

Proposed Rule Implementing Medicaid Financing Limitations Under Section 71116

Insights

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The Centers for Medicare & Medicaid Services (“CMS”) proposed the most significant changes to Medicaid financing in several years, which, if finalized, could substantially reduce supplemental payments made to safety-net providers and other providers that depend on Medicaid reimbursement. On May 22, 2026, CMS published its [proposed rule on Medicaid Managed Care State Directed Payments \(“SDP”\) and Medicaid Fee for Service \(“FFS”\) Targeted Medicaid Practitioner Payments \(“Proposed Rule”\)](#). The Proposed Rule, if finalized, would restrict the use of SDPs and these targeted payments. Public comments on the Proposed Rule close on July 21, 2026.

Background

The Proposed Rule would implement section 71116 of H.R.1 (Pub. L. 119-21), the budget reconciliation bill that President Trump signed into law on July 4, 2025 (formerly known as the One Big Beautiful Bill Act, and referred to by CMS as the Working Families Tax Cuts legislation). Section 71116 limits the total payment rate for each SDP for four services: (1) inpatient hospital services, (2) outpatient hospital services, (3) nursing facility services, and (4) qualified practitioner services at academic medical centers. However, as discussed below, CMS proposes additional SDP limits beyond those set forth in section 71116 as well as limits on targeted Medicaid FFS payments. CMS states that these additional limits are intended to align the rulemaking with the June 6, 2025 Presidential Memorandum entitled *Eliminating Waste, Fraud, and Abuse in Medicaid*.

CMS frames its overarching goal in the Proposed Rule as addressing its concerns that states are utilizing Medicaid financing mechanisms like SDPs and targeted FFS payments in ways that could obscure fraud, waste, and abuse and threaten Medicaid’s overall financial solvency. CMS particularly highlighted its concern with providers—instead of states—funding the non-federal share of Medicaid payments through provider taxes and intergovernmental transfers (“IGTs”). This framing, however, is in tension with the wide use of these Medicaid financing mechanisms, which allow states to maintain the stability of their Medicaid programs—one of the largest categories of general fund spending in state budgets—despite fluctuations in state general funds. Moreover, the Proposed Rule does not identify any evidence of fraudulent activities that are enabled by these financing mechanisms.

SDPs

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SDPs allow states to direct specific payments to providers through Medicaid managed care plans to implement initiatives designed to improve access and quality of care for Medicaid beneficiaries. Since 2024, the total payment rate for each SDP has generally been limited to 100 percent of the average commercial rate.

Payment Limits on SDPs

The Proposed Rule would implement the cap on the total payment rate for each SDP at 100 percent of the “specified total published Medicare payment rate” in states that expanded Medicaid and 110 percent of this rate in non-expansion states and establishes a deadline of the first rating period on or after January 1, 2029. Where no Medicare rate is available, states are directed to use the Medicaid state plan base rate.

In the Proposed Rule, CMS would extend the payment limit to all services covered by SDPs and all SDPs that are not otherwise grandfathered—not just SDPs for the four services specified in section 71116 and not just SDPs that require prior written approval from CMS. The Proposed Rule also would extend the payment limit to SDPs in U.S. territories in addition to all states and D.C. The Proposed Rule’s application of the payment limit to services beyond the four specified in section 71116 means that some services, like home and community based services, will be capped at the Medicaid rate, effectively wiping out any enhanced payment for these services through SDPs.

Importantly, the specified total published Medicare payment rate would be calculated at a service or discharge specific level, as opposed to an aggregate level using an upper payment limit-like approach. So, for example, inpatient discharges would be calculated based on the Medicare diagnostic related group rate including, but not limited to, payment adjustments such as the area wage index and quality adjustments—however, the Proposed Rule is silent as to others like disproportionate share hospital payments.

CMS further proposed that providers reimbursed on a cost-based methodology, like critical access hospitals, certain cancer hospitals, and freestanding children’s hospitals, submit their most recent and complete Medicare cost report to serve as the basis for the applicable payment limit. CMS noted that it considered alternative methodologies for providers reimbursed on a cost-basis, including to apply the State plan approved rate or the published Medicare payment rate. CMS declined to propose either of those options because they are lower than cost-based payments, but CMS specifically requested comments on this issue.

Grandfathering of Certain SDPs

Section 71116 also established a grandfathering period to phase down the total amount of certain SDPs over time, beginning with the first rating period on or after January 1, 2028. Grandfathered SDPs are those that exceed the payment limit, and meet these three criteria:

1. The SDP requires written prior approval and is for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center.
2. The SDP is for a rating period that includes any business days between October 11, 2024, through July 3, 2025, or between July 5, 2025, and March 27, 2026. These periods are 180 business days before or after the date section 71116 was enacted on July 4, 2025.
3. The state submitted a completed preprint for the SDP to CMS before July 4, 2025. The preprint must include an eligible rating period and documented total dollar amount. CMS also describes certain “statuses” that could qualify, including where written prior approval was made (or a good faith effort to receive approval was made) for SDPs other than for rural hospitals before May 1, 2025, and for rural hospital SDPs before July 4, 2025.

For grandfathered SDPs, the total payment for each SDP would be initially limited to the grandfathered total dollar amount, and this limit would decrease by 10 percentage points each year until the limit reaches either 100 or 110 percent of the specified total published Medicare payment rate, as applicable. The Proposed Rule does not specify how the 10-percentage point reduction would interact with the proposal to apply the specified total Medicare payment rate limit on a service-by-

service basis, raising questions about how calculations would be made in practice. Under this proposal, phase down time will vary for SDPs depending on how far above the limit the SDP started.

CMS specifically flagged that its proposed temporary grandfathering framework would allow states to transition away from uniform increase SDPs, noting its concern that states typically fund these types of SDPs with IGTs or provider taxes.

Targeted Practitioner/Provider Payment Limits

The Proposed Rule would also cap the total Medicaid FFS payment rate (including base and supplemental payments) for practitioners and providers receiving targeted payments at the same caps established for SDPs—100 percent of Medicare rates in Medicaid expansion states and 110 percent of Medicare rates in non-expansion states, where a reasonable Medicare-equivalent payment rate exists. Payments are considered targeted when they are directed to a subset of providers otherwise furnishing the same service. For example, a targeted payment would include an add-on payment available to public, but not private, providers of ground emergency medical transportation services. Under the Proposed Rule, the cap would be applied as a provider-specific limit, as opposed to an aggregate upper payment limit. The Proposed Rule would require compliance with the caps by the start of the first State fiscal year that begins on or after January 1, 2029.

Impact

If finalized, the Proposed Rule would overall reduce Medicaid payments to a broad range of health care providers that rely on this funding, amplified by other Medicaid reductions in section 71116 and expected in upcoming CMS rulemaking on provider taxes. CMS predicts that the Proposed Rule would cut Medicaid spending by about \$775 billion over 10 years—a figure that is over five times larger than the savings estimated by the Congressional Budget Office based on the as-enacted language in section 71116. CMS acknowledged that hospitals would bear the brunt of these reductions, and also recognized that nursing facilities, physicians, academic medical centers, and emergency medical transportation providers would be subject to reimbursement reductions. Impacts could be seen more broadly, including at health systems and counties that rely on Medicaid supplemental payments to support their operations.

Moreover, CMS specifically highlighted its position that payments exceeding the limits imposed would be overpayments subject to the 60-day report and return requirements under section 1128J(d) of the Social Security Act.

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