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New Restrictions Limiting Medicaid State Directed Payments: Impact on Providers, Patients and State Health Care Systems

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 examines the impact of these changes on providers, Medicaid beneficiaries and state health care systems. A companion explainer offers more in-depth background on the SDP mechanism, H.R. 1's changes to SDPs and CMS' new proposed rule.

State directed payments: New statutory and proposed regulatory restrictions

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 various state-defined health care goals, including:

- **Increasing** Medicaid beneficiary access to primary care and specialty providers.
- **Addressing** workforce shortages.
- **Supporting** rural providers.
- **Shifting** care to lower-cost community settings.
- **Incentivizing** preventive care and screenings.

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").[2] This wide payment flexibility gave states latitude to direct managed care plans to boost payments for certain types of providers or services or in certain areas of the state, where needed, to ensure access to care for Medicaid beneficiaries.

H.R. 1 sets new limitations on SDPs for hospital and nursing facility providers, capping pay at the *Medicare* rate, which is often far below commercial payment rates.[3] In May 2026, CMS proposed to extend these limitations to *all* SDPs for *all* Medicaid providers — including primary care, behavioral health, dental, home- and community-based service providers and other provider types — along with other proposals that would significantly curtail the use of SDPs nationwide and restrict similar payments made through Medicaid fee-for-service. Families USA's companion explainer, offers a more in-depth look at SDPs, H.R. 1's changes and CMS' proposed additions.

Impact on Medicaid provider payments and access to care

Should CMS finalize their proposed rule, states will no longer have the ability to target any payments to Medicaid providers above Medicare rates. CMS estimates its rule would **reduce reimbursement to Medicaid providers by more than $780 billion over 10 years, representing a 54.5% cut in pay to Medicaid providers by 2035.**[4]

Anticipated reduced payments to Medicaid providers are a result of at least three shifts post–H.R. 1: (1) managed care organizations paying Medicaid providers less for services provided; (2) providers dropping out of Medicaid provider networks altogether and incurring no further program expenses; and (3) H.R. 1's new eligibility hurdles (including work reporting requirements and more frequent redeterminations) causing major enrollment fluctuations that may interrupt care and prevent providers from achieving desired quality outcomes and resultant add-on SDP payments. In addition, should CMS finalize its proposed rule, payment cuts will come when states drop SDPs that they cannot restructure to meet new regulations.

Any cut to these payments — let alone billions of dollars in cuts — without corresponding efforts to address workforce shortages, support struggling safety-net providers or incentivize quality care for vulnerable populations will mean reduced access to primary and specialty care for Medicaid patients nationwide. These are not just cuts around the margins:

- SDPs represent 26% of all payments though managed care, forming a substantial component of reimbursement for health care services provided to the 78% of Medicaid enrollees who are enrolled in managed care plans.[5]
- As 80% of SDPs are designated for inpatient and outpatient hospital services,[6] 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.[7]

Impact on states

The impact of H.R. 1's SDP restrictions and CMS' proposed additions will vary widely across states, depending on how heavily states rely on these payment mechanisms:

- **Nine states do not operate Medicaid managed care systems and, therefore, do not use the SDP mechanism.** **Alabama, Connecticut, Idaho, Maine, Montana, South Dakota, Vermont** and **Wyoming** are not managed care states and are not impacted by this change.[8] However, **Idaho** is planning a shift to managed care in 2030 and could put SDPs in place in the future.[9] CMS' proposed rule, if finalized, may lower fee-for-service Medicaid payments in these states.
- **Not every managed care state relies heavily on SDPs.** According to an analysis from RAND, **Georgia, Mississippi, South Carolina, Tennessee** and **Texas** are heavily dependent on SDPs to support hospital and/or nursing facility provider payments; providers in these states will be most affected by H.R. 1's new restrictions.[10] However, providers in other states will see minimal impact. While **North Dakota** has managed care,[11] it does not have SDPs in place; **Arkansas** does have some SDPs, but not any in place for hospitals and nursing facilities.[12] Other states, including **Florida** and **Nebraska**, have SDPs, but do not depend strongly on them to support hospital and nursing facility provider payments, meaning providers in these states will see minimal impacts.[13] While these states are less impacted today compared to other states, should they pursue additional SDPs in the future, payments will be capped at Medicare rates. We note that a different mix of states could be more heavily impacted by CMS' proposed extension of SDP caps to other Medicaid providers.
- **H.R. 1's impact on a given state or provider type depends on how high states set SDPs above Medicare rates.** H.R. 1 will eventually force down all hospital and nursing facility SDPs that sit above the Medicare rate. However, SDP payment levels vary widely. A 2025 RAND analysis converted hospital and nursing facility SDP payment rates to Medicare rates, estimating that, nationally, these SDPs ranged from 36% of Medicare to more than 300%, with the median rate being nearly twice the Medicare rate.[14] According to RAND, **South Carolina** and **Nevada** have the highest mean SDP rates relative to Medicare (at 280% and 251%, respectively); impacted providers in these states can expect the greatest drop in payment rate. But where payments sit closer to Medicare rates, providers are less impacted.[15] An analysis by Manatt estimates that H.R. 1's SDP changes mean hospitals in **Missouri** and **New York** will see rates drop by less than 10%, while hospitals in **Iowa, Michigan, North Carolina, South Carolina** and **Utah** will see payment rates drop by more than 40%.[16]

Impact on SDPs and Medicaid payments going forward

Despite new statutory limits and proposed regulatory restrictions, SDPs remain a viable mechanism to compensate safety-net providers and fund important objectives within Medicaid:

- **States are not slowing down on their use of SDPs and CMS is still actively approving them, even if above Medicare rates.** Families USA observes that between H.R. 1's passage (July 4, 2025) and April 30, 2026, CMS approved 252 SDPs across 37 states, including 165 SDPs for hospital and nursing facility providers (provider types impacted by H.R. 1's cuts). Of these, 153 (92.7%) were tied to the average commercial rate (some equal to commercial rates, others well below commercial rates but still pegged to them). While we expect to see states adjusting their SDPs down to Medicare rates in the future, for now CMS is still approving SDPs up to the average commercial rate, and these higher payment rates can remain in place for the time being, until the close of the temporary grandfathering period.
- **Nearly every current hospital and nursing facility SDP meets H.R. 1's grandfathering criteria.** Of 252 total SDPs approved by CMS since H.R. 1's passage (between July 4, 2025, and April 30, 2026), CMS flagged only one payment in **Iowa** as being ineligible for grandfathering status under the statute.[17] This means that even in an H.R. 1 environment, CMS is still allowing states to maintain increased payments to providers through SDPs in the short term.
- **Policymakers and providers in heavily impacted states have time to plan and adjust.** Under H.R. 1's multi-year phase-down starting in 2028, it will take **Nevada**, a Medicaid expansion state with mean SDP rates at 251% of Medicare, about 16 years (until 2042) to bring payments down to 100% of the Medicare rate. It will take **South Carolina**, a nonexpansion state with mean SDP rates at 280% of Medicare, about 18 years (until 2044) to bring rates down to 110% of Medicare. Policymakers in states like these have time to determine a pathway forward to keep Medicaid provider networks strong, including by reducing administrative hurdles to Medicaid participation (see below).
- **Where SDPs sit below Medicare rates, states may still raise them.** H.R. 1 sets a cap on the amount states can pay hospital and nursing facility providers through the SDP mechanism, and CMS proposes to extend this cap to other provider types. However, the law does not prevent states from pursuing new SDPs or raising rates of current ones. As many SDPs sit below the Medicare rate — particularly payments for primary care, behavioral health, and home- and community-based service providers — there is room for payment increases, and states may still pursue SDPs as a means of achieving important program objectives.

Interaction with H.R. 1's provider tax restrictions and other SDP funding considerations

Any time there is an increase in pay to providers who treat patients on Medicaid — either through the SDP mechanism or in other ways — it comes at a cost to the state, which must pay its share. States have many options for generating revenue to cover provider reimbursement, including through state general funds (e.g., income and sales taxes), funds transferred from local governments and taxes on health care providers ("provider taxes").[18] However, in a significant blow to state Medicaid budgets, H.R. 1 permanently limits states' ability to generate revenue for Medicaid through provider taxes.[19] As about 18% of state Medicaid funds nationally come from this source,[20] new limits on provider taxes will undoubtedly create significant budget shortfalls for states which, without alternative sources of Medicaid revenue, may further impact states' ability to sustain or increase reimbursement to providers through the SDP mechanism.

