



# All-State Medicaid and CHIP Call

## May 27, 2026



# Agenda

- Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments Proposed Rule (CMS-2449-P)
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coverage Guide
- Community Engagement Outreach Toolkit
- Q&A



# Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments Proposed Rule (CMS-2449-P)



**CMCS All State Call**  
May 27, 2026

# Agenda of Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments

- General Background
- State Directed Payments in Medicaid Managed Care
  - Background: State Directed Payments
  - Proposed Rule Managed Care Policies
- Targeted Medicaid Practitioner Payments in Fee-for-Service
  - Background: Fee-for-Service Supplemental Payments
  - Proposed Rule Fee-for-Service Policies
- Conclusion

# General Background

- On June 6, 2025, President Trump signed a Presidential Memorandum titled “Eliminating Waste, Fraud, and Abuse in Medicaid”
  - The memorandum directed the Secretary of Health and Human Services to eliminate fraud, waste, and abuse in Medicaid, including by ensuring Medicaid payment rates are not higher than Medicare, to the extent permitted by applicable law.
- On July 4, 2025, Public Law 119-21 was enacted (which CMS refers to as the “Working Families Tax Cut” (WFTC) legislation).
  - Section 71116(a) of the WFTC legislation directed the Secretary to revise 42 CFR 438.6(c)(2)(iii) to limit the total payment rate for certain State directed payments (SDPs).
- On May 22, 2026 CMS published the Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments Proposed Rule (91 FR 30400).
  - The public comment period closes on July 21, 2026.

# General Background (continued)

- The proposed rule supports the Administration's priorities to promote financial integrity and operational efficiency in the Medicaid program through efficient stewardship of taxpayer funds.
- The proposed rule addresses payment limits in Medicaid managed care and fee-for-service (FFS), ensuring alignment between delivery systems.

# **State Directed Payments in Medicaid Managed Care**

# Background: State Directed Payments

- Generally, in Medicaid risk-based managed care, managed care plans are responsible for negotiating provider payment rates.
- A State directed payment (SDP) is an arrangement in which the State directs a managed care plan's expenditures under 42 CFR 438.6(c) regarding provider reimbursement.
- States are estimated to have paid over \$143.8 billion in SDPs in Federal Fiscal Year (FFY) 2025.
- SDPs accounted for over 14 percent of all national Medicaid benefit spending and 26 percent of Medicaid managed care payments in FFY 2025.
- SDP spending was projected to grow to over \$316 billion in FFY 2035 absent any additional limits or the impact of WFTC legislation.

# Proposed Rule Policies Tied to Section 71116 of WFTC Legislation

- Beginning with the rating period on or after July 4, 2025, all States and the District of Columbia must reduce the payment rate for certain SDPs with inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center to:
  - 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.
  - In the absence of a total published Medicare payment rate for the Medicaid covered service, the payment limit would be 100 percent of the State plan approved rate.
- The payment rate limit for SDPs would be assessed at the individual claim or service level rather than in aggregate.
- There are no exceptions to this SDP payment limit for certain providers of applicable services, unless the SDP qualifies for the temporary grandfathering period (as described on the next slide).

# Proposed Rule Policies Tied to Section 71116 of WFTC Legislation (continued)

- SDPs meeting certain criteria would be eligible for a temporary grandfathering period until the rating period beginning on or after January 1, 2028.
- A grandfathered SDP would be defined as an SDP for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at academic medical centers that meets all of the following:
  - Receives written prior approval by CMS;
  - Is for a rating period that includes at least 1 business day between October 11, 2024 and July 3, 2025, or July 5, 2025 and March 27, 2026;
  - Was described as a complete preprint with an eligible rating period and documented total dollar amount that was submitted to CMS on or before July 4, 2025; and
  - Exceeds the payment limit established in section 71116 of the WFTC legislation.
- Beginning with the rating period on or after January 1, 2028, the total dollar amount of a grandfathered SDP must be phased down by 10 percentage points annually until the payment limit is reached.

