ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

DATA POINT

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Only 7.8% of all SDP Spending Goes to Rural Hospitals.

$75.2 billion of the estimated $81.6 billion in savings (92.1%) from 2026-2035 comes from preventing rural state directed payment spending from increasing above its 2025 level of $11.5 billion annually.

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KEY POINTS

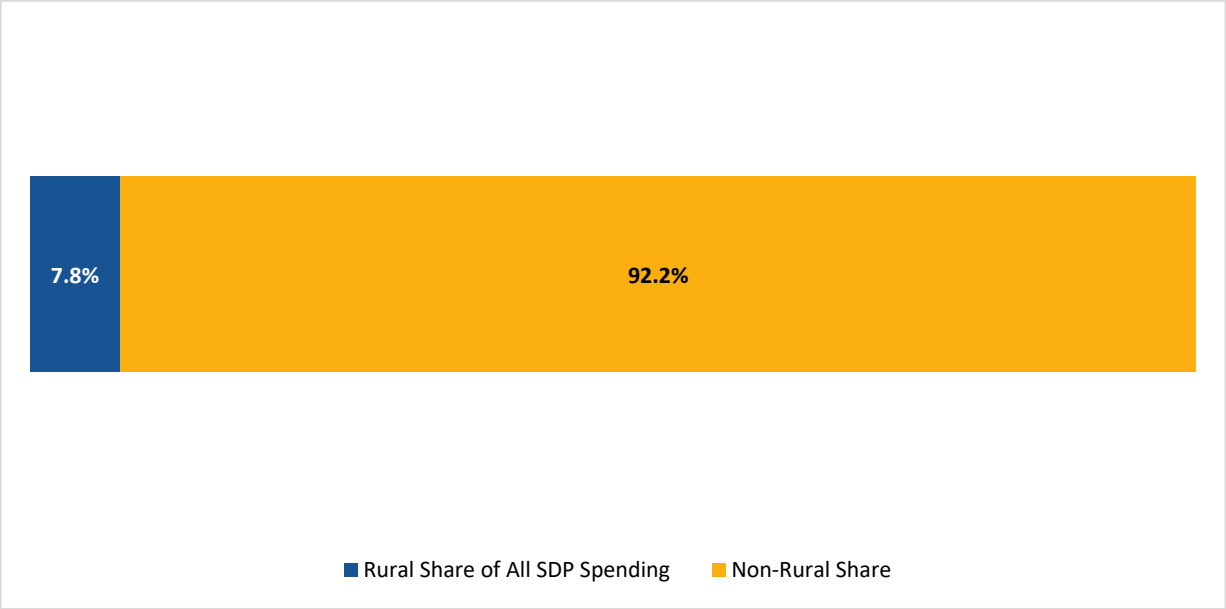
- State directed payments (SDPs) for inpatient and outpatient services at rural hospitals accounted for only 7.8 percent of total SDP spending in FY2025.
- The overwhelming majority (92.1 percent) of savings associated with the 2025 Working Families Tax Cut Legislation attributable to rural hospitals are savings derived from theoretical foregone growth.

BACKGROUND

Enacted July 4, 2025, the Working Families Tax Cut Legislation (WFTCL) is a broad budget reconciliation law that changes federal tax, spending, and health policy. Before the WFTCL, CMS's 2024 managed-care rule set the average commercial rate (ACR) as the ceiling on total provider payment rates for certain state directed payments (SDPs), including inpatient and outpatient hospital services. WFTCL lowers the ceiling to 100 percent of the published Medicare rate in Medicaid expansion states and 110 percent in non-expansion states; qualifying existing SDPs are temporarily grandfathered and begin phasing down by 10 percentage points annually with rating periods beginning on or after January 1, 2028. [1] ASPE has identified broad effects on lowering non-Medicaid prices and from the SDP and provider-tax changes.[2,3] The analysis in this Data Point builds on that work by focusing specifically on SDPs for health care services in rural areas.[i] This is important for properly assessing how the WFTCL will affect health funding in rural areas, given recent research showing that most SDP payments went to non-rural hospitals.[4]

