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.

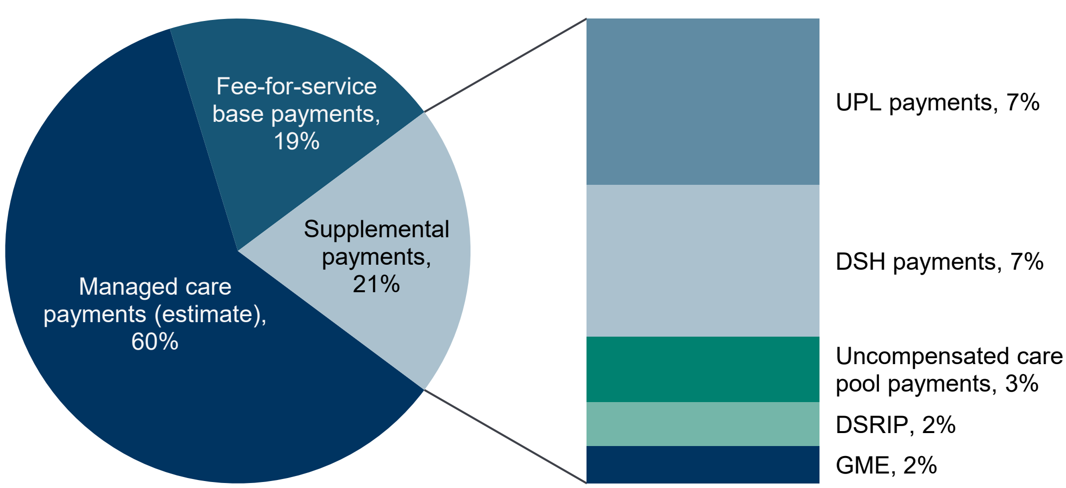
This issue brief reviews each type of Medicaid hospital payment, with information on payment goals, payment amounts, and the relationship to other types of Medicaid payments. It also provides illustrative examples showing how the use of supplemental payments varies by state and additional information 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 $245.3 billion on hospital care in 2021.[1] Hospital spending accounted for 37 percent of total Medicaid spending and Medicaid payments to hospitals accounted for 19 percent of all payments to hospitals in 2021 (OACT 2022).

In fiscal year (FY) 2021, 60 percent of Medicaid payments to hospitals were made through managed care delivery systems and the remainder were made on a fee-for-service (FFS) basis (Figure 1). Of the approximately 40 percent of payments to hospitals made through FFS, less than half were base payments for services and over half were supplemental payments.

FIGURE 1. Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2021



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.

Source: MACPAC, 2023, analysis of CMS-64 net expenditure data as of June 8, 2022 and CMS-64 Schedule C waiver report data as of September 19, 2022.

Base Payments

Base payments to hospitals are for specific services provided to Medicaid enrollees. Payment policies, including payment methods and amounts, differ among states and between FFS and managed care delivery systems within states.

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 submitted by the state as part of the Medicaid state plan. 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 among hospitals 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. MACPAC found that in 2011, FFS base payment rates were 78 percent of Medicare for the 18 Medicare-severity diagnostic-related groups 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 (42 CFR 438.4). Managed care plans typically have flexibility in determining the rates they will pay providers but must meet state network adequacy requirements. CMS reviews the overall capitation rates for managed care contracts each year and requires states to conduct external quality reviews at least once every three years, but CMS does not review the rates or methods that managed care plans use to pay providers.

Payment amounts. The limited data available on managed care payments to hospitals suggests that managed care organizations (MCOs) pay similar rates to FFS in some states, but use different payment rates in others. For example, an analysis of hospital payment-to-cost ratios in Florida in state fiscal year (SFY) 2013 found that the Medicaid managed care payment-to-cost ratio (80 percent) was similar to FFS (78 percent). However, a similar analysis of payments in Massachusetts in FY 2014 found that the managed care payment-to-cost ratio (87 percent) was much higher than FFS (72 percent) (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 in those states closely tracked 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 (MACPAC 2022b).

Supplemental Payments

There are five major types of Medicaid supplemental payments to hospitals in FFS (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 FFS Supplemental Payments to Hospitals, FY 2021

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	$14.1	48	✓	✓	
UPL	$15.4	32	✓		
Uncompensated care pools	$6.1	7	✓	✓	
DSRIP	$4.1	7			✓
GME	$3.4	36			✓

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, 2023, analysis of CMS-64 FMR net expenditure data as of June 8, 2022 and CMS-64 Schedule C waiver report data as of September 19, 2022.

