Why are Medicaid Supplemental Payments Important for Hospitals and Nursing Facilities?

What are Supplemental Payments?

- Supplemental payments are a substantial revenue source for hospitals and nursing facilities and are critical for ensuring access to care for low-income and vulnerable individuals enrolled in the Medicaid program.[1] Supplemental payments include state directed payments (SDPs), Disproportionate Share Hospital (DSH) Payments; Upper Payment Limit (UPL) Payments; Graduate Medical Education (GME) Payments; and 1115 demonstration payments including uncompensated care pools.
- In many states, Medicaid **base payments** – the initial payment to providers for a service delivered to a Medicaid beneficiary – do not cover the cost of care and are significantly lower than Medicare and commercial payments. States utilize **supplemental payments** – any payment over and above these base payments – to help mitigate these payment gaps. However, even when including supplemental payments, there is a $27.5 billion difference between what Medicaid pays and the costs of providing care.[2]
- **Supplemental payments help to ensure that the nearly 80 million Medicaid beneficiaries, including 32 million children and 15.5 million individuals with disabilities, have providers available to deliver high-quality, life-saving services.[3, 4]** Any cuts to supplemental payments will impact Catholic providers' financial viability and the care they provide to individuals.

What are State Directed Payments?

- SDPs are a type of Medicaid supplemental payment where states require, subject to federal approval, managed care organizations (MCOs), to make to additional payments to designated providers to promote access to and quality of care. Since their inception in 2016, SDPs have grown significantly and surpassed other forms of supplemental payments, reflecting the shift toward Medicaid managed care.
- 40 states use SDPs to raise reimbursement rates for providers treating Medicaid patients.[5]
- In 2023, SDPs totaled more than 15% of total Medicaid managed care spending. 70% of SDPs spending went to hospitals for inpatient and outpatient services.[6]
- CMS codified in 2024 that states can use the "Average Commercial Rate (ACR)" – the average amount hospitals and other providers would be paid by commercial insurers for the same service – as the payment ceiling for SDPs.[7] This promotes greater rate parity across Medicaid and commercial payers and improves provider participation in a state's Medicaid program.

The Bottom Line

- More than 1 in 7 patients in the U.S. are cared for in a Catholic hospital each day and Medicaid supplemental payments are a critical funding stream for Catholic hospitals, nursing facilities, and health systems that provide care to millions of low-income and vulnerable individuals across the country.[8] Scaling back SDPs would exacerbate the existing shortfall between Medicaid payments and providers' costs impacting their ability to provide care to their communities.
- Before modifying supplemental payments, Congress and the White House should undertake a full analysis of the potential impacts on access to high-quality health care.

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[1] "Estimates of Nursing Facility Payments Relative to Costs," Medicaid and Chip Payment and Access Commission. January 2023
[2] "Fact Sheet: Medicaid Hospital Payment Basics," American Hospital Association. February 2025
[3] "October 2024 Medicaid & CHIP Enrollment Data Highlights," CMS. 2025
[4] "5 Key Facts about Medicaid Coverage for People with Disabilities," Kaiser Family Foundation. February 2025
[5] "Directed Payments in Medicaid Managed Care," Medicaid and CHIP Access and Payment Commission. October 2024.
[6] "Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule," CMS. May 2024.
[7] Ibid.
[8] "U.S. Catholic Health Care," Catholic Health Association of the United States. April 2024