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Lifelines in Jeopardy: How Medicaid State Directed Payments Support Critical Health Care Providers

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Introduction

Medicaid serves as a lifeline for nearly 80 million people nationwide, yet the payments providers receive for treating Medicaid patients often fall well below the actual cost of delivering care. This chronic underfunding leaves nursing homes, hospitals, outpatient clinics, and other providers—especially those that serve large numbers of Medicaid enrollees—struggling to keep their doors open, much less invest in the innovations needed to strengthen care quality and improve efficiency. The impact of low Medicaid payments can be seen in nursing homes struggling to fully staff their facilities and outpatient providers increasingly reporting longer wait times for primary and specialty care.[1,2] Hospitals serving large numbers of Medicaid enrollees and hospitals in rural communities are also feeling the impacts of low Medicaid payments. Hospitals often operate on razor-thin margins, making it nearly impossible for them to modernize facilities, expand services, or implement care delivery reforms that drive better outcomes. Additionally, in recent years, low margins have led to a significant number of hospital closures, particularly in rural communities.[3] Without adequate reimbursement, these hospitals face difficult choices, including to limit services, delay infrastructure improvements, or, in the worst cases, shut down entirely, jeopardizing access to care for the nation's most vulnerable populations.

State Directed Payments (SDPs) have become a crucial tool for states operating their Medicaid programs through Medicaid managed care, enhancing rates for hospitals and other providers to sustain operations, enhance care quality, and support system-wide reforms. Established in 2016, SDPs allow states to direct Medicaid managed care organizations to implement targeted provider payment models—by, for example increasing payment rates—that strengthen access and care delivery. Like other Medicaid spending, states and the federal government share the cost of SDPs. For many hospitals that disproportionately serve Medicaid patients and have little revenue from commercial insurance, SDPs provide a financial bridge, offsetting shortfalls in base payments and helping to sustain vital services in communities where health care options are scarce. For hospitals that are not primarily serving Medicaid patients, raising Medicaid rates through SDPs helps to open the doors to specialty care and other services that might otherwise not be available to Medicaid enrollees.

Now, however, these essential payments are at risk. Congress and the Administration are considering substantial changes to Medicaid financing. Congress' joint budget resolution passed on April 10 calls for $880 billion in cuts from the House Energy and Commerce Committee (E&C)—which has primary jurisdiction over Medicaid—over the next ten years.[4] On May 14, the House E&C Committee advanced a set of significant Medicaid policy proposals to meet the budget reconciliation instructions for consideration before the full House of Representatives.[5] Included is a policy that limits the level of new SDPs that the federal government will approve, while allowing states with current SDPs to maintain them at current levels. Other options to reduce or modify SDPs have been under consideration. Even if the provisions limiting SDPs contained in the current legislative language are not enacted, the Administration could also pursue reductions to SDPs through rulemaking in the coming months. These factors make SDP policy a continuously moving target.

SDP cuts would have profound consequences for a wide range of hospitals and other providers. In particular, SDP cuts would impact high-Medicaid hospitals, including certain urban hospitals, rural hospitals, and children's hospitals, all of which already struggle to stay afloat. Scaling back SDPs would exacerbate existing

financial distress, forcing hospitals to make wrenching decisions about reducing staff, eliminating critical service lines, or even closing altogether. The ripple effects would be felt hardest in underserved communities, in health care "deserts" where access to care is already limited, and where Medicaid is the predominant payer.

This brief presents an **original analysis of potential state-level SDP reductions,** takes a closer look at the role of SDPs in sustaining high-Medicaid urban hospitals, children's hospitals, and rural hospitals, and assesses the potential consequences of proposed SDP reductions. Drawing on publicly available data and direct insights from potentially impacted hospitals, we quantify the state-level impact of SDP cuts across 25 states and examine the specific risks facing hospitals serving underserved populations. As Congress and the Administration debate Medicaid spending reductions, the future stability of America's most vulnerable hospitals—and the communities they serve—hangs in the balance.