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]

Some states make managed care directed payments that appear similar to FFS supplemental payments, but information on spending and the goals of these arrangements are not publicly available and they are not included in the counts of supplemental payments in this brief (MACPAC 2020b). For additional information on supplemental payments within managed care see Chapter 2 of MACPAC's June 2022 *Report to Congress on Medicaid and CHIP* (MACPAC 2022a).

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 individuals** include 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 (excluding institutions for mental diseases) totaled $14.1 billion in FY 2021. State DSH spending is limited by federal allotments, which vary widely by state and are largely based on each state's DSH spending in 1992, when the allotments were first established.[5] In FY 2021, federal funds allotted to states for DSH payments totaled $14.3 billion; accounting for both state and federal funds, DSH spending was $18.9 billion.[6] State-specific federal 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).

States typically have up to two years to spend their DSH allotments after the end of the fiscal year.[7] As of the end of FY 2022, $1.9 billion in federal DSH allotments for FY 2020 were unspent.[8] There are two primary reasons states do not spend their full DSH allotment: (1) they lack state funds to provide the non-federal share, and (2) the DSH allotment exceeds the total amount of hospital uncompensated care in the state. (DSH payments to an individual hospital cannot exceed that hospital's level of uncompensated care.)

Relationship to other payments. DSH payments can be used to 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.[9]

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. Additional information about Medicaid DSH payment policy is provided in MACPAC's latest report to Congress, *Annual Analysis of Disproportionate Share Hospital Allotments to States* (MACPAC 2023).

Upper payment limit payments

Payment goals. UPL payments are lump-sum payments that are intended to cover the difference between FFS base payments and the amount that Medicare would have paid for the same service. FFS and UPL payments for services cannot exceed a reasonable estimate of what would have been paid to a class of providers, in the aggregate, 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). Additional information about rules for UPL supplemental payments is provided in MACPAC's issue brief, *Upper Payment Limit Supplemental Payments* (MACPAC 2021).

Payment amounts. UPL payments for inpatient and outpatient hospital services totaled $15.4 billion in FY 2021.[10] The use of UPL payments varies widely by state: in FY 2021, UPL payments to hospitals were less than 1 percent of Medicaid benefit spending in 12 states and more than 10 percent of Medicaid benefit spending in 5 states.

Relationship to other payments. UPL payments are 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 hospital's costs as long as total payments for each class of providers are below the UPL. This policy is different than DSH, which cannot pay any individual hospital more than its uncompensated care costs.

Uncompensated care pool payments

Payment goals. Uncompensated care pools authorized under Section 1115 demonstrations were initially used as a way to preserve 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 without a FFS payment base. Seven states reported uncompensated care pool spending in FY 2021 (Arizona, California, Florida, Kansas, Massachusetts, Tennessee, and Texas).

States negotiate the parameters of their uncompensated care pools with CMS and may develop uncompensated care 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 $6.1 billion in FY 2021. 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 2020a).

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 totaled $4.1 billion in FY 2021. Most DSRIP are directed to hospitals, but some DSRIP support non-hospital providers.[11]

Relationship to other payments. Because DSRIP 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 denied DSRIP demonstration renewals. For example, New York requested to renew its DSRIP program in 2020, but CMS declined and argued that New York's DSRIP program was a one-time investment (CMS 2020). 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.[12] 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.

