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# Is It Time to Reform Medicaid and Medicare Supplemental Payments?

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Between Medicaid and Medicare, we estimate more than $80 billion was made in supplemental payments to acute care providers, primarily hospitals, in 2020. Separate from and beyond regular Medicaid and Medicare payment for services to program enrollees, Medicaid and Medicare have a long history of providing supplemental payments to providers.

Though supplemental payments are a significant revenue source for providers, at times they have been controversial. Policymakers and stakeholders alike have called for improvements to the payments but any meaningful change has been limited, largely because of the political obstacles to making such reforms: entrenched parties—most prominently, states and health care providers—have a strong vested interest in maintaining the existing funding flow.

In this brief, we provide an overview of the major Medicaid and Medicare supplemental payments made to acute care providers. We discuss key features of the payments, highlighting policy issues pertaining to the different supplemental payments. We conclude with a discussion of two possible strategies to redirect a portion of Medicaid and Medicare supplemental payments. To conduct the analysis, we rely on secondary data sources as well as secondary data analyses completed by others. Key findings include:

- Nationally, among payments considered, $82.4 billion in Medicaid and Medicare supplemental payments were paid to acute care providers in 2020. Medicaid accounted for most of the payments ($71.7 billion); Medicare spending totaled 10.7 billion in the year. The federal share of payments totaled $51.0 billion ($40.3 billion paid out through the Medicaid program and $10.7 billion in Medicare.)
- As has been well documented by government groups, Medicaid supplemental payments have a long track record of being complicated, murky, and inefficient.

- Though less controversial than Medicaid supplemental payments, Medicare supplemental payments have been shown to be ill-targeted and in need of reform.
- Better ways to use supplemental payments could be devised with some of the current federal funding repurposed to support other health care initiatives. Two examples we consider: a portion of federal funds used to support Medicaid and Medicare supplemental payments could be redirected to more equitably allocate funds across hospitals in need or to help finance a coverage expansion to the uninsured and shore up existing insurance programs for lower-income individuals (e.g., enhancing subsidies for Marketplace coverage).

Changing the current flow of funding in Medicaid and Medicare supplemental payments would be a dramatic policy change, one that would disrupt a considerable amount of funds for many vested interested parties. It would be challenging, both technically and politically; undoubtedly, there would be winners and losers. But preserving the existing flow of a sizable share of federal funds paid as supplemental payments is not sound policy. There are more equitable and more efficient ways to use these funds.

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# Introduction

Medicaid and Medicare have a long history of providing supplemental payments to hospitals and, more recently in Medicaid, to other health care providers. Separate from and beyond regular Medicaid and Medicare payment for services to program enrollees, supplemental payments include disproportionate share hospital (DSH) payments and uncompensated care (UC) payments. With time, supplemental payments have become an important way to compensate providers, especially safety net providers.

Though supplemental payments are a significant revenue source for providers, at times they have been controversial. Concerns have been raised, ranging from the inequity in allocation of federal funds across states to the dated formulas used to distribute payments to distortions and overstatements of Medicaid spending associated with supplemental payments.

Policymakers and stakeholders alike have called for improvements to supplemental Medicaid and Medicare payments. Examples include improving targeting to meet policy objectives, increasing federal oversight, and restricting selected state financing practices (e.g., provider taxes) often used to pay the state share of Medicaid supplemental payments. Any meaningful change to supplemental payments, however, has been limited, largely because of the political obstacles to making such reforms: entrenched parties—most prominently, states and health care providers—have a strong vested interest in maintaining the existing funding flow.

In this brief, we provide an overview of the major Medicaid and Medicare supplemental payments made to acute care providers. We discuss key features of the payments, such as spending levels, policy goals, and payment eligibility and distribution. We also highlight policy issues pertaining to the different supplemental payments. We conclude with a discussion of two possible strategies to redirect a portion of Medicaid and Medicare supplemental payments, to more equitably allocate funds across hospitals in need or to help finance a coverage expansion to the uninsured and shore up existing insurance programs for lower-income individuals (e.g., enhancing subsidies for Marketplace coverage). To conduct the analysis, we rely on secondary data sources as well as secondary data analyses completed by others.

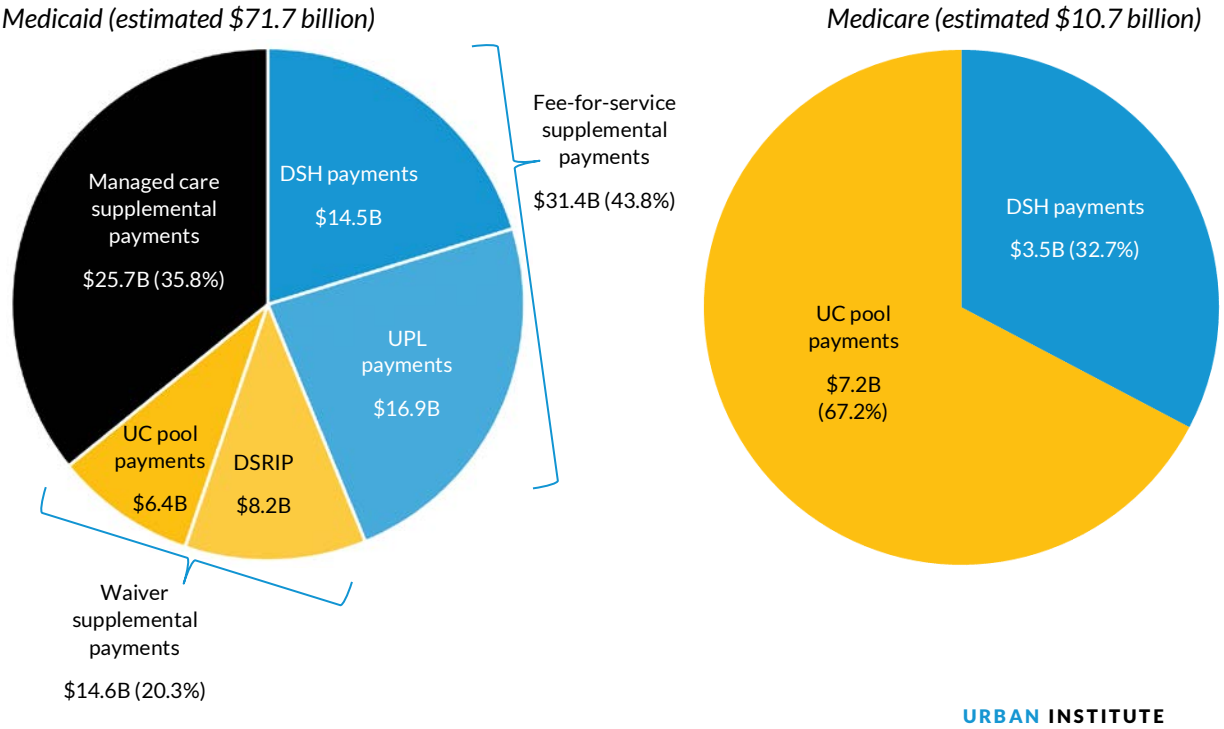
# Medicaid and Medicare Supplemental Payments

Medicaid and Medicare both make supplemental payments to acute care providers, but the policies governing them differ substantially between the programs, and, under Medicaid, across states as well. In this section, we discuss the main supplemental payments in Medicaid and Medicare targeted at acute care providers serving low-income and uninsured patients. Because of this focus, we exclude some supplemental payments made to acute care providers, such as Medicare supplemental payments paid to rural or isolated hospitals, as well as Medicaid and Medicare graduate medical education payments.[1]

Among the payments we include in this analysis, we estimate, based on publicly available figures, that between Medicaid and Medicare more than $80 billion was made in supplemental payments to acute care providers, primarily hospitals, in 2020 (figure 1). Medicaid accounted for most of the payments ($71.7 billion), which, as we discuss below, is likely a conservative estimate. States make supplemental payments through both Medicaid fee-for-service (FFS) and managed care delivery systems. Supplemental payments can also be made as part of state Section 1115 Medicaid waiver demonstrations. Medicare spending on supplemental payments to acute care providers totaled $10.7 billion in the year.