SDPs Strengthen Access to Care

Federal rules historically prohibited states from directing managed care plans with respect to the rates plans pay their providers.[6] As states increasingly shifted services and populations from fee-for-service to managed Medicaid programs, states sought ways to increase reimbursement to providers through managed care.[7] Prior to 2016, some states, without explicit federal authority, had set up "pass through" payments where the state would provide supplemental Medicaid funds to the plans to be passed through to designated providers. These payments were not linked to services actually provided to Medicaid enrollees. In regulations issued in 2016, the Centers for Medicare & Medicaid Services (CMS) phased out pass through payments and created the authority for states to require managed care plans to direct payments to providers using specified provider payment methodologies.[8] **Notably, SDPs must be linked to utilization, meaning payments must be tied to actual service delivery, flow to a state-defined class of providers, and align with Medicaid's broader goals of promoting access, quality, and delivery system reform.** These payment arrangements are subject to CMS review and approval and must be documented in managed care contracts and rate certifications.

SDPs have grown markedly since 2016. The Medicaid and CHIP Payment and Access Commission (MACPAC) has estimated that, as of August 1, 2024, approved SDPs account for approximately $110.2 billion in annual Medicaid spending, with hospital services receiving around 70% of these payments.[9,10]

Quick Facts About SDPs

SDPs are a payment methodology which allow states to direct managed care plans to pay providers using specified payment methodologies. States and the federal government share the cost of SDPs.

Among other requirements, SDPs must:

- Be tied to the utilization of services;
- Flow to a defined class of providers;
- Advance the goals of the Medicaid program;
- *Not* exceed the average commercial rate; and
- Be approved by CMS on an annual basis.

Source: 42 CFR § 438.6 (access here)

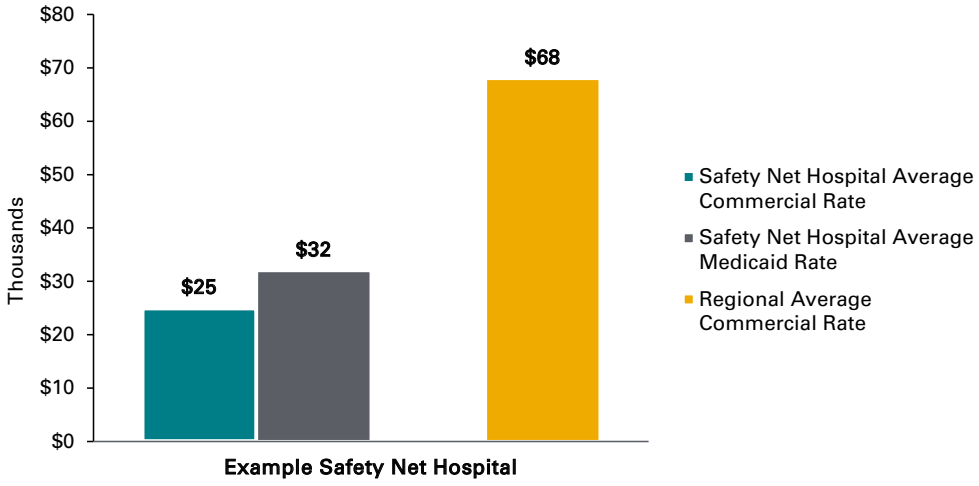
The level of payments vary across states, with CMS approving SDPs up to the amount commercial health plans pay for services—also known as the Average Commercial Rate (ACR). In 2024, CMS issued regulations codifying the ACR as the upper limit of SDPs, noting in the final rules that this flexibility enables states to ensure Medicaid managed care enrollees have access to care that is comparable across the general public.[11]

Research has consistently demonstrated that increasing Medicaid payment levels (for example, through SDPs) is associated with increased access.[12] For example, a 2019 literature review found that raising Medicaid payment rates was correlated with an increased likelihood of provider participation in Medicaid, ultimately expanding access to care for enrollees.[13] Additionally, studies have shown that higher Medicaid payments increase the likelihood that providers will see additional Medicaid patients and increase the number of Medicaid enrollees with a usual source of care.[14,15]

States Leverage SDPs to Support High-Medicaid Urban, Rural, and Children's Hospitals

SDPs are a tool by which states can promote access by supporting specific types of health care providers that play a central role in providing care to Medicaid enrollees. Hospitals serving a high proportion of Medicaid enrollees often operate with slim or negative margins,[16] with SDPs helping them to stay financially afloat. Financial challenges for these hospitals are compounded by the fact that they tend to have relatively low share of commercially insured patients and that the commercial insurance reimbursement rates they receive are, on average, lower than those of other hospitals.[17] Nationally, a 2020 RAND analysis found that