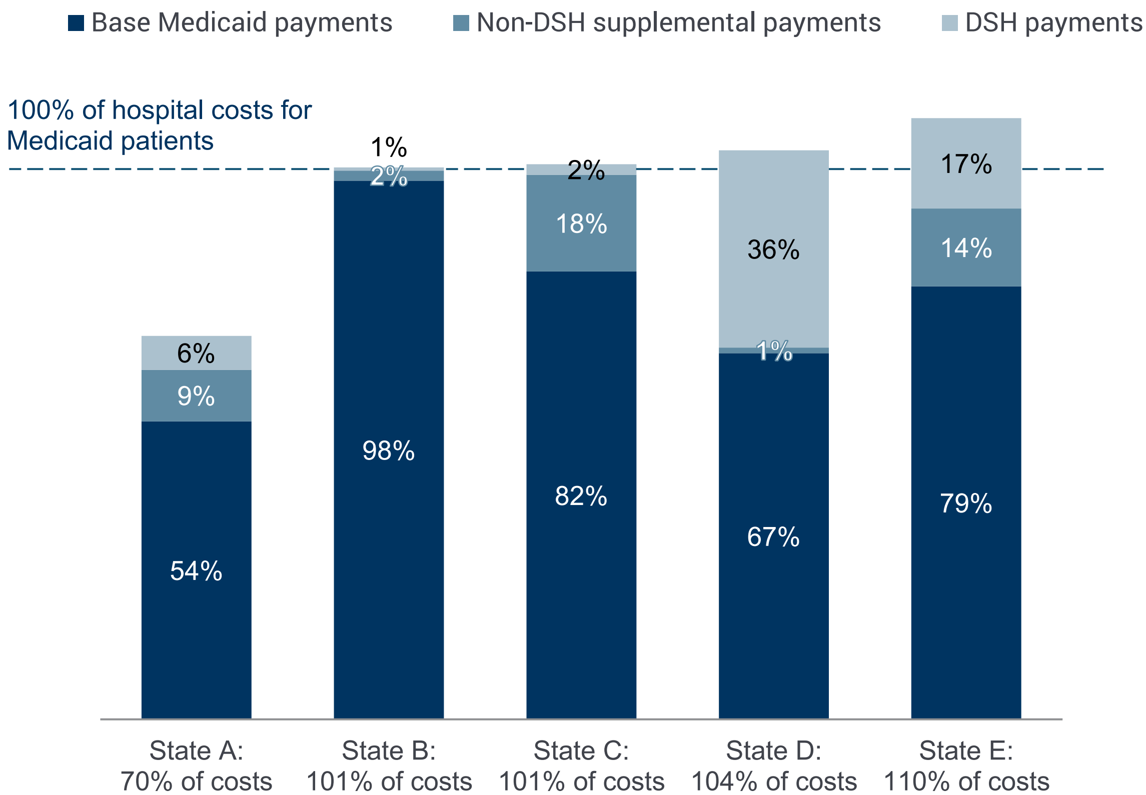
Payment amounts. In FY 2021, 36 states reported $3.4 billion in Medicaid GME supplemental payments. States do not separately report GME payments included in base payment rates to hospitals.

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 70 percent of costs in state A to 110 percent of costs in state E.[13]

FIGURE 2. Medicaid Payments to DSH Hospitals as a Percentage of Medicaid Costs for Selected States, SPRY 2018



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. A total of 2,355 DSH hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2020 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. DSH payments can cover Medicaid and uninsured costs, but this figure calculates DSH and other Medicaid payments as a percentage of Medicaid costs. 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. States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a managed care base payment or as a supplemental payment. Payments shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers do not sum to 100 percent due to rounding.

Source: MACPAC, 2023, analysis of SPRY 2017-2018 as-filed Medicaid DSH audits.

