Illinois Health and Hospital Association

June 1, 2026

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

TO: Chief Executive Officers, Member Hospitals and Health Systems
Chief Financial Officers
Government Relations Leaders

FROM: A.J. Wilhelmi, President & CEO
Ben Winick, Group Vice President, Healthcare Finance

SUBJECT: **State Directed Payment Limits under H.R. 1**

On May 22, 2026, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule on the implementation of limitations to State Directed Payments (SDPs) mandated by H.R. 1, also known as the Working Family Tax Cut Act (WFTC), formerly known as the One Big Beautiful Bill Act (OBBBA).

This memo outlines the history of SDPs, as well as the changes that have been proposed by CMS. The proposed rule goes beyond what is required under H.R. 1. If this rule is adopted, members should expect significant changes in the way that Illinois' current Hospital Assessment Program (HAP) is designed and implemented.

IHA will submit comments on the proposed rule on behalf of the full membership, and we encourage members to review the proposed rule and submit comments as well. Comments are due to CMS by July 21, 2026 and can be submitted *here*.

Background

Under current law, there are few regulations in place regarding the amount that Medicaid Managed Care Organizations (MCOs) are permitted to pay specific providers. Under existing regulations, CMS views those arrangements as private transactions that should not be interfered with by state Medicaid agencies. Prior to 2016, states frequently required MCOs to make specific payments to providers that were based on fiscal negotiations without any ties to utilization or quality of services provided to a state's Medicaid population (known as pass-through payments). In 2016, adopted federal regulations phased out these pass-through payments and introduced SDPs as a mechanism that could, so long as the SDP amounts were tied to utilization or quality, serve as an exception to the general requirements that states cannot require MCOs to make specific payments to providers.

In the Medicaid fee-for-service (FFS) delivery model, how much certain provider types (including hospitals) can be paid in the aggregate is limited by the Upper Payment Limit (UPL),

which is determined by how much Medicare would pay for the same level of service. No similar limit existed for payments made by MCOs. In 2017, CMS began receiving and approving requests for new SDPs which had payment levels that were above what Medicare would have paid. Unsure initially of how to handle these aggregate payment requests above Medicare, CMS informally adopted a policy that so long as payments were below the Average Commercial Rate (ACR) for that provider class, the requested SDP was approvable. This policy was formally adopted in regulations by CMS in 2024.

H.R. 1

H.R. 1 was signed into law by President Trump on July 4, 2025, and became Public Law 119-21. H.R. 1 made numerous changes to the Medicaid program for the purpose of significantly reducing federal spending, including a new limit on SDPs. Under H.R. 1, SDPs, when combined with claims-based payments, can no longer exceed 100% of Medicare in expansion states like Illinois or 110% of Medicare in non-expansion states. The law permits certain SDPs to be grandfathered in (which applies to all existing SDPs in Illinois), and requires grandfathered SDPs to be reduced by 10 percentage points each year beginning in calendar year 2028 until the payments are at or below the new limits. CMS' May 22, 2026 proposed rule implements this provision.

CMS Proposed Rule on SDPs

The proposed rule goes further than what is required under H.R. 1, making changes to SDPs that are fiscally conservative interpretations on how those provisions could be implemented.

CMS proposed that the phased-in reductions required by H.R. 1 will be from the total projected spend for all classes outlined in the SDP. The reductions would be 10% of that total each year as a fixed amount until the projected aggregate spend in the SDP is at or below the targeted amount (100% of Medicare). The SDP amount approved by CMS for the Illinois HAP in the aggregate is $8 billion per year. This means that beginning Jan. 1, 2028, the projected SDP amount that CMS may approve will need to be reduced by $800 million per year until total spending is projected to be at or below the Medicare level of spending. IHA believes this will be within four to five years once the reductions begin. During this period, the current HAP can likely continue to operate as-is, though at reduced levels of spending, until the targeted amount is reached.

