Class 3: Medicaid Hospital Finance

July 29, 2026

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Introduction

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- Welcome to the third session of FPI's "Medicaid Boot Camp"!
- Slides and recordings will be shared.
- Organization of the class:
  - **Session 1:** Medicaid in General
  - **Session 2:** Long-term care
  - **Session 3:** Hospital finance, supplemental payments and provider taxes.
  - **Session 4:** The 1115 waiver and the future of Medicaid in New York
- Email me!
  - kinnucan@fiscalpolicy.org

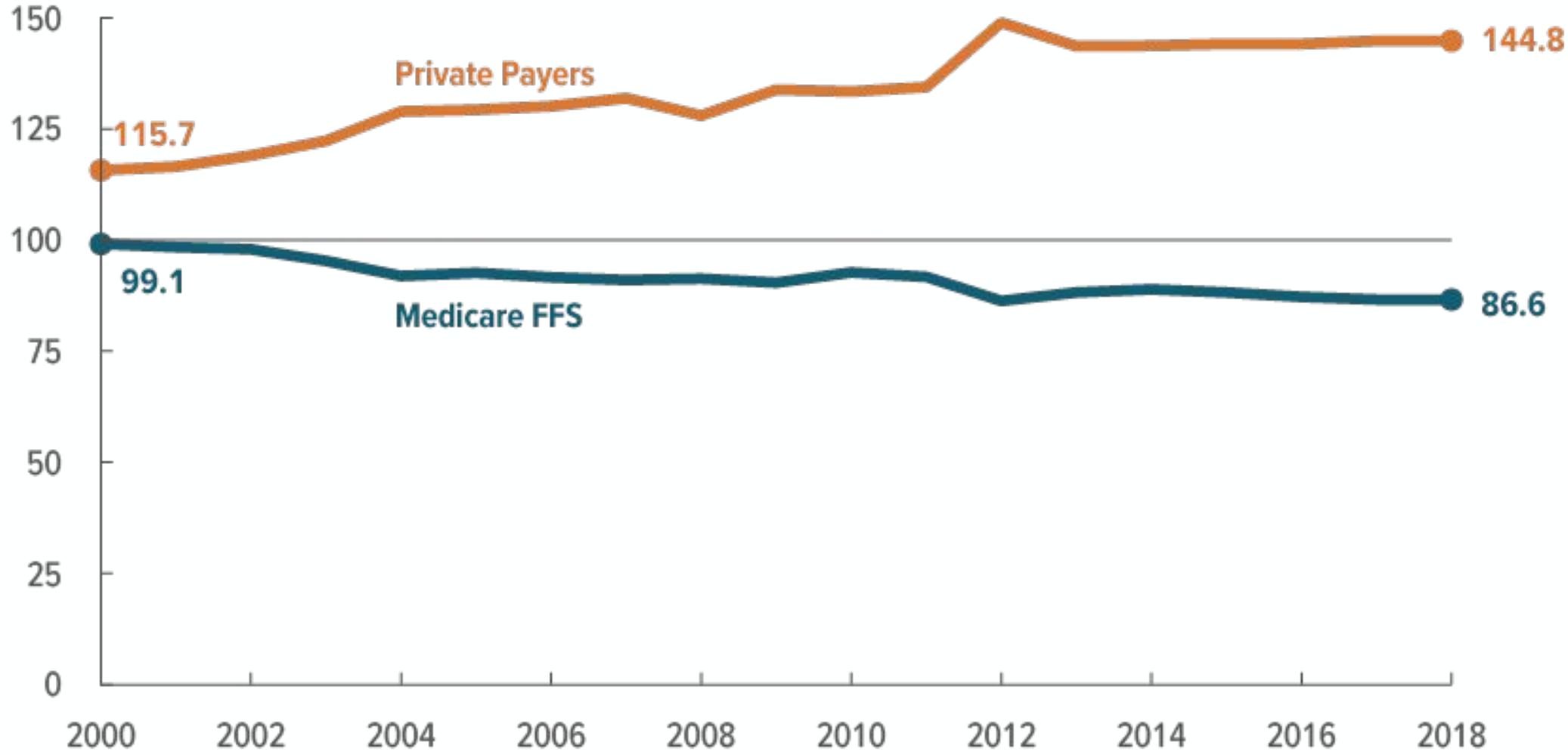
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Safety Net Hospital Finance