Disparities in Safety Net Hospital Payment Rates
Example: Acute Respiratory Infection Average



hospitals in the 75th percentile for commercial reimbursement rates are paid 45% more than hospitals in the 25th percentile.[18] A Manatt analysis of safety net hospitals in New York City also found significant disparities between the regional ACR and the Medicaid and commercial rates paid to safety net hospitals (see graph).[19]

This flexibility to enhance Medicaid rates through SDPs is especially important since base Medicaid rates often fall short of costs. Further, providers with limited commercial revenue are unable to offset negative margins on Medicaid with higher commercial margins. Nationally, hospitals receive 88 cents for every dollar spent caring for Medicaid patients.[20] Hospitals with a relatively high share of Medicaid patients struggle to close this gap in reimbursement through payments from other payers. As a result, they have fewer days of cash on hand and lower operating margins than hospitals with a lower Medicaid payer mix.[21] SDPs up to the ACR help to fill this financial gap for providers, allowing them to continue to provide life-saving care to their communities.

A 2022 analysis of a group of 335 high-Medicaid hospitals—where Medicaid enrollees made up 35% of inpatient days, while commercial insurance made up only 18% of inpatient days—found that the average operating margin among those hospitals was -9%[22] (nationally, Medicaid covers ~24% of inpatient days, while commercial insurance covers ~23%).[23] For these hospitals, if Medicaid Disproportionate Share Hospital (DSH) payments and other supplemental payments, including SDPs, went away, margins would have worsened to -14%.[24]

A central component of the health care delivery system that is particularly at risk is rural hospitals. Rural hospitals often serve as the primary provider of a broad range of health care services for Medicaid enrollees and broader rural communities. These hospitals are facing stark financial challenges, threatening their sustainability over time and resulting in hospital closures across the country. Since 2010, 152 rural hospitals in the U.S. have closed and over 700 are at risk of closure, including more than 300 at immediate risk.[25] A recent analysis identified approximately one in five rural hospitals as vulnerable to closure, with certain states—such as Florida, Nebraska, Tennessee, North Carolina, Kansas, and Utah—facing particularly high risks.[26] Small rural hospitals, in particular, struggle with low reimbursement rates across payers, resulting in Medicaid patient service margins averaging -10% and private payer margins averaging -5%.[27] SDPs serve as a financial lifeline for these facilities, enabling them to continue to provide essential care in their communities.

Medicaid also plays a prominent role in ensuring access to care for children at children's hospitals, which typically rely more heavily than adult hospitals on Medicaid as a payor. Despite making up only 5% of the nation's hospitals, children's hospitals account for 45% of hospital days for all children on Medicaid. Medicaid only covers approximately 79% of the cost of care provided in children's hospitals, resulting in a financial gap for facilities that provide care to children with complex medical conditions. Supplemental payments, including SDPs, help to fill this gap and ensure that the services children's hospitals provide remain available to the communities they serve.[28]

Potential Impacts of SDP Reductions

Reductions in SDPs would have profound implications for health care access, particularly in communities that rely on high-Medicaid urban, children's, and rural hospitals. The latest House Energy and Commerce proposals for reducing SDPs under discussion include reducing the SDP ceiling from the ACR to 100% of Medicare rates for new SDPs, while allowing states with existing SDPs above Medicare rates but at or under the ACR to continue to receive the amount already approved. While this policy would allow existing SDPs up to the ACR to continue, it presents two challenges. First, the value of existing SDPs will remain fixed and will not keep pace with inflation. Second, states that have not yet increased payments to the ACR would be prevented from taking advantage of the opportunity to use SDPs to support their providers. Congress and the Administration have also considered reducing SDPs to Medicare rates without "grandfathering" previously approves SDPs, and the final form of SDP policy changes is yet to be seen. **Below, we analyze the impact of imposing an overall cap on SDP spending at Medicare rates starting in federal fiscal year 2026.** This analysis does not take into account any SDP grandfathering. (See the Appendix for details on the calculation methodology.)

