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Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee For-Service Targeted Medicaid Practitioner Payments [CMS-2449-P]
Summary of Proposed Rule

On May 22, 2026, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS), published in the Federal Register (91 FR 30400) the proposed rule entitled "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee For-Service Targeted Medicaid Practitioner Payments." The proposed rule includes proposals to implement the provisions of section 71116 of Public Law 119-21 (referred to as the "Working Families Tax Cut" legislation (WFTC)), which modify the limit on the total payment rate and other requirements for State directed payments (SDPs) in Medicaid managed care with respect to certain service types and SDPs. The proposal rule also includes proposals to expand application of the modified limit to all SDPs and all service types and to set a limit for certain targeted Medicaid payments in Medicaid fee-for-service (FFS).

Comments on the proposed rule are due by July 21, 2026.

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I. Background

The Medicaid program[1] is a Federal-State partnership under which Federal Medicaid funds are provided to States to carry out Medicaid programs, in accordance with an approved State plan, to provide medical assistance to individuals with limited income and resources. The dollar amount of the Federal share of Medicaid expenditures is called Federal Financial Participation (FFP). States may raise their "non-Federal share" in various ways, including through health care-related taxes—that is, taxing health care items or services, or the providers of those items and services.

[1] The Medicaid program is established under title XIX of the Social Security Act (in this summary referred to as the "Act").

Depending on the State and its Medicaid[2] program, Medicaid services are available through fee-for-service (FFS) or managed care delivery systems. States have great flexibility in designing their Medicaid programs but must comply with Federal statutory and regulatory requirements.

The June 6, 2025, Presidential Memorandum titled "Eliminating Waste, Fraud, and Abuse in Medicaid"[3] ("the Presidential Memorandum") directed the Secretary of Health and Human Services (the Secretary) to eliminate fraud, waste, and abuse under Medicaid, including by ensuring payment rates are not higher than those under Medicare. The memo noted (among other concerns) the growth in State directed payments (SDPs).

Public Law 119-21 (referred to as the "Working Families Tax Cut" legislation (WFTC)) was enacted on July 4, 2025. Section 71116(a) of the WFTC directs the Secretary to revise regulations[4] to, effective with the first rating period beginning on or after July 4, 2025, limit the total payment rate for certain SDPs for inpatient hospital services, outpatient hospital services, nursing facility services, or qualitied practitioner services at an academic medical center (AMC) (referred to in the rule and this summary as the "four services"). Section 71116(b) of the WFTC provides for a temporary grandfathering period for certain SDPs, with a phase down beginning with the first rating period beginning on or after January 1, 2028.

CMS issued preliminary guidance on February 2, 2026, on the agency's interpretation of section 71116 of the WFTC. The guidance signaled the agency was considering proposing changes to the limit for the total payment rate for SDPs for services beyond the four services specified in section 71116 of the WFTC.

A. Medicaid Managed Care Delivery Systems

States may implement a voluntary managed care program under section 1915(a) of the Act. States may also use several Federal statutory authorities to implement Medicaid managed care programs under which beneficiaries are required to enroll in order to access Medicaid benefits. These authorities (other than section 1915(a)) allow the States to bypass traditional FFS rules, such as statewideness, comparability of services, and freedom of choice. These authorities include:

- State plan amendments (SPA) – States can implement a mandatory managed care delivery system through an SPA, which must meet standards under section 1932(a) of the Act and be approved by CMS. This authority does not allow States to require beneficiaries who are dually eligible for Medicare and Medicaid (dually eligible beneficiaries), American Indians/Alaska Natives (except as permitted in section 1932(a)(2)(C) of the Act), or children with special health care needs to enroll in an applicable managed care program. State plans remain in effect until modified by the State, with CMS approval.
- Section 1915(b) waivers – Under this authority States can require all Medicaid beneficiaries to enroll in a managed care delivery system. After CMS approval, a State

[2] CMS clarifies that in the rule, all references to Medicaid refer to States' programs operated under title XIX of the Act, including those that cover Medicaid expansion CHIP populations, but do not include separate CHIP programs.
[3] https://www.whitehouse.gov/presidential-actions/2025/06/eliminating-waste-fraud-and-abuse-in-medicaid/.
[4] 42 CFR 438.6(c)(2)(iii).

may operate a section 1915(b) waiver for a 2-year period before requesting renewal for an additional 2-year period. If a 1915(b) waiver includes individuals who are dually eligible for Medicare and Medicaid, the waiver may be approved for an initial 5-year period and renewed for additional 5-year period.

- Section 1115 demonstrations – States may require all Medicaid beneficiaries to enroll in a managed care delivery system through a section 1115(a) wavier. States may provide services under these waivers that are not typically covered under Medicaid.

B. Relevant Medicaid Managed Care Rules

CMS reviews several of its rules related to Medicaid managed care. One of such rules is the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" final rule (2024 final rule), which (among other policies) addressed impermissible redistribution arrangements related to SDPs and codified, for certain types of SDPs, a limit to the total payment rate (total payment rate limit) at the average commercial rate (ACR).

C. History of State Directed Payments

Contracts between States and managed care organizations (MCOs) must provide for payments under a risk-based contract for services and associated administrative costs to be actuarially sound.[5] Prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs) are also required to satisfy the actuarially sound capitation rates criterion.[6] In risk-based managed care programs, managed care plans[7] manage the financial risk of the contract. The plans negotiate provider payment rates with their network providers, in accordance with Federal requirements and State contract requirements.

Generally, States are not allowed to direct the expenditures of a Medicaid managed care plan under the contract between the State and the plan or to make payments to providers for services covered under the contract. There are specific exceptions under §438.6(c)(1)(i) through (iii) to this general prohibition, which have become known as SDPs. These regulatory exceptions (i.e., permissible SDPs) must be included in the applicable managed care contract and specify how and when the State involved may direct expenditures of their Medicaid managed care plans. Permissible SDPs include, for example, certain fee schedule requirements for provider payments. Most SDPs must be approved in writing by CMS before implementation, and to obtain that approval States must submit to CMS a "preprint" that documents how the SDP complies with Federal requirements under §438.6(c). Most preprints are submitted for renewal on an annual basis. CMS states it aims to complete the review of these submissions within 90 days, but there are no regulatory requirements delineating when the agency must complete the review.

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[5] Section 1903(m)(2)(A)(iii) of the Act.

[6] See §438.4 through §438.7 of title 42, Code of Federal Regulations (CFR). In this summary references to a regulatory section are to the section in title 42, CFR, unless specified otherwise.

[7] In the rule, and this summary, the term "managed care plan" includes MCOs, PIHPs, and PAHPs.

D. Historical SDP Payment Rate Limits

As part of the preprint review process, States must demonstrate that SDPs result in provider payment rates that are reasonable, appropriate, and attainable.[8] Medicare payment rates are currently used as a benchmark in Medicaid FFS. For example, the upper payment limits (UPLs), which apply to certain classes of institutional providers (such as hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID)) are based on a reasonable estimate of the payment rate that Medicare would pay.

Since 2018, CMS has interpreted §438.6(c)(2)(i) to allow total payment rates in an SDP up to the ACR paid health care practitioners and providers and required that States demonstrate that total payment rates under the SDP would not exceed the ACR.[9] CMS describes concerns, with the growth of SDPs, about States' reliance on provider taxes and local government funds used for intergovernmental transfers (IGTs) that shift responsibility for Medicaid payments away from States. In response to these concerns, the 2024 final rule codified that each SDP must ensure that the total payment rate for each service, and each provider class included in the SDP must be reasonable, appropriate, and attainable and, upon request from CMS, the State must provide documentation demonstrating the total payment rate for each service and provider class.[10] The 2024 final rule also finalized a limit of 100 percent of the ACR for the total payment rate for each SDP for the four services.

