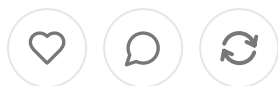


CMS-2449-P recasts Medicaid State Directed Payments & FFS targeted practitioner supplements @ the Medicare benchmark, kills the ACR ceiling, bans uniform increases & projects \$774.8B in 10yr savings

MAY 21, 2026 • PAID



Video Preview



 **Podcast episode for paid subscriber only.**



CMS-2449-P recasts Medicaid State Directed Payments & FFS targeted practitioner supplements @ the Medicare benchmark, kills the ACR ceiling, bans uniform increases & projects \$774.8B in 10yr savings

CMS just proposed a rule that could cut Medicaid spending by \$774.8B over ten years. It targets State Directed Payments, a financing mechanism most people outside Medicaid policy have never heard of. Here is why it matters...

 Listen now

2 hours ago · Thoughts on Healthcare

Table of Contents

1. The setup, in plain English
 2. How SDPs got to \$144B before anyone noticed
 3. What the proposed rule actually does
 4. Grandfathering, the eligibility maze, and the ten percentage point glide path
 5. The death of the uniform increase SDP
 6. Grey area payments, third party fees, and the provider class problem
 7. The FFS side at 447.381, which is almost the same rule with different plunk
 8. The dollar impact, plus the relative price assumptions that drive it
 9. Who actually loses, because the gross numbers are not the net numbers
 10. Open comment questions worth flagging
- Rule: CMS-2449-P, scheduled for Federal Register publication 5/22/2026, 60 comment period

- Statutory basis: Section 71116 of the Working Families Tax Cut legislation (L. 119-21, enacted 7/4/2025), plus the 6/6/2025 Presidential Memorandum on waste, fraud, and abuse in Medicaid
- Two regulatory pieces: managed care SDPs at 42 CFR 438.6, and a new FFS targeted practitioner payment limit at 42 CFR 447.381
- Old SDP ceiling under the 2024 final rule: 100% of the Average Commercial (ACR) for the four statutory services (inpatient hospital, outpatient hospital, nursing facility, qualified practitioner services at AMCs)
- New ceiling under WFTC: 100% of total published Medicare for Expansion States, 110% Medicare for Non-Expansion States, 100% State plan rate when Medicare equivalent exists
- Applied per service or per discharge, not as an aggregate UPL
- CMS goes further than the statute and extends the same Medicare-based limit all SDPs in all states (including Territories) and all services, applicable with rating period on or after 1/1/2029
- Grandfathered SDPs: limited to completed preprints submitted before 7/4/25 for rating periods within 180 business days of enactment; phase down at 10 percentage points of the grandfathered total dollar amount per year starting 1/1/2028
- Uniform increase SDPs eliminated for new and renewal SDPs starting 1/1/26 except inside the grandfathering window
- Confirms grey area payments impermissible; bans SDP funds from being routed through provider associations or consultants
- Parallel FFS rule: 100%/110% Medicare for targeted practitioner payments, applied at the provider-specific level, with exceptions for cost-reconciled payments and services without a Medicare equivalent; transition deadline 1/1/2029
- Projected ten-year impact (medium scenario, 2026 to 2035): -\$774.8B total computable, -\$510.1B Federal, -\$264.4B State, plus another -\$2.44B from the provisions

- Low and high scenarios on the SDP piece run from -\$408.4B to -\$989.7B over the same window
- Current SDP spending: \$97.8B in FY 2024, projected to hit \$295.9B by FY 2028 absent the rule
- 80.8% of SDPs above Medicare today are funded in whole or part by intergovernmental transfers (IGTs) or provider taxes

The setup, in plain English

For roughly a decade the SDP has been the dominant fiscal lever in Medicaid managed care. Two states submitted four SDP preprints in 2016, the year the framework was born. By 2024 that number was 41 states and 366 preprints. Cumulative submissions since inception now exceed 1,950. The 2024 final rule under the Biden administration tried to draw a line by codifying a ceiling at 100% of the ACR for four big service buckets, plus various transparency and quality-eval requirements. Roughly 18 months later, the line is being redrawn.

Two things changed. First, the Trump White House issued a presidential memorandum 6/6/2025 titled Eliminating Waste, Fraud, and Abuse in Medicaid, which instructed HHS to ensure Medicaid payment rates do not exceed Medicare, to the extent permitted by law. Second, Congress wrote that instruction into statute. Section 71116 of the Working Families Tax Cut, signed 7/4/2025, directs CMS to revise 42 CFR 438.6(c)(2)(iii) to cap the total payment rate under SDPs for inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services at AMCs. The cap is 100% of the total published Medicare rate for Expansion States, 110% for Non-Expansion States, and the State plan rate when there is no Medicare comparator. Section 71116(b) carves out a grandfathering window with a phase down beginning with the first rating period on or after 1/1/2028.

CMS-2449-P is the implementing rule. It does the statutory minimum, then goes further by extending the same Medicare-based limit to all SDPs, all services, all payers, including the Territories, and to parallel FFS targeted practitioner payments under the brand new 42 CFR 447.381. The proposed effective date for the broader expansion

the first rating period on or after 1/1/2029, which roughly aligns the managed care timeline with the FFS transition deadline.

How SDPs got to \$144B before anyone noticed



Continue reading this post for free, courtesy of Thoughts on Healthcare.

Claim my free post

Or purchase a paid subscription.

← Previous