Payment Reforms:

Accounting, Compliance, & Reimbursement

February 26, 2026

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Agenda

1. Factors Impacting State-Directed Payment (SDP) Program Revenue Recognition
2. Rural Health Transformation Program (RHTP) Funding Uniform Guidance & Other Compliance Considerations
3. Recent Reimbursement Development & Strategic Insights for Adapting to Payment Reforms

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Your Presenters

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Factors Impacting SDP Program Revenue Recognition

SDP Program Background

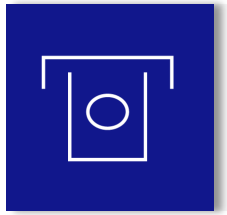
SDPs: Overview

SDPs allow states to direct Medicaid MCO payments to providers using state-defined methodologies that are tied to the state's quality strategy and applied uniformly to a state defined class of providers

- Individual states design their plan (*i.e.,* provider class, payment methodology, pool size, quality metrics) and submit SDP preprint to CMS for approval
- Upon approval by CMS, MCOs make payments based on state defined methodology often distributed pro-rata from the provider pool based on Medicaid utilization metrics (days, visits, paid claims)
- Quality add-ons and retrospective pool reconciliations are common
- Most SDPs are funded through provider taxes and intergovernmental transfers as permissible Medicaid funding sources to allow states to magnify each dollar through federal matching
- Stay tuned for future updates to the SDP program

SDP Program Background: Continued

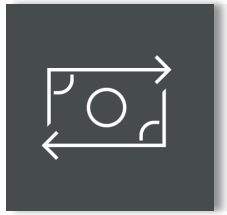
OBBBA signed into law on July 4, 2025, resulting in an estimated $1T reduction in federal Medicaid funding over 10 years, and included the following SDP implications:



Imposes caps on SDP rates tied to Medicare (100% expansion states/110% non-expansion states)

Allowed grandfathering for SDPs for good faith effort completed preprints at higher rates

Permitted grandfathered SDPs to continue paying at higher ACR-based payments allowed until Jan 1, 2028



CMS estimated SDP funding for FY2026 of $144.5 billion

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State-Directed Payments: Recent Developments

2/2/2026 CMS Letter: Expands the scope of SDP programs that qualify for temporary grandfathering under Section 71116 of the OBBBA

- Change from calendar days to business days for the 180-day window (originally 180 days before or after 7/4/2025)
- Warns states not to revise previous preprints

	9/9/2025 CMS Letter	2/2/2026 CMS Letter	Impact
Grandfathering Rate Period	1/5/2025–7/3/2025 & 7/5/2025–12/31/2025	10/11/2024–7/3/2025 & 7/7/2025–3/27/2026	Broaden SDPs that are grandfathered
Eligible Rating Periods	SFY25, CY25, SFY26	+ CY24 & +CY26	Adds additional years of SDPs
Calculation of 180 days	Calendar days	Business days	Extends window substantially
Warning About Circumvention	None	Included	Stronger compliance posture

State Directed Payments

Impact of 2/2/2026 CMS Letter

- Originally grandfathered at CY2025 amounts
- Now grandfathered at CY2026 amounts
- Increases grandfathered SDPs by $700M
- Softens the blow of 2028 scheduled cuts

SDPs Revenue Recognition Considerations

ASC 606 revenue recognition framework unchanged but current regulatory environment introduces complexity in estimating and recognizing revenue. **Does a contract exist?**

01 **Evaluation on a state-by-state basis**

02 **Varied provider year-ends complicate the assessment**

03 **Provider eligibility must be confirmed under the state specific SDP**

04 **Was SDP program approved before July 4, 2025, OBBBA date**

05 **State + CMS approval timing critical**

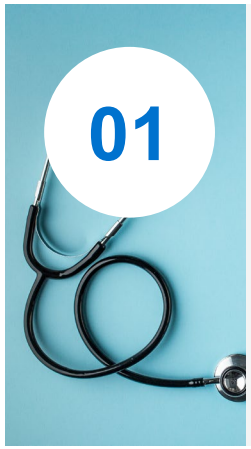
06 **SDP program fiscal year-end differences from provider year-ends add another factor**

SDPs Revenue Recognition Considerations

Key Factors to Consider

CMS Approval

Significant changes to the historical SDP. Does SDP meet the OBBBA grandfathering provisions?



If CMS approval has not occurred as of a provider's year-end, is subsequent approval by CMS substantive or more administrative in nature?

Medicaid Service Utilization

SDP is influenced by MCO attribution and encounter patterns, which may increase variability of performance obligations.

What are the SDP defined Medicaid service utilization performance obligations?