FIGURE 1

**Estimated Spending Totaled $82.4 Billion for Selected Medicaid and Medicare Supplemental Payments to Acute Care Providers, 2020**




**Sources:** MACPAC, "Medicaid Base and Supplemental Payments to Hospitals" (Washington, DC: MACPAC, 2022), https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/; "MACStats: Medicaid and CHIP Data Book" (Washington, DC: MACPAC, 2021), https://www.macpac.gov/wp-content/uploads/2021/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2021.pdf; "Directed Payments in Medicaid Managed Care" (Washington, DC: MACPAC, 2022), https://www.macpac.gov/wp-content/uploads/2022/06/June-2022-Directed-Payments-Issue-Brief-FINAL.pdf; MedPAC, *Medicare and the Health Care Delivery System: Report to the Congress* (Washington, DC: MedPAC, 2022), https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

**Notes:** Medicaid payments amounts are for fiscal year 2020, except for managed care supplemental payments which are for calendar year 2020 and are projected payment levels for a portion of approved managed care supplemental payments in that year. Percentages may not sum to 100 because of rounding.

B = billion; DSRIP = delivery system reform incentive payment; DSH = disproportionate share hospital; UC = uncompensated care; UPL = upper payment limit.

## Medicaid Supplemental Payments to Acute Care Providers

As mentioned, supplemental payments are separate from and made in addition to the regular base payments providers receive for rendering services to program enrollees. Medicaid supplemental payments are generally paid in lump sums and not linked to a Medicaid patient or a specific policy objective, such as improving timeliness of care or addressing equity issues. Though the bulk of Medicaid acute care supplemental payments is paid to hospitals, physicians and other practitioners also receive these payments.

As shown in figure 1, supplemental payments through the Medicaid FFS system accounted for the largest share (43.8 percent; $31.4 billion) and comprise Medicaid DSH payments and upper payment limit (UPL) payments. Supplemental payments to providers made through managed care plans accounted for another 35.8 percent ($25.7 billion).[2] The balance ($14.6 billion) was made through state waiver demonstrations. Except for DSH payments, which are required under Medicaid statute, supplemental payments are optional, an option that most states have taken up.

Below, we discuss the types of Medicaid supplemental payments paid through FFS, waivers, and managed care.

## MEDICAID FFS SUPPLEMENTAL PAYMENTS

Two basic types of FFS Medicaid supplemental payments are made to acute care providers—DSH and UPL payments. UPL payments made to acute care providers are paid largely to hospitals, though physicians and other practitioners also receive these payments (table 1).

***Medicaid DSH payments.*** DSH payments are the only Medicaid supplemental payments states are statutorily required to make (table 1). They have also been one of the most contentious components of the Medicaid program. Many factors have contributed to the controversy: At first, states were slow to make DSH payments, prompting Congress to pass further legislation on several occasions during the 1980s to compel states to make the payments (CRS 2020). Then, during the early 1990s, Medicaid DSH spending grew rapidly, largely fueled by states beginning to use provider taxes and local government transfers to fund their share of DSH payments. By 1996, DSH payments accounted for 1 of every 11 dollars spent in the Medicaid program but with wide variation across states (Coughlin and Liska 1997). These and other issues prompted federal policymakers to pass yet more legislation centered on Medicaid DSH payments but this time around, the aim was to control program spending on the payments.

One important policy that came out of this period was setting facility-specific caps in which DSH payments cannot exceed a hospital's UC costs for Medicaid and uninsured patients. Another was imposing an annual cap on federal Medicaid DSH spending for each state, a policy in stark contrast to the open-ended federal funding available for most other Medicaid spending. Each year, federal law sets DSH allotments, which are the maximum amount of federal matching funds a state may claim for DSH payments.

Today, federal DSH allotments are primarily based on a state's DSH spending in 1992, when allotments were established. Since that time Congress has made only minimal changes to the allotments: states that had the highest DSH payments in 1992 still have biggest allotments, and states that spent the least in 1992 still have the smallest. Put another way, federal DSH allotments are not based on a state's need for federal funds (e.g., number of uninsured, size of low-income population) but instead on the willingness of a state to have maximized federal funds through DSH payments more than three decades ago.

TABLE 1

**Spending, State Use, and Selected Features of Medicaid Fee-for-Service Supplemental Payments Made to Acute Care Providers, Fiscal Year 2020**

| FFS acute care supplemental payment | Total spending ($ billions) | Number of states reporting spending[a] | Required Medicaid payment | Eligible providers | Federal allocation spending limit | Provider-specific limit |
|---|---|---|---|---|---|---|
| Disproportionate share hospital (DSH) payments | 14.5 | 48 | Yes, states must at least meet the federal minimum DSH requirement | Hospitals | Each year, the federal government sets annual state allotments limiting how much federal matching funds are available for DSH payments | DSH payments cannot be higher than a hospital's uncompensated care costs for uninsured and Medicaid patients |
| Upper payment limit (UPL) payments | 16.9 | 41 | No | Range of providers | No federal spending limit, but Medicare UPL limit is imposed on institutional providers; physicians are not subject to UPL limits | Varies by type of provider |
| Hospital UPL payments[b] | 15.3 | 35 | No | Hospitals | No federal spending limit, but payments for classes of hospitals payments are limited to the Medicare UPL | No hospital-specific limits, but Medicare UPL limit is imposed for classes of hospitals |
| Physicians and other practitioners UPL payments[b] | 1.6 | 26 | No | Physicians and other practitioners | No federal limit on spending and no federal or regulatory statute that establishes a UPL for physicians and other practitioners | No provider-specific or class limits; states can pay rates greater than Medicare |

**Sources:** "Medicaid Base and Supplemental Payments to Hospitals" (Washington, DC: MACPAC, 2022), https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/; *MACStats: Medicaid and CHIP Data Book* (Washington, DC: MACPAC, 2021, exhibits 24 and 25), https://www.macpac.gov/wp-content/uploads/2021/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2021.pdf.

**Note:** DSH payments are those made to hospitals only; DSH payments to institutions for mental diseases are excluded.

[a] Number of states reporting spending includes the District of Columbia.

[b] As proportion of "upper payment limit (UPL) payments.

For example, as shown in table 2, nationally, federal DSH allotment per person with income less than 200 percent of the federal poverty level was $136.27 in 2019. But there was a tenfold difference among states, with allotments ranging from less than $40 per low-income person in eight states (Florida, Hawaii, Idaho, New Mexico, Oklahoma, Tennessee, Utah, and Wyoming) to $400 or more per low-income person in four states (District of Columbia, Louisiana, New Hampshire, and New Jersey).[3] The disparity across states is greater still for the federal DSH allotment per uninsured person, ranging from less than $100 per uninsured person in five states to over $1,500 in six.

TABLE 2

**Federal Medicaid Disproportionate Share Hospital Allotments by State, Per Low-Income Person by State, and Per Uninsured Person by State, Fiscal Year 2019**

| | Federal DSH Allotment | | | | |
|---|---|---|---|---|---|
| State | DSH allotment by state ($ millions) | DSH allotment per person below 200% FPL | DSH allotment per person below 200% FPL relative to national | DSH allotment per uninsured person | DSH allotment per uninsured person relative to national |
| **Total** | **$12,590.7** | **$136.27** | **1.0** | **$429.00** | **1.0** |
| Alabama | $352.9 | $208.15 | 1.5 | $766.47 | 1.8 |
| Alaska | $23.4 | $136.54 | 1.0 | $290.39 | 0.7 |
| Arizona | $116.2 | $51.35 | 0.4 | $147.25 | 0.3 |
| Arkansas | $49.5 | $43.05 | 0.3 | $186.25 | 0.4 |
| California | $1,258.0 | $116.34 | 0.9 | $418.60 | 1.0 |
| Colorado | $106.2 | $81.13 | 0.6 | $243.08 | 0.6 |
| Connecticut | $229.5 | $291.90 | 2.1 | $1,122.34 | 2.6 |
| Delaware | $10.4 | $44.94 | 0.3 | $166.23 | 0.4 |
| District of Columbia | $70.3 | $411.29 | 3.0 | $2,904.55 | 6.8 |
| Florida | $229.5 | $34.15 | 0.3 | $83.25 | 0.2 |
| Georgia | $308.4 | $93.98 | 0.7 | $223.65 | 0.5 |
| Hawaii | $11.2 | $39.53 | 0.3 | $205.21 | 0.5 |
| Idaho | $18.9 | $33.79 | 0.2 | $102.74 | 0.2 |
| Illinois | $246.7 | $75.41 | 0.6 | $272.36 | 0.6 |
| Indiana | $245.3 | $126.00 | 0.9 | $430.27 | 1.0 |
| Iowa | $45.2 | $53.79 | 0.4 | $312.97 | 0.7 |
| Kansas | $47.3 | $59.90 | 0.4 | $182.56 | 0.4 |
| Kentucky | $166.4 | $111.17 | 0.8 | $603.56 | 1.4 |
| Louisiana | $786.9 | $463.65 | 3.4 | $1,966.17 | 4.6 |
| Maine | $120.5 | $318.94 | 2.3 | $1,147.59 | 2.7 |
| Maryland | $87.5 | $70.16 | 0.5 | $252.10 | 0.6 |
| Massachusetts | $350.0 | $251.92 | 1.8 | $1,730.18 | 4.0 |
| Michigan | $304.1 | $104.55 | 0.8 | $541.51 | 1.3 |
| Minnesota | $85.7 | $70.63 | 0.5 | $323.44 | 0.8 |

