# Medicaid Base and Supplemental Payments to Hospitals

States make a number of different types of Medicaid payments to hospitals and have broad flexibility to design their own payment methods. The two broad categories of payments are (1) base payments for services and (2) supplemental payments, which are typically made in a lump sum for a fixed period of time. States vary in the mix of base and supplemental payments that they make, as well as the overall level of payment to hospitals.

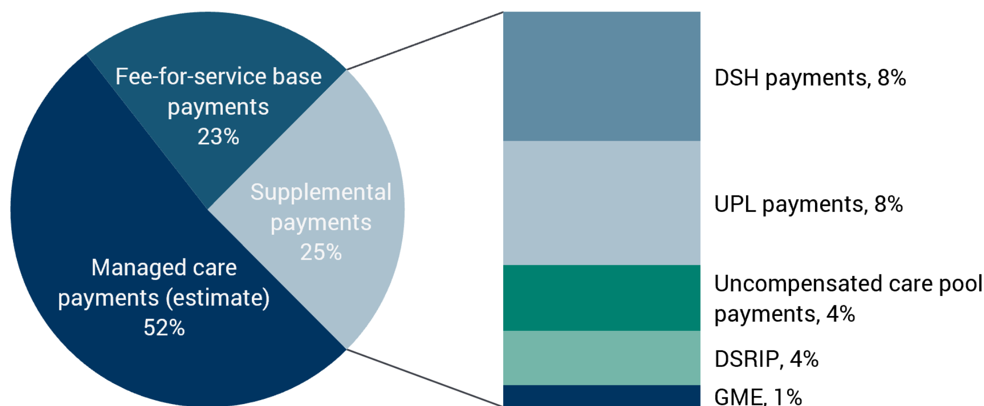
This issue brief reviews each type of Medicaid hospital payment, with information on payment goals, payment amounts, and the relationship to other types of Medicaid payments. It also provides illustrative examples showing how the use of supplemental payments varies by state and additional information about how state methods for financing Medicaid payments affect net hospital payments. We provide complete state-by-state information on supplemental payments to hospitals in Appendix A.

## Medicaid Spending on Hospitals

Medicaid spent $206.6 billion on hospital care in 2019.[1] Hospital spending accounted for 34 percent of total Medicaid spending and Medicaid payments to hospitals accounted for 17 percent of all payments to hospitals in 2019 (OACT 2020).

In fiscal year (FY) 2019, about half of Medicaid payments to hospitals were made on a fee-for-service (FFS) basis and about half of payments were made through managed care delivery systems (Figure 1). About half of FFS payments were base payments for services and about half were supplemental payments.

**FIGURE 1.** Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2019

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**Notes:** FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. DSRIP is delivery system reform incentive payment. GME is graduate medical education. DSRIP and uncompensated care pool payments must be authorized under Section 1115 waivers. Managed care payments to hospitals are estimated based on total managed care spending reported by states. Totals do not sum due to rounding.

**Source:** MACPAC, 2021, analysis of CMS-64 net expenditure data as of August 05, 2020 and CMS-64 Schedule C waiver report data as of September 24, 2020.

# Base Payments

Base payments to hospitals pay for specific services provided to Medicaid enrollees. Payment policies differ among states and between FFS and managed care delivery systems.

## Fee for service

**Payment goals.** FFS payment policies are required to be consistent with the statutory goals of efficiency, economy, quality, and access (§ 1902(a)(30)(A) of the Social Security Act). Specifically, payments must be sufficient to enlist enough providers so that services are available to Medicaid-enrolled patients at least to the extent they are available to the general population in the geographic area. The Centers for Medicare & Medicaid Services (CMS) assesses the adequacy of FFS payments when it approves FFS payment methodologies. Under 2015 regulations for monitoring access, states must submit access monitoring review plans every three years and whenever the state proposes a reduction in provider payments (42 CFR § 447.203).

**Payment amounts.** FFS base payments for inpatient hospital services vary considerably across states. Based on analysis of 2011 claims data, payments for inpatient services ranged from 49 percent to 169 percent of the national average (MACPAC 2017a). States were not consistently high or low payers across all inpatient services. Payment amounts for the same service also varied within each state.