E. Fee-For-Service Supplemental Payments

A State that operates its Medicaid program through a FFS delivery system establishes a State plan that includes a description of the payments the State will make to Medicaid providers, which is generally comprised of base and supplemental payments. Base payments are typically standard payment amounts paid to Medicaid providers on a per claim basis for specific services furnished to Medicaid beneficiaries. Supplemental payments are payments for providers that are in addition to the base payment.[11]

Sometimes States make FFS supplemental payments under their Medicaid State plan that are targeted to certain health care providers (for example, ground emergency medical transportation (GEMT) providers, air emergency transportation providers, and non-emergency medical transportation (NEMT)). States often have targeted supplemental payments to State or non-State government owned or operated entities that fund the non-Federal share of the supplemental payment with an IGT. States have used an ACR calculation to establish an upper limit for these supplemental payments. As with all FFS payments made under a State plan, ACR-based supplemental payments must be consistent with efficiency, economy, and quality of care, and sufficient to enlist enough providers.[12]

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[8] *https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf*.

[9] This proposed rule does not propose any changes pertaining to Medicaid Disproportionate Share Hospital (DSH) payments, but CMS notes the interaction between SDPs and Medicaid DSH. Specifically, SDPs paid to a hospital for inpatient or outpatient services, when made in accordance with §438.6(c), are considered payments for Medicaid services and therefore are offset from costs when a State calculates the hospital-specific DSH limit.

[10] 42 CFR 438.6(c)(2)(ii)(I).

[11] See 1903(bb)(2) of the Act.

[12] Section 1902(a)(30)(A) of the Act.

When States propose to utilize an ACR methodology (payment up to the ACR or Medicare equivalent of the ACR) to target payments to physicians or other practitioners, States submit data to CMS from each practitioner's top (generally five) commercial payers and provide an explanation of the data that was extracted from the practitioners' accounts receivable systems. The State compares the Medicaid payment for each billing code directly to either: (1) the average payment amount allowed by commercial payers for the same services, or (2) the Medicare equivalent of the commercial payers' average payment amount for the same services.

II. Provisions of the Proposed Regulations

A. State Directed Payments in Medicaid Managed Care (§438.6)

CMS describes its updated estimates of SDP spending from the projections in the 2024 final rule, which project SDP spending to increase to $97.8 billion in FY 2024 and $246 billion in FY 2034 under current SDP regulatory requirements. CMS believes the increase suggests States are relying on SDPs as a way to increase Federal funding, including through IGTs and provider taxes, without appropriate State funding contributions toward the non-Federal share. CMS describes that SDPs that result in total provider payment rates up to the ACR are frequently funded by provider taxes and IGTs from local government sources or State university teaching hospitals and generally include only providers that have the ability to fund the non-Federal share of the ACR payments. IGTs and health care-related taxes can be permissible methods to generate the non-Federal share to finance Medicaid programs. However, since the State often collects money to fund the non-Federal side for SDPs from the same sources that then receive the funds, this results in higher provider payment rates than they would have received and increases the amount of the Federal share. CMS believes these arrangements therefore call for greater scrutiny to ensure fiscal integrity.

1. <u>Payment Limit for SDPs (§438.6(a), 438.6(c)(2)(ii)(I) and 438.6(c)(8))</u>

The proposed limits to Medicaid managed care expenditures described in this section would apply only when providers receive payments through SDPs. Medicaid managed care plans may otherwise continue to negotiate provider payment rates that exceed the proposed limit when needed to ensure a sufficient provider network.

a. Regulatory Revisions Required by WFTC Legislation

CMS' initial proposals in the rule are to implement the provisions of section 71116 of the WFTC, which require CMS to reduce the total payment rate limit for certain SDPs for the four services (inpatient hospital services, outpatient hospital services, nursing facility services, and qualitied practitioner services at an AMC) and include a grandfathering period for certain SDPs until the rating period beginning on or after January 1, 2028, at which time those temporarily grandfathered SDPs would gradually transition down to the new payment limit.

Specifically, section 71116 directs the Secretary to revise §438.6(c)(2)(iii) such that the total payment rate for any of the four services does not exceed (i) in the case of an expansion State,

100 percent of the specified total published Medicare payment rate (or payment rate under a Medicaid State plan (or waiver) if the Medicare payment rate is not available) or (ii) in the case of a non-expansion State, 110 percent of the specified total published Medicare payment rate (or Medicaid rate if the Medicare rate is not available). The new payment limit is to apply to services furnished during a rating period beginning on or after July 4, 2025, unless the SDP is eligible for the temporary grandfathering period. The statutory payment rate limit is applicable for all 50 States and DC, but does not apply to the territories. A temporary grandfathering provision under section 71116(b) provides that for certain SDPs for which written prior approval (or a good faith effort to receive such approval) was made before May 1, 2025, or before July 4, 2025, as applicable, the revised total payment limit would be incrementally phased-in beginning with rating periods beginning on or after January 1, 2028. During that phase-in period, the total amount of the SDP would be reduced by 10 percentage points each year until the payment rate is equal to the revised total payment rate limit. CMS proposes to codify these statutorily-directed revisions in §438.6(a) and (c).

b. Regulatory Revisions for Other SDPs, Services, and Territories

CMS proposes to extend the provisions and payment limits it is proposing to codify for implementing section 71116 of the WFTC to apply to all SDPs, all services, and in all States, D.C., and the territories. The agency is interpreting sections 1902(a)(4) and 1903(m)(2)(A)(iii) of the Act to provide it with authority to do so.

Definitions.

Specified total published Medicare payment rate. The term "specified total published Medicare payment rate" is used in section 71116(a) of the WFTC. CMS interprets this term to reference the existing regulatory term "total published Medicare payment rate" and its definition in §438.6(a), which means amounts calculated as payment for specific services that have been developed under Parts A and B of title XVIII of the Act and refers to the exact total published Medicare payment rate for a specific service furnished to a Medicaid managed care enrollee.

State plan approved rates. Under section 71116 of the WFTC, for each of the four service types, if a total published Medicare payment rate for a Medicaid covered service is not available, then the payment is limited to the payment rate under the Medicaid State plan (or waiver). CMS is interpreting this to reference the existing definition of "State plan approved rates" under §438.6(a), which CMS has interpreted to include rates that are approved through a waiver of the State plan. State plan approved rates do not include supplemental payments.[13]

CMS proposes to revise the regulatory definition of the term "State plan approved rates" as follows (the italicized language shows the proposed additions): "State plan approved rates means amounts calculated for specific services identifiable as having been provided to an individual beneficiary described under ~~CMS approved~~ rate methodologies in the Medicaid State plan *approved by CMS before the start of the rating period*. Supplemental payments contained in a State plan are not, and do not constitute, State plan approved rates."

[13] Under §438.6(a) supplemental payments are defined as amounts paid in addition to State plan approved rates.

States are currently permitted to submit SPAs at any time during a State fiscal quarter, which can be approved by CMS with an effective date retroactive to the start of the quarter. For Medicaid FFS, the State may (i) make payments under a submitted SPA before approval (and risk disallowance of the related FFP if the SPA is not approved) or (ii) once the SPA is approved, make retroactive payment to FFS providers to account for the difference in payment for services rendered when the SPA was retroactively in effect. In contrast, under Medicaid managed care, if a State directs their plans to pay providers a minimum fee schedule SDP using State plan approved rates, the State's actuaries develop the capitation rates based on the State plan approved rates in effect for the rating period. If a SPA is not approved before the start of the rating period and the State wants to direct plans to implement the updated payment rates through an SDP retroactive to the effective date of the approved SPA, the State must submit contract amendments and rate certifications to effectuate the changes. CMS believes requiring States to use the State plan rates approved before the start of the rating period would be consistent with prospective rate-setting processes and would add stability and predictability to SDPs.

Expansion and non-Expansion States. Section 71116(a)(1) of the WFTC requires, for SDPs that require written prior approval and include any of the four specified service types, different SDP payment limits depending on whether or not the State has implemented Medicaid expansion. Therefore, CMS proposes to add the terms "Expansion State" and "Non-Expansion State" to §438.6(a). The term Expansion State would be defined as a State that provides medical assistance to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act under a State plan under title XIX of such Act or under a waiver of such plan that provides minimum essential coverage as defined in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986. A Non-Expansion State would mean any State that is not an Expansion State.

