THIRD WAY

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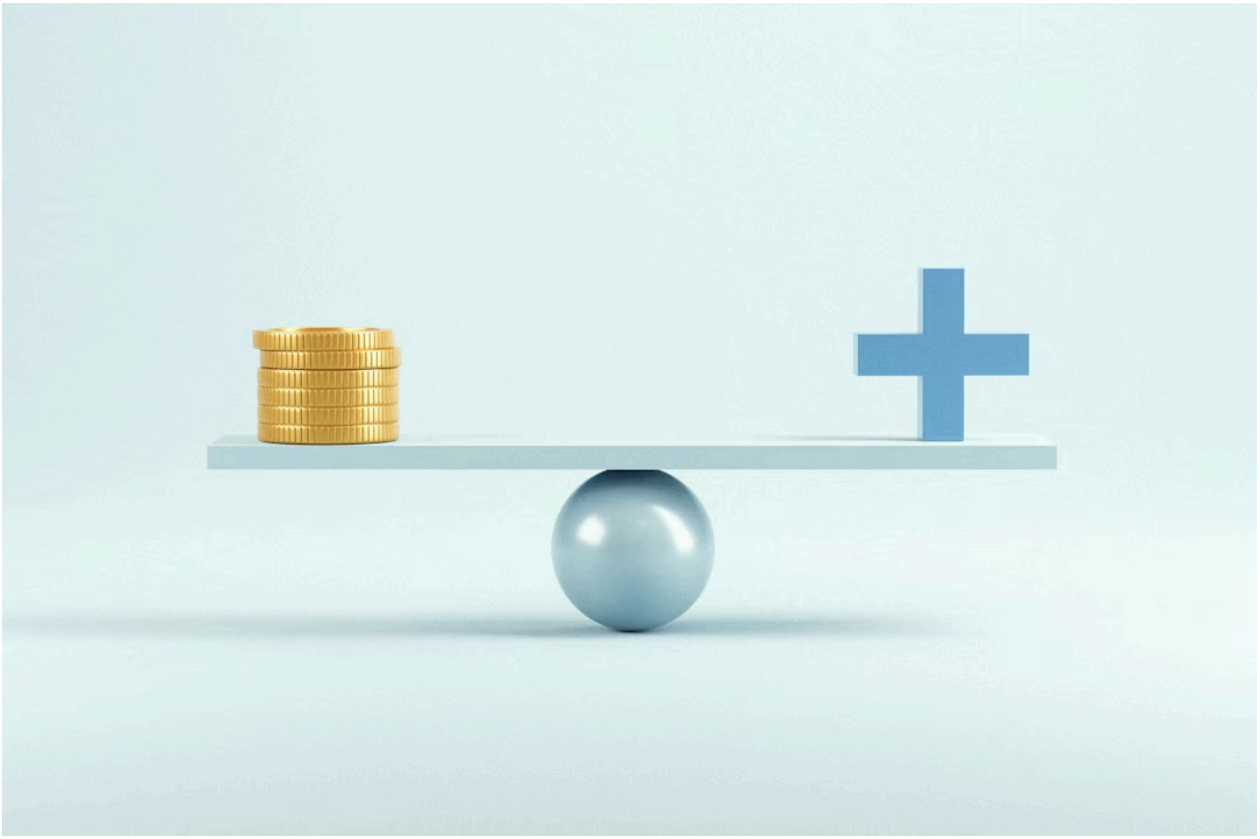
How to Improve Medicaid's Supplemental Payments to Hospitals



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In the aftermath of the Republicans' draconian cuts to the Medicaid program, Democrats should fight to rescue coverage for working families but also rebuild Medicaid to make it stronger and financially secure for states to administer. One area that receives less attention for policymakers to explore is supplemental payments to hospitals. In recent years, these extra payments have grown to be 40% of what Medicaid spends on hospital care and have a significant impact on costs and access to care. In this memo, we break down the different types of supplemental payments to hospitals, how much we are spending on each, and where current spending can be better targeted.

The Basics

Historically, Medicaid has paid providers less than what it costs to treat a patient. As a result, some providers in non-emergency settings would decline to treat Medicaid patients, leaving Medicaid

enrollees with limited access to care. Medicaid *supplemental payments* seek to make up some, or all, of the difference for hospitals. Supplemental payments are additional funds provided by states to hospitals in addition to base payments from the Medicaid program.

Supplemental payments can be critical for certain safety-net providers serving high shares of Medicaid or uninsured patients—ensuring they remain financially stable and continue serving vulnerable communities. Supplemental payments can also cut back on the number of providers who decline to treat non-emergent Medicaid beneficiaries, and in some cases, these payments help hospitals cover the cost of caring for uninsured patients.

Since Medicaid is a state-administered program, states have the authority to determine how supplemental payments are administered to hospitals. As a result, there is significant variation from state to state in how much is spent on supplemental payments and which hospitals receive the extra funding. For example, supplemental payments in 14 states account for less than 5% of total state Medicaid spending and seven states with supplemental payments over 20%.