| State | Federal DSH Allotment | | | | |
|---|---|---|---|---|---|
| | DSH allotment by state ($ millions) | DSH allotment per person below 200% FPL | DSH allotment per person below 200% FPL relative to national | DSH allotment per uninsured person | DSH allotment per uninsured person relative to national |
| Mississippi | $175.0 | $148.27 | 1.1 | $472.61 | 1.1 |
| Missouri | $543.7 | $294.55 | 2.2 | $905.97 | 2.1 |
| Montana | $13.0 | $40.54 | 0.3 | $150.42 | 0.4 |
| Nebraska | $32.5 | $65.43 | 0.5 | $218.98 | 0.5 |
| Nevada | $53.1 | $57.40 | 0.4 | $152.08 | 0.4 |
| New Hampshire | $183.7 | $729.08 | 5.4 | $2,171.73 | 5.1 |
| New Jersey | $738.8 | $400.00 | 2.9 | $1,070.21 | 2.5 |
| New Mexico | $23.4 | $30.41 | 0.2 | $116.59 | 0.3 |
| New York | $1,843.3 | $355.78 | 2.6 | $1,843.14 | 4.3 |
| North Carolina | $338.5 | $103.99 | 0.8 | $292.02 | 0.7 |
| North Dakota | $11.0 | $59.90 | 0.4 | $203.00 | 0.5 |
| Ohio | $466.2 | $137.31 | 1.0 | $613.43 | 1.4 |
| Oklahoma | $41.6 | $30.73 | 0.2 | $72.78 | 0.2 |
| Oregon | $51.9 | $45.56 | 0.3 | $176.99 | 0.4 |
| Pennsylvania | $644.1 | $190.82 | 1.4 | $908.32 | 2.1 |
| Rhode Island | $74.6 | $307.86 | 2.3 | $1,718.75 | 4.0 |
| South Carolina | $375.8 | $229.94 | 1.7 | $696.90 | 1.6 |
| South Dakota | $12.7 | $52.05 | 0.4 | $155.52 | 0.4 |
| Tennessee | $53.1 | $24.51 | 0.2 | $78.46 | 0.2 |
| Texas | $1,097.4 | $118.98 | 0.9 | $210.75 | 0.5 |
| Utah | $22.5 | $29.50 | 0.2 | $74.13 | 0.2 |
| Vermont | $25.8 | $169.21 | 1.2 | $970.71 | 2.3 |
| Virginia | $100.5 | $52.43 | 0.4 | $153.52 | 0.4 |
| Washington | $212.3 | $122.46 | 0.9 | $434.25 | 1.0 |
| West Virginia | $77.5 | $120.71 | 0.9 | $676.53 | 1.6 |
| Wisconsin | $108.5 | $77.44 | 0.6 | $331.76 | 0.8 |
| Wyoming | $0.3 | $1.79 | 0.0 | $3.76 | 0.0 |

**Sources:** Medicaid Program; Final FY 2018, Final FY 2019, Preliminary FY 2020, and Preliminary FY 2021 Disproportionate Share Hospital Allotments, and Final FY 2018, Final FY 2019, Preliminary FY 2020, and Preliminary FY 2021 Institutions for Mental Diseases Disproportionate Share Hospital Limits, 87 Fed. Reg. 51 14858 (March 16, 2022), https://www.govinfo.gov/content/pkg/FR-2022-03-16/pdf/2022-05459.pdf; "Distribution of the Total Population by Federal Poverty Level (Above and Below 200% FPL)" (San Francisco: KFF, 2021), https://www.kff.org/other/state-indicator/population-up-to-200-fpl/?dataView=1&currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; "Health Insurance Coverage of the Total Population" (San Francisco: KFF, 2019), https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

**Notes:** "Uninsured" includes those without health insurance and those who have coverage under the Indian Health Service only. "Medicaid enrollees" includes individuals who are enrolled in Medicaid at any time during the calendar year.

DSH = disproportionate share hospital; FPL = federal poverty level.

Importantly, DSH allotments are the maximum amounts states can claim in federal matching funds for DSH payments. In general, states have up to two years to spend their allotments, but some states do not use their full allotments. For fiscal year 2019, $1.4 billion in allotments went unspent as of the end of fiscal year 2021 (MACPAC 2022a). The Medicaid and CHIP Payment and Access Commission (MACPAC) identifies two main reasons for unspent DSH allotments: states are not able to raise their share of DSH payments or states do not have enough hospital UC costs to fully draw their DSH allotments.

Apart from the distribution of federal DSH allotments across states, another factor contributing to the long-standing controversy surrounding Medicaid DSH payments is how many states finance their share of the payments.

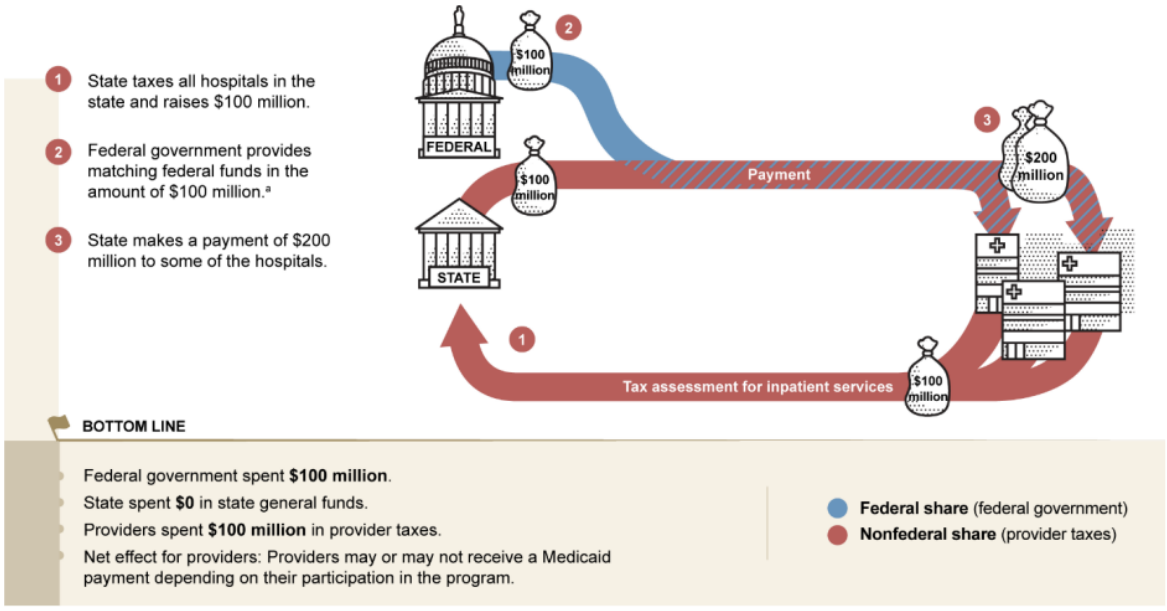
Like most Medicaid spending, the federal government pays its share of DSH payments according to each state's federal medical assistance percentage (FMAP). State financing of DSH payments (as well as other Medicaid supplemental payments), however, is often distinct from that of regular Medicaid hospital payment: rather than using state general funds (which states primarily use to pay their share of Medicaid services), many states rely heavily on provider taxes or fund transfers from local governments to finance their portion of DSH payments. In 2018, for example, provider taxes and local fund transfers accounted for about 23 percent of the state share of all Medicaid FFS payments, whereas provider taxes and transfers from local governments accounted for 65 percent of the state share of Medicaid DSH payments (GAO 2021).