Rural inpatient and outpatient hospital payments accounted for approximately $11.5 billion, or 7.8 percent, of the $148.3 billion in identified FY2025 SDP spending included in the analytic sample. CMS Office of the Actuary (OACT) estimates indicate that rural hospitals received about $21 billion, or 7 percent, of the $291 billion in national Medicaid inpatient and outpatient hospital spending in FY 2025.[5]

Figure 1. Rural Share of SDP Spending



Notes: The 7.8 percent SDP share equals $11.5 billion in estimated rural inpatient and outpatient hospital SDP spending divided by the complete SDP baseline of 148.3 billion in FY 2025 calculated from the CMS OACT SDP pre-print data.

METHODS

In this Data Point we analyzed CMS OACT SDP preprint data covering FY2025, defined by rating-period start dates from October 1, 2024 through September 30, 2025. Our analytic sample includes payments where the provider class had a geographically rural designation or was explicitly for a rural emergency hospital (REH) or a critical access hospital (CAH)[ii]. We define rural SDPs as SDP payments to rural hospitals, including payments made through SDP arrangements that cover both rural and non-rural hospitals. Our analysis focuses on the

[i] In FY 2025 these were all at rural hospitals.
[ii] We also included one SDP for sole community hospitals (most of which are rural).

rural hospital recipients of these payments, rather than whether an SDP arrangement exclusively targets rural hospitals.

Total FY2025 SDP spending was $148.3 billion. For 7.6 percent of the sample, we cannot identify whether this spending was for a rural provider or not, therefore total spending with a known rural/non-rural provider classification is $137.1 billion. In this sample, rural hospital payments accounted for approximately 7.8 percent of sampled spending ($10.6/$137.1 billion). We applied this 7.8 percent share to the total FY 2025 spending ($148.3 billion) to estimate $11.5 billion in FY2025 rural hospital SDP spending and scaled the modeled rural SDP phasedown under the WFTCL accordingly. All payments in the sample used ACR as the rate basis; on average, Medicaid reimbursement inclusive of the SDP equaled 87.7 percent of ACR, or 204.8 percent of Medicare.[iii] To calculate SDP spending under the WFTCL, we first determined the full-phase payment limits by converting the provider-service specific final payment rates (inclusive of base payments, other adjustments, SDP payments, and pass-through payments) from Medicaid-to-ACR ratios to Medicaid-to-Medicare ratios.

We then calculated remaining SDP dollars by multiplying reported SDP dollars by the share of the original SDP that could remain below the new statutory limit in each year and aggregated the results across states. We then incorporated a quantity adjustment equal to 5 percent of FY2025 SDP spending for each year after FY2025, without compounding, as an assumed proxy for quantity growth.[iv] Adding our two cumulative adjustments together (a negative change in SDP payments relative to FY2025 and an increase in quantity) gave us the total estimated change in SDP spending relative to FY2025. Overall, we calculate that total nominal cumulative spending on rural SDPs falls by 42.9 percent from 2026-2035, whereas OACT estimates that total cumulative spending falls 40.8 percent during this period.[6] We estimate a larger spending decline in our sample because the average dollar weighted payment rates are higher for rural SDPs than the average of all SDPs (88.4 percent ACR vs 85.6 percent in 2025), which means that rural providers have more room to reduce rates to meet the new limits of 100 to 110 percent of Medicare.

For the pre-WFTCL baseline, we increased estimated total FY2025 rural hospital SDP spending using year-specific nominal growth rates, so that total payments increased by approximately 89% from 2026–2035, reflecting the same baseline growth rates estimated by OACT.[6,v]