On average, Medicaid FFS base payments are below hospitals' costs of providing services to Medicaid enrollees and are below Medicare payment rates for comparable services. In 2011, for example, FFS base payment rates were 78 percent of Medicare for the 18 Medicare-severity diagnostic-related groups that MACPAC studied (MACPAC 2017a).

**Relationship to other payments.** States can supplement low FFS base payments by using upper payment limit (UPL), disproportionate share hospital (DSH), or uncompensated care pool payments to pay for Medicaid shortfall, which is the difference between a hospital's Medicaid payments and its cost to provide services to Medicaid-enrolled patients.

## Managed care

**Payment goals.** Managed care capitation rates are required to be actuarially sound, meaning that they cover reasonable, appropriate, and attainable costs in providing covered services to Medicaid enrollees. Managed care plans typically have flexibility in determining the rates they will pay providers, but must meet state network adequacy requirements. CMS reviews capitation rates for managed care contracts and requires states to conduct external quality reviews at least once every three years, but CMS does not review the rates that managed care plans pay providers.

**Payment amounts.** The limited data available on managed care payments to hospitals suggests that these payments are similar to FFS in some states, but different in others. For example, an analysis of hospital payment-to-cost ratios in Florida in state fiscal year (SFY) 2013 found that Medicaid managed care payment rates were similar to FFS (a payment-to-cost ratio of 80 percent for managed care compared to 78 percent for FFS). However, a similar analysis of payments in Massachusetts in FY 2014 found that the managed care payment-to-cost ratio was much higher than FFS: an 87 percent payment-to-cost ratio for managed care compared to 72 percent in fee-for-service (MACPAC 2018a). During the summer of 2018, MACPAC interviewed state officials and stakeholders in five states (Arizona, Louisiana, Michigan, Mississippi, and Virginia) and found that Medicaid managed care payments to hospitals closely track those made under fee for service (Marks et al. 2018).

**Relationship to other payments.** States generally are prohibited from making supplemental payments for services provided in managed care delivery systems; however, a number of states have received waivers under Section 1115 of the Social Security Act in order to continue making supplemental payments when they expanded managed care.[2] In April 2016, CMS established a new option allowing states to require managed care plans to direct rate increases or payment for quality improvement activities to particular providers without a waiver (CMS 2016). Payments under this new directed-payment option differ from pass-through payments, which must be phased out under the new rule because pass-through payments in managed care are lump sum payments that are not directly tied to services.

## Supplemental Payments

There are five major types of Medicaid supplemental payments to hospitals (Table 1). Some of these supplemental payments are intended to pay for services provided to Medicaid-enrolled patients and some are meant to support other goals. For example, DSH, UPL, and uncompensated care pool payments help to supplement Medicaid base payment rates that are often below hospital costs, but DSH and uncompensated care pool payments also help to support the costs of care provided to uninsured patients. States vary in the mix and amount of supplemental payments they make (Appendix A).

**TABLE 1.** Spending and Implied Goals of Medicaid Supplemental Payments to Hospitals, FY 2018

| Type of supplemental payment | Total spending (billions) | Number of states reporting spending | Intent of payment implied from federal rules | | |
|---|---|---|---|---|---|
| | | | Medicaid enrolled patients | Uninsured individuals | Other purposes |
| DSH | $14.9 | 50 | ✓ | ✓ | |
| UPL | $14.3 | 32 | ✓ | | |
| Uncompensated care pools | $7.6 | 8 | ✓ | ✓ | |
| DSRIP | $6.3 | 10 | | | ✓ |
| GME | $2.5 | 30 | | | ✓ |

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. GME is graduate medical education. DSRIP is delivery system reform incentive payment. Analysis excludes managed care payments and DSH payments to mental health facilities. Number of states reporting spending includes the District of Columbia.

**Source:** MACPAC, 2021, analysis of CMS-64 FMR net expenditure data as of August 05, 2020 and CMS-64 Schedule C waiver report data as of September 24, 2020.