State. Section 71116(d)(3) of the WFTC specifically defines the term "State" to mean the 50 States and DC and to exclude territories. Federal statute defines the term in this way when the underlying rule is not intended by Congress to apply to the territories. However, CMS notes that the agency has not historically differentiated between the 50 States, DC, or territories with respect to its regulatory requirements for SDPs and therefore believes it should apply the section 71116 payment limit to the territories in addition to the 50 States and DC. Therefore, for the limited scope of §438.6(c)(8)(ii) and only until the first rating period beginning on or after January 1, 2029, CMS proposes to include a definition for the term "State" that would mean the single State agency of one of the 50 States or DC. For all other purposes and for all other rating periods, the term would be defined to also include territories. This would have the effect of applying the payment limit on SDPs to the territories beginning with the first rating period on or after January 1, 2029.

Payment limit. CMS proposes to add the term payment limit to §438.6(a) and would define the term as 100 percent of the total published Medicare payment rate for an Expansion State, 110 percent of the total published Medicare payment rate for a Non-Expansion State, and 100 percent of the State plan approved rate when there is no total published Medicare payment rate for the covered service.[14] The application of this definition would mean that the Medicare payment limit

[14] The statute is potentially ambiguous as to whether, for non-Expansion States, the "110 percent" is to apply to the Medicaid payment rate if no total published Medicare payment rate is available (similar to how it applies to the reference to the Medicare rate). The statute says "…(1) in the case of a State that provides coverage to all

would differ for Expansion and Non-Expansion States for SDPs that include any of the four services and require written prior approval. In the absence of a total published Medicare payment rate, the payment limit would be the payment rate under the Medicaid State plan (or waiver). CMS is interpreting section 71116 to require in such a case the exact Medicaid rate for both Expansion and non-Expansion States.

CMS proposes to apply the payment limit to each service included under an SDP. The payment limit would be calculated at a service or discharge specific level (not at an aggregate level), whether at the HCPCS code level or MS-DRGs.

CMS describes how for Medicaid managed care actuarially sound capitation rates are determined prospectively and, beginning with rating periods starting on or after July 9, 2026, States must submit SDP preprints to CMS prospectively.[15] The majority of Medicare services are based on prospectively published payment rates. Some Medicare providers (such as critical access hospitals, certain cancer hospitals, and freestanding children's hospitals) are paid using a cost-based payment methodology, which are not published or subject to public comment, but use retrospective cost reports. CMS believes that the prospective nature of risk-based managed care makes it difficult to use a per service SDP payment limit for a provider that is tied to a retrospective cost report.

CMS believes it is appropriate to consider the cost-based payment approach as the total published Medicare payment rate for the SDP payment limit for providers paid under a cost-based methodology in Medicare, but the agency would need to publish specific instructions on allowable cost-reporting and cost allocation methodologies specific to Medicaid managed care. CMS proposes to use the most recent and complete Medicare cost report to establish the prospective SDP payment limit on a per service or discharge basis.

Alternatively, CMS considered revising the definition of total published Medicare payment rate to exclude cost-based Medicare reimbursement methodologies. Under this alternative, the payment limit for providers paid by Medicare on a cost basis would fall under the State plan approved rate. Another alternative the agency considered was requiring the State to use only total published Medicare payment rates that undergo rulemaking, including for providers reimbursed by Medicare on a cost basis. This means the State would need to use the equivalent total published Medicare payment rate for cost-based providers. However, CMS is not proposing either alternative option because it believes that often the Medicare payment rate or State plan approved rate is significantly lower than payment under a cost-based methodology. CMS specifically requests comment on the proposal and alternatives.

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individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) that is equivalent to minimum essential coverage (as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and determined in accordance with standards prescribed by the Secretary in regulations) under the State plan (or waiver of such plan) of such State under title XIX of such Act, 100 percent of the specified total published Medicare payment rate (or, in the absence of a specified total published Medicare payment rate, the payment rate under a Medicaid State plan (or under a waiver of such plan)); or (2) in the case of a State other than a State described in paragraph (1), 110 percent of the specified total published Medicare payment rate (or, in the absence of a specified total published Medicare payment rate, the payment rate under a Medicaid State plan (or under a waiver of such plan))."

[15] Section 438.6(c)(2)(viii).

When a total published Medicare payment rate is not available for a Medicaid covered service included in an SDP, CMS proposes to define the payment limit for each service under the SDP as 100 percent of the State plan approved rate. The WFTC requires specifically for the four service types and for the 50 States and DC that the Medicaid payment rate is used when a published Medicare payment rate is not available. CMS is proposing to expand application of this rule and require for *all* services covered under SDPs and for *all* States, including DC and the territories, when a total published Medicare payment rate is not available for the service, the State plan approved rate that has undergone the SPA review process or that has been reviewed and approved by CMS as part of a section 1115 demonstration waiver or State plan waiver is used as the payment limit.

Payment Limits. CMS reviews the specific revisions to its regulatory language under §438.6 it is proposing. These revisions include:

- Revisions to maintain the current rules applicable to SDPs that do not require written approval until the proposed application date for the additional limits proposed for §438.6(c)(8)(iii) (discussed below).
- Revisions to §438.6(c)(8)(ii) that would apply the payment limits under section 71116 of the WFTC to SDPs for the four services that require written prior approval. Specifically, any SDP that requires written prior approval for one or more of the four services and that does not meet the definition of a grandfathered SDP would be subject to the payment limit (defined as discussed above) beginning with the first rating period beginning on or after July 4, 2025.
- A proposed new §438.6(c)(8)(iii) that would expand application of the payment limit (defined as discussed above) to *all* services covered under SDPs; to *all* SDPs (not just those that require written prior approval), and to the 50 States, DC, *and the territories*. CMS believes consistent application for all services within SDPs would help ensure States do not cost shift by increasing payments to providers for services other than the four services statutorily subject to the new limit. This expanded application (i.e., to services other than the four services, to SDPs other than those that require written prior approval, and to the territories) would be effective with the first rating period beginning on or after January 1, 2029.

CMS justifies its proposal to expand the application of the section 71116 requirements by pointing to sections 1903(m)(2)(A)(iii) and 1902(a)(4) of the Act. Section 1903(m)(2)(A)(iii) requires contracts between States and MCOs to provide prospective payment under a risk-based contract for services and associated administrative costs that are actuarially sound. The agency cites the State plan requirement under section 1902(a)(4) as providing authority to establish methods of administration for Medicaid that are necessary for the proper and efficient operation of the State plan.

Payment Limit Monitoring and Compliance. CMS proposes, for purposes of assessing and monitoring State compliance with the new payment limit, to require States to submit to CMS:

- A list of all providers eligible for the SDP and their national provider identifiers (NPIs).

- The total published Medicare payment rate or (when no such Medicare rate exists for the covered service) the State plan approved rate that is the basis of the payment limit for each service covered under the SDP.
- A detailed description of how the State will ensure the payment to each provider for each furnished service does not exceed the payment limit.
- For States implementing value-based purchasing (VBP) SDPs: a detailed validation methodology to ensure payments from the SDPs do not exceed the payment limit on a per service basis.
  - CMS seeks comment on an alternative approach for VBP SDPs that would require the State to work with its actuaries to develop the population or condition-based SDP using actuarial principles and have the actuary certify the provider payment under the SDP was developed in a way that payment to providers would not exceed the permissible applicable payment limit based on the services under the SDP.
  - CMS also requests ideas to operationalize alternative value-based arrangements in Medicaid.
- Any additional documentation that CMS requests.

CMS proposes these requirements would also apply for documentation from States with SDPs that do not require submission of a preprint for written prior approval to align with the proposed requirement to apply the payment limit to all SDPs beginning with the first rating period beginning on or after January 1, 2029.

CMS reminds States that payments to providers that exceed the applicable payment limit would be overpayments. Contracts with managed care plans must specify policies for reporting, documenting, and recovery of overpayments. States must reimburse CMS the amount equal to the Federal share of overpayments.[16]

CMS also proposes to issue guidance, as needed, on topics related to SDPs, including Federal requirements and standards for the SDP, documentation required to determine that the SDP has been developed in accordance with the requirements of §438.6(c), considerations for applicability of the payment limit, the documentation required to demonstrate compliance with the payment limit, updates or developments in the SDP review process to facilitate prompt CMS review, and any considerations for State monitoring, oversight, and evaluation of the SDP.

