states, 110% of Medicare nonexpansion states) for rating periods beginning on or after January 1, 2029.[32] This proposal would extend H.R. 1's Medicare cap to payments for primary care, behavioral health, dental, home- and community-based service providers and other provider types.

   Importantly, unlike for SDPs cut under H.R. 1, CMS' proposed rule does not include a grandfathering period or a multi-year phase-down for these new provider types. If finalized, this policy would mean that unless an SDP qualifies for H.R. 1's grandfathering period (see above), then it must abruptly recede to the Medicare rate by 2029.

   States often set non-hospital/non-nursing facility SDPs lower than the Medicare rate to begin with.[33] Where set above Medicare, SDP rates tend to fall very close to the proposed regulatory limits (for example, **Maryland** sets primary care provider payment at 108.5% of the Medicare rate[34]). Even if payments do not have far to fall under this proposal, the proposed cuts would still add up. For example:

- Reducing primary care provider payments in **Maryland** (a Medicaid expansion state) to 100% of Medicare would cut $10.5 million from Medicaid provider pay and hamper state goals to link all Medicaid beneficiaries with a primary care provider.
- Chopping **Florida's** SDP from its current level of 134.1% of Medicare down to 110% (Florida is a nonexpansion state) would cut more than $9.4 million from primary care and hinder efforts to reduce the median wait time for a Medicaid beneficiary to see a primary care provider.[35]

Overall, CMS estimates that these proposed cuts would **reduce Medicaid payments by $5.34 billion over 10 years for primary care, behavioral health, dental, home- and community-based service providers and other provider types newly impacted by the proposed rule,** further devastating access to health care for Medicaid beneficiaries.

2. **Restricting ways states can structure their SDPs:** CMS proposes to restrict the types of SDPs states can pursue, eventually eliminating all SDPs that set a uniform dollar or percentage increase (for example, an increase of $10 per claim to incentivize preventive screenings). As "uniform increase" payments are the most common type of SDP,[36] if this proposal moves forward, beginning January 1, 2028, many states will have to redesign SDPs to meet CMS' new standards (restructuring them instead as a minimum or maximum fee schedule, for example, by setting payment at 80% of Medicare[37]). This proposal may hamper state efforts to incentivize providers to address important chronic disease and public health goals.

For example, **Tennessee** offers a uniform rate increase of $4 per member per month to providers participating in patient-centered medical homes to meet certain minimum quality measures that incentivize preventive care, including cervical cancer and breast cancer screenings.[38] Although provider payment falls well below the Medicare cap (providers receiving this rate increase ultimately take home 77.62% of the Medicare rate for these services), because this SDP is structured as a uniform increase, the state would have to abandon this enhanced payment in 2028 if it cannot restructure it.

CMS does not propose any general grandfathering or phase-down period to help states adjust to this change, but it would allow SDPs with uniform increase payments that have grandfathering status under H.R. 1 (see above) to remain in place until the payment falls to the Medicare rate (until the end of H.R. 1's multi-year phase-down period). After this time the SDP is no longer valid and the state would have to reconfigure it to survive.

It is important to note, however, that CMS interprets H.R. 1 as grandfathering only those existing hospital and nursing facility SDPs that are *above* the Medicare rate. Where states have uniform increase SDPs in place for hospital and nursing facility

providers that are at or below the Medicare rate, CMS' proposal would impact the viability of these payments in 2028, much sooner than for grandfathered SDPs that sit above the Medicare rate. For example, both **Rhode Island's** 2.9% increase per claim to hospitals that successfully increase behavioral health care coordination[39] and **Illinois'** 2.0% increase to nursing home payments that meet patient quality measures[40] are set well below Medicare rates, but they are now vulnerable to elimination.

Given the complexity of the financial arrangements involved, it may not be easy to simply flip every uniform increase payment to a minimum/maximum fee schedule. Indeed, CMS anticipates that many states will have trouble converting some or all payments to stay within the law.

3. **Extending SDP cuts to territories:** CMS proposes to extend all SDP cuts — both in place under H.R. 1 and proposed here — to territories. H.R. 1 previously exempted territories from SDP caps, but CMS now proposes that territories must follow all SDP restrictions beginning with the first rating period on or after January 1, 2029. In addition, the proposed policy to prevent states from utilizing uniform increase SDPs is applicable to territories. Because SDPs in territories are not eligible for grandfathering under H.R. 1, no uniform increase SDPs can survive after January 1, 2028. **Puerto Rico** has 19 approved SDPs which are now at risk, including some that set a uniform increase.[41]
4. **Cutting provider pay under Medicaid fee-for-service:** While the majority of Medicaid beneficiaries (78%) are enrolled in managed care plans (where the health plan pays providers for all covered services either at rates negotiated between the plan and providers or at payment rates as directed by the state via an SDP), many states continue to offer Medicaid benefits on a fee-for-service (FFS) basis to some or all Medicaid enrollees (where the state pays providers directly for each covered service).[42] Similar to an SDP, states can offer a supplemental payment to a targeted set of providers on top of base FFS rates to help achieve various state health care goals.[43] For example, **Maine** does not contract with any managed care providers so does not have any SDPs in place. However, Maine frequently adjusts supplemental payments for providers, including a 15% add-on to the standard MaineCare rate for eligible adult family care homes and residential care facilities located on remote islands in the state; these additional payments help account for higher health care costs of delivering care in remote locations.[44]

   In its proposed rule, CMS aims to align all managed care and FFS payment policies, capping all targeted supplemental FFS payments at the Medicare rate (100% of the Medicare rate for expansion states; 110% of Medicare nonexpansion states). States may continue to set base Medicaid rates as they always have but would not be able

to set new supplemental payments higher than Medicare rates. CMS proposes to give states until January 1, 2029, to bring existing supplemental payments into compliance. CMS estimates that this change, if finalized, would **reduce total Medicaid payments (federal and state) to providers by $2.44 billion from 2029 through 2035, causing further provider payment cuts across the entire Medicaid system.**

In addition, the rule includes several changes to SDP requirements intended to ensure compliance with federal payment limits and to strengthen oversight and transparency of directed payment arrangements. CMS is providing a 60-day comment period for the proposed rule, through July 21, 2026.

Impact of Medicaid payment cuts

Should CMS finalize their proposed rule, states essentially no longer have the ability to target any payments to Medicaid providers above Medicare rates, whether those providers are paid through managed care or FFS Medicaid. With estimated cuts of more than $780 billion to Medicaid provider pay, H.R. 1 and CMS' proposed rule will mean Medicaid beneficiaries nationwide will struggle to find access to primary and specialty care providers who will accept Medicaid patients. In a companion piece, Families USA examines the impact of these cuts on patients, providers and state health care systems, and offers next steps for advocates concerned about access to care.

Endnotes

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