Figure 2 provides a hypothetical schematic in which a state relies on provider tax revenue to pay its share of a $200 million DSH payment made to hospitals. To start the transaction, the state receives $100 million in provider taxes from contributing hospitals. Then the state makes a $200 million DSH payment to hospitals. Assuming the state's FMAP is 50 percent, the state claims $100 million in federal matching funds. At the end of the transaction, the federal government has spent $100 million on DSH payments, the state has spent $0 in state general funds, and providers have netted just $100 million in DSH payments (after accounting for the $100 million in taxes they paid). However, DSH payments would be reported as $200 million.[4] Though the mechanics differ, when states use transfers from local governments to fund their share of DSH payments, the net effects are similar to those when provider taxes are used.

Though legal, states' use of provider taxes and transfers from local government to finance their share of DSH payments has important and broad implications for the federal government, states, and hospitals. For one, use of these financing arrangements reduces state general fund contributions to Medicaid while inflating the federal share. In the figure 2 schematic, for example, the state contributed no state general funds, making the effective FMAP 100 percent: even though DSH payments would be reported as $200 million, only the federal funds represent new spending. Put another way, the balance between state and federal program spending has shifted, so the federal government is paying more than its share of DSH payments.

FIGURE 2

**Example of a State Medicaid Payment Financed Using Provider Tax Revenue and Federal Funds**




**Source:** Reproduced from "Medicaid: Primer on Financing Arrangements," GAO-20-571R (Washington, DC: US Government Accountability Office, 2020), https://www.gao.gov/assets/gao-20-571r.pdf.

These financing arrangements also affect net provider payment: Because hospitals finance all or part of the state share of DSH payments, the net payment providers receive is considerably less than what is reported. So, available funding to help hospitals make up shortfalls in Medicaid reimbursement or to cover UC costs associated with the uninsured is less than reported. Finally, provider financing of the state share can also affect how supplemental payments are targeted—that is, more funds may be paid to providers that contributed tax revenue rather than to those most in need. Collectively, these issues raise important questions about whether DSH payments are economical or efficient, a basic tenet of Medicaid payment policy.

Given how federal allotments are allocated among states and states' heavy reliance on provider financing, DSH payments continue to be controversial. Indeed, reports completed by federal agencies (e.g., US Government Accountability Office, MACPAC) have repeatedly documented problems with Medicaid DSH payments, including the limited relationship between federal DSH allotments and state need for DSH funds, as well as the limited reporting and federal oversight of payments. Further, providers' financing of the state share of DSH payments raises concerns about the financial integrity and sustainability of the Medicaid program (GAO 2020, 2021; MACPAC 2022a).

***Medicaid UPL payments.*** As the federal government began to curtail Medicaid DSH spending in the 1990s, states turned to UPL payments as a way to maintain federal matching funds (GAO 2000). States' use of hospital UPL payments in particular grew rapidly: In 2000, 15 states made $4.5 billion in UPL payments to hospitals.[5] By 2020, 35 states made hospital UPL payments with spending totaling $15.3 billion. States also make UPL payments, though at a much lower level of spending, to physicians and

other practitioners.[6] In 2020, 26 states made supplemental payments to physicians with spending totaling $1.6 billion. Between hospital UPL and physician UPL payments, 41 states made these payments in 2020 (table 1) (MACPAC 2022b).

DSH and UPL payments share many similarities: For example, UPL payment and financing mechanics are essentially a variant of DSH payments. Akin to DSH, UPL payments are generally paid in lump sums to providers and are not tied to a particular Medicaid service or patient. In addition, states rely heavily on provider taxes and local fund transfers to pay their share of UPL payments. In 2018, provider taxes and local government transfers accounted for 46 percent of the state share for non-DSH supplemental payments, including UPL payments (MACPAC 2022c). So, like DSH payments, UPL payments shift the balance of federal and state spending on Medicaid and inflate program spending.

Though the payment mechanisms differ, DSH and UPL also share some common policy goals in that payments are intended to give financial support to providers caring for Medicaid patients. UPL payments are largely meant to supplement Medicaid FFS base payments that in recent years many states have reduced or frozen, but states have also relied on UPL payments to support safety net providers (CRS 2018; GAO 2019; MACPAC 2022c). MACPAC in its work reports that the most common types of hospitals receiving UPL payments are government-owned hospitals, safety net hospitals, and rural hospitals. And for physicians, a large share of UPL payments is made to government-owned teaching hospitals or state academic medical centers (MACPAC 2021).

At the same time, important differences exist between the two supplemental payments (table 1). Unlike DSH, UPL payments are not required under Medicaid statute; instead, they are made at a state's option. Another important difference between the UPL and DSH can be found in payment policy. Hospital UPL payments do not have the hospital-specific caps or annual federal spending limit DSH payments do. There is, however, a ceiling on the federal match that can be paid for Medicaid FFS payments to hospitals. Specifically, states must abide by the UPL rules that stipulate states can make up the difference (through a UPL payment) between their base Medicaid FFS payment for hospital services and a reasonable estimate of what Medicare would have paid for comparable services.

Importantly, the UPL is not determined for Medicaid services provided by an individual hospital. Rather, the UPL is set for a "class" of providers based on ownership (e.g., county-owned hospitals). While states are required to abide by the aggregate Medicare UPL for a class of providers, they have considerable latitude in determining how much an individual hospital within a class receives in UPL payments. As a result, some hospitals may receive combined Medicaid base and UPL payments that far exceed their cost of caring for Medicaid patients. Indeed, how much a provider receives in UPL payments can be linked to how much the provider contributes (either through taxes paid or local fund transfers) to the state share. Thus, like DSH payments, important policy questions and challenges surround UPL payments.

For physician UPL payments, the situation is different still. For these payments, there are no federal regulations that set out an UPL for physicians. As such, states can pay more than Medicare rates. In fact, federal guidance suggests that states can use average commercial rates in setting the UPL for

physicians. MACPAC in its review of physician UPL payments found that states often used average commercial rates to set the UPL and in many instances, UPL payments were higher than the Medicaid base payment to physicians (MACPAC 2021).

UPL payments have declined somewhat in recent years as states moved Medicaid enrollees to managed care. The UPL applies only to Medicaid FFS payments; capitation payments to managed care plans are excluded. Thus, with the shift to managed care, states' ability to make UPL payments correspondingly declined. However, some states secured Medicaid Section 1115 waivers that enabled them to use different supplemental payment strategies. (See the Medicaid Waiver Supplemental Payments section below.) In addition, several states began making supplemental payments through their managed care delivery systems to maintain the value of UPL payment funds. (See the Managed Care Supplemental Payments section below.)

Over the years, as with DSH payments, Medicaid UPL payments have been the subject of GAO and MACPAC reports calling for improved state reporting on the payments (e.g., state financing of payments, payments to individual providers) and improved federal efforts to ensure state compliance with the UPL itself (GAO 2016; MACPAC 2019). Toward that end, the Consolidated Appropriations Act of 2021 (P.L. 116-260) included provisions for a new reporting system for non-DSH Medicaid supplemental payments (including UPL payments) through which states are now required to submit provider-level data on UPL payments as well their targeting protocols and goals for UPL payments.

***State-specific spending on FFS supplemental payments.*** Reflecting different state Medicaid policies and choices, the extent to which states rely on supplemental payments in their FFS systems varies widely. For DSH payments, though, the variation is also attributed to how much a state spent on these payments in 1992 when the federal DSH allotments were set, as we discussed above.