The Great Rate Divergence

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Source: CBO 2022



The Great Rate Divergence

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- Until the 1990s, Medicare, Medicaid and private payers paid around the same rates for hospital care.
  - In New York, rates were **set by the state** until 1996.
- Beginning in the 1990s, rates diverged dramatically. Why?
  - Two separate cost control strategies: Managed care and price-setting.
  - The private sector tried to use managed care to control costs – and failed.
  - Medicare (and Medicaid) used price-setting – and succeeded.
- Today, commercial payers pay **2.5 times** as much as private payers for inpatient care.
  - Medicaid pays somewhat less than Medicare.

Safety Net Hospitals and the Rate Divergence

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- For a hospital with a good “payer mix” (plenty of commercial patients), the *average* rate of payment is adequate.
- For a hospital with a high share of public (especially Medicaid) patients, the average rate of payment is too low.
- Hospitals may be in this situation because of:
  - Geography
  - Mission
  - Perceived quality and reputation
- Hospitals with a high Medicaid patient mix can’t survive on basic Medicaid rates alone.

Other Sources of Hospital Financial Distress

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- Low Medicaid (and Medicare) prices are a major cause of hospital financial problems but not the only one.
- Other causes include:
  - **Service mix:** Some services (labor and delivery, inpatient psych, trauma care) just aren't paid well.
  - **The shift to outpatient care:** Fewer hospitals needed, more empty beds.
  - **Low private pay rates:** Safety nets get paid the least by all payers.
  - **Hospitals being bad:** Sometimes hospitals are mismanaged and provide bad care.
- Despite these nuances, "financially distressed" safety net hospitals are a **structural feature** of the US healthcare system.

Poor Hospitals Subsidize Rich Hospitals

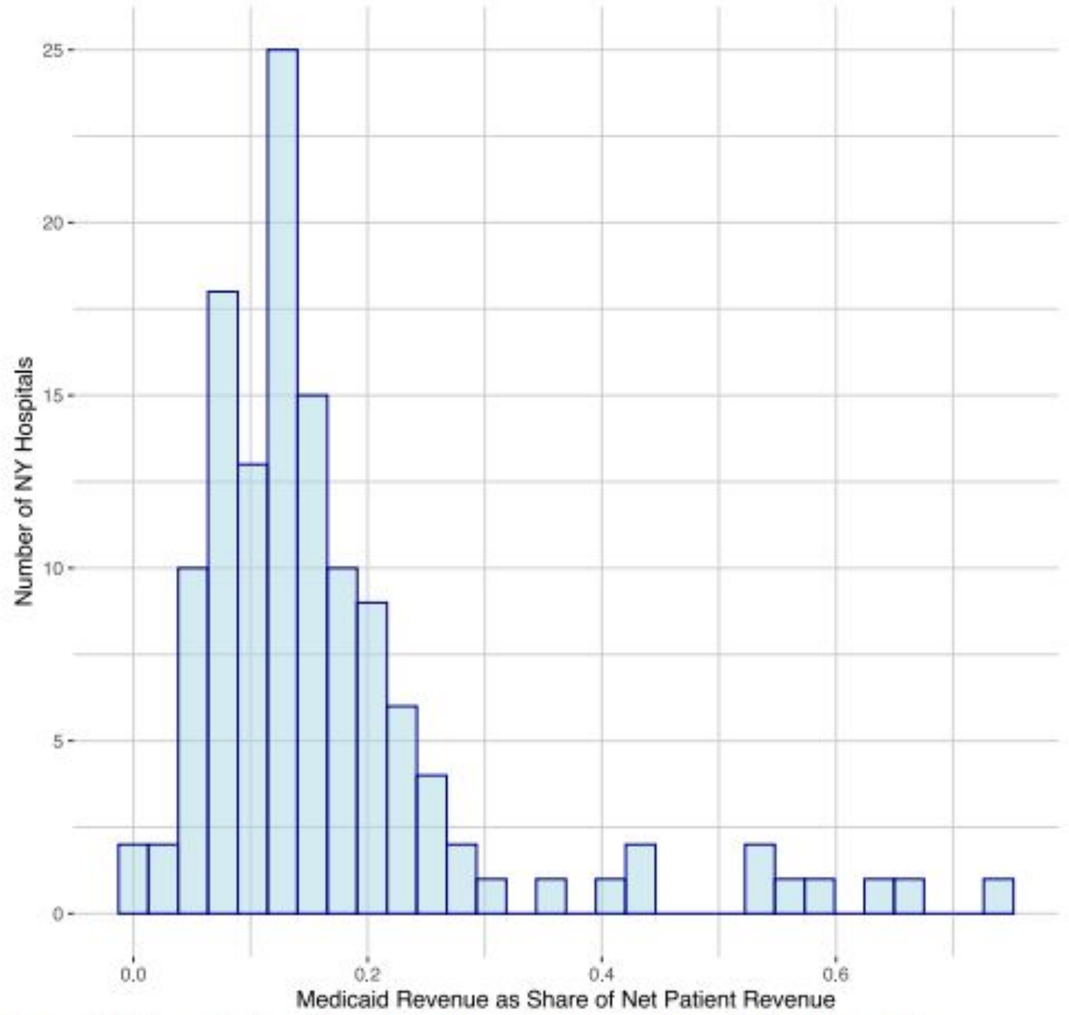
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- In the US, caring for some patients “pays” 2.5x as much as caring for other patients.
- Some patients are uninsured and “pay” nothing at all.
- There’s a mix of profitable and unprofitable patients – but everyone has a right to get care somewhere.
- The “poor” (safety net) hospitals take the unprofitable patients, allowing the “rich” hospitals to profit.
- Safety net hospital financial distress is inevitable, and allows other hospitals to profit.