State Expansion Status. Section 71116(c) of the WFTC states that if a non-Expansion State begins providing expansion coverage on or after July 4, 2025, the State then becomes subject to the SDP payment limits that apply to Expansion States beginning with services furnished during the first rating period beginning on or after July 4, 2025. CMS interprets that, because section 71116(c) ties the applicability of the payment limit to the rating period in which the service is furnished, the payment limit for an Expansion State would apply beginning with the first rating period that begins on or after the date the State begins providing expansion coverage.

[16] See section 1903(d)(2) of the Act and §433.312.

In addition, even though the statute does not provide that an Expansion State that becomes a non-Expansion State would then be subject to the payment limit for non-Expansion States, CMS believes that is how the policy should be implemented and enforced. CMS does not propose specific regulatory text to address this policy, but believes its proposals to define and implement the payment limit provide it with the ability to enforce this interpretation.

2. Grandfathered SDPs (§438.6(a) and (c)(2)(iii))

Section 71116(b) of the WFTC (referred to as the "grandfathering provision") permits delayed compliance with the payment limit for certain SDPs (referred to as "grandfathered SDPs"). For a temporary period (referred to as the "temporary grandfathering period"), grandfathered SDPs are not subject to the new payment limit required under section 71116(a) of the WFTC. After this period, section 71116(b) provides that the total amount of a grandfathered SDP must be phased-down to the new payment limit.

a. Definition of Grandfathered SDP

CMS proposes that a grandfathered SDP must satisfy the following criteria:

Criterion 1. The SDP requires written prior approval and is for any of the four services (inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an AMC).

- The WFTC specifies the SDP must be described in §438.6(c)(2)(iii), which is limited to SDPs that require written prior approval and are for the four services.

Criterion 2. The SDP is for an "eligible rating period" – meaning a rating period[17] that includes at least 1 business day between October 11, 2024 and July 3, 2025, or between July 5, 2025 and March 27, 2026.

- The WFTC requires the SDP to be for a rating period occurring within 180 days of the date of enactment of the WFTC (which was July 4, 2025).
    - CMS interprets "180 days" to refer to "180 business days".
    - CMS interprets "occurring within" to encompass rating periods that begin within 180 business days occurring before or occurring after the effective date of the WFTC. This would mean the grandfathering provision would apply to eligible SDPs in rating periods that include any business days between October 11, 2024 through July 3, 2025, or between July 5, 2025 and March 27, 2026.
    - The resulting eligible rating periods would include rating periods for CY 2024, State fiscal year (SFY) 2025, CY 2025, SFY 2026, and CY 2026. Rating periods that do not include any business days within those timeframes (such as SFY 2027) would not qualify.

[17] A rating period is defined in §438.2 as a period of 12 months selected by the State for which actuarially sound capitation rates are developed and documented in the rate certification submitted under §438.7(a) – resulting in States using different rating periods.

Criterion 3. A completed preprint with an eligible rating period and documented total dollar amount (as specified in item 4 of the current SDP preprint) was submitted for the SDP to CMS before July 4, 2025.

- The WFTC requires the SDP to satisfy one of the following statuses:
    - Status 1: For SDPs other than for rural hospitals – written prior approval (or a good faith effort to receive approval) was made before May 1, 2025.
    - Status 2: For SDPs other than for rural hospitals – a good faith effort to receive approval was made before May 1, 2025.
    - Status 3: For SDPs for rural hospitals – written prior approval was made before July 4, 2025.
    - Status 4: For SDPs for rural hospitals – a good faith effort to receive approval was made before July 4, 2025.
    - Status 5: A completed preprint for the SDP was submitted before July 4, 2025.
- Rural hospital is defined in section 71116(d)(2) of the WFTC.
- Written prior approval (per section 71116(d)) incorporates the meaning of such term as used in §438.6(c)(2)(i).
- The term "completed preprint" is not defined in section 71116 of the WFTC or existing regulation. CMS proposes to define this term as used in §438.6(a) to mean an SDP preprint with all relevant sections of the preprint filled out, and all information provided only in the fillable sections of the preprint and published addendum tables, as applicable. Further, CMS proposes an explicit requirement in §438.6(c)(2)(i) that preprints be submitted for all SDPs that require written prior approval.
- The term "good faith effort" is not defined in section 71116 or existing regulation. CMS is interpreting the term to mean submission of a completed preprint because it believes submission of a preprint is the only objective action that initiates its review.
- However, CMS views that status 5 already covers all SDPs that would otherwise be eligible under statuses 1 through 4. Therefore, rather than repeat all 5 statuses, the agency proposes that an SDP would satisfy the third criterion if a completed preprint was submitted before July 4, 2025.

States would not be permitted to revise a preprint submission after July 4, 2025 to change the rating period or to increase the total dollar amount of a grandfathered SDP.

CMS also proposes the grandfathering provisions apply only when an SDP exceeds the new payment limit. What this means is that beginning with the first rating period for which a grandfathered SDP meets the payment limit, the SDP would no longer be considered grandfathered and would be subject to all requirements to which non-grandfathered SDPs are subject.

b. Temporary Grandfathering Period

Grandfathered SDPs are eligible for a temporary grandfathering period after which they are subject to a phase down of the total amount of the SDP to the new payment limit. The phase down begins with the first rating period on or after January 1, 2028.

CMS interprets the "total amount" of the SDP specified in section 71116(b) of the WFTC to refer to the total amount of the SDP approved for the rating period for which the SDP qualified for grandfathered SDP status (for example, SFY 2025, CY 2025, CY 2026 or SFY 2026). For SDPs that require written prior approval, States are required to submit an SDP for written prior approval using the current CMS issued preprint. Item 4 of the current SDP preprint captures the State's estimated total dollar amount associated with the SDP.

CMS proposes to use the total dollar amount specified in item 4 of the approved preprint of a grandfathered SDP as the maximum amount of expenditures that would be allowed for the SDP during the temporary grandfathering period before the phase down begins. CMS proposes to define the term "grandfathered total dollar amount" to mean the total dollar amount approved by the agency for a grandfathered SDP. When preprint submissions of the same SDP for different rating periods each meet the definition of a grandfathered SDP, the highest approved total dollar amount would be the maximum grandfathered total dollar amount.

A separate payment term under an SDP is a contractual arrangement where the State has a pre-determined pool of funding, which the State pays separately to plans to disburse to providers. Section 438.6(c)(6) prohibits separate payment terms. CMS proposes to permit a State to delay compliance with the separate payment term prohibition (i.e., a temporary exemption to the prohibition) in §438.6(c)(6) and the preprint timing submission requirements in §438.6(c)(2)(viii) for a grandfathered SDP until the first rating period in which the new payment limit is met. With the first rating period that the payment limit is met (as demonstrated by the total payment rate comparison in Table 2 of the preprint submission), the State would be required to incorporate the SDP as an adjustment to the capitation rates, submit the preprint prospectively (if applicable) and, if the SDP is for a rating period that starts on or after January 1, 2028, the State would be required to comply with the permissible types of SDPs (that is, minimum fee schedule, maximum fee schedule or value-based payment arrangement).

CMS is considering and seeking comment on whether to define "separate payment term" as a pre-determined and finite funding pool that the State establishes and documents in the Medicaid managed care contract for a specific SDP. CMS also seeks comment on whether it would be beneficial to propose a regulatory revision that the separate payment term could not exceed the total dollar amount in the written prior approval for each SDP.