SDPs Revenue Recognition Considerations

Perhaps the most challenging step related to SDP programs is determination of the transaction price and variable constraint considerations:

- Payments are often distributed based on pool proportional service utilization
- Reminder that variable consideration can only be recognized to the extent a significant reversal will not occur when uncertainty is resolved

What are the challenges?

> Lack of transparency into underlying participating provider pool data
>
> Quality based metrics may be provider-specific, pool-based, or a combination of both
>
> Retrospective reconciliation settlements with potential provider appeals
>
> Lack of historical SDP program information

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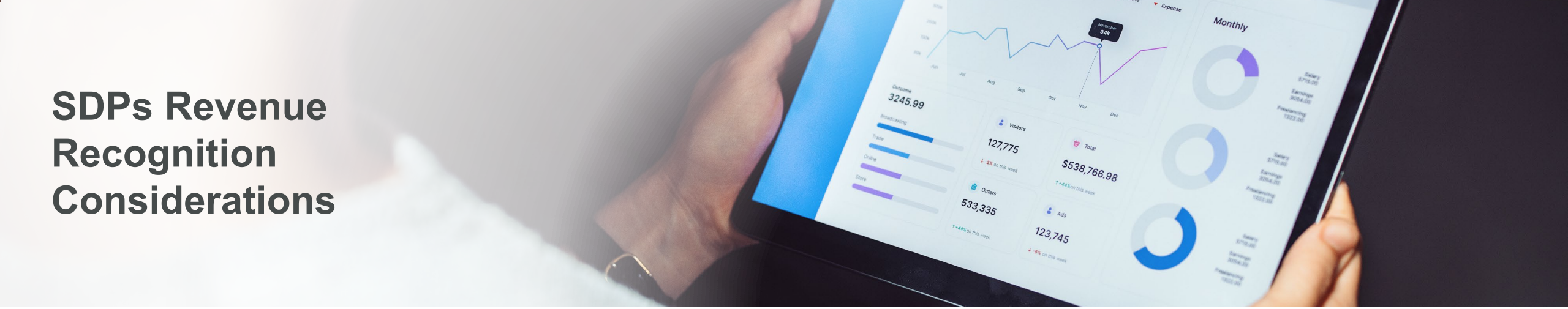
SDPs Revenue Recognition Considerations



Varying Conclusions

Inconsistencies across the industry are likely as conclusions are dependent on individual state-specific program design, CMS approval dates, provider FYE, SDP program FYE, timing and availability of underlying performance obligation data/metrics, etc.

Baseline Payments

Providers may conclude that they can estimate the baseline payments, but none or only a portion of the quality component due to significant uncertainty constraining such revenue.

Subsequent Information

Consideration should be given to information that becomes available subsequent to a provider's year-end through the date the financials are issued or available to be issued.

Is subsequently available information recognizable in the current year or non-recognized until subsequent fiscal year that may require disclosure.

SDPs Revenue Recognition Action Plan

Providers should formally document their considerations and assumptions utilized to formulate their conclusion, including variable constraint considerations.

Management should consider robust financial statement footnote disclosures including state-specific SDP program summary information, amount of revenue recognized in the periods presented, uncertainties and key assumptions associated with estimates, amounts that cannot yet be estimated, and the amounts recognized in the current year related to revisions of prior-year estimates, like third-party settlements.

RHTP Funding Uniform Guidance & Other Compliance Considerations

RHTP Overview

What Is It?

A federal funding initiative designed to **strengthen rural** healthcare

Administered by **Office of Rural Health Transformation (ORHT)**

Commits **$50 billion** over five years (2026–2030), $10 billion each year

- 50% baseline funding (all 50 states have been approved and will be awarded to states equally)
- 50% for workload funding – based on workload data such as state policies and data metrics
- 2026 state specific amounts were approved in December 2025 (for both parts)
- Funding amounts for states after first year will be determined through annual compliance and performance reassessments by ORHT
- For providers:
  - Applications to be submitted per state guidelines to seek funding
  - Timing of applications to be submitted by providers will depend on initiatives/work plan of each state
  - For eligibility purposes, be sure to review state application

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Compliance Considerations

Allowable uses of funds

- Preventative medicine and chronic disease management
- Provider payments – reimbursements for rural health services (no more than 15%)
- Telehealth and IT infrastructure (no more than 5% on electronic medical record (EMR) upgrades if EMR system was in place at 9/1/2025)
- Mental health, behavioral health, and substance abuse
- Training and technical assistance
- Innovative care models – value-based care, alternative payment models
- Capital expenditures (no more than 20%) – facility upgrades, equipment, and minor renovations
- Workforce recruitment – incentives for rural service commitments (minimum five-year commitment)
- Community collaboration
- Travel – when necessary for project following standard federal cost rules