Distribution of Medicaid Share

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Figure 5. Distribution of New York hospitals, by the share of Net Patient Revenue from Medicaid



Source: NASHP data on NY hospitals, with government-owned hospitals removed.

The Myth of Cost-Shifting

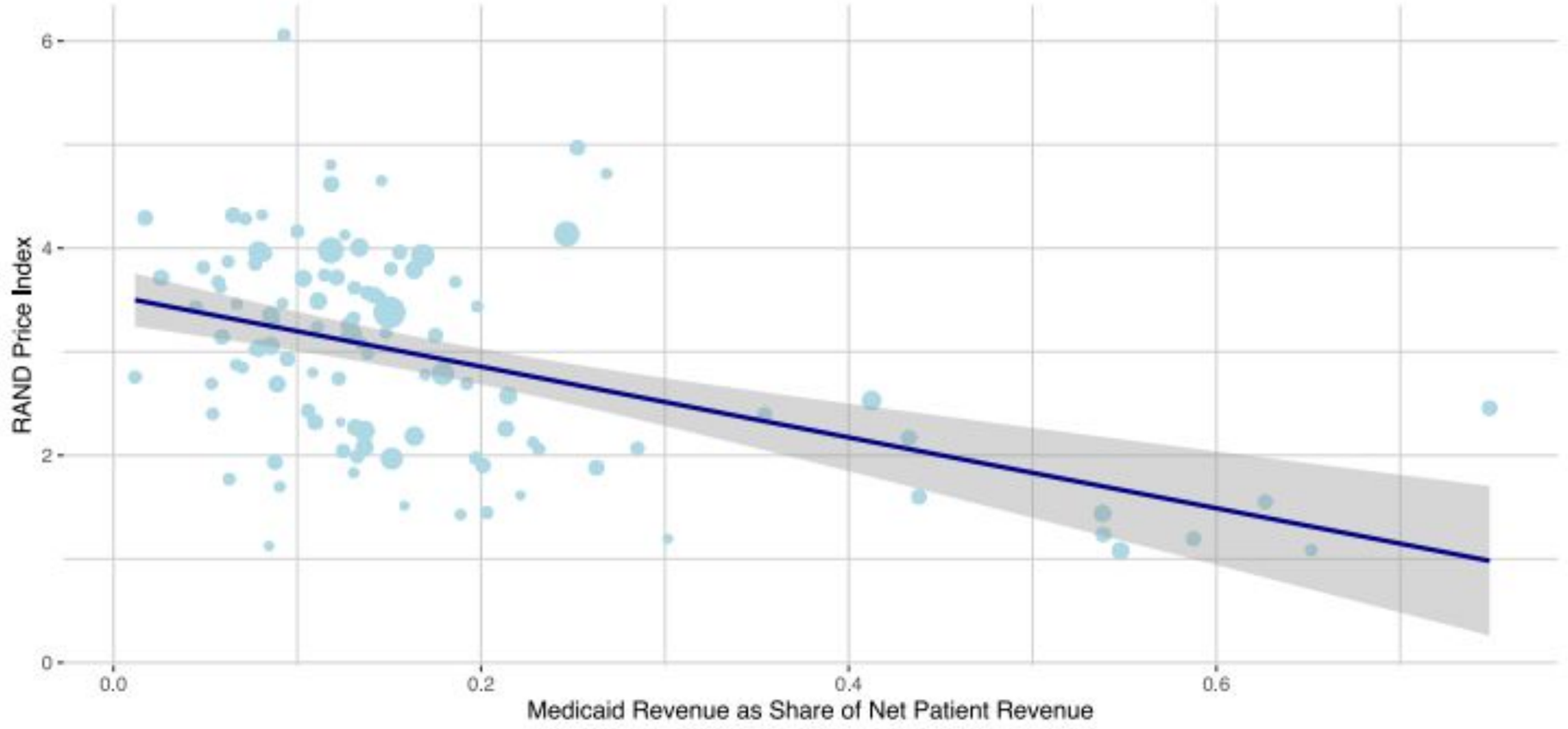
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- The hospital lobby often claims that private prices are high **because** Medicaid and Medicare prices are too low
  - Hospitals are forced to “cost-shift” from public onto private payers.
- There is no evidence for this and it is not true!
- If cost-shifting happened you would expect the high-Medicaid hospitals to (be forced to) charge high private prices.
- What we see is the exact opposite.