In addition, CMS proposes to specify in §438.6(c)(2)(iii)(A) that renewals of or amendments to a grandfathered SDP must not exceed the grandfathered total dollar amount for each rating period beginning on or after July 4, 2025 but before January 1, 2028. The limits on the total amount and phase down applicable to a grandfathered SDP would not be able to exceed the ACR. CMS proposes to monitor for a limited period how the total payment rate under a grandfathered SDP would compare to the ACR. Specifically, the State would continue to provide an ACR demonstration and total payment rate comparison using ACR for a grandfathered SDP until the first rating period beginning on or after January 1, 2029. The agency requests comment on whether the ACR monitoring requirement should apply for one year or for more years (up to 10 years) to ensure appropriate oversight.

c. Phase Down of Grandfathered SDPs

Beginning with the first rating period on or after January 1, 2028, for grandfathered SDPs, the grandfathered total dollar amount would be reduced by 10 percentage points each year until the total amount of the SDP is equal to the new allowable payment limit. CMS interprets the instruction in section 71116(b) of the WFTC that the "total amount of such payment shall be reduced by 10 percentage points each year" to mean an annual reduction equal to 10 percentage points of the grandfathered total dollar amount, calculated using the original grandfathered total dollar amount as the baseline for each year of the phase down (rather than an annually compounding reduction) until the allowable payment limit is reached.

CMS provides the following example. If the grandfathered total dollar amount for a CY 2025 rating period is $1 billion under the proposal, the State would be permitted to submit SDP renewals to maintain or reduce that grandfathered total dollar amount for each of CYs 2026 and 2027 rating periods. Beginning with the CY 2028 rating period the State would be required to phase down the grandfathered total amount by at least 10 percentage points annually ($100 million each year) until the applicable payment limit is reached. CMS proposes that if a State opted to phase down by more than the annual reduction amount for a year, the reduction amount for subsequent years could be pro-rated to reflect the cumulative reduction required. So, under the example, if the State chose to phase down by $150 million in the first rating period of the phase down, in the subsequent rating period it could phase down by $50 million instead of $100 million.

To monitor compliance with the payment limit during the phasedown of a grandfathered SDP, CMS proposes to require for each grandfathered SDP certain documentation be submitted to the agency beginning with the first rating period on or after January 1, 2027. The State would annually monitor the total payment rates for each grandfathered SDP and submit (beginning with the first rating period on or after January 1, 2027) a total payment rate comparison for services included in the grandfathered SDP demonstrating whether the payment limit proposed under §438.6(c)(8) has been met – using Medicare or State plan approved rates, as applicable, as the point of comparison. CMS provides an illustrative example in Table 5 of the proposed rule. The total payment rate comparison would need to be certified by an actuary.

CMS also considered an alternative approach (illustrated by an example shown in Table 6 of the proposed rule) under which the phase down would apply to the total payment rate (expressed as a percentage of the total published Medicare payment rate) in the grandfathered SDP instead of to the total dollar amount of the SDP.

3. <u>Types of Permissible SDPs and Provider Classes (§438.6(c)(1)(iii), (c)(2)(i), and (c)(2)(iii)(E))</u>

a. Minimum Fee Schedule SDPs

Section 438.6(c)(1)(iii)(B) currently allows States to adopt a minimum fee schedule for providers that provide a particular service under the contract. The minimum fee schedule to be used by the managed care plan is 100 percent of the total published Medicare payment rate, using a total

published Medicare payment rate that was in effect no more than 3 years prior to the start of the rating period. States are not required to submit these SDPs to CMS for written prior approval via the current CMS issued preprint, but the SDPs must be documented in the applicable managed care contracts and rate certifications and must comply with the requirements currently at §438.6(c)(2)(ii). Similarly, current §438.6(c)(1)(iii)(A) allows for SDPs that use minimum fee schedules tied to State plan approved rates and these SDPs do not require written prior approval.

CMS' proposal (described in section II.A.1) would, beginning for rating periods beginning on or after January 1, 2029, apply the new proposed payment limit – 100 percent of the total published Medicare payment rate for Expansion States, 110 percent of such rate for non-Expansion States, and, if such rate is not available for the Medicaid covered service, 100 percent of the State plan approved rate – for all SDPs (whether or not they require written prior approval). Given this proposal, CMS is concerned about continuing to allow minimum fee schedule SDPs to use minimum fee schedules tied to State plan approved rates if the service has a published Medicare rate.

The agency therefore proposes to revise §438.6(c)(1)(iii) to limit the use of the existing minimum and maximum fee schedule arrangements in current §438.6(c)(1)(iii)(A) through (E) to rating periods beginning from July 9, 2024, but before January 1, 2028. For rating periods beginning on or after January 1, 2028, CMS proposes, instead of the three existing categories of minimum fee schedule SDPs, to combine them and instead allow States to direct managed care plans to implement a minimum fee schedule up to the proposed payment limit. Specifically, the revised regulatory language would allow for "a minimum fee schedule for providers that provide a particular service under the contract and the minimum fee schedule is no greater than the payment limit."

b. Maximum Fee Schedule SDPs

CMS proposes in a new §438.6(c)(1)(iii)(B)(*2*) to allow States to require managed care plans to adopt a maximum fee schedule for providers that provide a particular service under the contract and to state that such a maximum fee schedule would "be no greater than the payment limit, so long as the MCO, PIHP, or PAHP retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract without exceeding the payment limit." The preamble of the rule indicates this would be applicable beginning with the first rating period on or after January 1, 2029, but the proposed regulatory revisions in the rule show §438.6(c)(1)(iii)(B)(*2*) with a January 1, 2028 reference date (the same one applied to the minimum fee schedule revisions discussed above) instead of January 1, 2029.

c. Uniform Increase SDPs

Uniform increases are currently permitted under existing §438.6(c)(1)(iii)(D). CMS is concerned that States are inappropriately using SDPs that require managed care plans to pay uniform increases. CMS describes that States almost exclusively fund uniform dollar or percentage increase SDPs with IGTs or provider taxes and will design the SDP so that the uniform increase changes based on utilization during the rating period (such as to have the effect of rewarding providers with higher payments on a per-service basis for funding fewer services to Medicaid

beneficiaries). CMS is particularly concerned with SDPs that enable Medicaid payments to be returned to certain providers that have supplied the non-Federal share of those payments through the use of IGTs or provider taxes.

In the 2024 final rule, CMS defined the term "uniform increase" under §438.6(a) to mean any SDP that directs the managed care plan to pay the same dollar amount or the same percentage increase per Medicaid covered service in addition to the rates the managed care plan negotiated with the providers included in the specified provider class for the service identified in the SDP. Since uniform increases are uniform dollars or percentages paid in addition to the negotiated rates, CMS is concerned with ensuring compliance with the new proposed payment limit, which CMS is proposing to apply to each service furnished by a provider receiving payment that includes an SDP. If plans and providers negotiate a rate that varies significantly from historical rates then plans may unintentionally be required to pay uniform increases that result in total payment rates exceeding the payment limit on a per service basis.

CMS therefore proposes that beginning with the first rating period on or after January 1, 2028, new uniform increase type SDPs and renewals of non-grandfathered uniform increase type SDPs would no longer be permitted. Minimum and maximum fee schedule SDPs would become the only options included (as reflected under the proposed §438.6(c)(1)(iii)(B)).

CMS proposes to allow uniform increase SDPs for grandfathered SDPs but only until the first rating period in which the payment limit is reached for the grandfathered SDP. Once the payment limit is met, the State must comply with the uniform increase prohibition.

d. Grey Area Payments and Other Prohibited Practices

Grey area payments are general or vague contract requirements for provider payment that are not subject to approval as an SDP under §438.6(c) nor as a pass-through payment under §438.6(d). CMS emphasizes that these payments are impermissible and reiterates that States may not direct managed care plan expenditures under the contract other than consistent with the exceptions under §438.6(c)(1). CMS describes several scenarios that would be considered grey area payments or unallowable practices.

A couple examples include the following:

- States are permitted to implement a managed care plan level incentive arrangement or withhold arrangement as long as the State complies with all Federal regulatory requirements. These arrangements must be payments only to managed care plans and cannot be used as substitutes for SDPs (which are payments to providers). Therefore, States cannot direct a managed care plan's expenditures under one of these arrangements by requiring funding in the incentive or withhold be paid to providers.
- States have attempted to direct managed care plans to pay a portion of SDP expenditures to specific entities for activities not based on the utilization and delivery of services. A State sometimes implements this type of arrangement through the managed care contracts or SDP preprint by requiring a third-party arrangement as part of the eligibility criteria for an SDP provider class. This is not permissible.