Compliance Considerations

- **Non Allowable** uses of funds will be outlined in your Notice of Award (grant agreement)

- New construction or major facility upgrades
- Pre-award spending
- Supplanting
- Replacing payment (revenue) for clinical services that could be reimbursed by insurance
- Clinician salaries or wages at facilities with non-compete agreements
- Independent research and development
- Covered telecommunications and video surveillance equipment
- More than 10% of administrative costs (direct and indirect combined)
- Meals, unless they are for subjects/patients under study, specifically approved, or part of per diem related to allowable travel

Compliance Considerations

Where to Start as a Provider?

Review RHTP Regulations, Guidance, & Award Agreements

Develop a Grants Compliance Matrix

Update Grants Management Policies & Procedures

Maintain Accurate Records/Develop Internal Controls

Focus on Measurable Outcomes & Financial Transparency

Stay Informed on Updates

Compliance Considerations

Internal Controls to Be Considered

Formal designation of an RHTP lead

- Accountable for compliance, reporting, and program alignment

Defined roles & responsibilities

- Financial management controls (unique general ledger cost centers/project codes, budget-to-actual monitoring, reconciliations performed, journal entries recorded, retaining documentation)
- Program implementation controls (understanding requirements and allowable costs, ensuring proper approvals received, procurement method in place with vendors, subrecipient vs. contractor determination, performance tracking/monitoring)
- Reporting management controls (accurate and timely reporting, reconciliation between financial records and progress metrics submitted, review and certification with the state or CMS/ORHT)

Records retention

- Minimum 3 years after final reporting

Compliance Considerations

Subrecipient or contractor?

- Crucial determination to understand potential compliance requirements
- Has not been fully determined, but likely can be either
  - Some states are setting up regional hubs to disburse funds
  - Some states may disburse directly to providers
- Question to ask – is the state buying a service or providing funds for initiatives?
  - Notice of Award will outline subrecipient or contractor
  - If determination is subrecipient then provider is subject to additional compliance requirements under Title 2 of the Code of Federal Regulations – Grants and Agreements (2 CFR)
  - If determination is contractor, then provider is not subject to additional compliance requirements under 2 CFR, but still required to follow terms of the agreement with the state and standard procurement, payment, and general federal requirements

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Compliance Considerations

Receipt of grant funds

- Cost-reimbursement OR advance payments – Notice of Award will outline
- IF cost-reimbursement:
  - Providers will incur allowable costs first and then be reimbursed through state or federal payment system
    - Direct service delivery costs or administrative/operational expenses where documentation is required to substantiate actual spend
  - Provider implications
    - Plan to front project costs – cash-flow planning is crucial
    - Tight cost tracking and documentation
    - Monthly/quarterly reimbursement requests
- IF advance payments:
  - Providers may have start-up or capacity-building needs – staffing, systems, reporting
  - Help avoid cash-flow barriers

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Compliance Considerations

Other Subparts that are applicable:

B Subpart B – General Provisions

C Subpart C – Pre-Federal Award Requirements and Contents of Federal Awards

D Subpart D – Post-Federal Award Requirements

Subparts not applicable:

E Subpart E – Cost Principles

Non-profit guidance – assistance listing #93.798

If provider expenditures exceed $1 million and are determined to be a subrecipient, subject to single audit under 2 CFR Part 200 Subpart F – Audit Requirements (Uniform Guidance) and 2 CFR Part 300 (HHS-specific modifications – Part 300 effective 10/1/2025).

Compliance Considerations

- Single audit compliance requirements

- **Subpart F** Applicable Compliance Requirement Categories Subject to Audit Procedures:
  - Activities allowed/unallowed – align expenditures with the five statuary program goals
  - Reporting – same reporting requirements as the states
  - Special tests and provisions (grant agreement specific)
  - Financial management
    - Included on the Schedule of Expenditures of Federal Awards (SEFA)
      - Providers: Pass through from the state on SEFA
  - Internal control over compliance

Compliance Considerations

For-profit guidance – assistance listing #93.798

If for-profit provider and determined to be a subrecipient, single audit under 2 CFR 200 Part F NOT required, but subject to 2 CFR Part 300.218

- Profit is prohibited (amounts received cannot exceed allowable direct and indirect costs)
- Program income is restricted

May be subject to an award-specific or compliance audit, but not required

- Audit requirement & compliance requirements outlined in the Notice of Award
- Could look similar to a Uniform single audit for not-for-profits
- Possible reference source GAQC Practice Aid: HHS Requirements for For-Profit Entities with Awards from the Provider Relief Fund Program and Other HHS Awards