Cost-Shifting: Nope!

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Figure 6 Private insurance prices are higher at hospitals with less Medicaid revenue



Which Price is Right?

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- If Medicare (and Medicaid) pay so much less than commercial insurance, who pays the right/fair/cost-covering price?
  - Is Medicaid too low or is commercial insurance too high?
- In Maryland, where all payers pay around the same rate, that rate is about 134% of Medicare.
- There is no such thing as “covering costs” – prices are political!
- Commercial price-setting has proven inflationary.

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Safety Nets and Medicaid

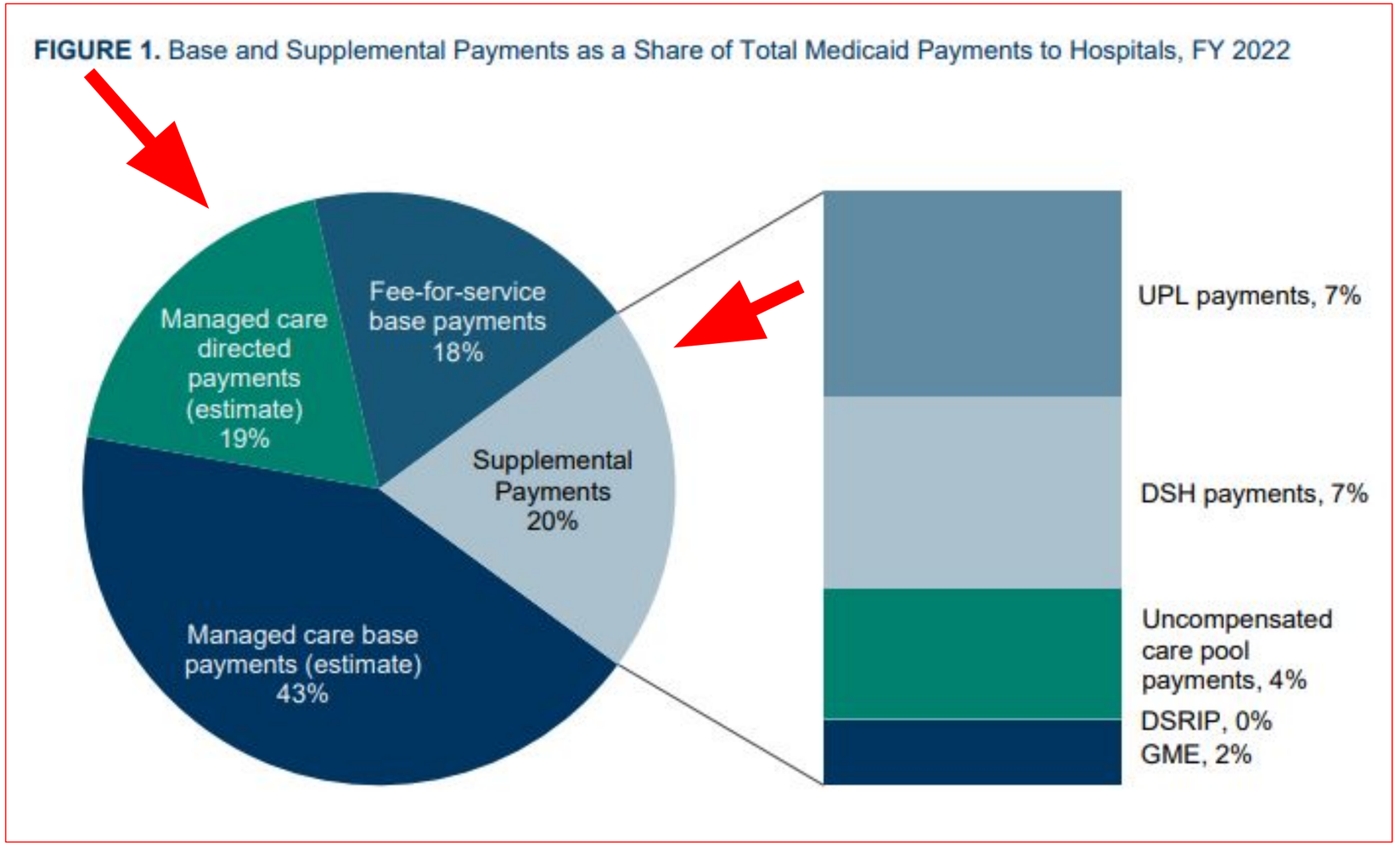
Safety Net Hospitals and Medicaid Finance

