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CMS Proposes Sweeping Limits on Medicaid Supplemental Payments

On May 20, 2026, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule that would cap Medicaid managed care state directed payments (SDPs) and certain fee-for-service (FFS) supplemental practitioner payments at 100% of the published Medicare rate, or 110% in states that have not expanded Medicaid under the Affordable Care Act (ACA).[1] CMS projects that the rule, together with provisions of the One Big Beautiful Bill Act (OBBBA),[2] would reduce Medicaid spending by $774.8 billion over ten years, of which $510.1 billion would be the federal government's share.[3] This Health Capital Topics article examines the proposed rule's scope, key payment limit provisions, and initial industry response.

Background: The Growth of State Directed Payments

SDPs are arrangements under which a state requires its Medicaid managed care organizations (MCOs) to pay contracted providers at a specified rate. Created by CMS's 2016 Medicaid managed care final rule, SDPs were designed to advance value-based purchasing and delivery system reform goals while preserving actuarially sound capitation requirements.[4] Their use has expanded rapidly: only two states employed SDPs when the mechanism was formalized; by 2026, 41 states have adopted them.[5] CMS projects that SDPs will account for 26.4% of total Medicaid managed care spending in fiscal year 2025.[6]

Medicaid is jointly funded by the federal government and states, with each state's federal matching rate determined by its per capita income relative to the national average. Much of the growth in SDPs has been financed through intergovernmental transfers (IGTs) and provider taxes, arrangements through which a state collects taxes from providers, uses those funds as the non-federal share of Medicaid capitation to draw down federal matching payments, and then directs enhanced payments back to those same providers. CMS estimates that over 80% of SDPs exceeding Medicare rates are funded, in whole or in part, through IGTs or provider taxes.[7]

For FFS Medicaid, a parallel supplemental payment structure exists for practitioners. Currently approved payments to physicians and other licensed practitioners under average commercial rate (ACR)-based methodologies average 207% of the Medicare equivalent of the ACR for physicians and 153% for other licensed practitioners in participating states; in one state, CMS reports payments exceeding 530% of the Medicare equivalent of the ACR for physicians.[8]

What the Proposed Rule Would Change

The proposed rule's core provision adds a new "Payment Limit" definition, setting the ceiling for SDP payments at 100% of the total published Medicare rate in ACA expansion states and 110% in non-expansion states.[9] Where no Medicare rate exists for a covered service, the State plan approved rate would serve as the limit.[10]

The proposed caps reach considerably beyond what Congress directed in OBBBA.[11] That legislation required CMS to apply Medicare-based payment limits to four categories of services in the 50 states and the District of Columbia: inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services at academic medical centers. The proposed rule would extend the Medicare-based cap to all SDP service categories, including physician services outside academic medical centers, behavioral health, home- and community-based services (HCBS), and federally qualified health centers (FQHCs), as well as to FFS targeted practitioner payments not currently subject to a federal payment limit.[12] CMS cites a June 2025 Presidential Memorandum directing the Health and Human Services (HHS) Secretary to ensure Medicaid payment rates are not higher than Medicare, to the extent permitted by law, as additional authority for the expanded scope.[13]

For SDPs already in place before July 4, 2025, the rule proposes a phase-down commencing with the first rating period on or after January 1, 2028.[14] CMS proposes to reduce the total dollar amount of each grandfathered SDP by 10 percentage points of the original baseline per year, converging all such arrangements to Medicare levels within 10 years.[15] CMS considered but rejected an alternative methodology under which the applicable rate percentage would fall by 10 percentage points per year, noting that approach would not result in full convergence to Medicare limits until 2075 in some cases.[16]

The proposed rule also prohibits the "uniform increase" SDP structure outside of grandfathered programs going forward. Under this most widely used design, all contracted providers in a service category receive a flat percentage or dollar increase. Future SDP arrangements would instead be required to tie payment increases to specific performance metrics, financial data, or defined service lines.[17]

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Beyond the payment limits themselves, the proposed rule would impose extensive new monitoring, documentation, and compliance requirements on states and MCOs, including provider-level payment tracking, validation methodologies for value-based payment arrangements, and expanded CMS oversight authority.[18]

Industry Reaction

The hospital industry responded quickly and with measured but sharp opposition. The American Hospital Association (AHA) stated that the rule "raises important questions about how the statutory requirements will be implemented and the potential impact on providers' ability to rely on critical Medicaid payments," warning that changes to SDPs and health care-related taxes "will have very real consequences for access to care in communities across the nation."[19] The Federation of American Hospitals (FAH) called SDPs "a critical part" of the equation for sustaining hospital services, particularly in rural areas where hospitals are often the only source of care for miles.[20]

America's Essential Hospitals argued that the proposed rule "goes far beyond what Congress intended," asserting that it would cut SDPs by hundreds of billions of dollars beyond what the Congressional Budget Office projected and would "devastate essential hospitals' ability to provide high quality care to the patients and communities they serve."[21] The Association of American Medical Colleges (AAMC), whose member institutions provide nearly a third of all Medicaid inpatient care across the U.S., urged CMS to "withdraw the proposed provisions that go beyond the statutory framework" of OBBBA.[22]

Conclusion

The proposed rule represents the most consequential Medicaid payment rulemaking of the current administration. If finalized as proposed, it would fundamentally restructure how states supplement Medicaid payments to hospitals and other providers, extending Medicare-based payment limits well beyond what Congress addressed in OBBBA and phasing out the supplemental payment tools that many safety net hospitals rely upon to offset chronically low Medicaid base rates. Whether CMS narrows the rule in response to the industry's statutory authority challenges, or stands firm on its expansive reading of OBBBA and pre-existing regulatory power, will go a long way toward determining how fundamentally the Medicaid supplemental payment landscape shifts in the years ahead.

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6 *Ibid*.
7 Federal Register, Vol. 91, No. 99 (May 22, 2026), p. 30400.
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15 Federal Register, Vol. 91, No. 99 (May 22, 2026), p. 30400.
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LEADERSHIP

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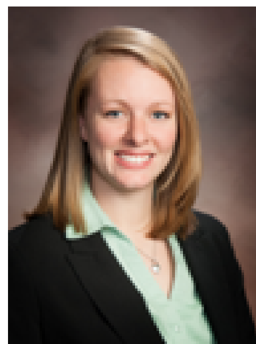

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