DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SUBJECT: Section 71116 of One Big Beautiful Bill Act on State Directed Payments

September 9, 2025

Dear Colleague:

Section 71116 of the One Big Beautiful Bill Act[1] became effective for Medicaid managed care rating periods[2] beginning on or after July 4, 2025. Section 71116 directed the Centers for Medicare & Medicaid Services (CMS) to revise 42 CFR § 438.6(c)(2)(iii) to reduce the total payment rate limit for state directed payments (SDP) for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center.[3] Section 71116 also included a provision temporarily grandfathering certain SDPs until the rating period beginning on or after January 1, 2028.[4]

CMS is preparing a notice of proposed rulemaking to revise 42 CFR part 438 as required by section 71116 and consistent with the Presidential directive outlined in the Presidential Memorandum, dated June 6, 2025.[5] As part of this rulemaking effort, CMS is considering changes to the total payment rate limit for SDPs for other services beyond the four services mandated by section 71116.

To aid state planning efforts until a final rule is promulgated, CMS is providing guidance on section 71116. This information is preliminary in nature and final policies will depend on the contents of the final rule. Certain SDPs will qualify for the temporary grandfathering period, including SDPs with rating periods for state fiscal year (SFY)[6] 2025, calendar year (CY) 2025, and SFY 2026 for which a completed preprint was submitted to CMS before May 1, 2025, or for some SDPs, July 4, 2025. In addition, SDPs for these periods for which we determine that the state made a good faith effort to obtain approval before the applicable date (May 1, 2025 or July 4, 2025) as further explained in the "Grandfathering Certain SDPs" section below, will qualify for the grandfathering period.

Background

SDPs permit states to implement contractual Medicaid managed care arrangements that direct a managed care organization's, prepaid ambulatory health plan's, or prepaid inpatient health plan's expenditures under 42 CFR § 438.6(c). The use of SDPs has grown substantially since they were first introduced in 2016; in CY 2024, CMS received more than 330 SDP preprint submissions from 39 states and territories. For federal fiscal year (FFY) 2024, CMS's Office of the Actuary

[1] Public Law 119-21.
[2] Rating period is defined in 42 CFR § 438.2.
[3] Inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center are defined in 42 CFR § 438.6(a).
[4] Section 71116 applies to all 50 states and the District of Columbia and does not apply to U.S. territories.
[5] https://www.whitehouse.gov/presidential-actions/2025/06/eliminating-waste-fraud-and-abuse-in-medicaid/
[6] The term "state fiscal year" is used for ease of reference and is assumed to be the same as a state's annual rating period that begins in a month other than January. A rating period is defined in 42 CFR § 438.2 as a 12-month period and can begin in any month.

(OACT) projected that annual SDP spending exceeded $97.8 billion (total computable) and projected that spending would increase to approximately $124.3 billion (total computable) for FFY 2025 and $144.6 billion for FFY 2026, representing a significant proportion of Medicaid managed care expenditures.

Section 71116

Section 71116(a) requires that the total payment rate for any SDP for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center furnished during a rating period beginning on or after July 4, 2025 be limited to:

1. 100 percent of the specified total published Medicare payment rate[7] (or, 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)) for an expansion state;[8] or
2. 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 the Medicaid State plan (or under a waiver of such plan)) for a non-expansion state.

A limited exception to section 71116(a) is permitted for SDPs that qualify for the grandfathering period in section 71116(b).

Grandfathering Certain SDPs

Applicable Rating Period Criteria

Section 71116(b) stipulates that SDPs meeting certain criteria are eligible for a temporary grandfathering period. One such criterion is the rating period. More specifically, certain SDPs in rating periods occurring within 180 days of the date of enactment of section 71116 are eligible for the grandfathering period. CMS interprets this to mean that the grandfathering period would apply to SDPs in rating periods occurring 180 days before or 180 days after July 4, 2025. In practice, this means the grandfathering period applies to eligible SDPs in rating periods that include any days from January 5, 2025 through July 3, 2025 or July 5, 2025 through December 31, 2025. For example, this could include eligible SDPs, as described below, in rating periods occurring in SFY 2025, CY 2025, and SFY 2026; however, this would not include SDPs in other rating periods, such as those occurring in SFY 2024, CY 2024, CY 2026 and SFY 2027.

Preprint Status Criteria

Section 71116(b) specifies additional criteria SDPs must meet to qualify for the grandfathering period. The criteria are:

(1) SDPs (other than for rural hospitals[9]) for which written prior approval[10] was made by CMS before May 1, 2025;

[7] Total published Medicare payment rate is defined in 42 CFR § 438.6(a).
[8] Section 71116(a)(1) defines an expansion state as "a State that provides coverage to all 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."
[9] The definition of a rural hospital is specified in section 71116(d)(2).
[10] Written prior approval has the meaning given to such term in 42 CFR § 438.6(c)(2)(i).

(2) SDPs (other than for rural hospitals) for which a good faith effort to receive CMS approval was made before May 1, 2025;
(3) SDPs for rural hospitals for which written prior approval was made by CMS before July 4, 2025;
(4) SDPs for rural hospitals for which a good faith effort to receive CMS approval was made before July 4, 2025; and
(5) SDPs for which a completed preprint was submitted to CMS prior to July 4, 2025.

