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Hospital Non-DSH Supplemental Payment and Directed Payment Targeting Analyses

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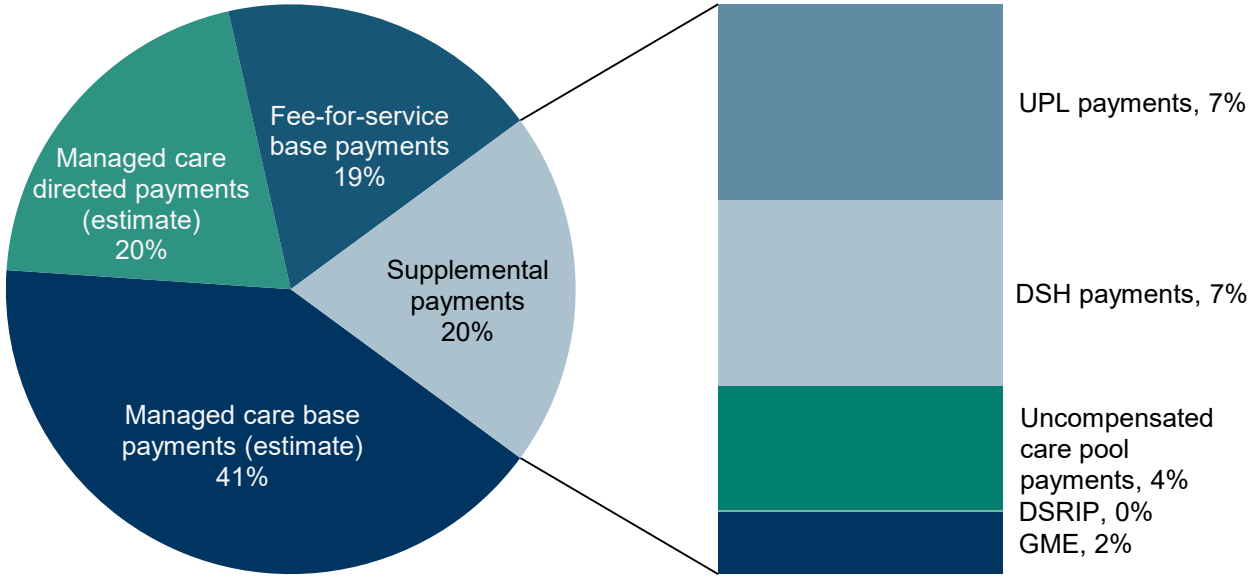
Background

Supplemental Payment Characteristics

Type of supplemental payment	Delivery system	CMS approval	Payment limits
DSH	FFS and managed care	State plan; DSH audit	Total payment limited to DSH allotment Hospital-specific limit of uncompensated care costs for both Medicaid-enrolled and uninsured patients
UPL	FFS	State plan; UPL demonstration	Difference between FFS base payment and estimate of Medicare payment for class of providers
GME	FFS and managed care	State plan	NA
Uncompensated care pools	FFS and managed care	Section 1115 demonstration authority	1115 waiver terms and conditions and budget neutrality
DSRIP	FFS and managed care	Section 1115 demonstration authority	1115 waiver terms and conditions and budget neutrality
Directed payments	Managed care	Managed care rate certification and preprint	Limit of average commercial rate

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. NA is not applicable. 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. DSRIP spending is a non-zero amount that rounds to 0%.
Sources: MACPAC, 2024, analysis of CMS-64 net expenditure data as of May 30, 2023 and CMS-64 Schedule C waiver report data as of September 29, 2023, and directed payment arrangements approved through February 1, 2023.

Supplemental Payments are a Large Share of Medicaid Hospital Spending, FY 2022



Total payment: $227.8 billion

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. DSRIP spending is a non-zero amount that rounds to 0%.
Sources: MACPAC, 2024, analysis of CMS-64 net expenditure data as of May 30, 2023 and CMS-64 Schedule C waiver report data as of September 29, 2023, and directed payment arrangements approved through February 1, 2023.

Supplemental Payments Have Different Goals

Type of supplemental payment	FY 2022 total spending (billions)	Number of states reporting spending	Intent of payment implied from federal rules			
			Medicaid-enrolled patients	Uninsured individuals	Quality improvement	Support for specific types of hospitals
DSH	$15.0	47	✓	✓		
UPL	15.8	35	✓			
GME	4.9	35				✓
Uncompensated care pools	10.0	7	✓	✓		
DSRIP	0.2	7			✓	
Directed payments	47.8[1]	35	✓		✓	

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 but excludes the US territories.