# Proposed Rule Policies – Managed Care

- Extend the payment limit under section 71116 of the WFTC legislation to all SDPs for all services in all States, the District of Columbia, and Territories beginning with the rating period on or after January 1, 2029.
- Permit states to adopt minimum or maximum fee schedule SDPs that are no greater than the applicable payment limit without CMS prior approval beginning with the rating period on or after January 1, 2028.
- Eliminate uniform increase SDPs as a permissible type of SDP beginning with the rating period on or after January 1, 2028.

# Proposed Rule Policies – Managed Care

- Permits certain flexibilities for grandfathered SDPs, until the payment limit is reached:
  - Delayed compliance with the proposed prohibition on uniform increases.
  - Delayed compliance with the existing separate payment term prohibition and preprint submission timing requirements.
- Clarifies payment arrangements that are considered impermissible practices or grey area payments.
- Requests comment and additional information to inform future rulemaking efforts on SDP provider class definitions.

# **Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments**

# Background: FFS Supplemental Payments

- FFS supplemental payments are defined in section 1903(bb)(2) of the Social Security Act generally as payments made to providers that are in addition to the base payment the provider receives.
- Many FFS supplemental payments are limited by a Medicare upper payment limit (UPL), but some supplemental payments or alternate fee schedules are permitted to the average commercial rate (ACR).

# Proposed Rule Policies - FFS

- Establishes a limit for targeted Medicaid FFS payments equal to:
  - 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
- This limit would apply for all payments for services not subject to an existing limit, like a UPL, where a payment is targeted to a subset of practitioners or providers within a geographic area.
- Where no Medicare rate is available for the service(s) tied to the payment, a State must demonstrate the rate is economic and efficient through alternate means.

# Proposed Rule Policies – FFS (continued)

- States with approved State plan payments that exceed the proposed FFS limits would be required to submit a State plan amendment to remove these payments or update them to comply no later than the first State fiscal year that begins on or after January 1, 2029.
- The new limit would otherwise apply to new payment proposals after the effective date of a final rule.

# Conclusion

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**Please submit questions or comments on the proposed rule via the Federal Register.**

**The comment period closes on July 21, 2026.**



# Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coverage Guide

*Susan Ruiz*

*May 27, 2026*

# What is the EPSDT Coverage Guide?

- A compilation of longstanding policy in one place.
- A reference for state staff and others that uses plain language to explain how various EPSDT requirements work together with other Medicaid policies.
- Part of the CMS portfolio of child-focused work, along with the Children's Behavioral Health Toolkit, quarterly technical assistance webinars, and reviews of each state's EPSDT implementation.



# What's in the Coverage Guide?

- **Descriptions of EPSDT requirements, such as:**
  - Informing
  - Screenings
  - Diagnostic and treatment services
- **Sections on the interplay between EPSDT requirements and:**
  - Permissible limitations to services
  - Services available under other federal authorities
  - Notices and fair hearings
  - Managed care
  - Quality reporting and monitoring

# What's new?

- This Coverage Guide updates the previous version to:
  - reflect coverage of clinical trials
  - include Health Homes
  - add detail on the interplay of EPSDT services provided under Medicaid State Plan and other authorities, such as Home and Community Based Services waivers
  - include mandatory reporting on the Child Core Set of Quality Measures

# Questions?

- The guide will be a topic of an upcoming webinar for state staff, to review in more detail and answer questions.
- For questions, or to add staff to the mailing list for this and other EPSDT webinars, please contact [EPSDT@cms.hhs.gov](mailto:EPSDT@cms.hhs.gov).



# New Resource for States: Community Engagement Outreach Toolkit

Alyssa Walen

May 2026

# Community Engagement Outreach Materials

## Medicaid Changes are Coming!




### 4 Things to know

Medicaid eligibility rules are changing. If you have Medicaid or you're thinking about applying for coverage, here are 4 important things to know.