Nationally, DSH and UPL payments accounted for a full third (33.1 percent) of total Medicaid FFS hospital payments in 2020 ($90.4 billion) (table 3). However, in nine states (Alaska, Arizona, Delaware, Idaho, Massachusetts, New Mexico, North Dakota, South Dakota, and Tennessee). DSH and UPL payments accounted for less than 10 percent of total FFS hospital payments. But in seven states (Louisiana, Michigan, Nebraska, New Hampshire, Pennsylvania, Vermont, and Virginia) they accounted for more than 60 percent of total FFS hospital payments.

Though fewer states made UPL payments to physicians, the variation was similarly wide. In three states (Florida, Michigan, and Virginia) UPL payments accounted for more than 50 percent of total FFS payments to physicians in 2020.

TABLE 3

**Medicaid Fee-for-Service Supplemental Payments Made to Acute Care Providers by Provider Type and State, Fiscal Year 2020**

*$ millions*

| | Inpatient and Outpatient Hospitals | | | | | Physicians and Other Practitioners | | |
|---|---|---|---|---|---|---|---|---|
| State | DSH payments | UPL payments | Total FFS supplemental payments | Total Medicaid FFS payments | FFS supplemental payments as % of total FFS payments | FFS supplemental payments | Total FFS Medicaid payments | FFS supplemental payments as % of total FFS payments |
| **Total** | **$14,539.5** | **$15,336.8** | **$29,876.3** | **$90,373.3** | **33.1** | **$1,638.3** | **$10,041.0** | **16.3** |
| Alabama | 466.7 | 980.2 | 1,446.9 | 2,437.4 | 59.4 | — | 478.8 | — |
| Alaska | 9.3 | — | 9.3 | 619.2 | 1.5 | — | 187.2 | — |
| Arizona | 109.2 | — | 109.2 | 1,328.8 | 8.2 | — | 66.7 | — |
| Arkansas | 3.5 | 441.4 | 444.9 | 1,196.0 | 37.2 | 39.4 | 343.6 | 11.5 |
| California | 589.6 | 4,623.8 | 5,213.4 | 16,354.8 | 31.9 | 192.3 | 652.3 | 29.5 |
| Colorado | 197.9 | 1,237.1 | 1,435.0 | 2,781.3 | 51.6 | 172.5 | 478.3 | 36.1 |
| Connecticut | 17.2 | 692.7 | 709.9 | 2,591.7 | 27.4 | 14.7 | 680.5 | 2.2 |
| Delaware | — | — | 0.0 | 59.8 | 0.0 | — | 10.2 | — |
| District of Columbia | 76.2 | 21.7 | 97.9 | 435.3 | 22.5 | 4.5 | 54.4 | 8.3 |
| Florida | 228.1 | 104.0 | 332.1 | 2,420.4 | 13.7 | 386.9 | 581.5 | 66.5 |
| Georgia | 436.9 | 230.4 | 667.3 | 2,287.2 | 29.2 | — | 344.4 | — |
| Hawaii | 10.4 | 0.4 | 10.8 | 21.8 | 49.5 | — | 0.2 | — |
| Idaho | 24.6 | 13.0 | 37.6 | 691.5 | 5.4 | — | 175.7 | — |
| Illinois | 400.8 | 562.7 | 963.5 | 2,983.9 | 32.3 | — | 232.8 | — |
| Indiana | 668.9 | — | 668.9 | 1,537.9 | 43.5 | — | 177.7 | — |
| Iowa | 71.8 | — | 71.8 | 163.8 | 43.8 | 8.4 | 17.8 | 46.9 |
| Kansas | 58.7 | — | 58.7 | 176.6 | 33.2 | 1.6 | 6.2 | 25.5 |
| Kentucky | 171.0 | 6.9 | 177.9 | 825.8 | 21.5 | — | 42.0 | — |
| Louisiana | 1,116.5 | 72.2 | 1,188.7 | 1,437.0 | 82.7 | 1.2 | 31.7 | 3.8 |
| Maine | — | 96.2 | 96.2 | 732.4 | 13.1 | 2.6 | 173.8 | 1.5 |
| Maryland | 94.9 | — | 94.9 | 889.9 | 10.7 | — | 165.7 | — |
| Massachusetts | — | 238.4 | 238.4 | 3,109.4 | 7.7 | 29.3 | 364.2 | 8.0 |
| Michigan | 551.1 | 488.3 | 1,039.4 | 1,634.8 | 63.6 | 182.5 | 302.5 | 60.3 |
| Minnesota | 59.6 | 38.6 | 98.2 | 614.6 | 16.0 | 38.7 | 350.4 | 11.0 |
| Mississippi | 220.4 | — | 220.4 | 639.3 | 34.5 | 8.4 | 115.2 | 7.3 |
| Missouri | 728.0 | — | 728.0 | 2,894.9 | 25.1 | — | 19.9 | — |
| Montana | 0.1 | 335.6 | 335.7 | 785.2 | 42.8 | — | 183.8 | — |
| Nebraska | 41.6 | — | 41.6 | 64.0 | 65.0 | 0.3 | 2.9 | 11.4 |

| State | Inpatient and Outpatient Hospitals | | | | | Physicians and Other Practitioners | | |
|---|---|---|---|---|---|---|---|---|
| | DSH payments | UPL payments | Total FFS supplemental payments | Total Medicaid FFS payments | FFS supplemental payments as % of total FFS payments | FFS supplemental payments | Total FFS Medicaid payments | FFS supplemental payments as % of total FFS payments |
| Nevada | 1.1 | 135.4 | 136.5 | 443.1 | 30.8 | 7.4 | 179.7 | 4.1 |
| New Hampshire | 217.7 | 24.2 | 241.9 | 284.0 | 85.2 | — | 5.9 | — |
| New Jersey | 502.7 | 220.7 | 723.4 | 1,580.9 | 45.8 | — | 81.2 | — |
| New Mexico | 31.8 | 8.6 | 40.4 | 445.4 | 9.1 | 4.4 | 71.8 | 6.1 |
| New York | 2,775.0 | 1,157.3 | 3,932.3 | 9,950.9 | 39.5 | 44.2 | 412.1 | 10.7 |
| North Carolina | 335.3 | 1,162.5 | 1,497.8 | 4,462.3 | 33.6 | 92.9 | 1,013.5 | 9.2 |
| North Dakota | 0.8 | 0.9 | 1.7 | 144.0 | 1.2 | — | 46.6 | — |
| Ohio | 574.1 | 102.9 | 677.0 | 1,349.8 | 50.2 | 30.4 | 213.1 | 14.3 |
| Oklahoma | 59.1 | 638.4 | 697.5 | 1,760.9 | 39.6 | 5.4 | 506.8 | 1.1 |
| Oregon | 55.5 | 14.3 | 69.8 | 419.1 | 16.7 | — | 65.0 | — |
| Pennsylvania | 754.7 | 418.1 | 1,172.8 | 1,747.0 | 67.1 | — | 42.8 | — |
| Rhode Island | 128.1 | 2.7 | 130.8 | 233.0 | 56.1 | — | 8.5 | — |
| South Carolina | 434.0 | 38.8 | 472.8 | 1,123.5 | 42.1 | 39.5 | 143.6 | 27.5 |
| South Dakota | 0.8 | — | 0.8 | 241.6 | 0.3 | — | 65.7 | — |
| Tennessee | 74.3 | — | 74.3 | 754.7 | 9.8 | — | 28.5 | — |
| Texas | 1,719.9 | — | 1,719.9 | 9,513.2 | 18.1 | 90.2 | 316.8 | 28.5 |
| Utah | 27.0 | 41.1 | 68.1 | 435.6 | 15.6 | 16.1 | 99.2 | 16.2 |
| Vermont | 22.7 | — | 22.7 | 25.9 | 87.6 | — | — | — |
| Virginia | 24.1 | 1,054.6 | 1,078.7 | 1,696.7 | 63.6 | 217.2 | 289.1 | 75.1 |
| Washington | 263.2 | — | 263.2 | 856.3 | 30.7 | 7.2 | 64.9 | 11.1 |
| West Virginia | 53.6 | — | 53.6 | 233.0 | 23.0 | — | 40.8 | — |
| Wisconsin | 130.9 | 98.5 | 229.4 | 831.3 | 27.6 | — | 62.6 | — |
| Wyoming | 0.5 | 34.2 | 34.7 | 126.1 | 27.5 | — | 42.2 | — |

**Sources:** Adapted from *MACStats: Medicaid and CHIP Data Book* (Washington, DC: MACPAC, 2021, exhibits 24 and 25), https://www.macpac.gov/wp-content/uploads/2021/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2021.pdf; "Medicaid Base and Supplemental Payments to Hospitals," (Washington, DC: MACPAC, 2021, table 1-A), https://www.macpac.gov/wp-content/uploads/2022/05/Base-and-supplemental-payments-to-hospitals.pdf.