Definitions of "Completed Preprint" and "Good Faith Effort"

CMS interprets the term "completed preprint" in criterion (5) above to be equivalent to the definition of a completed preprint described on page 6 of the CMCS Informational Bulletin (CIB) published on November 7, 2023,[11] which states that "[a] complete State directed payment preprint submission requires a State directed payments preprint form[12] as well as the preprint addendum tables in an Excel workbook,[13] as necessary….The preprint must be completed in full, and all information must be provided only in the fillable sections of the preprint and the addendum tables."

A state must submit a completed SDP preprint form to CMS as a good faith effort to receive CMS approval. Therefore, the term "good faith effort" in criteria (2) and (4) above are synonymous with a "completed preprint." CMS also notes that there is no practical difference in giving a broader meaning to "good faith effort" for criteria (2) and (4), because under any reasonable interpretation of this phrase, we have ascertained that no additional SDPs beyond those already included under criteria (1) and (5) would be included.

Limits for Grandfathered SDPs

The phase down for grandfathered SDPs is effective for rating periods beginning on or after January 1, 2028. Until then, the total dollar amount of a grandfathered SDP (as specified in item 4 of the current SDP preprint form) cannot increase and a state cannot increase this amount under any change or revision to the grandfathered SDP, including a revision to the preprint,[14] amendment SDP,[15] or renewal SDP.[16] However, states may choose to decrease this amount at any time.

If a state's SDP qualifies for the grandfathering period under more than one rating period (e.g., SFY 2025 and SFY 2026), CMS will permit the SDP with the higher total dollar amount to be grandfathered.[17] Grandfathered SDPs must comply with the total payment rate limit and must not exceed 100 percent of the average commercial rate as specified in 42 CFR § 438.6(c)(2)(iii). Further details on the phase down requirements will be proposed as part of rulemaking.

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[11] https://www.medicaid.gov/federal-policy-guidance/downloads/cib11072023.pdf
[12] https://www.medicaid.gov/sites/default/files/2022-12/sdp-4386c-preprint-template-12192022.pdf
[13] The preprint addendum is an Excel document, entitled "Section 438.6(c) Preprint Addendum Tables" which can be downloaded from here.
[14] A revision to a preprint refers to a state submitting a revised preprint for a pending SDP under review by CMS.
[15] An amendment SDP is an SDP that specifies in Item 6(a) of the preprint form that it is an amendment.
[16] A renewal SDP is an SDP that specifies in Item 6(b) of the preprint form that it is a renewal.
[17] For example, if a state has an SDP preprint for a SFY 2025 rating period totaling $100 million (as specified in item 4 of the preprint form) that qualifies for the grandfathering period, and an SDP preprint for a SFY 2026 rating period totaling $105 million (as specified in item 4 of the preprint form) that qualifies for the grandfathering period, CMS would permit the state to utilize the $105 million SDP as the grandfathered SDP.

Next Steps

Every applicable SDP preprint for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center submitted to CMS before July 4, 2025 that does not qualify for the grandfathering period, must comply with section 71116 for each rating period beginning on or after July 4, 2025. For these SDPs, if applicable, the state must submit a revised preprint before CMS would continue its review, as required at 42 CFR § 438.6(c)(2)(i). For example, if the state has submitted a new SDP preprint[18] for a CY 2026 or SFY 2027 rating period that exceeds the applicable total payment rate limit required in section 71116(a), the state must revise the preprint before CMS would continue review. Additionally, any amendment or renewal SDP preprint that does not qualify for the grandfathering period must be revised, if necessary, to comply with section 71116 requirements before CMS would continue review.[19] For example, states will be required to revise any amendment or renewal SDP preprint that has a total dollar amount that is greater than the total dollar amount included in an SDP that is determined to be eligible for the grandfathering period (such as a CY 2026 SDP renewal for a grandfathered CY 2025 SDP).[20]

As previously outlined in this letter, certain SDPs including those for a SFY 2025, CY 2025, and SFY 2026 rating period for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center that were approved by CMS before the date of this letter are preliminarily grandfathered. For applicable SDP preprints that are currently under review by CMS as required at 42 CFR § 438.6(c)(2)(i), CMS will include preliminary feedback in our adjudication letters on whether that preprint is likely eligible for the grandfathering period. As a reminder, all approved SDP preprints and adjudication letters are posted on Medicaid.gov[21] on a routine basis. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that revises the initial assessment or as a result of regulatory changes.

States must ensure that all SDPs comply with all federal requirements, including section 71116 and in 42 CFR part 438.

Closing

CMS is committed to working with states to address fraud, waste, and abuse and to improve the program and fiscal integrity of the Medicaid program, and ensuring that SDPs comply with federal requirements, including section 71116. As part of CMS's standard process to review pending SDP preprints, CMS will provide preliminary feedback on whether an SDP is likely eligible for the grandfathering period as part of our standard adjudication letters. If you have any questions about this guidance, please contact StateDirectedPayment@cms.hhs.gov.

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[18] A new SDP is an SDP that specifies "yes" in item 5 of the preprint form.
[19] This example also applies to any future amendment or renewal of a grandfathered SDP.
[20] For example, if a state has a pending SDP preprint for a CY 2026 rating period totaling $55 million (as specified in item 4 of the preprint form) that is pending with CMS, and an SDP preprint for a CY 2025 rating period totaling $50 million (as specified in item 4 of the preprint form) that qualifies for the grandfathering period, the state would need to revise its CY 2026 SDP to be no greater than $50 million before CMS would continue review of the pending CY 2026 SDP preprint.
[21] https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints

Sincerely,

/s/

Caprice Knapp
Acting Deputy Administrator and Director