Across states with SDPs for hospitals in 2023 or 2024 (34 states), the impact of reducing the SDP limit from the ACR to Medicare rates starting in federal fiscal years 2026 varies widely. For 25 of these states, there was sufficient information publicly available to allow us to analyze the impact of reductions to SDPs on total hospital Medicaid spending in those states. The amount and structure of public data to allow for SDP impact estimates is inconsistent across states. This analysis relies on a combination of information provided by states and other stakeholders, as well as publicly posted CMS-approved SDP preprints (i.e., approval documents), which specify the amount of the SDP and its relationship to the ACR or Medicare equivalent payments. We note that preprint data reflects the maximum dollar amount of SDPs approved in each state and actual payments to hospitals may fall below this amount. For the purposes of this analysis, we assume SDPs are made up to the amount listed in public preprints, unless other public data is available reflecting actual payments.

We calculate potential SDP reductions as a percent reduction in total Medicaid **hospital** spending by state because this best reflects the experience of hospitals under this potential policy and takes into account the fact that base rates—and the extent to which a state relies on SDPs to enhance those base rates—vary significantly by state.

In states where SDPs make up a significant share of Medicaid revenue for hospitals, proposed SDP cuts would have the largest impact on hospitals' bottom lines. Regardless of the scale of SDP cuts in any given state, reductions in payments would exacerbate existing financial challenges for hospitals, leading to service cutbacks and, ultimately, diminished access to care for Medicaid enrollees.

We note that these figures are statewide aggregates across all hospitals in each state; however, the impact of SDP reductions would be felt differently by different hospitals. First, the structure of the SDP could have an impact on the distribution of the cuts. Some states target SDPs to a sub-group of hospitals (e.g., high-Medicaid, rural, or children's), while others allow most hospitals to qualify. In states with targeted SDPs, the average reduction in Medicaid hospital payments may understate the impact on hospitals targeted by the

SDPs. For example, in New York, while statewide Medicaid hospital payments would be reduced by 8%, this cut would be primarily borne by providers the state has deemed "financially distressed," with at least 36% of inpatient days and outpatient visits attributable to Medicaid and to New York City Health & Hospitals, the public system that is New York's largest provider of care to Medicaid patients.[29] The 7% statewide average in New York, therefore, obscures the sizable difference in impact across high-Medicaid versus other hospitals in the state. Further, since the analysis looks only at the reduction in **Medicaid** payments, it does not account for the impact that payer mix has on hospitals' abilities to weather significant cuts. For providers that rely heavily on Medicaid, even a small reduction in Medicaid payments may be financially catastrophic.