Once reductions are complete and the grandfathering period is over, the proposed rule appears to fundamentally alter the HAP as currently constructed. Current SDPs are designed as a uniform dollar increase for each class. The proposed rule eliminates uniform dollar increases as a permitted type of SDP going forward once the grandfathering period is over. The proposed rule also establishes that the payment limit is not going to be treated in the aggregate across all hospitals (like the Upper Payment Limit for FFS) once the final payment limit comes into effect. Instead, the proposed rule reads as if the Medicare rate is going to be the limit on each individual discharge for SDPs.

While this may not impact hospitals classified as High Medicaid and Other Acute as severely, it may be difficult to determine the applicable payment limit for hospitals that receive payments from the HAP on a per diem basis. It appears that the payment limit will not be known until the time of discharge, and only at that point will it be possible to ascertain whether the per diem adjustments made based on the length of stay would put the total level of reimbursement above the Medicare limit. IHA will be seeking additional clarification in our comments on this proposed rule.

For hospitals that are not paid under the Medicare Prospective Payment System, such as Critical Access Hospitals, states may make SDPs up to the Medicare determined cost rate for those hospitals.

CMS also proposed these same limitations for all SDPs, not just for those services specifically outlined in H.R. 1 (i.e., hospital services, nursing facility services, and services provided by physicians at Academic Medical Centers (AMCs)). This means that SDPs for physician services would no longer be approved if the requested spending is above what Medicare would have paid for the same services in a hospital setting. This is the administration's attempt to limit the state's ability to shift spending from one provider type that is required to have reductions (i.e., hospitals) to those provider types which are not subject to the same limitations under the statute (i.e., clinics).

In 2024, CMS adopted regulations requiring all SDPs to be paid to the MCOs via capitation payments beginning Jan. 1, 2028. Currently, these payments are paid outside of the capitation rates as separate lump sums, often referred to as separate payment terms and conditions. The proposed rule would delay the capitation payment requirement for grandfathered SDPs until the targeted payment level is reached.

<u>Targeted FFS Payments</u>

Although not addressed within H.R. 1, in the proposed rule CMS also seeks to remove existing policies that permit states to receive State Plan approval for targeted payments to providers that are up to the ACR. Some of the providers specifically mentioned in the proposed rule are payments to physicians at AMCs and emergency medical transportation providers (i.e., ambulance services). CMS defines targeted payments as payment rates that are only being made available to a subset of providers within a provider type and that provider type is not otherwise subject to an Upper Payment Limit. If all physicians were paid under the state plan at the ACR, that would continue to be permissible under the proposed rule. If only physicians at AMCs are paid at the ACR, that is no longer allowable.

The state currently pays the ACR to physicians employed by the University of Illinois at Chicago College of Medicine and the Southern Illinois University School of Medicine. The state also has a State Plan Amendment pending with CMS to pay the ACR to physicians affiliated with other government-run medical schools that have hospital operations within the State of Illinois.

Under the proposed rule, targeted payments will be limited to the Medicare non-facility rate and must be implemented by July 1, 2029. This has a significant impact on the University of Illinois in particular, but other hospitals across Illinois may also be impacted by this proposed change if they have affiliations with a public medical school. Hospitals where these physicians practice should evaluate the potential impact of these changes on their relationship with those universities and their own ability to continue to provide impacted patient services if the university is no longer able to provide doctors capable of providing that level of care.

There are two notable exceptions to these limitations: (1) if there is not a Medicare comparable rate, and (2) if the rate is determined on a cost basis instead of the ACR. CMS is seeking comments on what an appropriate rate limitation would be in instances where a comparable Medicare rate does not exist. Illinois currently pays public emergency transportation providers (i.e., fire departments) on a cost basis, so those payments are not impacted by this proposed rule. Similarly, payments made for physician services within the Cook County Health and Hospital System are paid a cost-based encounter rate. Those payments are also not expected to be impacted by this proposed change.