Medicaid Stakeholders Flag Administrative Hurdles, Grandfathering Issues With SDP Rule

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While stakeholders are telling CMS to go back to the drawing board on its proposed state-directed payments rule, their concerns go way beyond the proposed expansion of the SDP cap to flag structural issues, including, among other things, how the administration's implementation will increase administrative burden to the point that states will effectively become "MACs."

The 2025 reconciliation bill directed CMS to cap state-directed payment for certain Medicaid services -- inpatient hospital, outpatient hospital, nursing facility and qualified practitioner services -- at Medicare levels in expansion states and Medicare plus 10% in non-expansion states.

In May, the Trump administration unveiled its proposed rule on implementing the new policy and went a big step further by proposing to extend the H.R. 1 limits to all SDPs in all states and territories starting with the Jan. 1, 2029, rating period.

Expanding the cap

H.R. 1 was designed to generate $149.4 billion in federal savings over 10 years by reducing the hospital payment limit each year from the existing average commercial rate limit to either 100% or 110% of the Medicare rate, in 10-percentage-point increments. CMS has interpreted this to mean that the annual reduction should equal 10% of the 2027 rate each year, resulting in a reduction estimated to exceed $510 billion over the next decade-- more than triple the intended amount.

Stakeholders opposed CMS' proposed extension in their comment letters as expected, and many urged the administration to go back to the drawing board with its proposed rule.

The National Association of Medicaid Directors urged CMS to limit the state-directed payment cap to what was spelled out in H.R. 1, but if CMS decides to expand the cap to all types of payments, then Medicaid directors ask the administration to also apply H.R. 1's phase down provisions to these additional payments.

"A uniform transition framework would simplify implementation, improve predictability for states and territories, providers, and reduce administrative complexity," NAMD's comment letter says. "States and territories also question the need for different transition schedules

across provider types and SDP arrangements if all arrangements are ultimately transitioning to the same payment limit framework."

Medicaid directors reminded CMS some states and territories have used SDPs intentionally higher than Medicare rates to address workforce shortages, improve beneficiary access or support services that have no direct Medicare equivalent -- a key point of concern when it comes to bringing certain Medicaid state-directed payment agreements into line with Medicare rates.

CMS needs to provide additional clarity on when states apply the proposed payment limits to Medicaid-specific payment methodologies and provider types, NAMD says. Stakeholders are lacking clarity on how to calculate payment limits for state-plan-approved bundled payment arrangements, managed-care-only services without a state plan equivalent, or certain services provided by federally qualified health centers.

Meanwhile, the American Hospital Association asked CMS in its comment letter to explicitly state that all add-ons and adjustments will be treated as components of the Medicare rate.

"Absent clear direction, states could construct the limit from a rate that omits these components, producing a ceiling that falls below total Medicare payment and understates even what Medicare itself pays for a service," AHA's letter says.

Increasing administrative burden

Medicaid directors and providers flagged the administrative hurdles states will face with CMS' proposal to have Medicaid agencies analyze the Medicare payment limit for SDPs based on the service- or discharge-level rather than comparing Medicaid rates to Medicare rates in the aggregate.

NAMD warns applying SDP limits on the individual provider level may have unintended consequences for quality improvement and value-based payment initiatives, including ones designed by the CMS Innovation Center.

"Under the approach described in the proposed rule, providers that have reached the payment limit could become ineligible for additional performance incentives, limiting states’ and territories' ability to reward high-quality care and potentially weakening incentives that support quality improvement efforts and value-based payment," NAMD's comment letter says. "In addition, provider participation may vary across managed care plans, creating operational challenges for states and territories as they calculate performance, develop capitation rates, and administer SDP arrangements."

NAMD urged the administration to partner with states on this issue so they can jointly develop reporting plans and create alternative ways to comply in the meantime, including using aggregate analyses or actuarial certifications.

CMS should also create pathways for more bundled pay models that will enhance financial accountability as a rigid per-service approach will put at risk such programs, NAMD says.

If CMS decides to have state Medicaid agencies reprice every claim paid through an SDP and then monitor if the cumulative payment exceeds the acceptable Medicare-based payment limit, the Oklahoma Hospital Association says it will increase Medicaid administrative costs and divert state resources away from program-integrity activities.

"This is, in substance, the same function performed by a Medicare Administrative Contractor (MAC), except performed by a State Medicaid agency with none of a MAC's specialized systems, staff, or dedicated federal funding for that specific purpose," Oklahoma hospitals say in their comment letter.

"State Medicaid agencies are simultaneously implementing numerous significant federal requirements, including community engagement and redetermination mandates, the 2024 managed care final rule, and enhanced program integrity procedures," it adds. "Layering a service-specific Medicare repricing and recoupment obligation of this magnitude on top of those existing obligations will place substantial additional strain on State agency resources."

Grandfathered rates

Congress set an immediate implementation date of July 4 for state-directed payment agreements, but lawmakers also created a vague temporary onramp for certain states with existing SDP agreements. Known as the grandfathering period, this pathway begins a 10% phase down each year starting in 2028 until it reaches the Medicare rate.

The Kansas Hospital Association urged CMS to take a different approach to this SDP phase down. Instead, SDPs should be phased down be as they compare to Medicare -- 200% of Medicare down to 190% of Medicare, etc. - as this would give providers time to adjust their reimbursement reduction without reducing or eliminating services for all members in their communities, the local hospital association says.

Stakeholders are also focused on what it takes to qualify for the grandfathering period, which is meant to give states with existing SDP agreements more time to find replacement Medicaid funding rather than a sudden financial cliff.

The Minnesota Hospital Association says its state is having difficulties qualifying for the grandfathering period it deserves.

The state's preprint remains pending despite Minnesota officials submitting its hospital directed payment preprint on July 3, 2025 -- within the statutory timeline Congress set -- and the state Medicaid agency completing two rounds of CMS questions.

"Whether Minnesota qualifies for grandfathering should not depend on the pace of CMS's own review process," the letter continues. "A state that met every statutory requirement and submitted its preprint on time should not lose grandfathered status because the agency has not completed its review. That outcome would be fundamentally inequitable and would effectively allow agency delay, not state action or federal law, to determine eligibility."

The local hospital association urges CMS to approve Minnesota's pending preprint without delay and clarify that "timely submitted directed payment arrangements will retain grandfathered status regardless of when CMS completes its review."

"More broadly, CMS should establish predictable review timelines for directed payment preprints, such as issuing a determination or substantive response within 90 days of a complete submission and within 60 days after receiving responses to follow-up questions," MHA says. "States and providers should not be left in prolonged uncertainty over programs that are critical to financing Medicaid services and supporting patient access to care."