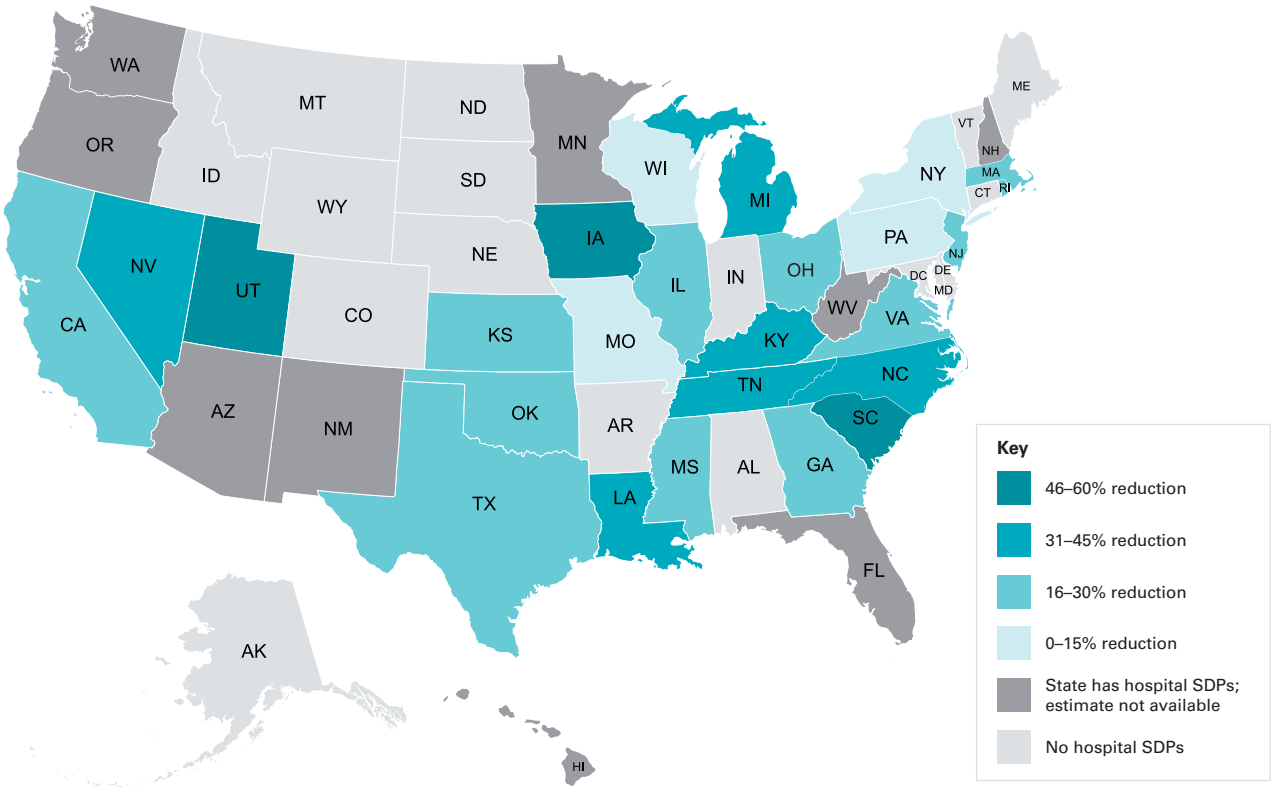
Looking at the ten-year budget window (federal fiscal years 2025-2034), and assuming cuts would go into place in federal fiscal year 2026, reducing the SDP limit from the ACR to Medicare would result in Medicaid hospital payment losses ranging from up to 54% in Iowa to 0% in Wisconsin, where SDP payments are already set at levels up to or below Medicare rates (i.e., in the aggregate, Iowa hospitals would see a 54% decline in Medicaid net patient services revenue under this proposal). In 19 of the 25 states we analyzed, the reduction in total Medicaid payments to hospitals exceeds 20%. This range varies both based on the base Medicaid payment rates by state and the extent to which directed payments increase Medicaid rates beyond Medicare rates towards the ACR. As noted, the impact on particular hospitals within a state would vary based on how broadly the SDPs are spread across hospitals and how much each hospital relies on Medicaid, the scale of SDP cuts in any given state, reductions in payments would exacerbate existing financial challenges for hospitals, leading to service cutbacks, and, ultimately, diminished access to care for Medicaid enrollees and others who rely on high-Medicaid providers.

Estimated Reduction in Medicaid Hospital Spending if SDPs Were Limited to 100% of Medicare Rates, By State (FY 2026-2034)

State	Percent Reduction in Medicaid Hospital Payments*	State	Percent Reduction in Medicaid Hospital Payments*
Iowa	-54%	Virginia	-23%
South Carolina	-48%	Illinois	-22%
Utah	-46%	Kansas	-21%
North Carolina	-45%	Ohio	-21%
Michigan	-45%	Mississippi	-21%
Kentucky**	-41%	New Jersey	-20%
Louisiana	-36%	California**	-17%
Tennessee	-33%	Massachusetts	-16%
Nevada	-32%	Pennsylvania**	-14%
Georgia**	-27%	New York	-7%
Oklahoma**	-27%	Missouri	-2%
Rhode Island	-25%	Wisconsin	0%
Texas	-24%		

*SDP reductions are based on publicly available information on directed payments starting in 2023 or 2024, including directed payment preprints and, in some cases, information shared by states. Percent reductions are based on aggregate projected Medicaid hospital expenditures over FY2026-2034.

**Results in these states should be interpreted with caution. In these states, at least one SDP was analyzed directly using public information, but there was missing information for other SDPs. For the SDPs for which there was incomplete information, we applied an average reduction from other states to estimate the reduction for those SDPs.



SDP Impact Case Studies

To understand the full impact of a reduction in SDPs, we went beyond aggregate state-level analyses to understand how critical health care providers benefit from SDPs and how they put their SDPs to work today to benefit the Medicaid program.[30] A sharp reduction in SDPs threatens myriad investments to promote quality and maintain or improve access. Case studies from across the country crystallize the impact of these cuts.