— = zero (not applicable); DSH = disproportionate share hospital; FFS = fee for service; UPL = upper payment limit.

## MEDICAID WAIVER SUPPLEMENTAL PAYMENTS

Several states have secured Section 1115 demonstration waivers to help maintain the value of FFS supplemental payments when moving to managed care. Under these waivers, states are granted authority to make payments to providers that otherwise would not be permitted under Medicaid. The main types of waivers that states have employed to repurpose their FFS supplemental payments have been through UC pools and delivery system reform incentive payment (DSRIP) programs.

In 2020, a MACPAC analysis showed that 12 states paid $14.5 billion in supplemental payments through these two types of waivers: $8.2 billion via UC pools and $6.3 billion through DSRIP programs (table 4). The bulk of payments made through these waivers was paid to hospitals; combined spending under the waivers accounted for about 16 percent of total national FFS spending on hospitals in the year (MACPAC 2022c). As shown, 5 of the 12 states with these waivers had both waiver types—California, Kansas, Massachusetts, New Mexico, and Texas.

TABLE 4

**Medicaid Supplemental Payments through UC Pools and DSRIP Section 1115 Waivers by State, Fiscal Year 2020**

| State | Supplemental Payments ($ millions) | | Total supplemental payments through UC pools and DSRIP ($ millions) | Total FFS hospital Medicaid payments ($ millions) | Supplemental payments through UC pools and DSRIP as % of total FFS hospital payments (%) |
|---|---|---|---|---|---|
| | UC pools | DSRIP | | | |
| **Total** | **8,172** | **6,380** | **14,552** | **90,373** | **16.1** |
| Arizona | 22 | — | 22 | 1,329 | 1.6 |
| California | 2,296 | 1,310 | 3,606 | 16,355 | 22.1 |
| Florida | 903 | — | 903 | 2,420 | 37.3 |
| Kansas | 51 | 26 | 77 | 177 | 43.4 |
| Massachusetts | 480 | 283 | 763 | 3,109 | 24.5 |
| New Hampshire | — | 16 | 16 | 284 | 5.6 |
| New Mexico | 34 | 12 | 46 | 445 | 10.4 |
| New York | — | 1,783 | 1,783 | 9,951 | 17.9 |
| Rhode Island | — | 4 | 4 | 233 | 1.9 |
| Tennessee | 607 | — | 607 | 755 | 80.4 |
| Texas | 3,779 | 2,942 | 6,721 | 9,513 | 70.7 |
| Vermont | — | 3 | 3 | 26 | 12.4 |

**Sources:** Adapted from "Medicaid Base and Supplemental Payments to Hospitals" (Washington, DC: MACPAC, 2022), https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/; *MACStats: Medicaid and CHIP Data Book* (Washington, DC: MACPAC, 2021, exhibit 24), https://www.macpac.gov/wp-content/uploads/2021/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2021.pdf.

DSRIP = delivery system reform incentive payment; FFS = fee for service; UC = uncompensated care.

***Medicaid UC pools.*** Though specifics vary by each state's 1115 waiver, UC pools have been used to backfill low Medicaid payments and help support unpaid costs associated with the uninsured or underinsured. In 2020, eight states (Arizona, California, Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas) reported making $8.2 billion in supplemental payments through UC pools (table 4).

***Medicaid DISRIP waivers.*** DSRIP waivers aim to support providers (hospitals and others) that undertake infrastructure and other investments to improve access to and quality of care, among other things. As with UC pools, specifics for DSRIP waivers vary for each state. In 2020, nine states (California, Kansas, Massachusetts, New Hampshire, New Mexico, New York, Rhode Island, Texas, and Vermont) had a waiver that included provisions for DSRIP. In 2020, a total of $6.4 billion in DSRIP payments were made (table 4).

### MEDICAID MANAGED CARE SUPPLEMENTAL PAYMENTS

Finally, many states make supplemental payments to hospitals and other providers via their Medicaid managed care delivery systems. Called managed care directed payments, states, at their option, can "direct" managed care plan payments to specific providers. States use directed payments for varied purposes, including maintaining prior FFS payment arrangements and making new payments to providers (MACPAC 2022b).

Fairly new to the Medicaid program, directed managed care payments became available to states in July 2017. They replaced managed care pass-through payments, which had come under considerable federal regulatory scrutiny and activity (CRS 2018). Many states have elected to make directed payments: Between July 2017 and 2021, the federal government approved 660 state directed managed care payment proposals, according to GAO (2022). In 2021 alone, 36 states received approval to make one or more directed managed care supplemental payments. As with other supplemental payments in Medicaid, states have differed widely in the extent to which they have adopted these payments. As shown in figure 3, many states in 2021 did not receive approval to make any directed payments, whereas 5 states (Massachusetts, New Jersey, New Mexico, New York, and Tennessee) had more than 10 payment proposals approved (GAO 2022).

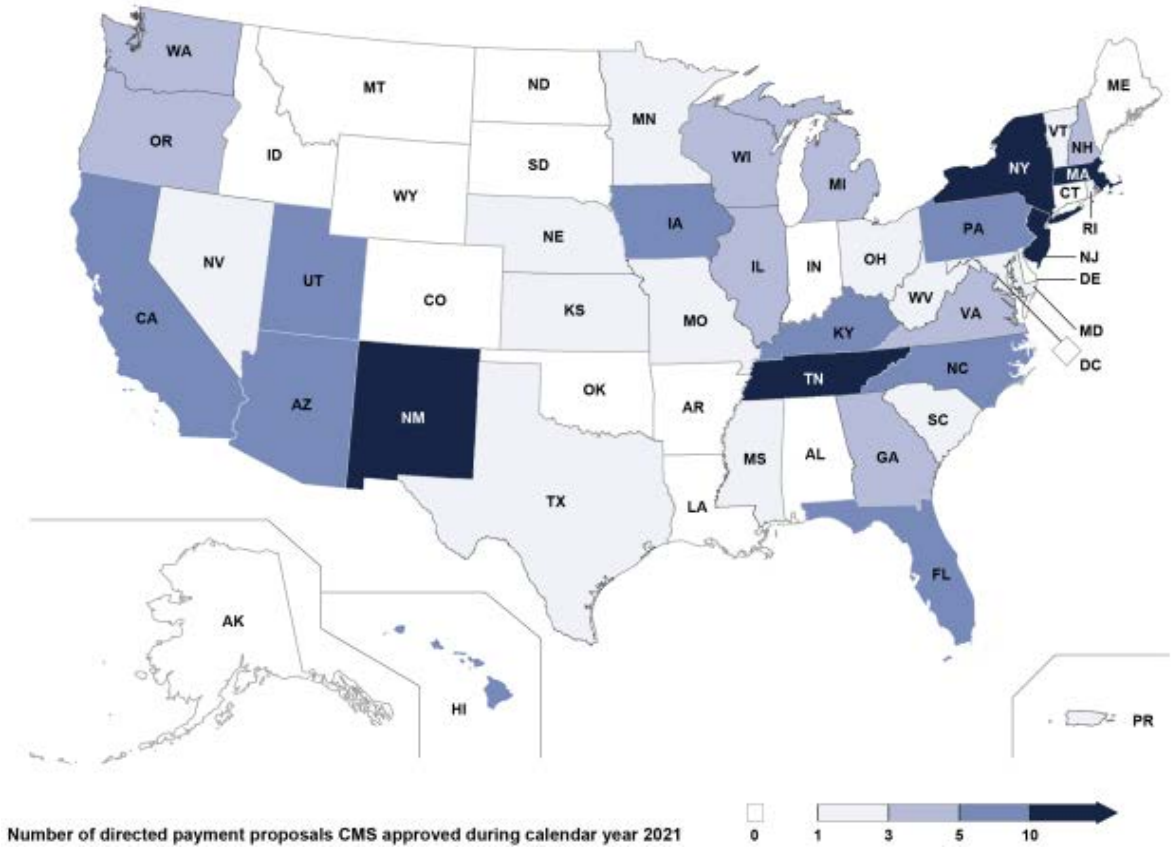
Data on spending for directed managed care payments are spotty. A recent MACPAC analysis found that projected spending on directed managed care payments totaled at least $25.7 billion in 2020. This accounted for nearly 8 percent of total Medicaid spending on managed care organizations in 2020.[7] But, according to MACPAC, this projection is likely a conservative estimate: Less than half of the 2020 approved directed managed care payments reviewed did not include spending projections, therefore, any expected spending under those approved payment plans is not accounted for in the $25.7 billion estimate. At the same time, $25.7 billion is an estimate based on state projections, not actual spending. Though state reporting on directed managed care payments is incomplete, the largest payments are reported to be paid to hospitals with state financing provided by the hospitals (MACPAC 2022d). In other words, directed managed care payments share many attributes with other Medicaid supplemental payments.

