OBBBA Harms People with Disabilities: Limits on State Directed Payments

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The One Big Beautiful Bill Act (OBBBA) includes many provisions that will harm people with disabilities. In this brief, we explain how the bill limits State Directed Payments (SDPs), discuss how these cuts will lead to slower and fewer services for disabled people, and offer potential avenues for future advocacy.

What are State Directed Payments?

Nationwide, 75% of Medicaid enrollees, including people with disabilities, get care through managed care plans run by private companies (MCOs).[1] States pay MCOs a fixed amount for each enrollee to administer Medicaid benefits, regardless of how many services a person uses. States are traditionally not involved in determining what rates MCOs pay their providers.

Provider rates directly influence access. When rates are too low, providers are less likely to participate in Medicaid, which limits care for enrollees and leads to longer wait times. That means services covered on paper may not actually be available. To address this, the Centers for Medicaid & Medicare Services (CMS) allows states to use SDPs.[2] SDPs let states require MCOs to pay certain providers more, to improve care and expand provider options.[3] States can use SDPs to set minimum or maximum provider rates for certain services (prior to OBBBA, up the Average Commercial Rate (ACR)), apply uniform rate increases for specific provider

[1] Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2022* (Dec. 2024), https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-30.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2022.pdf.

[2] Centers for Medicare & Medicaid Servs. (CMS) Final Rule, 81 Fed. Reg. 27,498 (May 6, 2016), https://www.federalregister.gov/d/2016-09581.

[3] Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Directed Payments in Medicaid Managed Care* (Oct. 2024), https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf; Scott Hulver, Alice Burns, and Jessica Mathers, Kaiser Family Foundation, *Reconciliation Language Could Lead To Cuts in Medicaid State-Directed Payments to Hospitals and Nursing Facilities* (June 27, 2025), https://www.kff.org/medicaid/issue-brief/reconciliation-language-could-lead-to-cuts-in-medicaid-state-directed-payments-to-hospitals-and-nursing-facilities/.

groups, or require MCOs to adopt value-based payment systems such as pay-for-performance programs.

Since February 1, 2023, CMS has approved over 800[4] new, amended, or renewed SDPs across 41 states, Washington, D.C., and Puerto Rico, including SDPs for:

- **Long Term Services and Supports (LTSS):** States leverage SDPs to improve access to and quality of long-term care services in a variety of ways. Citing the ongoing effects of COVID-19 on nursing home services in the state, an $80 million SDP in Tennessee provides a uniform payment increase for nursing facilities (3.6% rate increase for providers, which at the time was 80% of the ACR) that the state characterized in its application form as "provider stabilization funds".[5]
- **Home and Community Based Services (HCBS):** All but 11 states currently use MCOs to provide at least some HCBS for people with disabilities, so SDPs are a way to ensure adequate wages for HCBS providers that contract with MCOs.[6] Low wages for direct service providers have caused widespread shortages and inadequate care for people with disabilities.[7] States use these SDPs to ensure that Managed Care plans set adequate wages for essential direct care workers who deliver HCBS to Medicaid recipients.
- **Preventive Services:** Oklahoma uses a $134 million SDP to incentivize the provision of specific services when they are furnished by select providers, including behavioral health providers.[8]

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[4] CMS, Approved State Directed Payment Preprints, https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints (last visited 11/16/2025).
[5] Centers for Medicare & Medicaid Servs., Tenn. State Directed Payment Amendment (Jan. 1, 2025 - Dec. 31,2025), https://www.medicaid.gov/medicaid/managed-care/downloads/TN_Fee_NF_Amend_20250101-20251231.pdf.
[6] Alice Burns, Maiss Mohammed, Priya Chidambaram, Abby Wolk, and Molly O'Malley, Kaiser Family Foundation, *Payment Rates for Medicaid Home Care: States' Responses to Workforce Challenges* (Feb 18, 2025), https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-care-states-responses-to-workforce-challenges/.
[7] Centers for Medicare & Medicaid Servs., *Workforce Shortages in Home and Community-Based Services (2025)*, https://www.medicaid.gov/home-community-based-services/downloads/wrkfrce-shtgs-in-home-cmunty-bsed-srvcs.pdf.
[8] Centers for Medicare & Medicaid Servs., Okla. State Directed Payment Amendment (Apr. 1, 2024 – June 30, 2025), https://www.medicaid.gov/medicaid/managed-care/downloads/OK_Fee_Oth2_New_20240401-20250630.pdf.

OBBBA Changes to SDPs

OBBBA sets new limits on the way states can use SDPs. Effective July 4, 2025, states cannot use SDPs to set rates above certain limits for four specific services: inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center.[9] The maximum allowed rate for these four services cannot go above 100% of the Medicare rate in states that have expanded Medicaid and 110% of the Medicare rate in non-expansion states. These Medicare caps are likely to be significantly lower than the previous cap based on the ACR.[10]

SDPs that are not new – in other words, those approved before May 1, 2025, (or in the case of an SDP for a rural hospital, by date of enactment) – will still be reduced over time. These SDPs must be reduced, effective January 1, 2028, by 10% per year until they reach 100% of the Medicare rate (expansion states) or 110% of the Medicare rate (non-expansion states).[11] In some cases, a service may not have a published Medicare rate. When there is no published Medicare rate, the 100% or 110% ceiling is applied to the relevant Medicaid State Plan rate.

According to the Congressional Budget Office, the change to SDPs under OBBBA will result in over $149 billion in federal cuts over the next ten years.[12] On September 9, 2025, CMS released guidance announcing plans to update the rules for SDPs, as required by OBBBA.[13] The agency also said that it is considering payment limits to more SDP services, not only the four services mandated by OBBBA.