Supporting Urban High-Medicaid Hospitals

SDPs play a critical role in supporting hospitals in urban areas that serve a large share of Medicaid enrollees and uninsured patients. Urban high-Medicaid hospitals across several states have utilized SDPs to strengthen the health care workforce, expand outpatient care capacity, and invest in behavioral health.

In **Georgia**, SDPs include programs for public and private hospitals, a workforce-focused SDP for teaching hospitals, and a program for three public hospital systems serving as critical providers for Medicaid patients in their service areas. Total payments across all hospital-based SDPs will amount to approximately $1.89 billion in state fiscal year 2025—making up approximately 5% of hospital net patient services revenue and 45% of average hospital margins statewide.[31,32]

One of these SDP programs—GA-AIDE—was established in July 2022 to improve children's and women's health, as well as chronic disease management and preventative care. In state fiscal year 2025, GA-AIDE will provide payments up to the ACR, or $586.3 million to Georgia's largest provider of Medicaid services, Grady Memorial Hospital in Atlanta, and to public hospitals designated as both a teaching hospital and Sole Community Hospital (Phoebe Putney Memorial Hospital in Albany and Colquitt Regional Medical Center in Moultrie).[33] The program's success is measured by the use of 10 nationally recognized quality measures for each participating hospital and 10% of SDP payments are directly tied to the participant meeting select quality targets.

Since inception, Grady has used GA-AIDE SDPs to expand and improve service delivery for its patients. For example, SDP funding supported Grady's expansion of home visits for pregnant patients with hypertension, preeclampsia, and eclampsia, resulting in significant declines in blood pressure among these patients.[34] Grady also used SDPs to increase critical cancer screenings via its Mobile Screening unit and to open two new outpatient clinics in neighborhoods where more than 40% of individuals are covered by Medicare, Medicaid, or are uninsured.[35]

Capping SDPs at 100% of Medicare would result in approximately a 27% reduction overall in Medicaid payments for Georgia hospitals.[36] According to the Georgia Hospital Association, this would force the state to end its SDP initiative that progresses health workforce recruitment and retention entirely and would lead to a loss of $89.1 million in annual DSH funding for rural hospitals, potentially diminishing access to maternal health care and other critical services relied upon by Medicaid enrollees in rural areas.[37] Finally, cuts could also paralyze SPD-funded patient care initiatives by Grady and other providers, leading to a lost opportunity to improve health outcomes for their communities.

Finally, a **southwestern** state is supporting vital high-Medicaid hospitals serving its major metro areas through a targeted SDP. This SDP helps to maintain access to care for a hospital where over half of the patient population is covered by Medicaid, while 22% are uninsured.[38] The SDP was designed by the state to ensure the hospital could sustainably continue to offer care to Medicaid and uninsured patients and to maintain and expand services such as inpatient behavioral health.

Across SDP programs, according to SDP approvals from CMS, this high-Medicaid hospital received up to $334 million in SDPs in state fiscal year 2024, bringing total Medicaid managed care payments up to ~97% of the ACR. If SDPs were capped at 100% of Medicare in state fiscal year 2024, this hospital would lose up to **$288 million of these SDPs**.[39] This cut, if implemented during state fiscal year 2025, would pull a projected -0.3% operating margin down to -43%.[40]

Expanding Access at Children's Hospitals

SDPs across the country are helping to ensure that children enrolled in Medicaid have access to a full array of pediatric health services at children's hospitals. For example, in **Arizona**, a specific SDP program was developed for Phoenix Children's Hospital, which provides 60% of specialized care to pediatric patients covered by Medicaid statewide.[41] The health system serves children in both rural and urban parts of the state through a network of two pediatric hospitals, specialty and urgent care centers, 12 community pediatric practices, 20 outpatient clinics, two ambulatory surgery centers, seven community service clinics, and three mobile medical units.[42] More than half of the system's revenue comes from Medicaid.[43] Over the past five years, it has opened new specialty care pediatric clinics, increased behavioral health staffing across its hospitals, and implemented a new initiative to screen for and support youth with Adverse Childhood Experiences.[44]

SDPs have helped to ensure that Phoenix Children's can continue to provide high quality children's health care in Arizona. Across SDPs, Phoenix Children's received up to $202 million for the 2023-2024 rate year.[45] If SDPs were capped at 100% of Medicare, Phoenix Children's would lose up to 85% of the SDPs it receives—**a reduction of up to $172 million in SDPs**, out of the $202 million for 2023-2024.[46] If implemented in 2023, this would have amounted to a decline in operating margin from 8.4% to -3.9%.[47]

Note: Arizona is not included in the statewide SDP analysis above due to limited public information regarding Arizona's other SDPs.