Overall spending on Medicaid supplemental payments to hospitals has changed over time, and because many types of supplemental payments are interchangeable, changes to one type of payment may affect other payments. For example, after Congress imposed limits on DSH spending in the 1990s, UPL payments grew rapidly in the early 2000s.[3]

## Disproportionate share hospital payments

**Payment goals.** Medicaid DSH payments are statutorily required payments to hospitals that serve a high share of Medicaid and low-income patients.[4] DSH payments cannot exceed the hospital's uncompensated care costs for both Medicaid-enrolled and uninsured patients, defined as follows:

- **Medicaid shortfall** is the difference between a hospital's costs of serving Medicaid-enrolled patients and the payments that it receives for those services, including FFS, managed care, UPL, graduate medical education (GME), and uncompensated care pool payments, but excluding delivery system reform incentive payments (DSRIP).
- **Unpaid costs of care for uninsured patients** includes both charity care (for which the hospital does not charge the patient at all or charges the patient a discounted rate below the hospital's cost of delivering the care) and bad debt (for which the hospital charges the patient but is not able to collect). Medicaid DSH does not pay for bad debt expenses for patients with insurance who cannot pay because they cannot afford deductibles or copays.

**Payment amounts.** DSH payments to hospitals totaled $14.9 billion in FY 2019. This amount excludes DSH payments to institutions for mental diseases (IMDs), which are beyond the scope of this issue brief.

State DSH spending is limited by federal allotments, which vary widely by state. In FY 2018, federal funds allotted to states for DSH payments totaled $12.3 billion. State-specific DSH allotments that year ranged from less than $15 million in six states (Delaware, Hawaii, Montana, North Dakota, South Dakota, and Wyoming) to more than $1 billion in three states (California, New York, and Texas). DSH allotments are largely based on each state's DSH spending in 1992, when DSH allotments were first established.

**Relationship to other payments.** DSH payments can be used offset low base payments, but they are the only type of Medicaid payment in statute that is explicitly intended to pay for unpaid costs of care for uninsured patients.[5]

Changes to base and non-DSH supplemental payments can affect the amount of DSH funding a hospital is eligible to receive. For example, increases in base and non-DSH supplemental payments reduce a hospital's Medicaid shortfall and thus reduce the total uncompensated care costs that DSH can pay for.

## Upper payment limit payments

**Payment goals.** UPL payments are lump-sum payments that are intended to fill in the difference between FFS base payments and the amount that Medicare would have paid for the same service. In the aggregate for each class of providers, FFS and UPL payments for services cannot exceed a reasonable estimate of what would have been paid according to Medicare payment principles. Classes of providers are defined based on ownership (i.e., government, non-state government, and privately owned). States can use a variety of methods to estimate what Medicare would have paid, including a payment-based method (i.e., based on

the hospital's aggregate Medicare payments relative to its charges) or a cost-based method (i.e., the hospital's costs according to Medicare cost principles).

**Payment amounts.** UPL payments for inpatient and outpatient hospital services totaled $14.3 billion in FY 2019.[6] The use of UPL payments varies widely by state: in FY 2019, UPL payments to hospitals were less than 1 percent of Medicaid benefit spending in 16 states and more than 10 percent of Medicaid benefit spending in 4 states.

**Relationship to other payments.** UPL payments are explicitly intended to supplement low FFS base payment rates. If states increase base payments rates to hospitals, the amount of UPL payments that a state can make is reduced.

Because UPL limits are established in the aggregate, UPL payments to individual hospitals can exceed the hospitals' costs as long as total payments for each class of providers are below the UPL. This policy is different than DSH, which cannot pay more than a hospital's uncompensated care costs.

## Uncompensated care pool payments

**Payment goals.** Uncompensated care pools are authorized under Section 1115 demonstrations and were initially used as a way to preserve FFS supplemental payments when states expanded the use of managed care and could not otherwise continue to make the same level of UPL payments to hospitals. Eight states reported uncompensated care pool spending in FY 2019 (Arizona, California, Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas).