CMS proposes to clarify its policy by revising §438.6(c)(2)(ii)(A) to specify that SDPs must be based only on the utilization and delivery of services furnished by a provider and that States cannot condition provider participation in an SDP on paying any portion of an SDP to an entity other than the furnishing provider.

e. Provider Classes

Under current regulation, for all SDPs, when a State defines an eligible provider class under an SDP all providers within that class must be treated equally in terms of payment and performance under the SDP. CMS notes that this current standard does not require States to direct expenditures equally using the same terms of performance *for all providers* providing services under the contract.

States must provide documentation showing the total payment rate for each service and provider class. CMS notes that some States have defined provider classes in ways (for example, very narrowly) that maximize the total payment rate received by each provider in a class under an SDP while remaining at or below the currently required ACR payment limit. CMS has observed these arrangements are often associated with the source of the non-Federal share of payments (e.g., the SDP is financed through an IGT). When a provider class is designed so narrowly, for example, as to assign only one provider to the class, the design effectively functions as a provider-specific payment arrangement.

CMS solicits comment on whether and how to define "provider class" to determine if additional guardrails are needed to ensure that SDPs are used consistent with program requirements. The agency is considering (though not proposing at this time) defining provider class as a group of providers as defined in the approved Medicaid State plan. Another approach it is considering is to require a provider class for an SDP be directly tied to the goals and objectives of the State's Medicaid managed care quality strategy and be specific to the services and enrollees to which the SDP applies.

f. Written Prior Approval

CMS proposes revisions to §438.6(c)(2)(i) to clarify when States would need to submit preprints under CMS' proposals. Beginning with the first rating period on or after January 1, 2028, States would no longer be required to submit permissible minimum fee schedule or maximum fee schedule preprints for written approval.

B. Targeted Medicaid Payment Limit in an FFS Delivery System (§447.381)

CMS expresses its concerns about ACR-based FFS payments, specifically those funded by IGTs derived from State or local government funds, including revenues provided by State university teaching hospitals. CMS describes these payments as generally made exclusively to providers that fund the non-Federal share of the ACR payments. The agency is especially concerned about cases in which providers fund the non-Federal share of their own payment, resulting in the Federal government contributing its share while enabling State Medicaid Agencies to potentially have no budgetary incentive to ensure an appropriate Medicaid payment level. CMS states that

some States have sought approval to make Medicaid practitioner payments up to 530 percent of the Medicare rate for physicians. Currently approved payments average 207 percent of the Medicare rate for States using the Medicare equivalent of the ACR for physicians and 153 percent for other licensed practitioners.

CMS provides examples to illustrate its concerns. For instance, it describes how the largest FFS ACR supplement payment amount in FY 2024 was $277.5 million, which was targeted to 21 physicians/practices. The agency also states that ACR-based supplemental payments, which use proprietary commercial payment data, are not readily verifiable or auditable by the agency and therefore impedes their oversight ability.

CMS states that it “is seizing the opportunity” to address its concerns given the similar issues it is addressing in the proposed rule for managed care necessitated by the WFTC.

Therefore, CMS is proposing new limits on targeted payments that are currently limited to ACR. Specifically, CMS proposes to limit the total payment (that is, the base and supplemental payments) a State may make when payments are targeted to a subset of practitioners or providers instead of to all participating practitioners or providers in the State Medicaid program. This differs from an approach of targeting a limit specific to supplemental payments (or alternatively, specific to base payments). This is to prevent a loophole where the State could characterize targeted fee schedules as base rates and circumvent any limitation put specifically on supplemental payments. The agency clarifies it does not consider DSH payments to be targeted payments for purposes of its proposal.

The proposed limit would be practitioner or provider-specific – that is, for that practitioner’s or provider’s total payments – and based on actual Medicare payment rates for the same period as the Medicaid State plan rate year. The proposed limits therefore differ from current upper payment limits (UPLs), which are applied on an aggregate basis. That is, in contrast, UPLs apply to the total payments made to all entities in a UPL class (such as hospitals) and are calculated as a reasonable estimate of the amount Medicare would pay for the specified services.

1. General (§447.381(a))

CMS proposes at §447.381 to establish a Medicaid practitioner or provider specific limit for the total Medicaid FFS payment authorized under the State plan or waiver in instances where all or a portion of such payment is targeted to a subset of participating practitioners or providers furnishing the applicable Medicaid-covered services (i.e., not available to all practitioners or providers furnishing the same Medicaid-covered services under the State plan or waiver).

- A practitioner would include physicians, dentists and other dental practitioners, and other licensed practitioners. A provider would include providers such as GEMT providers, air ambulance providers, and NEMT providers, as well as providers such as clinics and providers that are entities including academic medical centers that are part of hospitals. The scope is essentially any individual or entity to which a payment can be targeted. Note that a payment targeted to a provider *service* subject to a UPL (as opposed to a payment targeted to a practitioner or provider) would be subject to the UPL regulatory requirements and not this proposed new limit.

- A State plan or waiver authority referenced in the proposed section would include services authorized under sections 1915(i), 1915(j), 1915(k) of the Act; section 1915(c) waiver authority; and section 1115(a) demonstration authority.
- Total payment amount means the entire Medicaid FFS payment on a per service basis (base and supplemental payment). In the case a base payment applies to all practitioners, but a supplemental payment would be available only to a subset, the proposed limit would then apply to the total payment, even though only a portion of the payment is targeted. But if different practitioners within a benefit category are paid differently for the same service and the difference is tied to provider qualifications then the payment is not targeted and the limit would not apply.

Under the proposal, targeted payments would be payments that a State directs to a specific practitioner or provider type or group of practitioners or providers furnishing Medicaid-covered services. CMS provides the following examples:

- A fee schedule developed specifically for certain practitioners or providers that exceeds fee schedules available to others (excluding when there are statutory requirements for a rate or methodology, such as for FQHCs or RHCs).
- Qualifications or eligibility requirements that target certain practitioners or providers that can receive the supplemental payment.
- A quality incentive payment or value-based payment that targets certain practitioners or providers and excludes other similar practitioners or providers.

CMS clarifies that if participation in the VBP methodology is open to all participating Medicaid practitioners or providers under the applicable service payment methodology then payments from those methodologies would not be considered targeted payments. CMS further acknowledges that States, under FFS State plan authority, may target a payment to certain practitioners or providers. To determine if a payment is targeted, the agency would examine the proposed payment methodology, including criteria that must be satisfied to receive the payment, as part of its standard rate proposal review practices to verify that all participating practitioners or providers of the relevant services will receive or have a reasonable opportunity to receive the payment.

2. Scope (§447.381(b))

CMS proposes that the limit on targeted payments would *not* apply when a State's FFS payment methods are uniform for all participating practitioners or providers within the State or within a geographic region (e.g., county, parish, borough, or other municipality) of the State that is referenced under a payment methodology specified in the State plan. CMS further proposes that for this exception a geographic region must be a county, parish, borough, or other municipality in order to prevent a State from defining a district solely for rate-setting purposes and to circumvent the proposed limit. CMS believes this uniformity exception would provide flexibility for States to establish rates that take into account needs of rural providers. Even if the uniformity test is satisfied, CMS would still scrutinize the features of the geographic areas associated with rates to ensure the economy and efficiency requirements under section 1902(a)(30)(A) for payment rates are met.

CMS seeks comments on whether there are other appropriate ways to identify State-defined rural districts which do not allow States to define such districts in a manner that targets a particular provider or practitioner.

CMS also proposes that the proposed limit would not apply to the extent the total payment is subject to another limit, for example when a Medicaid service is already subject to a limit under any of the following, to the extent the total payments are subject to such other limit:

- §447.271 (upper limit based on customary charges for inpatient hospital services);
- §447.272 (inpatient services furnished by hospitals, NFs, ICFs/IID, and IMDs);
- §447.321 (outpatient services furnished by hospitals and clinic);
- §447.325 (other inpatient and outpatient facility services, which includes psychiatric residential treatment facilities (PRTFs);
- Section 1903(i)(7) of the Act (limits Medicaid payments for certain DME expenditures); and
- Section 1903(i)(27) (limits Medicaid payments for certain clinical diagnostic laboratory services) of the Act.

