

CMS' Proposed State Directed Payment Rule Under Review At OMB

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Updated Story

The White House Office of Management and Budget is reviewing the proposed state directed payment rule Medicaid stakeholders have been waiting for in part to gain clarity on what additional Medicaid services the Trump administration could add to the SDP cap list.

State directed payments -- additional Medicaid funds that states use to address network adequacy issues in Medicaid and improve provider performance -- are set to be capped since the passage of the One Big Beautiful Bill Act, which ends the Biden-era policy that let states set their Medicaid directed payments as high as commercial rates. Under OBBBA, states that haven't expanded Medicaid will have certain services capped at 100% of the Medicare rate and non-expansion states will be capped at 110% of Medicare rate.

CMS began detailing OBBBA's changes to SDP payments in guidance released last year, including setting a phase down timeline. But the guidance also hinted the administration wants to go farther than OBBBA's changes to SDPs and is looking into adding more Medicaid services to the SDP cap list.

These additional changes are expected to be included in the proposed rule "Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments (CMS-2449)" that CMS sent to OMB on Feb. 27.

While the proposed rule's official pending status at OMB is new, stakeholders have known about the rule since the Trump administration first unveiled it in the Spring 2025 regulatory agenda. America's Essential Hospitals and LS Point each met with OMB over the summer to present their views on SDP and the rule generally.

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The Spring 2025 regulatory agenda says the economically significant proposed rule will propose to "set a limit for certain targeted Medicaid practitioner payments in Medicaid fee-for-service."

It also would “modify the limit on the total payment rate and other requirements for state-directed payments in Medicaid Managed Care. CMS would propose these changes based on its authority to interpret and implement section 1903(m)(2)(A)(iii) of the Social Security Act, which requires contracts between States and Managed Care Organizations to provide payments under a risk-based contract for services and associated administrative costs that are actuarially sound.”