States negotiate the parameters of their uncompensated care pools with CMS and can define uncompensated care using definitions that differ from those used for DSH purposes. For example, Florida's Low Income Pool pays for patients who are underinsured as well as for patients who are uninsured. California's Global Payment Program pays for hospital unpaid costs of care incurred outside of the hospital setting, but it does not pay for Medicaid shortfall.

**Payment amounts.** Uncompensated care pool payments totaled $7.6 billion in FY 2019. The payment amounts are established in each state's Section 1115 demonstration special terms and conditions. In some states, the amount of funding for uncompensated care pools declines over time to reflect expected declines in uncompensated care as a result of coverage expansions, but in other states, funding for uncompensated care pools increases each year based on inflation.

**Relationship to other payments.** States can use DSH, UPL, and uncompensated care pool payments interchangeably to pay for Medicaid shortfall.

## Delivery system reform incentive payments

**Payment goals**. DSRIP programs direct Medicaid funds toward provider-led efforts to improve health care quality and access. DSRIP programs are authorized under Section 1115 demonstrations, and like uncompensated care pools, some states have sought DSRIP programs as a way to preserve supplemental payments in managed care. Additional information about the design and structure of DSRIP programs is provided in MACPAC's issue brief, *Delivery System Reform Incentive Payment Programs* (MACPAC 2020).

DSRIPs are not considered to be payments for Medicaid services and are instead intended to pay for infrastructure and investments in care improvement activities for a state's safety-net health system as a whole.

**Payment amounts.** DSRIP payments totaled $6.3 billion in FY 2019. Most DSRIP payments go to hospitals, but some DSRIP payments support non-hospital providers as well.[7]

**Relationship to other payments.** Because DSRIP payments are not classified as payments for Medicaid services, they do not affect other hospital payments. Thus, even if a hospital is receiving the maximum amount of funding allowable under DSH and UPL rules, it can still receive additional DSRIP funding.

CMS has indicated that it views DSRIP funding as a one-time investment, and does not plan to renew DSRIP demonstrations. Instead, the agency is encouraging states to develop plans to sustain DSRIP by incorporating value-based purchasing strategies into managed care contracts.

## Graduate medical education payments

**Payment goals.** Medicaid GME payments help support teaching hospitals.[8] These institutions' higher costs can reflect both the direct costs of training (e.g., residents' salaries) as well as indirect costs associated with a more severe case mix. Some states make GME payments as a supplemental payment, while other states account for GME costs in the calculation of base payments to teaching hospitals.

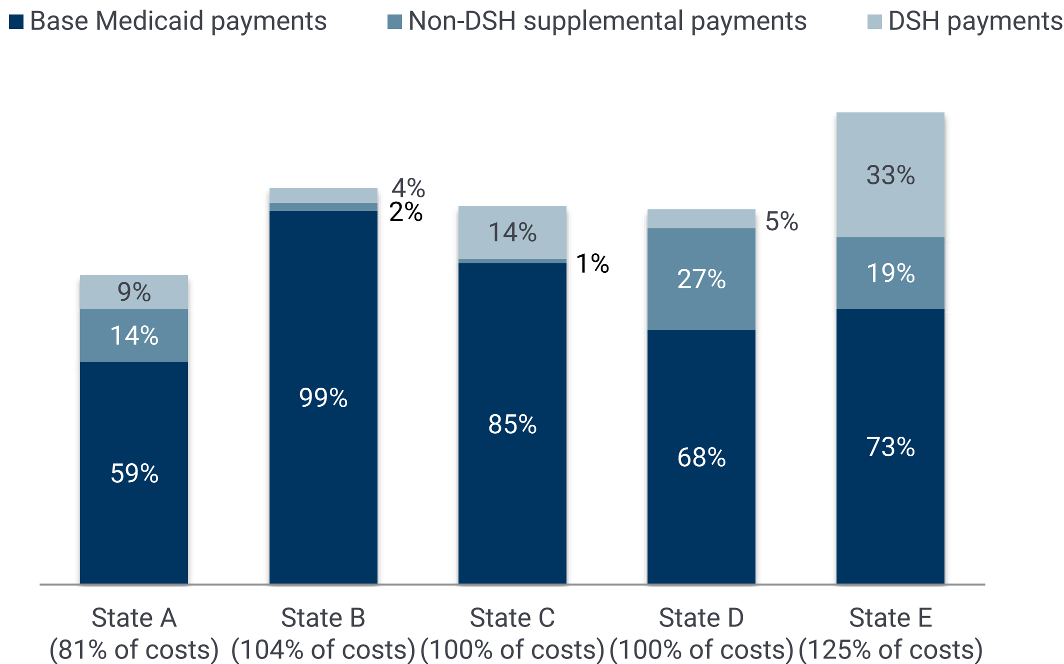
**Payment amounts.** In FY 2019, 30 states reported $2.5 billion in Medicaid GME supplemental payments. States do not separately report GME payments included in base payment rates to hospitals.