CMS further proposes that to the extent a targeted payment is subject to a specific statutory payment methodology, the proposed limit could not conflict with such rate requirements.

3. Targeted Medicaid Payment Limit (§447.381(c))

CMS proposes to limit the described targeted payments to a percentage of Medicare rates. Specifically, total Medicaid payments made to a practitioner or provider for a Medicaid-covered service could not exceed 100 percent in the case of Expansion States (or 110 percent in the case of non-Expansion States) of the Medicare FFS payment rate that would be paid if it were paid under the applicable Medicare Part A or B payment rates effective for the FY or CY, as applicable, that corresponds to the State plan rate year.[18] The targeted Medicaid payments should reflect the total computable payment amount that would constitute the payment-in-full (amounts paid by CMS plus any deductible, coinsurance or payment) for the provider. To ensure that the proposed limits would not conflict with statutory rate requirement (which may exceed Medicare rates), CMS proposes that for Medicaid payment rates subject to a statutory requirement for a payment rate or methodology, the limit could not be less than such rate or resulting rate.

CMS expects that States would operationalize this policy by identifying Medicare payment rates from the Medicare physician fee schedule (PFS) and ambulance fee schedule (AFS) under Part B because most services relevant to the proposal are covered under Part B. CMS explains one reason for this is that Medicare Part A payment rates are mostly associated with services subject to existing regulatory Medicaid UPLs or statutory Medicaid payment limits (such as inpatient hospital services) and therefore as described above would not fall under the scope of the proposal. For applying the PFS, CMS proposes to characterize the applicable payment rates under Part B as the non-facility payment rate (rather than the facility payment rate) as listed on

[18] For purposes of the proposal, the State plan rate year would be the first State plan rate year that begins while the applicable Medicare payment rate is in effect.

the PFS. The proposal would exclude Medicare Quality Payment Program (QPP) payment adjustments because not all providers are eligible for such adjustments.

The requirement to limit targeted payments would be reflected in the State's Medicaid State plan payment methodology. The SPA would need to demonstrate how the total payments for targeted practitioners or providers would not exceed the applicable percentage of the Medicare payment rates.

CMS seeks comment on the proposed use of Medicare FFS payment rates as the basis of the limit for targeted Medicaid payments.

In the case of a targeted Medicaid payment rate for a service that does not have an exact Medicare equivalent, CMS expects that a State would develop a methodology to identify a reasonably comparable Medicare payment rate for a comparable Medicare service. In cases where the State creates Medicaid bundled payment rates using State specific codes, the State would identify the constituent services within the bundled payment rate and crosswalk to the corresponding Medicare payment rate (or Medicare payment rate for a reasonably comparable Medicare service if a corresponding Medicare payment rate does not exist). Table 7 of the rule includes an illustrative example of a Medicaid bundled payment rate crosswalked to a Medicare equivalent rate.

CMS acknowledges there are instances in which a State may have bundled payment rates which the State does not have information regarding how the rates were initially developed and may lack the historical data needed to crosswalk each service to a corresponding Medicare rate. CMS states that the absence of historical data would not constitute an exception. The agency would expect the State to develop a reasonable methodology to identify the constituent services included in the bundled payment rate and to reasonably estimate the Medicaid payment rate attributable to each such service. The total Medicaid payments attributable to those services included in the bundle payment rate could not exceed the percentage of the corresponding Medicare payment rates. However, if after reasonable efforts a State could not identify a comparable Medicare payment rate for one or more constituent services then the State could seek an exception.

CMS states that under its proposal it would expect States that make targeted Medicaid payments to physicians and other practitioners to source the Medicare payment rates from the published Medicare fee schedule amounts on the Medicare PFS through the Physician Fee Schedule Look-Up Tool on the CMS website or Excel file downloads of the Medicare PFS Relative Value Files. CMS proposes that States rely on Medicare FFS payment rates for codes with a status indicator of A (active), R (restricted), or T (Injections) because these codes generally include RVUs and are subject to Medicare's standard rate-setting and update process.

For targeted Medicaid payment rates for transportation providers (e.g., GEMT, air emergency medical transportation, and NEMT providers) that are subject to the proposal and for which there is a Medicare equivalent rate, the Medicaid payment would be limited to the published Medicare AFS payment rates in effect for the relevant CY.

4. Exceptions (§447.381(d))

For payments falling within an exception (described below), CMS proposes that the State would need to explain and provide supporting information in the form and manner specified by the agency sufficient to demonstrate the payments are consistent with section 1902(a)(30)(A) of the Act. That section requires payments must be consistent with efficiency and economy (among other requirements). A State would provide supporting documentation only upon request from CMS and not on a regular or recurring basis.

CMS proposes the following exceptions:

- When there is no reasonable Medicare equivalent rate for some or all of the services included in the targeted payment.
    - CMS seeks comment on potential approaches States could use to demonstrate compliance with section 1902(a)(30)(A) when no Medicare rate exists, including benchmarks that would generally be less than ACR.
- In the case of payments that are reconciled to a practitioner's or provider's actual, incurred costs.
    - CMS provides the example when a State proposes to pay governmental providers based on reconciled costs while continuing to pay private providers under an existing, uniformly applicable fee schedule. In that example, the payment to the governmental providers would fall within the exception and the agency would not consider the payments to the private providers to be targeted based on the different treatment of governmental providers because the underlying fee schedule methodology continues to apply uniformly to all providers within that category.

5. Transition Period (§447.381(e))

CMS proposes that in the case of a State with a State plan that currently provides for targeted Medicaid payments that exceed the proposed limit, that the State would have until the start of the first State fiscal year beginning on or after January 1, 2029, to comply with the limit. The State would need to do so by submitting a State plan amendment to remove or update the payments with an effective date no later than the start of such first State fiscal year.

6. Compliance with the Targeted Medicaid Payment Limit (§447.381(f))

If the policy is finalized as proposed, if a State were to submit a SPA that includes a targeted Medicaid practitioner or provider payment that is more than the proposed limits, the agency would advise the State through formal written communication during the review process to amend its payment methodology. If the State did not amend its payment methodology, then CMS would document that in a Request for Additional Information after which if the State did not comply with the payment limit the agency would disapprove the SPA. For States that currently have a targeted payment that exceeds the proposed limit, CMS may reduce future grant awards if the State did not come into compliance by the end of the transition period. When an exception under proposed §447.381(d) (described above) applies but a State fails to furnish information

requested by CMS to demonstrate compliance with section 1902(a)(30)(A), CMS would disapprove the SPA.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), CMS is required to provide notice in the Federal Register and to solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval.

Table 12 of the proposed rule (shown below with editorial changes)[19] shows the burden estimates for the (i) proposed special contract provisions related to payment (§438.6), (ii) SPA submissions for targeted payments (§447.381), and (iii) UPL demonstrations for targeted payments (§447.381).

TABLE 12: PROPOSED BURDEN ESTIMATES

42 CFR Regulation Section	OMB Control No.	No. of Respondents	Total No. of Responses	Time per Response	Total Time (hours)	Total Cost ($)	Annualized Cost ($)	Annualized State Savings/Share
436.6(c)(1)(iii) (SDP)	0938-1483	42 States	272	10	2720	(280,976)	($283,076)	(141,538)
436.6(c)(2)(iii) (SDP)	0938-1483	38 States	60	15	900	(108,680)	(38,938)	(19,469)
447.381 (SPA)	0938-0193	25 States	25	19	475	44,350*	14,783	7,392
447.381 (UPL)	0938-0618	17 States	17	8	(136)	(11,723)	(11,723)	(5,862)
Total		Varies	324	Varies	(3,281)	(401,379)	(318,954)	(159,467)

* When taking into account the Federal administrative match of 50 percent, CMS estimates a one-time State cost of $22,175 ($44,350 * 0.5). When annualized, this corresponds to $7,392 ($14,783 * 0.5).