[1] Spending total represents annualized amounts of projected spending from directed payment preprints, which may differ from actual FY 2022 spending.

Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 30, 2023; CMS-64 Schedule C waiver report data as of September 29, 2023; and directed payment arrangements approved through February 1, 2023.

Previous Analyses of Non-DSH Supplemental Payments

- Consolidated Appropriations Act, 2021 requires states to report provider-level data on non-DSH supplemental payments
  - Includes UPL payments, GME, and Section 1115 waiver supplemental payments as reported on the CMS-64 financial management report
  - Also includes narrative information about payment methods
- We analyzed FY 2022 non-DSH supplemental payment data collected by CMS as of June 2023
  - Supplemental payment amounts were reliable but information on base payments was not
  - Most hospitals in the data set could be linked to Medicare cost reports
- We did not have data on provider contributions to the non-federal share necessary to calculate net payments to providers

DSH and Non-DSH Payments by Hospital Characteristics

Hospital characteristics	Number of hospitals		DSH payments (SPRY 2019)		Non-DSH payments (FY 2022)	
	Number	Share of total	Spending (millions)	Share of total	Spending (millions)	Share of total
Total	**6,033**	**100%**	**$17,354.1**	**100%**	**$18,766.9**	**100%**
Receipt of Medicaid supplemental payments						
DSH and non-DSH payments	1,421	24	8,999.8	52	11,642.7	62
DSH only	1,107	18	8,354.2	48	—	—
Non-DSH only	1,600	27	—	—	7,124.2	38
No supplemental payments	1,905	32	—	—	—	—
Urban/ Rural						
Urban	3,578	59	15,247.0	88	17,320.2	92
Rural	2,448	41	2,069.3	12	1,446.6	8
Deemed DSH status						
Deemed	747	12	10,320.6	59	7,396.2	39
Not deemed	5,286	88	7,033.4	41	11,370.7	61

Notes: DSH is disproportionate share hospital. Non-DSH payments include upper payment limit supplemental payments, graduate medical education payments, and supplemental payments authorized through Section 1115 demonstration authority. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. FY is fiscal year. Excludes 65 DSH hospitals that did not submit a fiscal year 2021 Medicare cost report. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Total spending includes state and federal funds. Data for DSH hospitals in Montana were estimated using Montana's SPRY 2018 as-filed DSH audit because SPRY 2019 was unavailable.
Source: MACPAC, 2024, analysis of FY 2021 Medicare cost reports, SPRY 2018–2019 as-filed Medicaid DSH audits, and FY 2022 non-DSH supplemental payment data submitted to the Centers for Medicare & Medicaid Services.

Targeting Analyses

Analyses of Hospital Targeting Data for Non-DSH Supplemental Payments

- To understand how non-DSH supplemental payments were targeted to specific subclasses of providers, we reviewed FY 2022 narrative reports on non-DSH supplemental payments and state Medicaid plans
- The CAA requires states to submit a narrative describing the intended goals of each payment, the targeting criteria, and the payment methodology
  - Many states submitted incomplete narratives, so we supplemented our review using Medicaid state plans
- Our narrative analysis included only UPL and GME supplemental payments:
  - **UPL payments** often targeted government-owned hospitals, rural hospitals, and teaching hospitals. Targeting criteria varied based on hospital ownership, hospital type, patient case mix, geographic factors, and other state-defined criteria
  - **GME payments** targeted teaching hospitals. Some states prioritized GME payments for primary care and high-need specialties like maternity care

Number of States Targeting UPL Payments to Selected Hospital Types, FY 2022

Hospital type	Number of states
State-owned or public hospitals	28
Rural or critical access hospitals	15
Teaching hospitals	9
Children's hospitals	6
State-defined safety net or high Medicaid hospitals	6
Psychiatric hospitals or institutions for mental diseases	2

Notes: UPL is upper payment limit. FY is fiscal year. This analysis shows the number of states that explicitly made certain types of hospitals eligible for UPL payments as described in their non-DSH supplemental payment narrative report to CMS or Medicaid state plan. Totals do not sum because states may target UPL payments to multiple types of providers.
Source: MACPAC, 2025, analysis of FY 2022 non-DSH supplemental payment data submitted to the Centers for Medicare & Medicaid Services and Medicaid state plans.