**Relationship to other payments.** States can make GME supplemental payments in both FFS and managed care delivery systems. GME payments are considered Medicaid payments for the purposes of calculating Medicaid shortfall for DSH and UPL purposes.

# State Variation in Hospital Payment

Total Medicaid payments to hospitals vary widely by state because of differences in base payment rates and differences in the use of supplemental payments. Data from the annual, hospital-specific Medicaid DSH audits help illustrate this variation (Figure 2). In this example, overall Medicaid payment to DSH hospitals as a share of Medicaid costs ranges from 81 percent of costs in state A to 125 percent of costs in state E.[9]

**FIGURE 2.** Medicaid Payments to DSH Hospitals as a Percentage of Medicaid Costs for Selected States, SPRY 2014




**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with state fiscal year and may not align with the federal fiscal year. Institutions for mental diseases were excluded from this analysis. Base Medicaid payments include fee-for-service as well as managed care payments for services. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on DSH audits). DSH payments and non-DSH supplemental payments may also be used to pay for non-Medicaid costs, such as unpaid costs of care for uninsured patients. Payment levels shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. All states in this analysis distribute DSH payments to more than half of hospitals in their state. Numbers do not sum due to rounding.

**Source:** MACPAC 2018b.

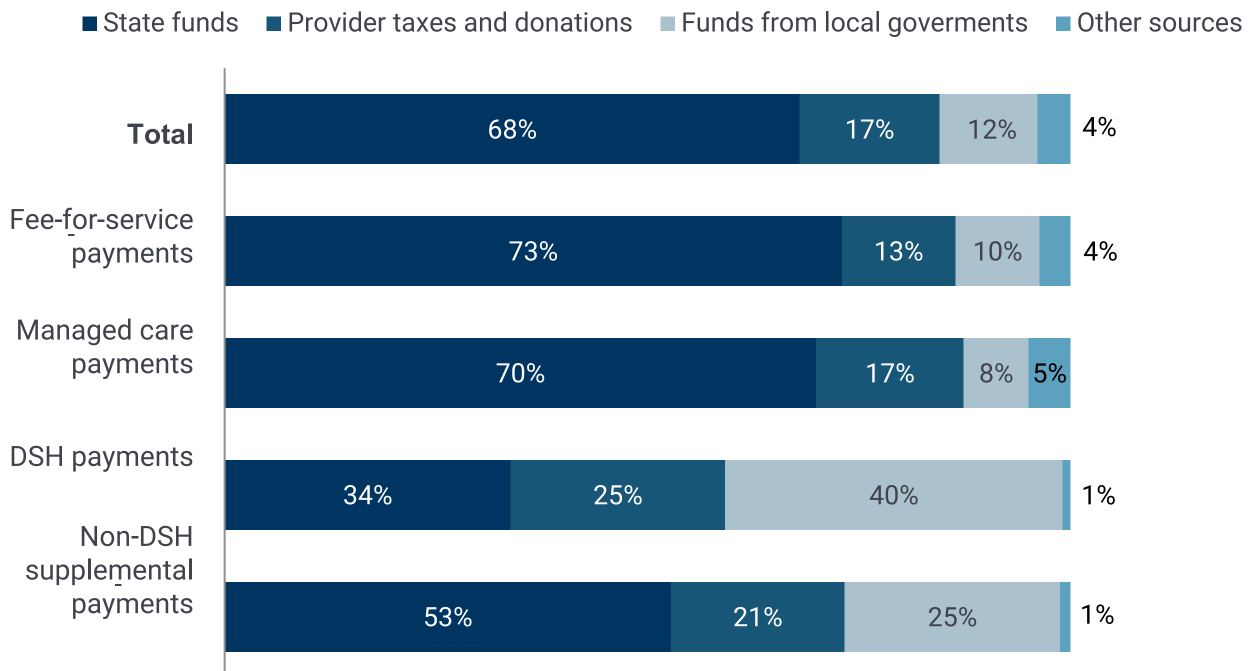
Although states B, C, and D pay hospitals roughly 100 percent of Medicaid costs, they differ in their use of supplemental payments. State B makes relatively small supplemental payments, while states C and D make relatively large supplemental payments to pay for Medicaid shortfall. However, state C makes more DSH payments than non-DSH supplemental payments, while state D makes more non-DSH supplemental payments than DSH payments.