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Compliance Considerations

Reporting to the states

Quarterly & Annual Progress Reports

- Submit updates on plans, timelines, outcomes, and milestones
- Use measurable data to show progress

Federal Financial Reports (SF-425)

- To be submitted annually or semiannually depending on the award terms
- Same form used for other federal awards

FFATA Compliance

- Report details on your organization and first-tier subawards ($30k or more)
- Additional reporting required when:
  - 80% of prior-year revenue is from federal awards
  - $25M+ of annual federal revenue
  - Executive compensation information is not publicly available

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Recent Reimbursement Developments & Strategic Insights for Adapting to Payment Reforms

Recent Reimbursement Developments

340B Rebate Model

Medicaid DSH Update

340B Rebate Model Pilot Program

What It Is (Was)

July 2025

- Introduced by HRSA as an alternative to the traditional 340B upfront discount model
- Changes the timing of 340B discount from up front to back-end
- Purchase drugs at WAC, then submit for a rebate
- Rebate = WAC – ceiling price
- Would require submission of unit level claims data (within 45 days after dispension)
- Manufacturers would pay the rebate within 10 calendar days

December 2025

- Maine Hospital Association and 4 health systems file a lawsuit
- Maine U.S. district court issues injunction

340B Rebate Model Pilot Program

What It Is (Was) – cont.

Jan. 2026

- Pilot formally paused
- Appellate court upholds injunction
- HHS appeal withdrawn

Feb. 2026

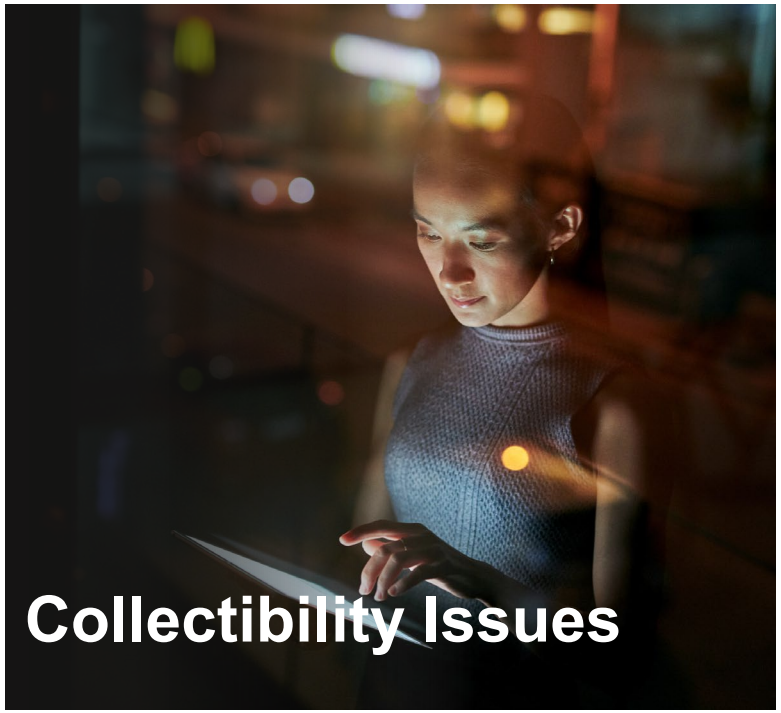
- HRSA formally scraps rebate model
- HHS vacates the program

Don’t celebrate just yet …

- One day passes … HHS initiates regulatory review of potential new rebate mode
- Any new model would require a new 90-day notice-and-comment period
- At a minimum, expect manufacturers to continue pushing for expanded reporting

340B Rebate Model Pilot Program

Accounting/Reporting Considerations



Medicaid Disproportionate Share Hospital (DSH) Funding

Background/Overview

Federal/State Medicaid funds intended to reimburse hospitals for uncompensated care associated with treating a disproportionate amount of Medicaid and uninsured patients

- State share typically funded through provider taxes, which are used to draw down the federal share
- States distribute DSH funds to qualifying hospitals
- Ultimately limited to a hospital's cost of uncompensated care (hospital-specific DSH limit)

Medicaid/Uninsured Cost

−

Claims Payments

−

Supplemental Payments (including SDPs)

=

Uncompensated Care (DSH limit)

Evolution of Uncompensated Care (aka DSH Limit)

PRE-CAA 2021

- Medicaid FFS
- Medicaid MCO
- Uninsured
- Dual Eligible

CAA 2021

- Medicaid FFS
- Medicaid MCO
- Uninsured

CAA 2026 (2/3/2026)