Rural Hospital Targeting Characteristics, FY 2022

Hospital targeting characteristics	Number of states reporting non-DSH spending	Total non-DSH spending (millions)	Non-DSH Hospital Spending to Rural Hospitals		
			Sum of spending (millions)	Mean spending per state (millions)	Share of total non-DSH spending
Total	**48**	**$18,766.9**	**$1,446.8**	**$30.1**	**7.7%**
Rural (including CAH)	15	7,106.9	792.8	52.9	11.2
CAH	11	3,285.3	595.7	54.2	18.1
No rural targeting	33	11,660.0	654.0	19.8	5.6

Notes: Non-DSH payments include upper payment limit supplemental payments, graduate medical education payments, and DSRIP supplemental payments in Texas authorized through Section 1115 demonstration authority. FY is fiscal year. CAH is critical access hospital. Total spending includes state and federal funds.
Source: MACPAC, 2025, analysis of FY 2022 non-DSH supplemental payment data submitted to the Centers for Medicare & Medicaid Services and Medicaid state plans.

Number of States Utilizing Selected UPL Payment Methodologies, FY 2022

Payment Methodology	Number of states
Proportionate to Medicaid shortfall	20
Proportionate to Medicaid volume	18
Proportionate to Medicaid charges	11
Proportionate to uncompensated care	4
Fixed dollar amount	10
Tied to achievement of quality goals or metrics	4

Notes: UPL is upper payment limit. FY is fiscal year. This analysis shows the number of states that used certain payment methodologies for UPL payments as described in their non-DSH supplemental payment narrative report to CMS or Medicaid state plan. Totals do not sum because states may use multiple types of payment methodologies to distribute UPL payments.
Source: MACPAC, 2025, analysis of FY 2022 non-DSH supplemental payment data submitted to the Centers for Medicare & Medicaid Services and Medicaid state plans.

Analyses of Hospital Targeting Data for Directed Payments

- States are increasingly using directed payments to make uniform rate increases for hospitals, similar to FFS supplemental payments
- In directed payment preprints, states may define the participating class of providers using varying levels of detail
  - We reviewed 129 distinct directed payment arrangements with rating periods in calendar year (CY) 2022 across 33 states
  - This analysis excludes minimum fee schedules set at state plan rates because CMS does not require preprint submissions for these
  - Several preprints were missing hospital targeting information or applied to a set of hospitals more broadly, so our analysis may not reflect all states that targeted the selected hospital types

Number of States Targeting Directed Payments to Selected Hospital Types, CY 2022

Payment Methodology	Number of states
Acute hospitals (general, specialty, long-term)	17
Teaching hospitals	11
Rural or critical access hospitals	10
Psychiatric hospitals	7
Children's hospitals	6
State-defined safety net or high Medicaid hospitals	5

Notes: CY is calendar year. This analysis shows the number of states that explicitly made certain types of hospitals eligible for directed payments as described in their preprint submission. We included directed payment arrangements whose rating period overlaps with any period of time in CY 2022. Minimum fee schedules based on state plan rates are not included because states no longer need to obtain prior approval for these arrangements. Totals do not sum because states may target directed payment arrangements to multiple types of providers. Due to incomplete preprint information, this analysis may not reflect all states that targeted the selected hospital types.
Source: MACPAC, 2025, analysis of directed payment arrangements approved through August 1, 2024.

Considerations and Next Steps

Areas for Consideration

- Compared to non-DSH payments, directed payments have more rigorous evaluation requirements under the 2024 managed care rule. Should non-DSH supplemental payments have similar evaluation requirements to monitor whether these payments are achieving specific policy goals?
- To what extent should the Commission consider the economy and efficiency of specific supplemental payment arrangements versus the overall effect of supplemental payments combined?
- Should there be different considerations for supplemental payments targeted more specifically to a subclass of hospitals versus those that support most hospitals uniformly?

Next Steps

- Continue monitoring non-DSH supplemental payments and directed payments
- Construct an updated payment index to assess total base and supplemental payments across states and relative to external benchmarks
  - We plan to use our hospital targeting analysis to inform sub-analyses of the updated hospital payment index

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