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- Safety nets are structurally disadvantaged – but they can't be closed because they provide vital care.
- To keep them open, the government needs to spend money.
- This is an important role for **Medicaid,** and is the source of Medicaid **supplemental payments.**
- Supplemental payments are:
  - Additional payments to safety net hospitals **beyond the regular the rates**
  - Highly regulated by the federal government.

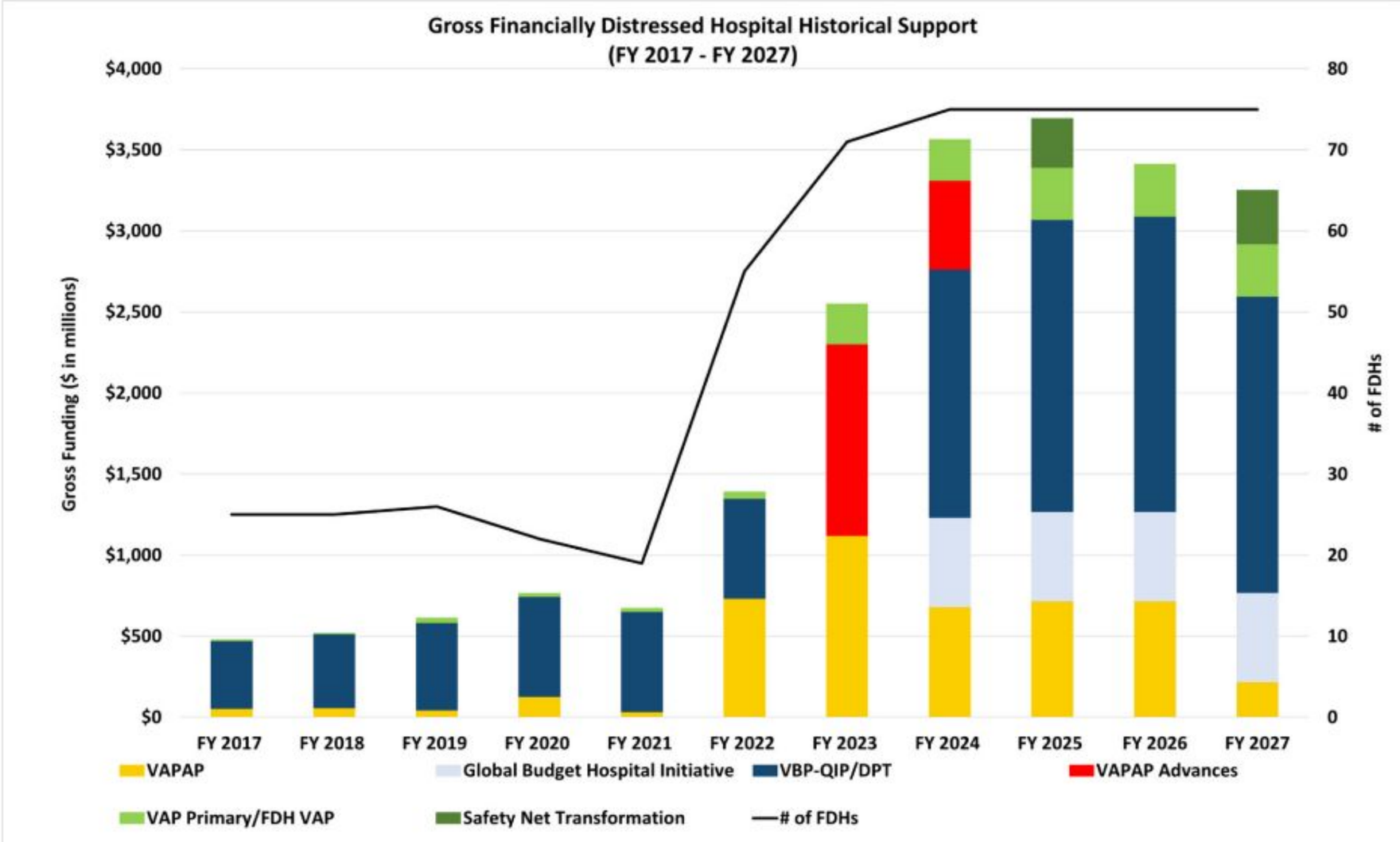
Supplemental Payments

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Supplemental Payments

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Why not just pay higher rates?

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- Why use supplemental payments when we could just raise Medicaid rates and not have financially distressed hospitals?
  - All hospitals take Medicaid and would get the money, but most aren't financially distressed.
  - Better Medicaid rates wouldn't help with uninsured patients.
  - The state has more control and discretion over supplemental payments.
- State Medicaid can make choices along a spectrum: The lower the rate you pay, the more you'll need to spend on supplemental payments.

Supplemental Payments and the State-Federal Partnership

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- CMS has always been a bit suspicious of supplemental payments, because:
  - They’re not exactly payment for services
  - They involve a lot of state discretion
  - Why should the federal government subsidize health system failures?
- As a result, supplemental payments are **capped** by the federal government (generally roughly at Medicare rates).
- Of course the state can write a check to a hospital whenever it wants but it can’t be **Medicaid matched** except under the cap.