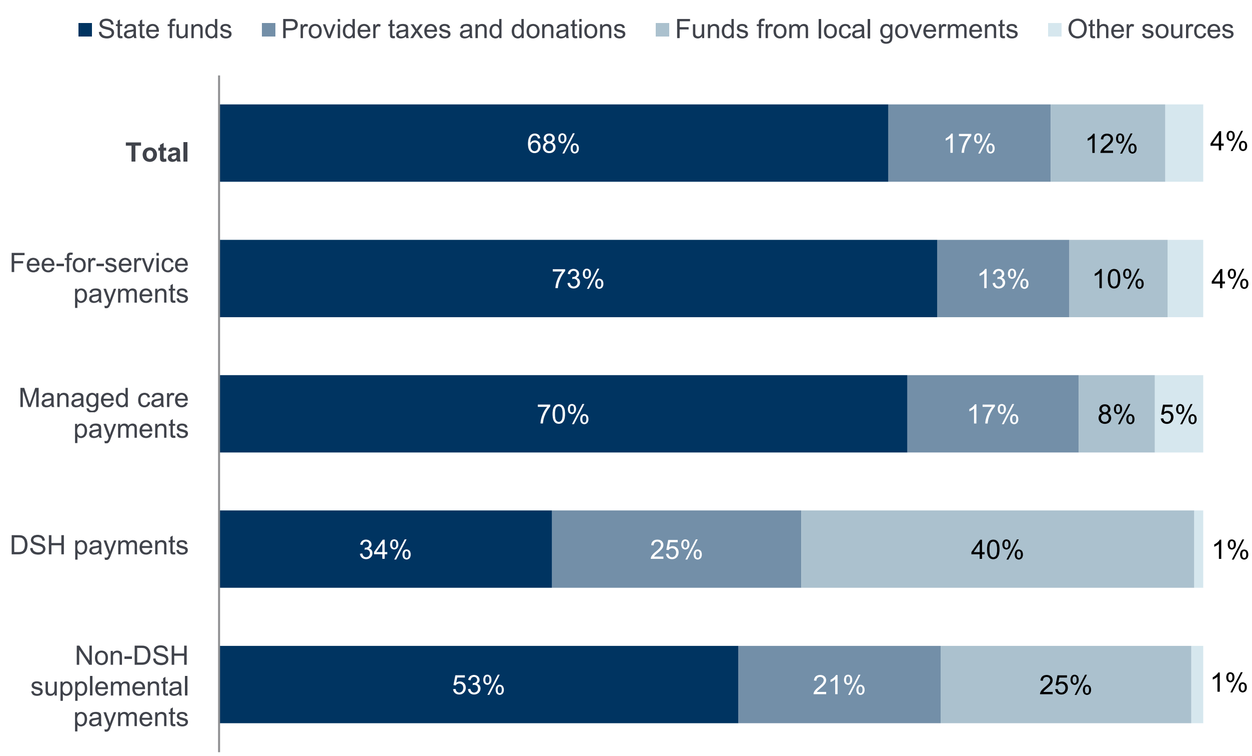
Although states B, C, and D each pay hospitals roughly 100 percent of Medicaid costs, they differ in their use of supplemental payments. State B makes relatively small supplemental payments, while states C and D make relatively large supplemental payments to pay for Medicaid shortfall. However, state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

State E is an example of a state that appears to pay hospitals well above the cost of serving Medicaid patients. However, total payments only cover 80 percent of hospital costs when both Medicaid and uninsured patients are included. It is likely that state E is using Medicaid supplemental payments to pay for care provided to uninsured individuals as well as Medicaid shortfall.

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 reflect all Medicaid payments, not just Medicaid payments to hospitals.

Source: U.S. Government Accountability Office 2021.

The approaches that states use to finance the non-federal share of these payments may affect how each type of payment is 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) required HHS to collect and report data on non-DSH supplemental payments beginning October 1, 2021, which partially addressed MACPAC's recommendation. However, provider-level data on managed care directed payments and sources of non-federal share are still not available.

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 Medicaid Disproportionate Share Hospital Payments to States, in MACPAC's March 2023 *Report to Congress on Medicaid and CHIP*
- *Upper Payment Limit Supplemental Payments* (November 2021 issue brief)
- 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*
- Oversight of Managed Care Directed Payments, in MACPAC's June 2022 *Report to Congress on Medicaid and CHIP*
- *Directed Payments in Medicaid Managed Care* (June 2022 issue brief)

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 are using different rules than Medicaid.

[5] DSH allotments increase every year by inflation, with some exceptions. FY 2020-2023 allotments were increased under the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) for each year of the COVID-19 public health emergency.

[6] DSH spending in FY 2021 includes spending funded from prior year allotments. Total DSH spending includes an estimate of the portion of California's spending under its demonstration waiver authorized under Section 1115 of the Act, which is based on the state's DSH allotment.

[7] States are required to submit claims for federal Medicaid funding within two years after the payment is made. However, states can sometimes claim federal match for adjusted DSH payments that are made after the initial two-year window (Virginia Department of Medical Assistance Services, DAB No. 1838).

[8] Analysis excludes unspent federal DSH funding that is reported for California and Massachusetts ($1.5 billion in FY 2020) because these states use their DSH allotment in the budget neutrality assumptions for their Section 1115 waivers.

[9] Section 1115 uncompensated care payments also can help pay for unpaid costs of care for uninsured patients. In FY 2021, seven states paid for unpaid costs of care through such payments.

[10] States also make UPL payments for nursing facility services and other types of Medicaid payments that are beyond the scope of this issue brief. For additional information about nursing facility payment see Chapter 2 of MACPAC's March 2023 *Report to Congress on Medicaid and CHIP* (MACPAC 2023a).

