

Restrictive Medicaid Financing Rules Put Access to Care at Risk



MMA urges federal policymakers to:

- **Rescind the SDP policy included in OBBA or consider legislating a higher cap for certain SDPs** to ensure provider participation in Medicaid is not harmed.
- **Rescind the moratorium on new provider taxes and block the scheduled phase down** of the tax from 6% to 3.5%.

The *One Big Beautiful Bill Act (OBBA)* includes major changes to how states generate their share of Medicaid funding, including new limits on state directed payments (SDPs) and provider taxes. These long-standing financing tools help states fund their Medicaid programs and support hospitals, nursing facilities and other providers that serve entire communities. Reductions in Medicaid funding can also affect access to care beyond the Medicaid population. Individuals with Medicare, Medicaid, Marketplace and private insurance often rely on the same hospitals, physicians and other healthcare providers.

The Centers for Medicare & Medicaid Services (CMS) recently issued proposed changes to SDPs, which placed additional restrictions on the funding mechanisms and provided operational guidance for implementing new SDP limits. CMS also proposed changes to provider taxes, which expanded the scope of taxes subject to CMS oversight and placed new, retroactive limits on some state taxes, in addition creating to the reporting necessary to support implementation of the OBBA changes.

If finalized as is, these rules would further constrain states' ability to finance their Medicaid programs and direct resources to the providers and communities that need them most. The result could be less support for essential hospitals, nursing facilities and other providers, and greater challenges maintaining access to care—particularly in rural and underserved communities.

As CMS and Congress consider changes to Medicaid financing rules, policymakers should preserve state flexibility, protect access to care and avoid changes that go beyond what Congress enacted in OBBA.

How States Rely on These Financing Tools Today

States rely on SDPs and provider taxes to help finance Medicaid programs and support providers that serve Medicaid beneficiaries and the broader community. By helping to sustain these essential providers, these financing tools support access to a healthcare infrastructure shared by Medicaid, Medicare and commercially insured patients.

- **SDPs** are a key Medicaid managed care financing tool funded jointly by states and the federal government. SDPs help states strengthen provider networks, improve access to care, advance quality goals and support providers that serve Medicaid beneficiaries, including hospitals, nursing facilities and other safety-net providers. While these payments are made through the Medicaid program, they support providers that are part of the broader healthcare delivery system.
- **Provider taxes** allow states to generate part of the non-federal share of Medicaid funding. These taxes have been used for decades, and 49 states and the District of Columbia use at least one provider tax to help fund their Medicaid programs. States rely on provider taxes to support Medicaid services and provider payments. Unlike the federal budget, states are unable to operate in a deficit, so they must have the ability to fund their share of the Medicaid program from taxes generated each year.

Together, these tools help states fund Medicaid in ways that reflect patients' needs at the local level.

What's Changing

OBBBA restricts both SDPs and provider taxes by capping allowable payment levels, narrowing the circumstances under which states can use these financing tools and phasing down key funding mechanisms, even though states have been relying on them with CMS approval for years. CMS has issued rules that provide further direction on how states should implement those changes.



State Directed Payments

OBBBA:

While prior rules allowed SDPs up to 100% of the Average Commercial Rate Caps, OBBBA caps certain SDPs at 100% of the published Medicare payment rate in Medicaid expansion states and 110% in non-expansion states. These limits apply to SDPs that require written prior approval and include inpatient hospital services, outpatient hospital services, qualified practitioner services at academic medical centers and skilled nursing facility services.

Proposed rule:

Would implement the statutory caps and impose several additional requirements **that go beyond the statute included within OBBBA**. CMS estimates the proposed rule would **cut federal spending by more than triple the CBO's initial estimate**—amounting to a \$510 billion reduction over a decade.¹ Specific changes within the proposed rule include:

- Applying payment limits at the service level, rather than allowing states to assess compliance at an aggregate level—creating extreme amounts of administrative complexity for states and providers;
- Applying the SDP limits to all SDPs, including those that do not require written prior approval;
- Applying the limits to all Medicaid services, not just the service categories listed in OBBBA;
- Extending the limits to U.S. territories despite that their federal funding is already capped, while the limits within OBBBA applied only to the 50 states and the District of Columbia;
- Phasing down certain grandfathered SDPs that exceed the new limits beginning with rating periods starting on or after January 1, 2028;
- Adding new provider-level monitoring and documentation requirements;
- Prohibiting new uniform increases of SDPs and renewals of non-grandfathered uniform increases of SDPs beginning with rating periods on or after January 1, 2028, even though they are the most commonly used form of SDP by states; and
- Establishing similar Medicare-based limits for certain targeted Medicaid fee-for-service practitioner payments beginning in 2029.



Provider Taxes

OBBBA:

Restricts states' ability to use provider taxes by limiting new or increased taxes and phasing down the provider tax safe harbor threshold for expansion states.

Proposed rule:

Would provide additional flexibility in determining whether taxes were enacted or imposed as of July 4, 2025, compared to CMS's previous interpretation, but also introduce new reporting and oversight requirements, including:

- Discontinuing the regulatory flexibility provided by the 75/75 test, which goes beyond the changes included in OBBBA. This flexibility currently allows a state to demonstrate that providers are in fact not being held harmless, so the indirect hold harmless restrictions should not be applied.
- Adding services of "health insurers" as a separate permissible health care-related tax class, giving CMS tools to regulate many state taxes with no direct connection to Medicaid, which is not required by OBBBA.
- Requiring more detailed state reporting on tax collections, net patient revenue, use of tax revenue and related Medicaid payments—all of which go beyond what was included in the OBBBA statute.

Together, the SDP and provider tax changes in OBBBA—and the way states are required to implement them under CMS regulations—could have significant consequences for state Medicaid programs, providers and the patients who rely on them.

Further restrictions placed on critical Medicaid financing programs will compound the financial shortfalls facing states, hospitals and community-based providers, putting coverage and access to essential care at risk for all Americans. Rural and underserved communities could be especially vulnerable to loss of services and providers where access to care is already limited.^w



The Path Forward

States rely on Medicaid financing tools like SDPs and provider taxes to support access to care and critical services for Medicaid patients as well as the broader community. As CMS moves forward with financing-related rules, Congress and the Administration should protect state flexibility, avoid unnecessary disruption and ensure Medicaid beneficiaries can continue accessing the care they need.

¹ <https://www.federalregister.gov/documents/2026/05/22/2026-10292/medicaid-program-medicare-managed-care-state-directed-payments-and-medicare-fee-for-service-targeted>