



Changes in Medicaid State Directed Payments

State directed payments (SDPs) are a tool that allows state Medicaid agencies to instruct managed care organizations (MCOs) to pay healthcare providers according to specific rates or methods, rather than leaving payment levels subject entirely to negotiation between plans and providers.

Rapid SDP growth raised oversight concerns, prompting the Centers for Medicare & Medicaid Services (CMS) to finalize several regulatory changes in its 2024 managed care rule:

- **Eliminating “separate payment terms”** effective July 2027, requiring all SDPs to be incorporated into base capitation rates so MCOs bear more financial risk
- **Prohibiting post-payment reconciliation** based on historical utilization, to ensure payments are tied to actual services delivered
- **Strengthening evaluation requirements**, including mandating at least two performance metrics and requiring states with large SDPs (exceeding 1.5% of total managed care costs) to submit evaluation reports every three years.

Recent CMS Guidance: OBBBA Implementation

The most significant changes to SDPs stem from Section 71116 of the One Big Beautiful Bill Act (OBBBA), enacted July 4, 2025. CMS issued preliminary guidance in September 2025—subsequently updated in February 2026—to begin implementing new federal payment limits. The guidelines address the following:

New payment caps: For rating periods beginning on or after July 4, 2025, SDPs for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers are capped at:

- 100% of Medicare rates in Medicaid expansion states
- 110% of Medicare rates in non-expansion states

This marks a major shift from the previous level of average commercial rates, which often reached 200%+ of Medicare.

Grandfathering: SDPs with completed preprints submitted before July 4, 2025 (May 1, 2025, for non-rural hospitals) may qualify for a temporary grandfather period, allowing them to continue at the average commercial rate ceiling. The February 2026 guidance expanded the eligibility window from 180 calendar days to 180 business days before or after the July 4 enactment date, making additional rating periods (including CY2024 and CY2026) eligible. Grandfathered SDPs cannot be increased and must begin phasing down for rating periods beginning on or after January 1, 2028.

Tightened preprint standards: Effective September 10, 2025, CMS will not accept a preprint as complete unless it includes minimum quality evaluation elements.

CMS acknowledged the September guidance is preliminary and formal rules will follow through notice-and-comment rulemaking. A proposed rule is expected to address the phase-down methodology and potentially extend new limits to additional service categories.