Sustaining Rural Hospitals

SDPs are a foundational source of funding for rural hospitals across the country. In **Kansas**, the largest SDP program provides approximately $400 million in annual funding to the state's critical access and general hospitals, with 42% of Kansas' general hospitals classified by the state as rural.[48] The state estimates base Medicaid payments for hospitals in Kansas cover only 72% of costs for inpatient services and less than 40% of costs on outpatient services,[49] making SDPs a critical tool to close the gap and help ensure rural hospitals can stay open.

These SDPs are paid as a percentage increase on top of base payments, bringing total hospital Medicaid managed care payments up to approximately 93% of the ACR. If SDPs in Kansas were reduced to 100% of Medicare, hospitals would see up to a 21% decline in Medicaid payments over the next ten years, severely impacting their ability to provide care in the communities they serve.

The negative impact of SDP reductions would exacerbate existing access challenges in Kansas where hospitals had an average operating margin of -4.7% in 2023, even after receiving SDPs.[50] In rural communities, 87% of hospitals are operating in the red, with 47 rural hospitals across the state vulnerable to closure.[51] Providing obstetrics services in rural areas has been a particular challenge in Kansas, with 17 obstetrics units closing since 2010.[52] Given these challenges, SDP cuts would threaten the sustainability of rural hospitals and the services they provide in Kansas at a fundamental level, diminishing care options for Kansas' rural communities.

In **Georgia**, rural hospitals have indirectly benefited from certain SDPs, which have had ripple effects throughout the state. Teaching and safety net hospitals previously received significant DSH payments, but increased SDPs have reduced or completely eliminated the need for DSH payments at many such hospitals. The state redirected their newly freed-up DSH funding to small rural hospitals and critical access hospitals to address uncompensated care provided to Medicaid and uninsured patients; nearly half of Georgia's rural hospitals had negative operating margins in 2023 and 20 are at risk of closing.[53,54] This DSH funding now serves as a financial lifeline for rural communities in Georgia.

Conclusion

SDPs have played a key role in bridging the gap between base Medicaid reimbursement rates and the actual cost of care, strengthening access to crucial care for Medicaid enrollees. Though SDPs have been adopted in many states, other states have yet to implement SDPs at the ACR for at least a subset of hospitals. Even if Congress and the Administration allow states to retain their current SDPs, capping new SDPs at Medicare payment levels forecloses additional states' chances to target vital support to high-Medicaid hospitals. If finalized, the proposals threaten access, financial stability, and operational capacity of hospitals, particularly those that care for a high number of Medicaid patients in states that have not yet implemented SDPs. Further, in states with existing SDPs, constraints on future payment growth limit the power of these payments to sustain high Medicaid hospitals in the future. These hospitals serve as a critical access point to health care for Medicaid enrollees and the broader community, allowing them to maintain essential services, invest in workforce retention, and support community health initiatives. Scaling back current and future SDPs would not only exacerbate existing access challenges for Medicaid enrollees but would also lead to hospital closures and service cutbacks and in communities these hospitals serve.

Appendix: Methods for Calculating State Directed Payment Reductions

To assess the impact reducing SDPs on Medicaid hospital spending, Manatt Health first developed baseline Medicaid enrollment and expenditure estimates by state and eligibility group through federal fiscal year (FFY) 2034 using the below approach.