Despite this variation, one thing is clear: spending on supplemental payments has grown rapidly, more than doubling in recent years (from $52 billion in 2019 to $105 billion in 2022). Medicaid now pays hospitals an average of 6% more than Medicare nationwide for many medical procedures, putting Medicaid and Medicare on a roughly even playing field.

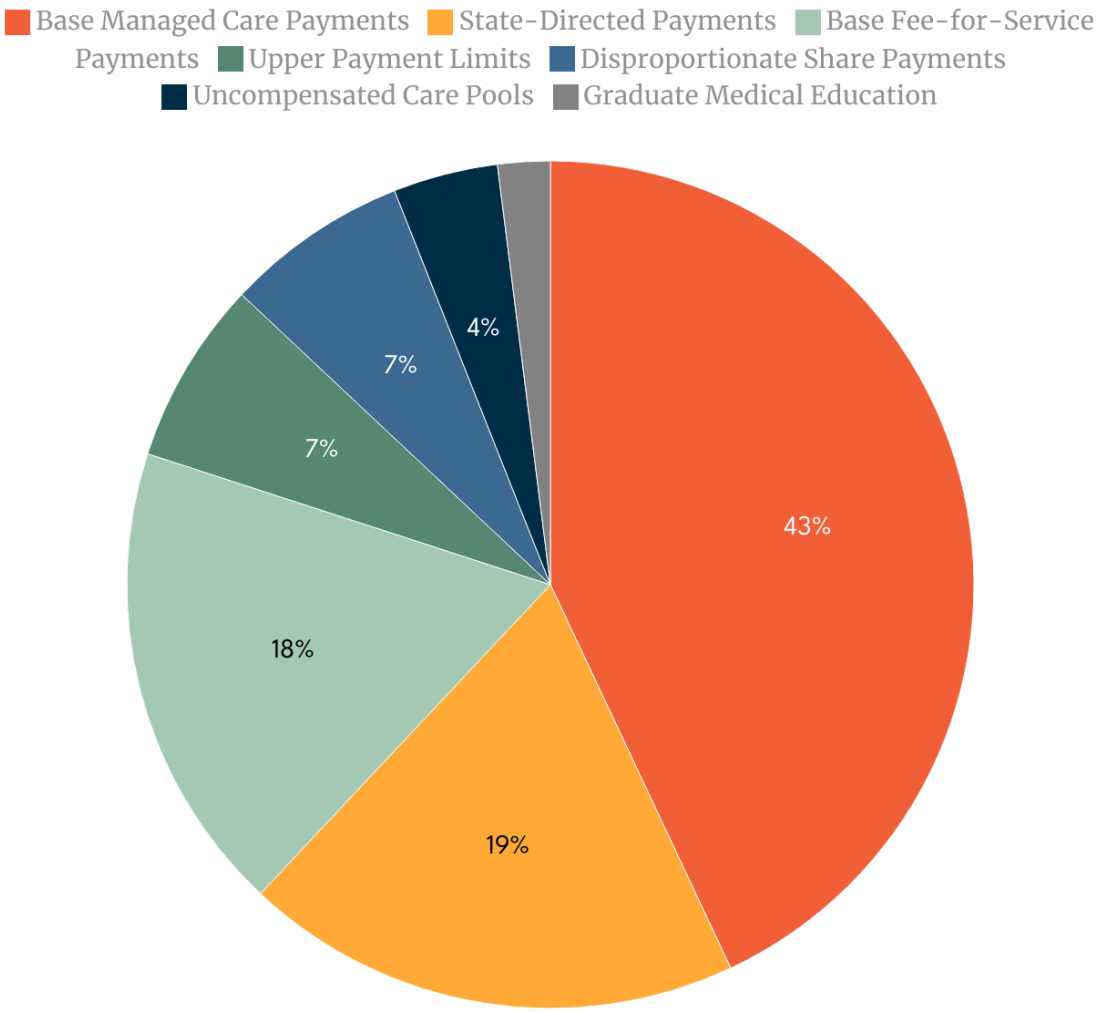
Where is the Money Going?

In some cases, supplemental payments make up for historic underfunding of care under Medicaid and ensure beneficiaries can access quality health care. In other cases, payments can be poorly targeted, overlap in goals without working together, and inflate the bottom line of wealthy hospitals, without ensuring funding is targeted towards hospitals and patients that need it most.

In 2022, Medicaid spent a third of its dollars ($263 billion) on hospital care, including base payments and supplemental payments. Supplemental payments represented 40% ($105 billion) of that spending. That $105 billion can be broken down into five different types of supplemental payments:

1. State-Directed
2. Upper Payment Limit
3. Disproportionate Share Hospital
4. Uncompensated Care Pool
5. Graduate Medical Education Payments

Medicaid Payments to Hospitals



Source: "Medicaid Base and Supplemental Payments to Hospitals." MACPAC, May 2024. https://www.macpac.gov/wp-content/uploads/2025/05/Medicaid-Base-and-Supplemental-Payments-to-Hospitals-UPDATE-2.pdf. Accessed 29 Aug 2025.