IV. Regulatory Impact Analysis

CMS believes most of the proposed revisions to parts 438 and 447 will minimally or moderately increase administrative burden and associated costs, but it is not able to quantify the benefits of this rule. Table 34 of the proposed rule (reproduced below) provides CMS' accounting statement for the policies it proposed in the rule.

TABLE 34: ACCOUNTING STATEMENT (in Millions of Real 2026 Dollars)

	Benefits
Non-Quantified	The proposed rule is expected to increase fiscal integrity and transparency of the Medicaid program. The proposed rule is also expected to reduce Federal administrative costs and burdens.
Paperwork reduction cost-savings: § 438.6(c)(SDPs)	The proposed rule is expected to reduce State administrative costs and burdens by removing the requirements for States to develop ACR demonstrations and prior written approval for a number of SDP types and for a number of FFS payments.

[19] Column 7 of Table 12 in the proposed rule is omitted. That column indicates for each row that the labor rate ($/hr) varies.

§ 447.381 (UPL)						
	Costs					
Non-Quantified	The proposed rule is expected to lead to costs for States, providers, and managed care plans in renegotiating contracts. The proposed rule could lead to some adverse impacts on some providers and beneficiaries.					
Regulatory Review Costs	0.1841					
Paperwork Costs or Savings	-0.159467					
	Transfers					
Annual Monetized Transfers	**Primary Estimate**	**Low Estimate**	**High Estimate**	**Units**		
				Year Dollars	**Discount Rate**	**Period Covered**
From Federal government to Providers and others	-46,655	-25,186	-58,254	2026	7%	2026-2035
	-49,159	-26,171	-61,760	2026	3%	2026-2035
From States to Providers and others	-24,210	-12,623	-30,442	2026	7%	2026-2035
	-25,496	-13,113	-32,268	2026	3%	2026-2035

A. Benefits and Costs

In citing benefits of its proposals, CMS highlights limiting Medicaid total payment rates through SDPs and targeted FFS practitioner payments to be no greater than 100 percent of the specified total published Medicare payment rate[20] for an Expansion State or, in the case of a Non-Expansion State, 110% of that rate.[21] The proposals would also reduce CMS' administrative costs and burdens.

CMS does not quantify the costs of its proposals but briefly notes, at a very high level, there may be adverse impacts on providers and consequently on beneficiaries, which for providers may include negotiating revisions to managed care plan contracts.

B. Transfers

1. SDPs

CMS cannot provide accurate cost estimates for its proposals, which it attributes to the following reasons:

- Projected and actual spending data collected from States is not standardized;
- Information received is often incomplete;
- States use different benchmarks for payment, making it difficult to compare SDP payment rates; and
- Information on ACR payment rates is limited, adding to the difficulty in determining how the ACR is calculated.

Thus, it proves a range of estimates using different relative price assumptions between Medicaid, Medicare, and the ACR.

[20] In the absence of a specified total published Medicare payment rate, the payment rate under the Medicaid State plan (or under a waiver of such plan) would be used.
[21] CMS notes that there is a limited exception to the payment limit for SDPs that qualify for a temporary grandfathering period.

The model CMS developed to estimate the impacts of the SDP provisions of this proposed rule is based on SDP data collected through the SDP preprints, including in Table 2 of the current preprint, and generally using payment data with effective dates starting in 2025. The model used data related to the service category, provider class, comparative rate basis for assessing the SDP payments, average base payment level from plans to providers before the application of the SDP, SDP change (*i.e.*, the effect of the SDP on the total payment levels), final payment levels by provider class, and the estimated total SDP amount. However, the agency cites challenges due to the limited detail in SDP preprints, including limited information on how relative prices compare across different payers. CMS says it reviewed some research comparing prices across Medicare, Medicaid and commercial payers (listed on pages 91 FR 30448 and 30449) to develop their estimates. Table 14 in the proposed rule shows the relative prices by payer and by service that CMS assumed for its estimates contained in Tables 15 and 16 for low and high assumed prices. The agency notes there is little information on nursing facility prices and the difference in coverage policies between the Federal entitlement programs and private payors.

CMS calculated new annual limits under what it refers to as the "pre-legislation SDP amounts" rules (meaning SDP amounts and rates determined under the law before enactment of the WFTC) and compared them to calculations using "post-legislation SDP limits." If the pre-legislation SDP amounts exceeded the post-legislation SDP limits for applicable rating periods, then the SDP was reduced by an amount such that the final payment was equal to the post-legislation SDP limit. If the pre-legislation SDP amounts were less than or equal to the post-legislation SDP limits, then CMS assumed that there was no change to the SDP. The agency also projected additional savings from reduced growth in new SDPs for the four services (*i.e.*, inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at AMCs.

The projected annual impacts of the proposed rule are shown in Table 18, which shows a reduction in total (Federal and non-Federal shares) Medicaid spending of $774.8 billion from 2026 through 2035. During that 10-year period, the projected reduction in the Federal share of Medicaid spending would total $510.1 billion, and State Medicaid spending would be reduced by $264.4 billion.

With respect to its proposal to extend these policies to other services not listed in section 71116 of the WFTC, it estimates reduced Medicaid spending of $5.34 billion over a 6-year period (2029 through 2035) of which Federal spending would be reduced by $3.51 billion, and State spending would be reduced by $1.83 billion.

CMS acknowledges that providers will lose revenue because of reduced SDPs, but it believes the impact may not be as severe as believed—highlighting a reduction in the amount of provider taxes collected by States. It also reiterates that there is significant uncertainty regarding its estimates, and for this reason develops estimates for high and low scenarios of spending impacts in Tables 22 and 23.

2. <u>Fee-for-Service Targeted Medicaid Payments</u>

CMS also finds it difficult to develop estimates for its policy proposals for FFS supplemental payments for many of the same reasons as those noted above, and in the case of supplemental payments, the agency noted there is less information available than for SDPs. It developed a range of estimates with different relative prices between Medicare, Medicaid, and the ACR, relying on the analysis it developed for SDPs. The agency used the percentage change in SDP spending for supplemental services (*e.g.*, physicians; other practitioners, including emergency medical transportation and dental services; and NEMT) for its assumptions of the impact on supplemental payments.

The agency projects its proposals would reduce total Medicaid spending (Federal and non-Federal shares) by $2.44 billion from 2029 through 2035; the annual impacts are shown in Table 27. During the 6-year period, the Federal and States savings are estimated to be $1.54 billion and $0.90 billion, respectively. Because there is significant uncertainty about its estimates, CMS also prepares estimates for high and low scenarios of spending impacts in Tables 30 and 31 for these proposals.

C. Regulatory Flexibility Act (RFA)

CMS states that the entities this proposed rule would regulate, if finalized, are State governments. Because of this, it concludes that the proposed rule, if finalized, will not have a significant economic impact on a substantial number of small businesses or other small entities. The agency also believes that because the policy operates at the State level and SDPs are optional for States to implement, it lacks data to reliably attribute or disaggregate these impacts to specific provider types or to small entities as defined by SBA size standards.

It reiterates that any effects on providers would be indirect and mediated through State-level policy and thus CMS cannot estimate impacts across disaggregated small entity sizes and apply thresholds for "significant impact" and "substantial number" at the small entity level. It is similarly incapable of estimating how managed care plan negotiations with providers could mitigate the impact of this rule.

D. Unfunded Mandates Reform Act (UMRA)

The agency merely states the requirements under the UMRA; it makes no conclusions with respect to the application of that statute to this rule.

E. Federalism

With respect to requirements imposed under Executive Order 13132, CMS concludes this "proposed rule would not impose substantial direct requirement costs on State and local governments, preempt State law, or otherwise have Federalism implications" and thus it has no obligations under that Executive Order.

F. Executive Order 14192

CMS estimates that the proposed rule would generate $0.13 million in annualized cost savings at a 7 percent discount rate relative to year 2024, over a perpetual time horizon; thus, it is exempt from requirements imposed under Executive Order 14192 to reduce costs under prior regulations.