Several factors have contributed to the rapid growth in directed managed care payments: One is the phasing out of managed care pass-through payments and states correspondingly transitioning to directed payments to preserve funds. Another likely factor is that there is no upper limit on how much states can make in directed payments. So, as with physician UPL payments, states can make directed

payments that exceed Medicare rates. MACPAC (2022d) reports that some states' directed payment arrangements paid hospitals nearly three times what Medicare would have for comparable services.

FIGURE 3

**State Directed Managed Care Supplemental Payments Approved in 2021**




**Source:** Reproduced from "Medicaid: State Directed Payments in Managed Care," GAO-22-105731 (Washington, DC: US Government Accountability Office, 2022), https://www.gao.gov/products/gao-22-105731.

To sum up: Across the supplemental payments discussed here, we estimate that at least $71.7 billion in Medicaid supplemental payments were paid to acute care providers in 2020. Applying the national FMAP of 56.2 percent in 2020, we estimate that $40.3 billion in federal funds and $31.4 billion in state funds were used to make these payments.

## Medicare Hospital Supplemental Payments

With the goal of helping to maintain access to care for program enrollees, Medicare also has several supplemental payment policies and programs that target hospitals. Reflecting the federal nature of the program, Medicare hospital supplemental payment policies are formulated at the national level and

generally consistently applied across hospitals, making them distinct from Medicaid supplemental payment policies that are largely set by states within federal Medicaid guidelines.

Given our focus on supplemental payments made to support acute care providers serving the low-income and uninsured populations, we limit our discussion to two Medicare hospital supplemental payments: Medicare DSH and UC pool supplemental payments. In 2022, estimated DSH payments and UC payments were, respectively, $3.5 billion and $7.2 billion (table 5). Combined, these two payments accounted for about 6 percent of FFS Medicare hospital payments (MedPAC 2022b).

Though less contentious than Medicaid DSH payments, Medicare DSH payments have also been subject to controversy. Established in the Consolidated Omnibus Budget Reconciliation Act of 1985, Medicare DSH payments were initially intended to compensate hospitals for caring for low-income Medicare patients. This patient population was thought to be more costly to treat than their higher-income counterparts, costs that were perceived as not having been captured in Medicare's diagnosis-related group reimbursement system.

Over the years, however, the premise that lower-income enrollees cost more to care for was questioned. Indeed, research by the Medicare Payment Advisory Commission (MedPAC) suggested that Medicare costs per case were not related to income and that Medicare DSH payments were not "empirically justified." Further, MedPAC also found that Medicare DSH payments were not well targeted to a hospital's level of uncompensated care (MedPAC 2007).

To address these and other issues, the Affordable Care Act (ACA) called for several modifications to Medicare DSH payments, with the goal of reducing payment amounts and redistributing funds to hospitals with high UC costs. Toward that end, two main ACA Medicare DSH provisions were implemented in 2014. The first reduced DSH payments to 25 percent of estimated pre-ACA DSH payments —the so-called empirically justified DSH payment. The second provision called for an additional payment to help fund UC costs in qualifying hospitals. These payments are referred to as uncompensated care pool payments.

### MEDICARE DSH PAYMENTS

Under empirically justified Medicare DSH payments, hospitals receive 25 percent of the DSH payments they would have otherwise expected under the pre-ACA DSH formula. How much a hospital receives in DSH payments is based on a hospital's "low-income share," defined as the sum of a hospital's two factors: (1) the share of a hospital's total inpatient days attributable to Medicaid enrollees and (2) the share of all Medicare inpatient days attributable to Supplemental Security Insurance enrollees (table 5).

TABLE 5

**Selected Medicare Supplemental Payments to Hospitals, 2020**

| Supplemental payment | Total spending ($ billions) | Payment eligibility | Payment method | Urban hospitals qualifying (%) | Rural hospitals qualifying (%) |
|---|---|---|---|---|---|
| Disproportionate share hospital (DSH) payments | 3.5 | Medicaid share plus SSI share of Medicare beneficiaries generally has to exceed 15% | Percentage add-on to inpatient services | 82 | 92 |
| Uncompensated care (UC) pool payments | 7.2 | Must qualify for DSH payments | Allocation based on hospital's share of UC relative to total UC of qualifying hospitals | 82 | 92 |
| **Total** | **10.7** | | | | |

**Source:** Adapted from MedPAC, *Medicare and the Health Care Delivery System* (Washington, DC: MedPAC, June 2022), https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

SSI = Supplemental Security Income.

To qualify for DSH payments, a hospital's low-income share usually must be greater than 15 percent. This is referred to as the DSH patient percentage. The percentage is not hard to meet, as over 80 percent of the nation's urban hospitals qualify for Medicare DSH payments. The percentage is higher still for rural hospitals. In 2022, government actuaries estimated that Medicare DSH payments would have been $14.0 billion under the pre-ACA formula. Thus, following the ACA provisions, 25 percent, or $3.5 billion, was to be paid to qualifying hospitals in empirically justified DSH payments. DSH payments are paid as a percentage add-on to the Medicare inpatient services payment, with the level of DSH payment determined by a hospital's low-income share (MedPAC 2022a).

### MEDICARE UC POOL PAYMENTS

Only hospitals that qualify for DSH payments are potentially eligible to receive Medicare UC pool payments. A fixed pot of funding is available in the pool, which is determined by two factors: (1) the remaining 75 percent of all DSH payments hospitals would have expected to be paid under the pre-ACA formula and (2) 1 minus the percent change in the national uninsured rate from 2013 among individuals younger than 65 years old. This second factor was intended to account for the expected decline in need for UC payments resulting from the ACA coverage expansion lowering the uninsured rate.

As mentioned, DSH payments were estimated at $14.0 billion in 2022 had pre-ACA DSH rules applied. Further, government officials estimated the uninsured rate in 2022 to be 68.57 percent of what it was in 2013. Applying these estimates, available UC care pool payments nationally in 2022 were $7.2 billion (0.75 × $14.0 billion × 0.6857).

The $7.2 billion in available UC pool payments is then allocated among qualifying hospitals (that is, only hospitals that qualify for Medicare DSH payments) based on a hospital's share of UC costs relative

to the total uncompensated care costs in all qualifying hospitals. Given that the availability of UC care pool payments is driven in part by the nation's uninsured rate, the funding level for these payments is not static. For example, in fiscal year 2023, pool payments are to drop to $6.9 billion (MedPAC 2022a).

Even with the changes included in the ACA, though, policy issues persist. An important one that MedPAC has highlighted in its recent work is that the formula used to qualify hospitals for DSH payments (a hospital's low-income share) excludes often financially challenging patients—namely, the uninsured and Medicare beneficiaries (O'Donnell and Stensland 2021). MedPAC also identifies concerns about how Medicare DSH payments continue to be targeted: For one, because the formula accounts only for a hospital's share of Supplemental Security Insurance Medicare patients, DSH payments may not track with hospitals' Medicare shares, which can lead to the odd result that high Medicare share hospitals possibly get lower DSH payments than hospitals that have lower shares of Medicare patients. And, moreover, Medicare may be indirectly subsidizing the Medicaid program because the level of a hospital's Medicaid inpatient share is one of the primary eligibility criteria to qualify for Medicare DSH payments and thus UC pool payments.