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

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

[13] 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 uncompensated care costs for DSH hospitals by state is included in Appendix A of Chapter 3 of MACPAC's March 2022 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 2021 (millions)

State	Total hospital supplemental payments	DSH payments	UPL payments	Uncompensated care pool payments	DSRIP[1]	GME
Total	**$43,058.4**	**$14,052.8**	**$15,415.7**	**$6,051.4**	**$4,089.2**	**$3,449.3**
Alabama	1,702.0	405.6	1,296.4	–	–	–
Alaska	7.6	7.6	–	–	–	–
Arizona[2]	248.5	95.9	–	23.9	–	128.7
Arkansas	496.8	8.9	478.0	–	–	10.0
California	9,207.5	510.0	5,080.8	2,332.2	824.2	460.4
Colorado	1,529.2	219.4	1,307.1	–	–	2.7
Connecticut	654.2	70.7	561.5	–	–	22.0
Delaware[3]	-0.0	–	–	–	–	-0.0
District of Columbia	120.1	100.0	–	–	–	20.1
Florida[3]	1,335.8	228.6	-127.3	962.9	–	271.7
Georgia	777.7	432.7	288.3	–	–	56.7
Hawaii	11.2	10.3	0.9	–	–	–
Idaho	67.7	25.6	42.0	–	–	–
Illinois	1,149.5	438.2	488.2	–	–	223.1
Indiana	201.1	139.4	–	–	–	61.7
Iowa	115.6	64.6	–	–	–	50.9
Kansas[2, 3, 4]	143.6	63.9	–	47.2	33.6	-1.1
Kentucky	329.7	228.0	20.2	–	–	81.6
Louisiana	967.9	821.3	109.5	–	–	37.1
Maine	101.9	–	86.6	–	–	15.3
Maryland	186.2	129.2	–	–	–	57.0
Massachusetts[2]	781.3	–	108.0	430.8	242.6	–
Michigan	767.9	216.9	520.0	–	–	31.0
Minnesota	98.7	53.7	23.3	–	–	21.7
Mississippi	273.0	235.1	–	–	–	37.8
Missouri	861.8	694.6	–	–	–	167.2
Montana	360.2	0.2	353.6	–	–	6.4
Nebraska	29.8	29.8	–	–	–	–
Nevada	270.8	94.6	146.6	–	–	29.6
New Hampshire	193.4	165.6	27.5	–	0.3	–

State	Total hospital supplemental payments	DSH payments	UPL payments	Uncompensated care pool payments	DSRIP[1]	GME
Total	**$43,058.4**	**$14,052.8**	**$15,415.7**	**$6,051.4**	**$4,089.2**	**$3,449.3**
New Jersey	1,134.8	780.3	112.5	–	–	242.0
New Mexico	236.5	33.5	14.7	–	12.0	176.3
New York	3,881.0	3,557.1	323.9	–	–	–
North Carolina	1,543.2	286.5	1,100.2	–	–	156.6
North Dakota	1.4	0.2	1.2	–	–	–
Ohio	594.2	594.2	–	–	–	–
Oklahoma	700.6	52.3	604.0	–	–	44.4
Oregon	191.2	66.7	–	–	–	124.4
Pennsylvania	1,384.8	693.5	556.9	–	–	134.4
Rhode Island	147.4	142.5	5.0	–	–	–
South Carolina	641.7	458.2	90.3	–	–	93.3
South Dakota	3.7	0.6	–	–	–	3.0
Tennessee	529.0	71.6	–	407.4	–	50.0
Texas	6,467.3	1,527.3	–	1,846.9	2,974.0	119.0
Utah	77.8	28.8	42.0	–	–	7.0
Vermont	25.2	22.7	–	–	2.5	–
Virginia	2,136.7	-44.4	1,684.8	–	–	496.3
Washington	99.4	99.4	–	–	–	–
West Virginia	63.7	52.5	–	–	–	11.2
Wisconsin	174.9	138.1	36.8	–	–	–
Wyoming	33.0	0.5	32.5	–	–	–

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] State made other supplemental payments through an uncompensated care pool under Section 1115 waiver expenditure authority.

[3] State reports negative non-DSH supplemental payments due to prior period adjustments.

[4] State made other supplemental payments through a DSRIP or DSRIP-like program under Section 1115 waiver expenditure authority.

Source: MACPAC, 2023, analysis of CMS-64 FMR net expenditure data as of June 8, 2022, and CMS-64 Schedule C waiver report data as of September 19, 2022.