FINDINGS

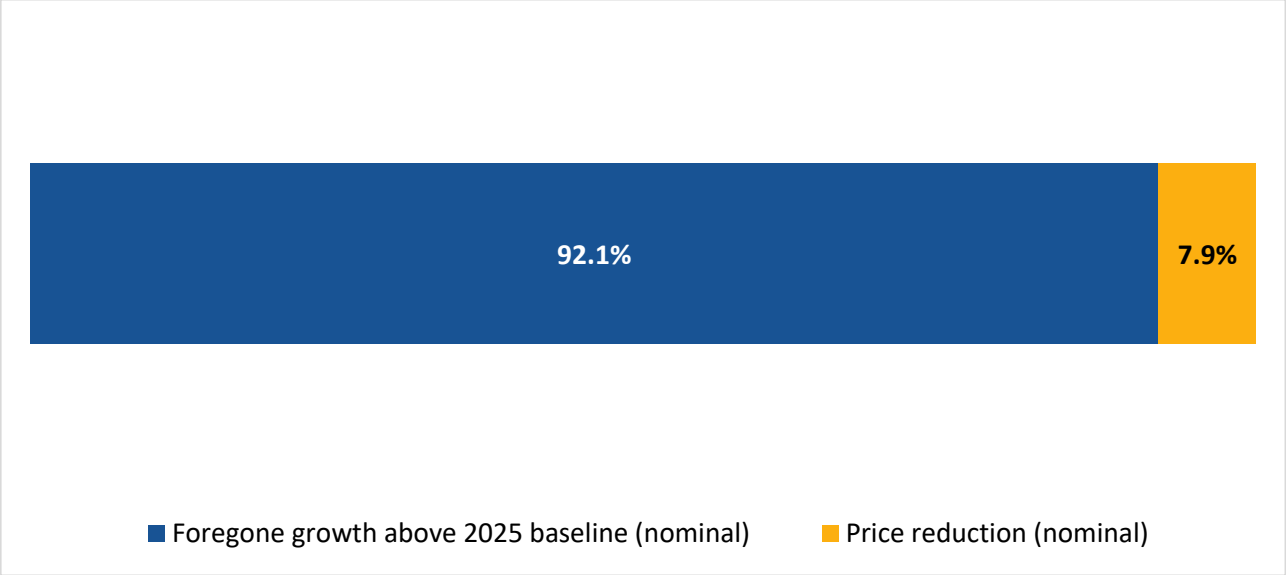
Figure 2 shows that 92.1 percent of the nominal projected rural SDP savings will come from payments not increasing beyond their estimated FY 2025 level of $11.5 billion. The remaining 7.9 percent comes from modest payment reductions. This shows that the vast majority of spending reductions on rural hospital services are the result of payments not continuing to increase beyond their 2025 level, as opposed to a payment reduction.

[iii] Using 2026 CMS assumed commercial-to-Medicare payment ratios of 1.89 for inpatient services and 2.63 for outpatient services from https://www.federalregister.gov/documents/2026/05/22/2026-10292/medicaid-program-medicaid-managed-care-state-directed-payments-and-medicaid-fee-for-service-targeted#h-52 (Table 14).

[iv] The 5 percent assumption followed OACT modeling, which assumes that SDP payments would grow 5 percent annually. We applied this rate as an assumed, non-compounding quantity-growth proxy relative to FY2025 SDP spending. Considering that rural SDPs represent 7.8 of total SDP spending and had a 3.3 percent higher dollar weighted payment rate in 2025 (88.4 vs 85.6 percent of ACR), using the 5 percent quantity increase led us to estimate rural SDP savings of about 8.2 percent of total SDP suggesting that our quantity adjustment is the appropriate size.

[v] OACT's national current-policy SDP projection increases from $167.4 billion in FY2026 to $316.0 billion in FY2035, equivalent to approximately an 89 percent increase from 2026-2035, implying a compound annual growth rate of approximately 7.3 percent.

Figure 2: Share of Nominal Rural SDP Savings (Reduction) Coming from Theoretical Foregone Growth above 2025 level vs A Payment Reduction



Note: Calculation for rural SDPs based on ASPE analysis of CMS OACT SDP pre-print data. In the baseline, rural SDP spending was projected to increase from $11.5 billion in 2025 to $25.3 billion in 2035. $75.2 billion of the total $81.6 billion (92.1%) estimated savings came from payments not increasing beyond $11.5 billion per year.

