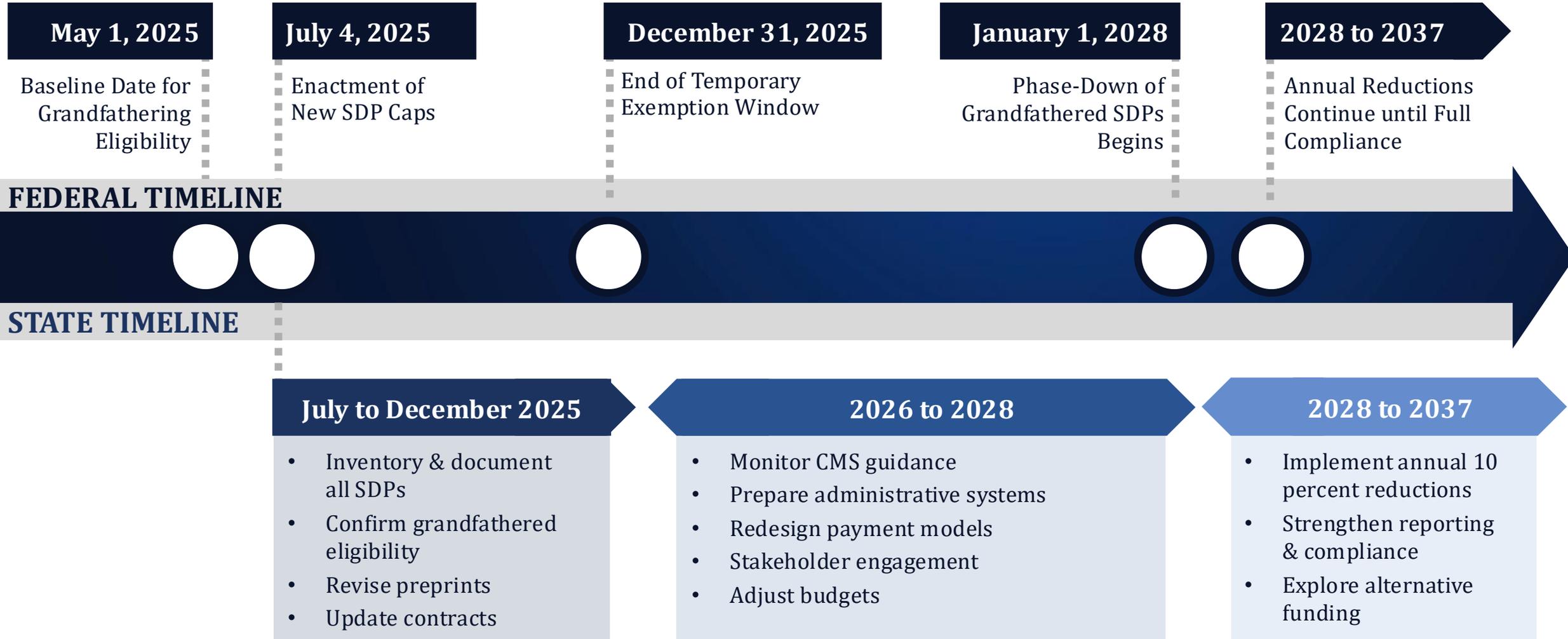


STATE ROADMAP FOR OBBBA SDP PROVISIONS

TRP's roadmap outlines how states may prepare for the OBBBA's new federal caps and phase-down requirements for Medicaid managed care State Directed Payments (SDPs).



Federal Deadlines

May 1, 2025 — Baseline Date for Grandfathering Eligibility

This date establishes the baseline for determining which SDPs may qualify for temporary exemption from the new OBBBA payment limits. SDPs approved by CMS before this date — or submitted in “good faith” with a completed preprint prior to May 1 — may qualify for grandfathering under the statute.

July 4, 2025 — Enactment of New SDP Caps and Limited Exceptions

Upon enactment, all new or renewed SDPs must comply with the statutory caps: 100 percent of Medicare rates for expansion states, 110 percent for non-expansion states, and Medicaid base rates where no Medicare equivalent exists. Certain SDPs tied to state plan rating periods occurring within 180 days of this date (ending December 31, 2025) — or those supporting rural hospitals — may also qualify for exemption if approved by CMS or submitted in good faith before July 4, 2025.

December 31, 2025 — End of Temporary Exemption Window

The final date for rating periods occurring within 180 days of enactment to be covered under the temporary grandfathering policy. After this date, all SDPs that have not received approval or submitted a completed preprint by July 4, 2025, must comply with the new federal caps.

January 1, 2028 — Phase-Down of Grandfathered SDPs Begins

States must begin reducing payment amounts for grandfathered SDPs by 10 percent annually until capped at the applicable Medicare-based rate. CMS is expected to issue operational guidance prior to this date clarifying the phase-down methodology, reporting requirements, and oversight expectations.

2028 to 2037 — Annual Reductions and Full Compliance

Grandfathered SDPs continue to be reduced each year by 10 percent until the statutory cap is reached. All programs must be fully compliant with the new federal limits no later than 2037, absent any future statutory extensions or modifications issued by CMS.

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State Timeline

Immediate Compliance

July 4 to December 2025

Following enactment on July 4, 2025, states should complete a full inventory of all SDPs and confirm which arrangements qualified for temporary grandfathering under the OBBBA. For any SDP not eligible for exemption, states should promptly submit revised preprints, renewals, or amendments reflecting compliance with the new Medicare-based caps. States should also review and update managed care contracts and payment terms accordingly, ensuring accurate documentation to support future CMS verification and audit requirements.

Operational Adjustments

2026 to 2028

During this period, states should focus on stabilizing their SDP frameworks under the new federal limits and preparing for the 2028 phase-down of grandfathered arrangements. This includes implementing revised payment structures for non-exempt SDPs, coordinating with CMS on amended preprint approvals, and integrating the capped payment amounts into managed care rate certifications. States should also monitor forthcoming CMS guidance and prepare administrative and reporting systems to track compliance under the new framework. At the same time, states, MCOs, and providers should engage stakeholders to review renewal opportunities for rating periods prior to January 1, 2028, maintain thorough documentation of correspondence with CMS, and model the fiscal impact of capped or phased-down SDPs — particularly on high-Medicaid hospitals, behavioral health networks, and value-based incentive pools. Early financial planning and budget adjustments will be critical to mitigating disruption ahead of the phase-down period.

Phase-Down and Compliance

2028 to 2037

Beginning January 1, 2028, states must implement a 10 percent annual reduction for grandfathered SDPs until full compliance with Medicare-based caps is achieved. States should strengthen reporting and compliance processes to demonstrate adherence to the statutory phase-down schedule, maintain clear documentation for CMS oversight, and evaluate alternative or value-based payment arrangements that can sustain provider participation within the capped structure.