

# Top 10 changes proposed by CMS to Medicaid State Directed Payments

Proposed May 20, 2026

Comment Period Ends July 21, 2026

#	Proposed change	What CMS proposes	Federal Register page	Likely beyond H.R. 1 / P.L. 119-21?
1	<b>New Medicare-based cap for certain SDPs</b>	CMS proposes to implement H.R. 1 section 71116 by capping SDPs requiring written prior approval for <b>inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services at academic medical centers at 100% of Medicare</b> in expansion states and <b>110% of Medicare</b> in non-expansion states, for services furnished in rating periods beginning on or after <b>July 4, 2025</b> , unless grandfathering applies.	30411	<b>No.</b> This is the core statutory implementation.
2	<b>State-plan-approved rate applies when no Medicare rate exists</b>	Where there is no total published Medicare payment rate for a Medicaid-covered service, CMS proposes to use <b>100% of the State-plan-approved rate</b> as the payment limit. CMS also says waiver-approved rates, including section 1115 and 1915(c) waiver rates, may qualify as State-plan-approved rates for this purpose.	30412–30413	<b>Mostly no / interpretive.</b> H.R. 1 required a fallback to the Medicaid State plan or waiver rate; CMS is operationalizing that standard.

#	Proposed change	What CMS proposes	Federal Register page	Likely beyond H.R. 1 / P.L. 119-21?
3	<b>Defines expansion-state and non-expansion-state treatment</b>	CMS proposes to apply the H.R. 1 cap differently depending on whether the state is an expansion or non-expansion state. CMS also interprets the rule so that if a state later changes expansion status, the applicable payment limit changes with that status.	<b>30412, 30418</b>	<b>Mostly no, but partly interpretive.</b> The 100% / 110% distinction is statutory; the treatment of later expansion-status changes is CMS interpretation.
4	<b>Creates operational rules for grandfathered SDPs</b>	CMS proposes criteria for grandfathered SDPs, including timing rules for eligible rating periods and the status of the SDP preprint: prior written approval, good-faith effort, rural hospital treatment, or completed preprint submission before the statutory dates.	<b>30419</b>	<b>No / partly interpretive.</b> H.R. 1 created grandfathering; CMS defines terms such as “completed preprint” and “good faith effort.”
5	<b>Phases down grandfathered SDPs by fixed dollar reductions</b>	Beginning with the first rating period on or after <b>January 1, 2028</b> , CMS proposes that the grandfathered SDP amount be reduced annually by at least <b>10 percentage points of the original grandfathered total dollar amount</b> until the payment limit is reached.	<b>30423</b>	<b>Possibly beyond / legally debatable.</b> H.R. 1 requires a phase-down, but CMS’s choice to use the original grandfathered total dollar amount as the baseline is a significant interpretation.
6	<b>Extends Medicare-based caps to all SDPs, not just H.R. 1’s four service categories</b>	CMS proposes to apply the 100% / 110% Medicare-based payment limit to <b>all services covered under SDPs</b> , not just the four categories listed in H.R. 1, beginning with the first rating period on or after <b>January 1, 2029</b> .	<b>30416</b>	<b>Yes.</b> This is one of the clearest provisions that goes beyond H.R. 1. CMS expressly says it is extending the limit to all SDPs to prevent cost

#	Proposed change	What CMS proposes	Federal Register page	Likely beyond H.R. 1 / P.L. 119-21?
7	<b>Applies the broader SDP cap to U.S. territories</b>	CMS states that H.R. 1 section 71116 applies to the 50 states and D.C. and <b>does not apply to U.S. territories</b> , but CMS separately proposes to extend the broader SDP payment limit to territories beginning with the first rating period on or after <b>January 1, 2029</b> .	<b>30411, 30416</b>	shifting to services outside the statute's four categories.  <b>Yes.</b> CMS acknowledges the statute does not apply to territories, then proposes territorial application under separate regulatory authority.
8	<b>Adds provider/service-level compliance and monitoring requirements</b>	CMS proposes requiring states to submit provider lists, NPIs, Medicare or State-plan benchmark rates, and detailed methods for ensuring payment to each provider for each furnished service does not exceed the payment limit. CMS also proposes per-service validation for value-based SDP arrangements.	<b>30416–30417</b>	<b>Likely beyond / aggressive implementation.</b> H.R. 1 imposes payment limits; CMS is adding a detailed operational compliance architecture.
9	<b>Eliminates new and renewed non-grandfathered uniform-increase SDPs</b>	Beginning with the first rating period on or after <b>January 1, 2028</b> , CMS proposes that <b>new uniform-increase SDPs and renewals of non-grandfathered uniform-increase SDPs</b> would no longer be permitted. Grandfathered uniform-increase SDPs could continue only during the grandfathering period.	<b>30427–30428</b>	<b>Yes.</b> H.R. 1 capped certain payment levels; it did not appear to ban uniform-increase SDPs as a payment design.

#	Proposed change	What CMS proposes	Federal Register page	Likely beyond H.R. 1 / P.L. 119-21?
10	<b>Creates a new Medicaid FFS targeted-payment limit</b>	CMS proposes a new <b>42 C.F.R. § 447.381</b> limiting certain targeted Medicaid fee-for-service practitioner or provider payments to <b>100% of Medicare</b> in expansion states and <b>110% of Medicare</b> in non-expansion states, with exceptions where no reasonable Medicare equivalent exists or payments are reconciled to actual incurred cost.	<b>30435–30436, 30465–30466</b>	<b>Yes.</b> This is another clear beyond-H.R. 1 provision because H.R. 1 section 71116 addressed Medicaid managed-care SDPs, not a new broad FFS targeted-payment cap.

#### The provisions most likely to go beyond H.R. 1

1. **Applying the cap to all SDPs beginning in 2029**, not just H.R. 1’s four service categories — **91 Fed. Reg. 30416**.
2. **Applying the broader SDP cap to U.S. territories**, despite CMS acknowledging that H.R. 1 section 71116 does not apply to territories — **91 Fed. Reg. 30411, 30416**.
3. **Creating a new FFS targeted Medicaid payment cap** at proposed **42 C.F.R. § 447.381** — **91 Fed. Reg. 30435–30436, 30465–30466**.
4. **Eliminating new or renewed non-grandfathered uniform-increase SDPs** beginning in 2028 — **91 Fed. Reg. 30427–30428**.
5. **Imposing a strict provider/service-level compliance framework** for demonstrating that payments do not exceed the cap — **91 Fed. Reg. 30416–30417**.
6. **Interpreting the grandfathering phase-down as a fixed-dollar reduction from the original grandfathered total dollar amount**, rather than a more flexible rate-based or compounding approach — **91 Fed. Reg. 30423**.