Questions have also been raised about the lack of targeting of UC pool payments. MedPAC work has shown that pool payments cover only about 20 percent of DSH hospitals' UC costs and that the payments lack targeting to safety net hospitals, the facilities that care for a high share of the uninsured (O'Donnell and Stensland 2022). More broadly, DSH payments are focused on hospitals while care continues to shift to the outpatient setting, where providers received limited additional support.

# Repurposing Medicaid and Medicare Supplemental Payments

We have shown that Medicaid supplemental payments have a long track record of being complicated, murky, and, moreover, generally not tied to a Medicaid or uninsured patient or promoting a particular outcome such as improving equity or access to quality care. In addition, the extent to which states rely on Medicaid supplemental payments varies considerably. In large part, that variation is driven by states' aggressiveness in using various financing and payment arrangements, such as relying on providers to finance their share of Medicaid spending and using supplemental payments to make up for low base Medicaid payments. In short, long-standing inefficiencies exist in Medicaid supplemental payments, all of which have been well documented by government groups (e.g., GAO, MACPAC), as well as health services researchers.

States' use of these financing and payment arrangements means that even the amount spent on the Medicaid program is uncertain because the actual state share is likely considerably overstated. At the same time, supplemental payments do not necessarily provide additional resources to the providers that receive them, nor are they always targeted to the providers most in need. While Medicare supplemental payments do not have issues with state financing and payment practices, these payments also have been shown to be ill-targeted and in need of reform.

Because of the various problems we identified above, better ways to use supplemental payment funds could be devised. Alternatives, for example, could repurpose much (but not necessarily all) of the federal funds used in Medicaid and Medicare supplemental payments to support other health care initiatives, with the aim of distributing funds more equitably and efficiently than they are now. Among the selected supplemental payments considered, we estimate that $82.4 billion is spent each year in Medicaid ($71.7 billion) and Medicare ($10.7 billion) supplemental payments to acute care providers, with hospitals by far being the largest recipient of the payments. We further estimate the federal share of these payments totals $51.0 billion ($40.3 billion paid out through the Medicaid program and $10.7 billion in Medicare.)

Some portion of that $51.0 billion could be redirected. Specifically, we assume that a sizable share of federal funds used to make Medicaid DSH payments, hospital and physician UPL payments, and waiver supplemental payments could be repurposed. Similarly, federal funds used to make Medicaid directed managed care payments could be repurposed. Given the way many states finance their share of supplemental payments, we do not consider state funds available. We have also assumed that federal Medicare DSH and UC pool payments could be redeployed.

One alternative would be to better target supplemental payment funds to the most vulnerable hospitals. But history shows that this is not so straightforward. It would not be just a matter of identifying hospitals with high levels of uncompensated care. We would also need to know the commercial payer mix, the amount of financial reserves, hospital efficiency, and availability of other revenue sources. The competition for such funds would be intense and the politics difficult, particularly because there would not be enough money to cover all uncompensated care provided by vulnerable hospitals.

The early distribution of Coronavirus Aid, Relief, and Economic Security (CARES) Provider Relief Fund payments meant to help providers weather the pandemic is one recent example of how difficult it is to target federal funds to the providers most in need. Nonetheless, CARES funds, after several rounds of distributions, are now thought to have become better allocated; as such, some of the distribution formulas used to make later CARES distributions could serve as a better model for repurposing Medicaid and Medicare supplemental payment funds.

Alternatively, some Medicaid and Medicare supplemental payments could be redirected to help finance an expansion of coverage and benefits. Even after the Inflation Reduction Act, estimates indicate that 28 million individuals will still be uninsured (Holahan and Simpson 2022). Repurposed Medicaid and Medicare supplemental payments could contribute significantly to financing a coverage expansion. For example, Holahan and Simpson (2022) recently estimated the cost and coverage impacts for a range of reforms—namely, expanding Marketplace coverage to the Medicaid gap population in the 12 nonexpansion states, introducing a federal reinsurance program, eliminating the employer firewall that excludes employees with an affordable offer of health insurance from being eligible for Marketplace subsidies, increasing federal matching rates in Medicaid expansion states, and making cost sharing in the ACA more generous. They found that expanding Marketplace coverage to the Medicaid gap population in nonexpansion states alone would cover 1.5 million individuals and cost $27.0 billion. If

all the policies considered were implemented, estimates suggested that 3.7 million would gain coverage at a cost of $50.4 billion. Importantly, not all this spending goes to expanded coverage: some would pay for those who had other coverage but switch into Medicaid, some would pay for improved benefits, and some would provide money for expansion states to achieve equity.

Blumberg, Holahan, and Levitis (2021) examined auto-enrolling uninsured individuals receiving SNAP or TANF benefits into Medicaid or Marketplace coverage, depending on their eligibility. Apart from auto-enrollment of uninsured SNAP and TANF enrollees, the analysis assumed several other policies were already in place (that is, Marketplace coverage had been extended to Medicaid-eligible individuals in the 12 nonexpansion states, the employer firewall was eliminated, a public option was implemented, and more generous cost-sharing subsidies in Marketplaces were provided). Assuming all these policies were adopted, estimates indicated that auto-enrollment of the SNAP and TANF populations would reduce the number of uninsured by 3.6 million at a cost of $33.8 billion.

Changing the current flow of funding in Medicaid and Medicare supplemental payments would be a dramatic policy change, one that would disrupt a considerable amount of funds for many vested interested parties. Undoubtedly, there would be winners and losers. States, for example, would lose the federal funds they now receive through supplemental payments, but they would realize new federal dollars with either a new funding formula or a new coverage expansion. Depending on how a state has financed and used Medicaid supplemental payments, some hospitals stand to lose substantial federal funding. At the same time, others stand to gain: because of better targeting of funds or increased coverage and improved related policies (e.g., insurance affordability), some hospitals would experience an influx of new funds that would more than compensate their loss of funding through supplemental payments.

Making such a wholesale change to supplemental payments would be challenging, both technically and politically. A transition period and some state and provider protections would be warranted while the reforms were phased in. But preserving the existing flow of a sizable share of federal funds paid as supplemental payments is not sound policy. There are more equitable and more efficient ways to use these funds.

# Notes

[1] Specifically, for Medicare, we exclude hospital supplemental payments made through the critical access hospital program, the sole community hospital program, Medicare-dependent hospital payments, and low-volume hospital payments. These payments help maintain access in isolated areas rather than adjusting for treating low-income patients and the uninsured, which is the focus of this analysis. We also exclude Medicare medical education payments and capital DSH payments. Finally, we do not consider supplemental payments to safety net providers other than hospitals. Medicare, for example, does provide incentive payments for physicians who work in primary care and mental health HPSAs (health professional shortage areas). In Medicaid, we exclude Medicaid DSH payments made to IMDs (institutions for mental diseases) and graduate medical education payments made to hospitals. Though not acute care providers, we also exclude Medicaid supplemental payments to nursing facilities, intermediate care facilities for individuals with intellectual disability, and mental health facilities.

[2] The $25.7 billion in managed care supplemental payments are projected payment levels, not actual payments, and represent a portion of approved managed care supplemental payments in 2020.

[3] Allotments for fiscal year 2019 were used rather than 2020 because at the time of this writing, this was the latest year available for which finalized allotments had been published.

[4] The exact amount a provider nets depends upon the design of the state provider tax program.

[5] Michael F. Mangano (Principal Deputy Inspector General, Office of Inspector General, US Department of Health and Human Services), memorandum to Thomas Scully, Administrator, Centers for Medicare and Medicaid Services, Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers (A-03-00-00216), September 1, 2001, https://oig.hhs.gov/oas/reports/region3/30000216.pdf.

[6] Hereafter, we will refer to the category of physicians and other practitioners as physicians.

[7] Urban Institute analysis of FY 2020 CMS-64 data, as of August 2021.

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