The Harm to People with Disabilities

Reducing SDPs means that states have less ability to influence MCO provider rates in hospitals, academic medical centers, and nursing facilities. Specifically for people with disabilities, this could mean lower rates for LTSS providers in nursing homes, as well as providers that furnish

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[9] Pub. L. 119-21, § 71116 (2025).

[10] In addition to the direct changes to SDP limits, OBBBA also limits provider taxes, which have been a key source of state funding for SDPs. See Geraldine Doetzer, National Health Law Program, *Medicaid Financing After OBBBA: State Directed Payments and Provider Taxes* (Sept. 17, 2025), https://healthlaw.org/resource/medicaid-financing-after-obbba-state-directed-payments-and-provider-taxes/.

[11] Revising 42 C.F.R. § 438.6(c)(2)(iii).

[12] Cong. Budget Off., Medicaid Baseline, 2025-2035 (Pub. No. 61570) (2025), https://www.cbo.gov/publication/61570.

[13] Centers for Medicare & Medicaid Servs., *Section 71116 of One Big Beautiful Bill Act on State Directed Payments* (Sept. 9, 2025), https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-09092025.pdf.

services to people with disabilities in hospitals and academic medical centers. In turn, this leads to reduced access to care, closures of hospitals and nursing facilities, and a reduction of LTSS capacity, including home and community-based services. As noted above, CMS may also issue regulations that include payment limits on other services or groups of providers that serve people with disabilities, beyond those required in statute, which could directly affect HCBS and Direct Care Workers.[14]

The loss of billions in federal funding as a result of this cut and others in OBBBA will create a budget hole that will force states to cut eligibility and services.[15] When confronted with drastic shortfalls in federal funding, states are more likely to respond with their own cuts to provider payments, benefits, and eligibility. States are likely to try to make up budget shortfalls by eliminating or curtailing optional benefits that have become core to the Medicaid program in many states, such as HCBS.[16] The cuts will also drive up uncompensated care, forcing many care providers to close, particularly in rural communities.[17] People will need to travel long distances to care — distances that will make accessing health care even more difficult for many disabled people.

In short, capping SDPs threatens state efforts to ensure adequate wages for providers, especially for services already strained by workforce shortages. This will lead to fewer providers and trickle-down cuts on essential services for people with disabilities, including those who rely on HCBS.

Opportunties for Advocacy

- **Education:** Advocates can review how their state is using state directed payments by visiting this website: **https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints**. By choosing "advanced search," this page can be filtered by state and by

[14] *Id.*
[15] Madeline Morcelle, Nat'l Health Law Prog., *Medicaid Work Requirements Would Gut State and Local Economies* (March 14, 2025), https://healthlaw.org/resource/medicaid-work-requirements-would-gut-state-and-local-economies/.
[16] Schubel, et al., History Repeats? Faced With Medicaid Cuts, States Reduced Support For Older Adults And Disabled People, Health Affairs (Apr. 16, 2025), https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled.
[17] *Id*; Amani Echols, Rolonda Donelson, and Madeline Morcelle, Nat'l Health Law Prog., *Gender Justice Coalition Letter to Congress: Medicaid Cuts Endanger Maternal and Child Health* https://healthlaw.org/resource/gender-justice-coalition-letter-to-congress-medicaid-cuts-endanger-maternal-and-child-health/.

"Provider Class." Knowing which providers receive state directed payments and therefore which services are likely to have payment reductions can help advocates prepare to respond to future cuts. The descriptions of the SDP may detail the relationship to Medicare rates, if it is a service that Medicare pays for. In other cases, rates may be expressed as a percentage of ACR, and advocates may need to determine the equivalent Medicare rate. If there is not an equivalent Medicare service, advocates may need to look up the Medicaid State Plan rate.

- **Accountability:** Even if a state is limited in its use of SDPs, states still have an obligation to ensure that individuals receiving Medicaid services can access such services.[18] States must set payment rates for services high enough to enlist sufficient provider participation and give individuals access to services comparable to those available in other forms of coverage. In the managed care context, for certain services, appointment wait time standards exist, and starting in 2028, compliance will be monitored by secret shopper surveys.[19] Advocates may want to focus on results of secret shopper surveys where SDPs are set to be reduced, and carefully document challenges with access.

- **Meeting LTSS Needs**: Even if a state is subject to an SDP limit for nursing facility services, individuals' needs for LTSS will not disappear. Advocates may want to highlight the need for increased funding for HCBS, to offset any reduced funding for nursing facilities due to caps on SDPs, and to meet the needs of people who need LTSS in different settings when possible.

- **Monitoring Future HCBS Threats:** Advocates should watch for additional services to be subjected to an SDP cap, with a particular focus on HCBS. If such restrictions are added, advocates can leverage participation in the newly established "Interested Parties Advisory Group" to advise on payment rates for certain home and community-based services. States must establish these work groups to inform the state on the adequacy of rates for direct care workers who provide HCBS.[20] Advocates can ensure that MCOs are included in IPAGs, are able to speak to the impact of any limits on SDPs to accessing services, and make formal recommendations to states regarding rates, and take steps to maximize IPAG findings.

[18] 42 U.S.C. § 1396(a)(30)(A).
[19] 89 Fed. Reg. 40542 (May 10, 2024) (codified at 42 C.F.R. pts. 431, 438, 441 & 447.
[20] 42 C.F.R. § 447.203(b)(6).