- You may need to meet a new monthly work requirement to qualify for Medicaid and keep your coverage. Some states have already started the new requirement and others will start soon.**  
If the new requirement applies to you, you must spend at least 80 hours each month on one or more of these activities:
  - Working (or earning at least \$580 a month).
  - Doing volunteer or community service.
  - Participating in certain job-training programs.
  - Participating in an educational program (like college, technical programs, or General Educational Development (GED) programs). If you're enrolled in school at least half-time (as defined by your school), you likely meet the new requirement. If you're enrolled less than half-time, your school hours can count toward your 80 hours.

You can combine different activities to reach your 80 hours.
- The new requirement applies to many (but not all) adults under 65.**  
It may impact you if all of these apply:
  - You live in a state where the new requirement applies. Contact your state Medicaid office to find out if your state is implementing the new requirement. Visit [Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip](https://www.Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip) to get the phone number for your state.
  - You're an adult between the ages of 19-64.
  - Your household income is up to 138% of the Federal Poverty Level (about \$22,025 a year for 1 person or \$29,863 for 2 people).
  - You don't qualify for an exclusion (some people might qualify for an exclusion if they're a parent or guardian of a child under 14, a member of an Indian or Urban Indian Tribe, pregnant, disabled, enrolled in Medicare, or a veteran with a total disability rating from the VA). Visit [Medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf](https://www.Medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf) for the full list of exclusions.

### General Awareness

Draft Message	Image concept:
<p>🔔 New Medicaid requirements are coming for adults. To keep your coverage, you may need to report the hours you work, volunteer, or go to school. See how they affect you. Visit [INSERT Medicaid website]</p>	 <p>(CE toolkit_image-3)</p>
<p>📌 If you're an adult on Medicaid, there are new steps to keep your coverage. You may need to work, volunteer or go to school -- and report your hours. See how the new requirements affect you. Visit [INSERT Medicaid website]</p>	 <p>(CE toolkit_image-4)</p>
<p>Medicaid rules are changing for adults! You may need to meet a work requirement to keep your Medicaid coverage. Visit [INSERT Medicaid website] for more information about the new Medicaid rules and how they might impact you.</p>	 <p>(CE toolkit_image-5)</p>

## Medicaid Community Engagement Requirements

### Qualitative Research Communication Summary

This summary of findings comes from a focus group study conducted with current Medicaid beneficiaries in four expansion states in early April 2026.

- Almost all participants had not heard about the new Medicaid work requirements.
- After reading a high-level description about the changes, participants understood the basics but had many questions.

#### Participants Lacked Awareness and Desire Specifics

After reading a high-level description, almost all participants said they hadn't heard of work requirements yet and desired more practical guidance. A list of common questions is provided in an appendix, but some of those questions are:

- What activities count?
- What documentation is required?
- Who verifies information?
- How often do you have to report?

#### Many participants could not determine if they qualify for exemptions

- Many weren't sure who determines if someone is exempt.
- Many weren't sure if they had to report that they were exempt.
- Uncertainty was highest among people with:
  - Chronic illness but no disability designation with the Social Security Administration (SSA)
  - Caregiving responsibilities

#### Message Guidance

We avoid describing the actual requirements because there are a variety of options to meet work requirements and to be exempt. These messages drive people to look for more information.

Short messages that motivate information seeking:

- "Medicaid rules are changing"
- "Find out how the new rules affect you"
- "Don't lose your coverage"
- "Keep your coverage"
- "Medicaid changes are coming"

Longer suggestions that combine these concepts:

- Don't lose your [state program name] coverage. Medicaid rules are changing for certain adults. Find out what you need to do.
- Do you have [state program name]? Rules are changing for certain adults under 65. Find out how they affect you, so you don't lose coverage.
- New requirements are here for certain adults on [state program name]. Find out what steps you need to take now so you don't lose your coverage.

#### Language to Avoid (If possible)

These terms are vague and can make it seem like requirements are optional.

- "May affect"
- "Stay engaged"
- "May help you keep your Medicaid"

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# Questions