CONCLUSION

Rural hospitals accounted for only 7.8 percent of total SDP spending in FY2025. Without the WFTCL, SDP spending could have continued increasing as Medicaid reimbursement rates approached 100 percent of average commercial rates. Our analysis finds that 92.1 percent of the projected rural SDP savings comes from limiting future spending growth above FY2025 levels. Only 7.9 percent comes from reductions below those levels. The projected savings primarily reflect slower spending growth, rather than cuts below existing spending levels.

APPENDIX: DETAILED METHODOLOGY

Our sample consists of SDPs to rural providers, all of which were rural hospitals providing inpatient and outpatient services. After applying all sample restrictions (keeping only rural SDPs), we retained 292 payment lines covering 21 SDP applications in 13 states. For the remaining 37 states and DC we set SDP payments to 0. The national sum is therefore the sum of payments in the 13 states with SDPs and no SDP spending in the remaining states and DC. All payments in the sample used the average commercial rate (ACR) as their rate basis; the average total Medicaid payment rate was 87.7 percent of ACR, while the SDP-dollar-weighted rate among the modeled rural-hospital payments was 88.4 percent of ACR.

To express WFTCL's Medicare-based limits on the same scale, we used Medicare-to-commercial ratios of 100/189 for inpatient services and 100/263 for outpatient services, then applied a limit of 100 percent of Medicare in expansion states and 110 percent in non-expansion states. For each payment line, we added the base rate, other adjustments, and pass-through payments, then calculated the allowable SDP increase as the lesser of the original increase or the remaining amount below the applicable limit, with negative amounts set to zero. We multiplied reported SDP dollars by the allowable SDP increase divided by the original SDP increase and aggregated the resulting amounts across payment arrangements and states. We then modeled fixed annual phase-down steps equal to 10 percent of original SDP dollars beginning in FY2028, stopping at each arrangement's full-phase amount, and added an assumed quantity adjustment equal to 5 percent of FY2025 SDP spending for each year after FY2025, without compounding. We converted nominal estimates to real 2026 dollars by dividing by the annual ratio of OACT's nominal and real baseline projections in Tables 13 and 18. For the nominal savings decomposition, we compared cumulative baseline and WFTCL spending with ten years of fixed FY2025 spending. Baseline spending above that reference represented foregone growth; the difference between the reference and WFTCL spending represented the remaining savings.

REFERENCES

1. Centers for Medicare & Medicaid Services, “Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F),” Fact Sheet, April 22, 2024, https://www.cms.gov/newsroom/fact-sheets/medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and-quality-final-rule. Public Law 119-21, § 71116, 139 Stat. 303–04 (2025), https://www.congress.gov/119/plaws/publ21/PLAW-119publ21.pdf#page=232.

2. Lipson, Debra J. “New Medicaid State-Directed Payment Limits Are Likely to Decrease Medicaid Spending by 10–25 Percent in 17 States.” *Health Affairs*, vol. 45, no. 9, 2026, pp. 986–93. https://doi.org/10.1377/hlthaff.2026.00116

3. Mulligan, C.B, Volkov, E., Whitman, A., Lee, A., Malani, A., Knapp, C., Bai, G. An Overview of State-Directed Payments and Medicaid Provider Taxes: History and Potential Effects of the Working Families and Tax Cut Legislation on Health Care Costs. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. September 2026. Accessed at: https://aspe.hhs.gov/sites/default/files/documents/9c1230f7f2cac6000a60fd5ed8e8849c/State-Directed-Payments-Report.pdf

4. Medrano, Chris, and Atticus Vernacchio. “In 2025, Over 90% of SDP Spending in TX and AZ Scheduled for Non-Rural Hospitals.” Paragon Health Institute, 6 Oct. 2026. https://paragoninstitute.org/paragon-pic/in-2025-over-90-of-sdp-spending-in-tx-and-az-scheduled-for-non-rural-hospitals/

5. The White House. 2025. *The One Big Beautiful Bill Is a Historic Investment in Rural Healthcare*. Memorandum. https://www.whitehouse.gov/wp-content/uploads/2025/07/OBBB-Rural-Memo.1.pdf.

6. Centers for Medicare & Medicaid Services. “Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments.” *Federal Register*, 22 May 2026, www.federalregister.gov/documents/2026/05/22/2026-10292.

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