State E is an example of a state that appears to pay hospitals well above their costs of serving Medicaid patients. However, in this case, total payments to hospitals in the state are 95 percent of hospital costs for Medicaid and uninsured patients. As a result, it is likely that state E is also using Medicaid supplemental payments to pay for care provided to uninsured individuals.

## Effect of State Financing Methods

In considering how Medicaid programs pay hospitals, it is also important to consider how these payments are financed. While the majority of the non-federal share of funds for Medicaid payments comes from state funds, most DSH and non-DSH supplemental payments are financed by provider taxes and funds from local governments (Figure 3).

**FIGURE 3.** Share of Non-Federal Funds for Medicaid Payments from Different Sources, SFY 2018




**Notes:** SFY is state fiscal year. DSH is disproportionate share hospital. State funds include state general funds and inter-agency transfers. Funds from local governments include intergovernmental transfers and certified public expenditures. Other sources include funds, such as tobacco settlement funds, that are used to fund the state's non-federal share of Medicaid expenditures and are not considered to fit in the other categories listed. Numbers do not add due to rounding. Data reflects all Medicaid payments, not just Medicaid payments to hospitals.

**Source:** GAO 2021.

The approaches that states use to finance the non-federal share of these payments may affect how they are targeted. For example, states that finance DSH payments with broad-based provider taxes often distribute DSH payments broadly, and states that finance DSH payments with funds from local governments (typically through public hospitals) often target DSH funds to public hospitals (MACPAC 2017b).

Provider taxes and intergovernmental transfers from public hospitals can reduce the net payments that providers receive. For example, assuming that DSH hospitals contributed to the non-federal share of payments financed with provider taxes and funds from local governments at the same rate as other providers, we estimate that these provider contributions reduced total Medicaid payments to DSH hospitals by 11 percent in 2011 (Nelb et al. 2016).

Hospital-specific data on the sources of non-federal share are not publicly available. In the February 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*, MACPAC recommended that the Secretary of the U.S. Department of Health and Human Services (HHS) collect and report hospital-specific data on all types of Medicaid payments to hospitals, as well as data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level (MACPAC 2016). The Consolidated Appropriations Act, 2021, (P.L. 116-260) requires HHS to collect and report data on non-DSH supplemental payments beginning October 1, 2021, but HHS is not required to collect and report data on the sources of non-federal share.

## Learn more:

- A Framework for Evaluating Medicaid Provider Payment Policy, in MACPAC's March 2015 *Report to Congress on Medicaid and CHIP*
- *State Medicaid Payment Policies for Inpatient Hospital Services* (December 2018 policy compendium and issue brief)
- *State Medicaid Payment Policies for Outpatient Hospital Services* (July 2016 policy compendium and issue brief)
- *Factors Affecting the Development of Medicaid Hospital Payment Policies: Findings from Structured Interviews in Five States* (October 2018 contractor report)
- Annual Analysis of Disproportionate Share Hospital Payments to States, in MACPAC's March 2021 *Report to Congress on Medicaid and CHIP*
- Oversight of Upper Payment Limit Supplemental Payments to Hospitals, in MACPAC's March 2019 *Report to Congress on Medicaid and CHIP*
- Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments, in MACPAC's March 2014 *Report to the Congress on Medicaid and CHIP*
- *Delivery System Reform Incentive Payments (DSRIP) Programs* (March 2018 issue brief)
- Using Medicaid Supplemental Payments to Drive Delivery System Reform, in MACPAC's June 2015 *Report to Congress on Medicaid and CHIP*

**Endnotes**

[1] Estimates of Medicaid hospital spending in National Health Expenditures Accounts data include both fee-for-service (FFS) and managed care payments for inpatient and outpatient hospital services. They also include payments for nursing facility services and home health services provided by hospitals.