However, states have many permissible ways to pay for SDPs. Our examination of CMS' database of approved SDP preprints (as of April 30, 2026) showed that no state relies solely on provider taxes to fund their entire portfolio of SDPs, and some states — including **Maryland, Minnesota** and **New York** — do not depend on provider taxes to fund any SDP, relying instead on state general revenue or other sources.

Still, states may want to put new SDPs in place over time (or otherwise increase Medicaid provider base pay rates) and, going forward, they will need revenue outside of provider taxes to do so. Recent SDP approvals show efforts by states to fund SDPs via alternative funding mechanisms, including:

- **Tobacco taxes or master settlement funds** (**Arizona,**[21] **California,**[22] **Colorado,**[23] **Missouri**[24]).
- **Liquor taxes** (**New Hampshire**[25]).
- **Prescription drug rebate funding** (**Arizona**[26]).
- **Funds generated through health care premiums** (**Missouri**[27] **and New Hampshire**[28]).

In addition, state legislatures that want to keep SDPs in their states are beginning to recognize the need for new sources of funding. For example, the **Kentucky** legislature passed H.B. 689 in April 2026, instructing the Department for Medicaid Services to seek permission from CMS for a new state-directed payment program to be paid for without revenue from the state's hospital provider tax.[29]

Beyond payment increases, states can address other significant hurdles that make it difficult for providers to participate in Medicaid

H.R. 1's SDP and provider tax restrictions may mean some states can no longer entice Medicaid participation and quality care through higher provider reimbursement. State policymakers can and should examine ways to reduce other burdens to make it easier for health care providers to participate in Medicaid. Providers face multiple administrative hurdles to Medicaid participation, including the complexity of health care billing, headaches of claims denials and resubmissions, haggling with insurers to collect payments, and the challenge of trying to enter or remain in Medicaid provider networks when managed care plans have incentives to limit networks as a means of controlling costs.[30] And more challenges are on the horizon: Medicaid work reporting requirements (which start by January 2027) will add additional time burdens for providers and their staff to provide patients with documentation to prove their health care status and exemption eligibility. States have opportunities to address these administrative burdens, and where states do so, they help blunt the impact of SDP cuts on provider participation.

Next steps for advocates

- **Understand what SDPs are achieving in your state and clearly articulate to policymakers the value of maintaining or expanding these SDPs to increase access, improve quality or incentivize cost-efficient care.** Advocates representing the needs of specific communities (for example, rural communities or patient groups) can be instrumental in pointing out where low provider reimbursement is limiting access to high quality care. Advocates can urge policymakers to pursue new SDPs or raise the rates of existing ones where they are set below legal limits.
- **Encourage state policymakers to pursue alternative Medicaid revenue sources for funding SDPs.** States have options to fund their Medicaid programs and need to determine solutions outside of provider taxes to generate the revenue needed to support provider participation in Medicaid.
- **Reduce other hurdles to Medicaid provider participation.** Beyond payment increases, states can address other significant hurdles — including state administrative burdens and restrictive managed care policies — that make it difficult for providers to participate in Medicaid. Resolving the many barriers that restrict access to care is critical, not only for Medicaid beneficiaries but for the overall financial stability of the health care system.
- **Comment on CMS' proposed rule and document the impact of reduced provider rates on patient care.** CMS has proposed a massive extension of H.R. 1's SDP cuts, impacting all provider types in all states and territories. It is important for CMS to hear from stakeholders — both during the comment period (through July 21, 2026) and beyond should these rules become finalized — about how cuts to SDPs may impact access and care quality or raise costs in other parts of the health care system. For example, if states have to drop SDPs that are aiming to shift care to lower-cost community settings, this may raise costs for emergency department care. Likewise, if states have to lower rates paid to primary care providers, there may be less access to preventive screenings leading to higher-cost care needs down the road.

Endnotes

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[14] Rao et al., *State-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act*.

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