- Medicaid FFS
- Medicaid MCO
- Uninsured
- Dual Eligible

Consolidated Appropriations Act, 2026

Impact on Medicaid DSH

- Signed into law on 2/3/2026
- Broadens the definition of uncompensated care (DSH limit)
  - All Medicaid eligible, regardless of TPL
- States permitted to redistribute unused DSH allotments back to FY2022
  - Previous payments made can not be re-couped if they complied with the rules at the time
- Postpones Medicaid DSH cuts through FY2027
  - Now scheduled for $8B reduction in FY2028

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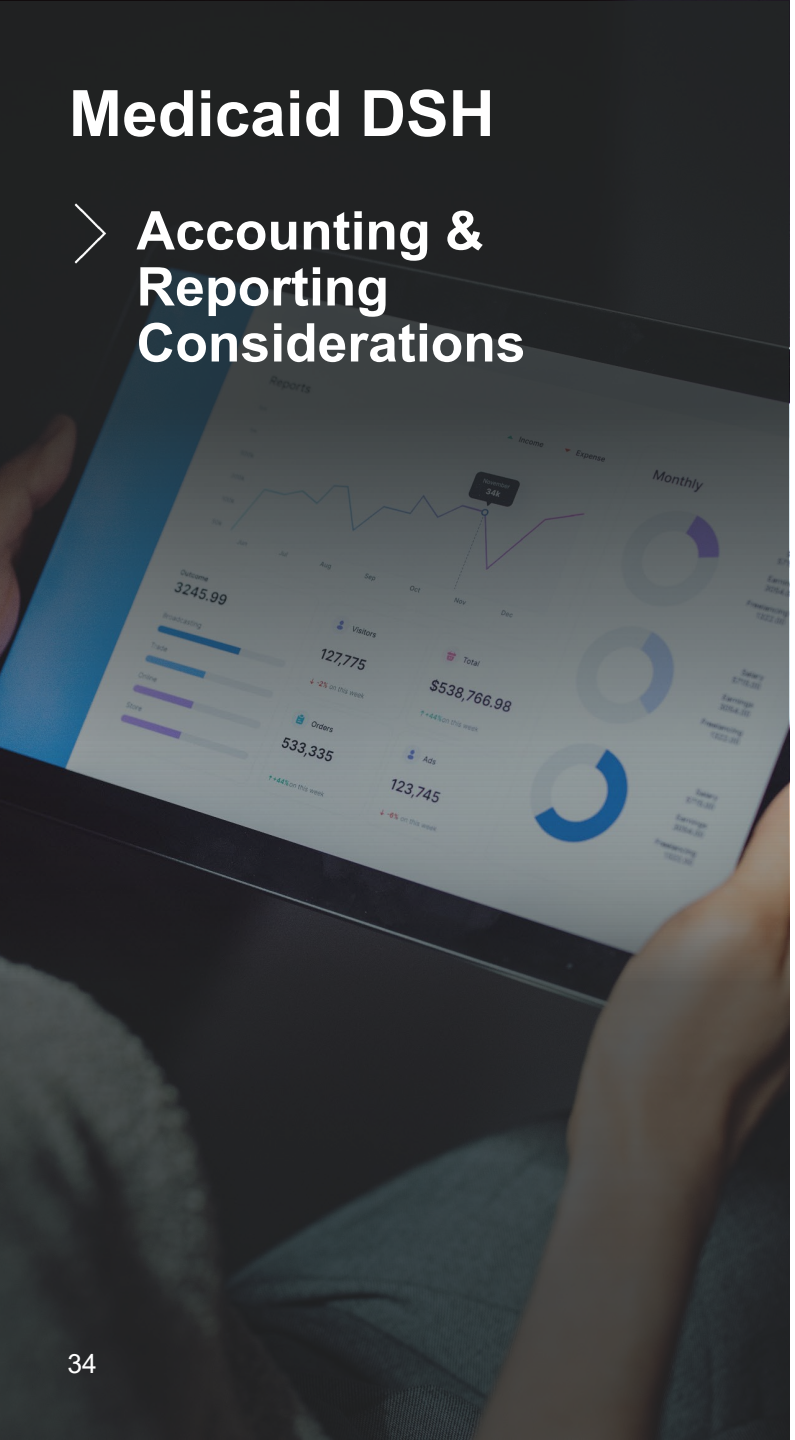
Medicaid DSH

Accounting & Reporting Considerations



1. Potential for retroactive settlements; impact of SDPs
2. Changes in how to estimate ongoing DSH
3. Awareness of changes to uncompensated care
4. Possible redistributions of unused funds

Late Breaking Developments

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