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State-Directed Payments allow state Medicaid programs to direct Medicaid Managed Care Organizations (private health insurance companies) to pay hospitals and other providers according to specific rules or rates. States tie payments to the value of the care, close gaps between the Medicare and Medicaid base payment rates, and establish more specified rates for certain services. One-fifth of overall Medicaid spending—and half of supplemental payment spending—in 2022 went toward state-directed payments.

In 2024, a major shift occurred when the Centers for Medicare & Medicaid Services (CMS) issued a new rule allowing states to raise these supplemental payments to the average of what hospitals charge patients with private insurance. Nationally, hospitals charge private insurers 254% of what Medicare pays for the same services.

The growth of these arrangements has been dramatic—and highly concentrated. In 2024, just 10% of state-directed payment arrangements accounted for 70% of total spending. This highlights how a small number of high-cost deals are driving the bulk of Medicaid's state-directed payments, often benefiting large hospital systems rather than the safety-net providers most in need.

Upper Payment Limit Payments close the gap between Medicaid and other payers' rates, similarly to state-directed payments, but in fee-for-service rather than to managed care organizations. States can choose to direct supplemental funds to providers to close payment gaps, but states can only pay up to the pre-determined "upper payment limit," as determined at the federal level by CMS. Upper limits are often based on the Medicare rate, but, in certain circumstances, they can be based on the average commercial rate. Overall, Upper Payment Limit Payments represent 7% of Medicaid spending.

Disproportionate Share Hospital (DSH) Payments are extra payments that states are required to give to hospitals that serve high shares of Medicaid and uninsured patients. The federal government grants each state a set funding allotment each year, set by metrics created in the 1990s, which states then pay out to qualifying hospitals. There is also a per-hospital limit on DSH payments. States can choose to give qualifying hospitals higher payments than allotted by the federal government, but they will not receive federal matching dollars to do so. Still, states maintain significant flexibility in which hospitals receive DSH payments and how much they each receive, totaling about 7% of annual Medicaid spending.

Uncompensated Care Pool Payments, together with DSH payments, generally supplement the cost of caring for the uninsured. Uncompensated care pool arrangements are determined between states and CMS using Section 1115 demonstration waivers, giving each state the opportunity to negotiate the structure of their payment program with CMS. As a result, there is variation in how states define their pools—some include underinsured patients in addition to those without any coverage—and how much money they receive. In 2022, only seven states received this type of payment; however, uncompensated care pool payments still contribute about 4% of total Medicaid spending.

Graduate Medical Education (GME) Payments cost Medicaid relatively little in comparison to other supplemental payment types. GME payments are given to teaching hospitals to support the training of medical residents and the indirect costs associated with operating as a teaching institution. States can choose to deliver GME payments as supplemental payments or can build the cost of residency training programs into base payments. In total, GME payments represent 2% of Medicaid spending.

While supplemental payments were designed with important purposes in mind, it's also important to ensure they still serve those purposes without further driving up hospital costs in Medicaid and for all Americans.

The Solution

A better, more comprehensive approach to supplemental payments would protect vulnerable hospitals, safeguard access to care for patients, and lower Medicaid program costs all at the same time. Here are three commonsense fixes:

First, better target payments to rural, safety net, and high-quality providers who consistently provide high-value care. Lawmakers should strengthen transparency requirements for hospitals to better identify the providers with the most need and ensure these various payments are working together. Certain supplemental payments, like state-directed payments, should also be tied to the value of care so all providers have an incentive to improve quality and lower costs instead of increasing the amount of care as they do under fee-for-service incentives.

Second, cap all state-directed payments at a percentage of Medicare levels, with more flexibility for rural and financially insecure hospitals. Congress should close the loopholes that allow states to tie Medicaid payments to inflated commercial prices. State-directed payments—whether new or existing—should be limited to a percentage of what Medicare pays for the same services. The exact percentage needs further analysis, but the 100% limit in the Republican budget bill for states that have expanded Medicaid is clearly too low. There should also be flexibility built into the cap to protect rural and financially unstable hospitals, ensuring they still have sufficient funding to serve their low-income and rural communities. Even efficient hospitals lose an average of 2% on Medicare fee-for-service payments, so Congress should direct the Medicaid and CHIP Payment and Access Commission to analyze the impact of caps at 110%, 120%, and 130%, for example.

Third, take on hospital pricing in the private market to reduce overall cost burdens. Even with reforms to state-directed payments, hospital prices remain out of control in the commercial market—driving up costs for patients, employers, and taxpayers. Congress should advance policies that rein in hospital monopolies, promote price transparency, and increase competition in the private insurance market. Addressing inflated commercial prices will not only help those with private coverage—it will also reduce the pressure to increase Medicaid payments up to inflated commercial prices.

Conclusion

Supplemental payments have an important role to play in protecting access to care for patients and supporting critical hospitals, but payments are often directed toward already well-off hospitals at the expense of the providers that need them most. As policymakers seek to help the Medicaid program

recover from major GOP cuts, they must develop a more effective supplemental payments system that is better targeted to the hospitals who need the most support. Smart reform can protect vulnerable hospitals, safeguard access to care for patients, and lower Medicaid program costs all at the same time. Larger efforts to rein in hospital costs will also lower costs for everyone, regardless of where they get their coverage.

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