[2] Section 1115 of the Social Security Act provides broad authority to the Secretary of the Department of Health and Human Services (HHS) to approve demonstrations that are likely to assist in promoting the objectives of the Medicaid program. This includes the authority to waive Medicaid requirements and to provide federal matching funds for costs that would not otherwise be matchable under the state plan, such as supplemental payments in managed care delivery systems.[3] Additional background information about the history of Medicaid DSH payment policy is included in Chapter 1 and Appendix A of

MACPAC's February 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments* and additional information about the history of UPL payments is provided in Chapter 2 of MACPAC's March 2019 *Report to Congress on Medicaid and CHIP*.

[4] Medicare also makes DSH payments to hospitals that using different rules than Medicaid.

[5] Section 1115 uncompensated care payments also can help pay for unpaid costs of care for uninsured patients, but these payments must be authorized under Section 1115 waivers.

[6] States also make UPL payments for nursing facility services and other types of Medicaid payments that are beyond the scope of this issue brief.

[7] We do not have data to distinguish DSRIP payments to hospitals and DSRIP payments to non-hospital providers.

[8] Medicare also makes GME payments to hospitals using different rules than Medicaid.

[9] Although DSH audit data are only available for hospitals that receive DSH payments, we selected five states that provide DSH payment and cost information for the majority of hospitals in their state so that these examples are more generalizable than DSH audit data from states that only provide DSH to one or two hospitals. Additional information on Medicaid payments and costs for DSH hospitals by state is included in Appendix A of Chapter 3 of MACPAC's March 2018 report, Annual Analysis of Disproportionate Share Hospital Allotments to States.

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# Appendix A. State-Level Data

**TABLE A-1.** Medicaid Supplemental Payments to Hospitals, by State, FY 2019 (millions)

| State | Total hospital supplemental payments | DSH payments | UPL payments | Uncompensated care pool payments | DSRIP[1] | GME |
|---|---|---|---|---|---|---|
| **Total** | **$45,669.0** | **$14,946.5** | **$14,268.4** | **$7,602.0** | **$6,316.9** | **$2,535.2** |
| Alabama | **1,310.0** | 486.3 | 823.7 | – | – | – |
| Alaska | **9.6** | 9.6 | – | – | – | – |
| Arizona | **445.5** | 135.4 | – | 16.5 | – | 293.6 |
| Arkansas | **479.6** | 81.3 | 389.7 | – | – | 8.6 |
| California | **10,393.7** | 636.5 | 5,852.1 | 2,413.2 | 1,491.9 | – |
| Colorado | **1,418.9** | 248.2 | 1,165.4 | – | – | 5.3 |
| Connecticut | **511.6** | 3.2 | 487.1 | – | – | 21.3 |
| Delaware | **9.1** | 9.1 | – | – | – | – |
| District of Columbia | **100.1** | 82.2 | 17.9 | – | – | – |
| Florida | **1,226.0** | 236.8 | 15.9 | 756.3 | – | 217.0 |
| Georgia | **463.8** | 455.8 | 7.9 | – | – | – |
| Hawaii[3] | **36.7** | 36.2 | 0.5 | – | – | – |
| Idaho | **37.5** | 26.0 | 11.5 | – | – | – |
| Illinois | **1,088.4** | 205.2 | 636.8 | – | – | 246.3 |
| Indiana | **303.9** | 267.4 | – | – | – | 36.6 |
| Iowa | **110.1** | 70.9 | – | – | – | 39.2 |
| Kansas | **142.5** | 68.1 | – | 50.8 | 22.1 | 1.5 |
| Kentucky | **220.7** | 212.9 | 6.3 | – | – | 1.4 |
| Louisiana | **1,182.4** | 1,080.3 | 62.3 | – | – | 39.8 |
| Maine | **91.1** | 1.8 | 75.3 | – | – | 14.0 |
| Maryland[2] | **52.9** | -0.2 | – | – | – | 53.1 |
| Massachusetts | **913.7** | – | 82.5 | 404.4 | 426.8 | – |
| Michigan | **788.0** | 160.9 | 564.2 | – | – | 62.9 |
| Minnesota | **194.9** | 61.6 | 56.6 | – | – | 76.7 |
| Mississippi | **230.1** | 230.1 | – | – | – | – |
| Missouri | **680.9** | 539.6 | – | – | – | 141.3 |
| Montana | **238.3** | 1.8 | 228.0 | – | – | 8.5 |
| Nebraska | **58.5** | 58.5 | – | – | – | – |
| Nevada | **330.8** | 101.8 | 197.2 | – | – | 31.8 |
| New Hampshire | **244.6** | 225.9 | 0.3 | – | 18.4 | – |
| New Jersey | **1,004.3** | 765.5 | – | – | – | 238.8 |

