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Advancing Health in America

Fact Sheet: Medicaid Hospital Payment Basics

The Issue

The Medicaid program is the largest single source of health care coverage in the United States, covering nearly half of all children, many low-income elderly and disabled, and working adults in low-wage jobs that do not offer affordable coverage. As such, it provides significant resources to the nation's hospitals and health systems and allows them to provide high-quality care to their patients and communities. Congress is currently considering policy options that would significantly alter the Medicaid program and reduce Medicaid financing to hospitals.

AHA Take

AHA urges Congress to reject reductions to hospitals' Medicaid payments.

Why?

- Supplemental payments made to hospitals through the Medicaid program are essential for hospitals to continue to provide care to vulnerable patients.
- The growth of certain types of supplemental payments, specifically state directed payment (SDP) arrangements, reflects the shift towards Medicaid managed care and the shared goal of states and hospitals to ensure beneficiary access to care.
- State Medicaid programs' low base payments have created the need for supplemental payments. Further restrictions on states' use of supplemental payments would exacerbate the existing shortfall between Medicaid payments and hospitals' costs impacting their ability to provide care.
- Hospitals and health systems already grapple with maintaining access to services due to this shortfall, and supplemental payments are expressly intended to ensure an adequate supply of providers can continue to serve Medicaid recipients.[1]
- The potential loss of access is not theoretical. Today, hospitals that serve disproportionately high rates of Medicaid and other public-payer patients routinely operate with negative margins and are often forced to terminate service lines or close entirely. Further restrictions on these supplemental payments would threaten access to care for entire communities across the country, not just Medicaid beneficiaries.

Background

State Medicaid programs (or the state's contracted Medicaid managed care organizations (MCOs)) pay hospitals through a combination of base payments for services and supplemental payments. Payment rates and approaches vary across states and service levels; however, payments made to hospitals on average are lower than the cost of caring for Medicaid patients.[2] Medicaid shortfall — or the difference between the hospital's cost of serving Medicaid patients and the payments it receives for services — was $27.5 billion[3,4] in 2023.

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States and Medicaid MCOs have broad authority to set payment rates. For example, states can establish a base payment and adjust that payment for certain hospital types, such as acute care, children's or other hospital types. State Medicaid agencies may supplement low payment rates for services with supplemental payments, including Medicaid Disproportionate Share Hospital (DSH) and non-DSH supplemental payments.

Payments for Services

Fee-for-service (FFS) Base Payments. States make FFS payments for hospital services provided to individual Medicaid beneficiaries at a CMS-approved rate.

Managed Care Base Payments. Under a managed care arrangement, Medicaid MCOs determine the rates they pay providers for inpatient hospital services. States make capitated payments to Medicaid managed care plans for Medicaid services provided under the contract. CMS reviews state capitation rates annually, and the rates must be actuarily sound.[5]

Supplemental Payments

Supplemental payments are a longstanding, vital tool that states can use to mitigate the chronic underpayments caused by low base rates for services provided to Medicaid patients. For example, excluding supplemental payments Medicaid FFS payments paid less than 58 cents for every dollar hospitals spent caring for Medicaid patients in 2023, and Medicaid MCOs paid less than 65 cents over the same period, according to industry benchmark data provided by Strata Decision Technology, LLC. Supplemental payments help mitigate low rates, but even including supplemental payments, Medicaid still pays less than the cost of providing care to Medicaid patients.

There are three common categories of supplemental payments, Medicaid DSH, UPL and SDPs, described below.

Medicaid DSH Payments. Federal law requires states to support hospitals that serve a significant portion of low-income, uninsured and Medicaid patients through supplemental payments known as Medicaid DSH. The objective of Medicaid DSH payments is to help lessen the Medicaid shortfall and uncompensated care costs for these hospitals.[6] The amount of Medicaid DSH payments available is capped at both the state and hospital level (for states, this is known as the federal allotment; for hospitals, it is the hospital-specific DSH limit). Hospitals' Medicaid DSH payments cannot exceed the costs a hospital incurs for providing care less the payments received for such care. Medicaid DSH payment arrangements, outlined in a Medicaid state plan, must be approved by CMS, and are subject to federal audits.

Upper Payment Limit (UPL) Payments. States can make supplemental payments to hospitals and other providers under FFS arrangements that are intended to cover the difference between the Medicaid FFS payment for a service and what Medicare would have paid for the same service. These payments are generally known as upper payment limit payments, or UPL payments. The UPL is set at the aggregate, and states can direct some or all UPL payments to certain hospitals within a class, even when it exceeds an individual hospital's costs if the total payment across hospitals is below the UPL. State discretion over UPL payments allows states to respond to policy and environmental shifts and helps stabilize funding for hospitals serving vulnerable populations. CMS requires that states submit hospital-level UPL data annually to demonstrate compliance with federal requirements.

SDP Programs. States may direct managed care plans to make additional payments to providers to pursue a state's overall Medicaid program and quality goals. There are three types of directed payments, including minimum or maximum fee schedule, uniform rate increase and value-based payment SDPs. CMS reviews and approves SDPs for each 12-month rating period. As SDPs are incorporated into the final MCO capitation rates, states must demonstrate that directed payments are actuarially sound and result in provider payment rates that are reasonable, appropriate and attainable.[7] Moreover, states must have an evaluation plan for each SDP that demonstrates the effectiveness of the directed payment in meeting program quality objectives for the directed payment to be renewed. The 2024 managed care final rule clarified expectations and established new requirements for SDPs, including defining the requirements for SDP evaluation plans and setting the average commercial rate as the upper payment limit for SDPs for inpatient and outpatient hospital services.[8]

Waiver-based Payments. Through the authorization of Section 1115 demonstration waivers, states may utilize other types of supplemental payments, such as uncompensated care pool payments and delivery system reform incentive payments, to address the Medicaid shortfall.

Changes in supplemental payment programs reflect broader trends in how states run their Medicaid programs. For example, SDPs have grown significantly in recent years, which correlates with growth in states' use of Medicaid MCOs. In 2022, 75% of state Medicaid enrollees participated in comprehensive, risk-based managed care, compared to 67% in 2016.[10] At the same time, as would be expected, supplemental FFS payments, including UPL payments, are declining. In FY 2022, states spent $47.8 billion on SDPs and $15.8 billion on UPL payments.

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