Medicaid Baseline Calculations

Calculate Medicaid enrollment baseline for all fifty states and the District of Columbia across six eligibility groups.[55] We start with FFY 2023 average monthly enrollment data by eligibility group and state from the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files. We then adjust eligibility group-specific enrollment by state to align with aggregate enrollment reported by states through the Medicaid Budget and Expenditure System (MBES) for FFYs 2023 and 2024. For FFY 2025, we uniformly adjust enrollment by state and eligibility group to align with projections from the Congressional Budget Office's (CBO) January 2025 Budget and Economic Outlook. For FFYs 2026-2034, we apply national, eligibility group-specific enrollment trend rates from CBO's June 2024 Medicaid Baseline.[56]

Calculate Medicaid expenditure baseline by eligibility group and state. We begin by adjusting estimates of per capita expenditures by state and eligibility group from a MACPAC analysis of FFY 2022 T-MSIS data to align with aggregate FFY 2023 expenditures reported by states through CMS Medicaid Financial Management Reports. For FFY 2024, we adjust aggregate state expenditures to account for new or expanded SDPs approved by CMS and to align with national expenditure projections from CBO. For FFYs 2025–2034, we trend forward per capita expenditures using eligibility group-specific growth factors from the June 2024 CBO Medicaid Baseline and apply uniform adjustments to align with aggregate expenditure projections from CBO's January 2025 Budget and Economic Outlook. Our estimates include all Medicaid benefit expenditures except for DSH payments. We calculate federal and non-federal expenditures by state and eligibility group by applying each state's standard medical FMAP or the enhanced 90% match for Medicaid expansion enrollees, as applicable, to total expenditures by eligibility group.[57] We additionally estimate the share of expenditures that are for hospital services based on data from MACPAC on base hospital spending, from CMS on fee-for-service supplemental payments, and from CMS approved preprints on hospital SDPs.

SDP Reduction Calculations

Using the enrollment and expenditure baseline described above, we calculate the impact of potential SDP reductions. Congressional Republicans have considered a proposal to reduce hospital SDPs by reducing the upper limit of SDPs from the ACR, as was codified in the 2024 Medicaid managed care final rule, to Medicare-equivalent rates. We assume this proposal would take effect in FFY 2026. Our estimates are limited to hospital SDPs and do not include impacts to other provider categories (e.g., physicians, skilled nursing facilities, etc.).

State-Level Reductions: To estimate the impact of this proposal at the state level, we first identified hospital SDP and Medicaid managed care base payment ("base payments") amounts for FFY 2023 and/or 2024 using a variety of sources, including preprints approved by CMS. We then determined the total hospital payment level (SDPs plus base payments) as a percentage of the ACR (or Medicare, depending on the SDP). Next, we express these values as a percentage of Medicare rates by using regional Medicare-to-commercial payment ratio developed by Milliman.

We then calculate the amount each SDP would need to be reduced such that the total hospital payment level (i.e., base payments plus SDPs) would align with either Medicare-equivalent rates or base Medicaid payments—whichever is higher. We then compare these reductions with baseline Medicaid hospital spending in each state to determine a percent reduction in overall Medicaid hospital spending by state.

Some states have SDP programs where there is insufficient data to perform the calculation described above. For these SDPs, we applied the average percent reduction in hospital SDPs from states where we did have sufficient information. The states included in the analysis all include at least one SDP that we were able to directly analyze.

Provider-Specific Reductions: Provider-specific SDP reduction estimates were conducted for select providers where public preprint information allowed for the analysis (as outlined at the state level above) at the provider level. This generally is possible where an SDP preprint details payments for a single hospital or hospital system. We assume the total SDP amount listed in the preprint is the total amount of the SDP, though in some cases providers may have received less than the SDP limit approved in the preprint.

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[7] Medicaid and CHIP Payment and Access Commission, *Directed Payments in Medicaid Managed Care* (2024), available at https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf

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[55] We use the approach developed by MACPAC for grouping enrollees. Eligibility groups include children, expansion adults, other adults (e.g., parents and pregnant individuals), elderly individuals, individuals with disabilities, and individuals with limited benefit coverage (e.g., individuals enrolled emergency-only or family planning coverage). We exclude all individuals enrolled in CHIP-funded coverage (including Medicaid expansion CHIP).

[56] We use trend rates from CBO's June 2024 Medicaid baseline to project forward enrollment in FFYs 2026 and beyond because the January 2025 Budget and Economic Outlook only provides enrollment projections for FFY 2025.

[57] Currently, nine states that provided expanded coverage to parents and childless adults prior to the enactment of the Affordable Care Act receive enhanced federal matching funds for the "not newly eligible" expansion adult group. All other states receive the regular match rate for not newly eligible expansion adults. We derive the proportions of newly and not newly eligible expansion enrollees by state from MBES enrollment reports.

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