| State | Total hospital supplemental payments | DSH payments | UPL payments | Uncompensated care pool payments | DSRIP[1] | GME |
|---|---|---|---|---|---|---|
| New Mexico | **231.3** | 32.3 | – | 68.9 | 12.0 | 118.2 |
| New York | **5,430.9** | 3,096.0 | 420.7 | – | 1,914.2 | – |
| North Carolina | **1,454.5** | 307.7 | 1,061.3 | – | – | 85.5 |
| North Dakota | **3.2** | 1.0 | 2.2 | – | – | – |
| Ohio | **1,741.8** | 1,315.2 | 426.5 | – | – | – |
| Oklahoma | **786.6** | 40.8 | 629.5 | – | 107.7 | 8.6 |
| Oregon | **132.2** | 29.4 | – | – | – | 102.8 |
| Pennsylvania | **1,240.4** | 811.3 | 287.6 | – | – | 141.6 |
| Rhode Island | **142.5** | 142.3 | 0.2 | – | – | – |
| South Carolina | **619.5** | 498.1 | 51.4 | – | – | 70.0 |
| South Dakota | **3.7** | 0.8 | – | – | – | 2.9 |
| Tennessee | **459.4** | 79.1 | – | 380.3 | – | – |
| Texas | **7,851.8** | 1,658.2 | – | 3,511.7 | 2,559.5 | 122.5 |
| Utah | **73.9** | 31.1 | 36.7 | – | – | 6.1 |
| Vermont | **25.8** | 22.7 | – | – | 3.1 | – |
| Virginia | **1,006.9** | 93.0 | 586.2 | – | – | 327.7 |
| Washington[3] | **-75.0** | 163.8 | – | – | -238.8 | – |
| West Virginia | **64.6** | 53.0 | – | – | – | 11.7 |
| Wisconsin | **121.5** | 71.5 | 50.0 | – | – | – |
| Wyoming | **35.1** | 0.5 | 34.6 | – | – | – |

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. GME is graduate medical education. DSRIP is delivery system reform incentive payment. Analysis excludes managed care payments and payments to mental health facilities. States also make DSH payments to institutions for mental diseases and also make UPL payments to non-hospital providers.
— Dash indicates zero.
[1] DSRIP funding supports hospital and non-hospital providers. Because the majority of DSRIP payments go to hospitals, these payments are reported as supplemental payments to hospitals. This column also includes DSRIP-like payments authorized under Section 1115 demonstrations that also incentivize delivery system reforms but have a different program name.
[2] Maryland reported negative DSH payments in FY 2019 due to prior period adjustments.
[3] Washington reported negative DSRIP payments in FY 2019 due to prior period adjustments.

**Source:** MACPAC, 2021, analysis of CMS-64 FMR net expenditure data as of August 05, 2020, and CMS-64 Schedule C waiver report data as of September 24, 2020.