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CMS Proposes New Medicaid Provider Payment Limits

Overview

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule on May 20, 2026, that would significantly change Medicaid provider payment limits in both managed care and fee-for-service (FFS) delivery systems. The proposal expands upon provisions established in H.R.1 and would place new limits on state-directed payments (SDPs) and certain fee-for-service payments.

Under the proposal, all SDPs would eventually be limited to 100% of Medicare rates for Medicaid expansion states and 110% of Medicare rates for non-expansion states. CMS also proposes new documentation, monitoring, and reporting requirements intended to demonstrate compliance with the payment limits.

Key proposed changes

- Expanding payment limits established in H.R.1 to all types of SDPs, not just for inpatient services, outpatient services, nursing facility services, and qualified practitioner services at academic medical centers
- Applying the same SDP payment limits to FFS supplemental payment arrangements that are targeted to a subset of providers within a provider class
- Limiting the types of permissible state directed payment methodologies over time
- Expanding documentation and provider-level reporting requirements
- Requiring additional payment comparisons and actuarial certifications
- Applying new oversight expectations for both managed care and fee-for-service supplemental payments
- Providing limited transition flexibility for certain [grandfathered SDPs](#)

Considerations for states

The proposed rule could require states to reassess existing financing strategies, directed payment structures, supplemental payment methodologies, and associated operational processes. States may

also need to evaluate data availability, provider payment monitoring capabilities, actuarial support requirements, and future financing approaches as part of long-term implementation planning.

Because the proposal affects both managed care and fee-for-service provider payments, states may need to consider impacts across multiple delivery systems, provider types, and financing mechanisms.

Looking ahead

CMS will accept public comments through July 21, 2026. If finalized, the rule could significantly reshape Medicaid provider payment and financing strategies over the coming years.

Mercer is continuing to evaluate the proposed rule and its potential implications for states, managed care organizations, and providers.

For More Information

To discuss the potential impact on your state Medicaid program, please contact authors, [Charlie Greenberg, JD, MPH](#), [Dianne Heffron](#), [Debbie Anderson](#), or your Mercer consultant.

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