- A lot of state-federal conflict happens around caps.

Historical Supplemental Payments: DSH and UPL

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- The **Disproportionate Share Hospital (DSH)** funding stream allows states to give (Medicaid-matched) funding to hospitals that serve a “disproportionate share” of uninsured/Medicaid patients.
  - Payments to a **specific hospital** capped at its “uncompensated care” costs.
  - Total state allotment capped by Congress at grandfathered levels in 1991. New York gets $2.4B of the $16B total (nice).
  - In 2010, the ACA included a provision phasing down DSH.
  - It has been deferred ever since!
- There’s a lesson here.

Upper Payment Limit (UPL) Payments

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- The “upper payment limit” is the Medicare rate.
  - States can’t pay a facility more for Medicaid services than Medicare would have paid for the same services.
- **Upper Payment Limit (UPL)** payments are supplemental payments to safety net hospitals that “top them up” to the Medicare rate.
- This used to be a huge part of NYS Medicaid finance.
  - But it only works in FFS! :(
  - The shift to Medicaid managed care has steadily reduced the “room” for UPL.

DSH, UPL, ICP

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- Remember: DSH and UPL aren't *sources of funding* for states.
- They are caps on how much **federally matched** Medicaid spending can happen.
- The (state share) money has to come from the state!
- Historically, New York has funded a lot of supplemental payments through the **Indigent Care Pool (ICP)** – originally intended to compensate hospitals for uninsured ("indigent") care.
- The pool taxes and redistributes around $1.1B across providers.
- That used to be a lot of money but now we spend even more in other ways.

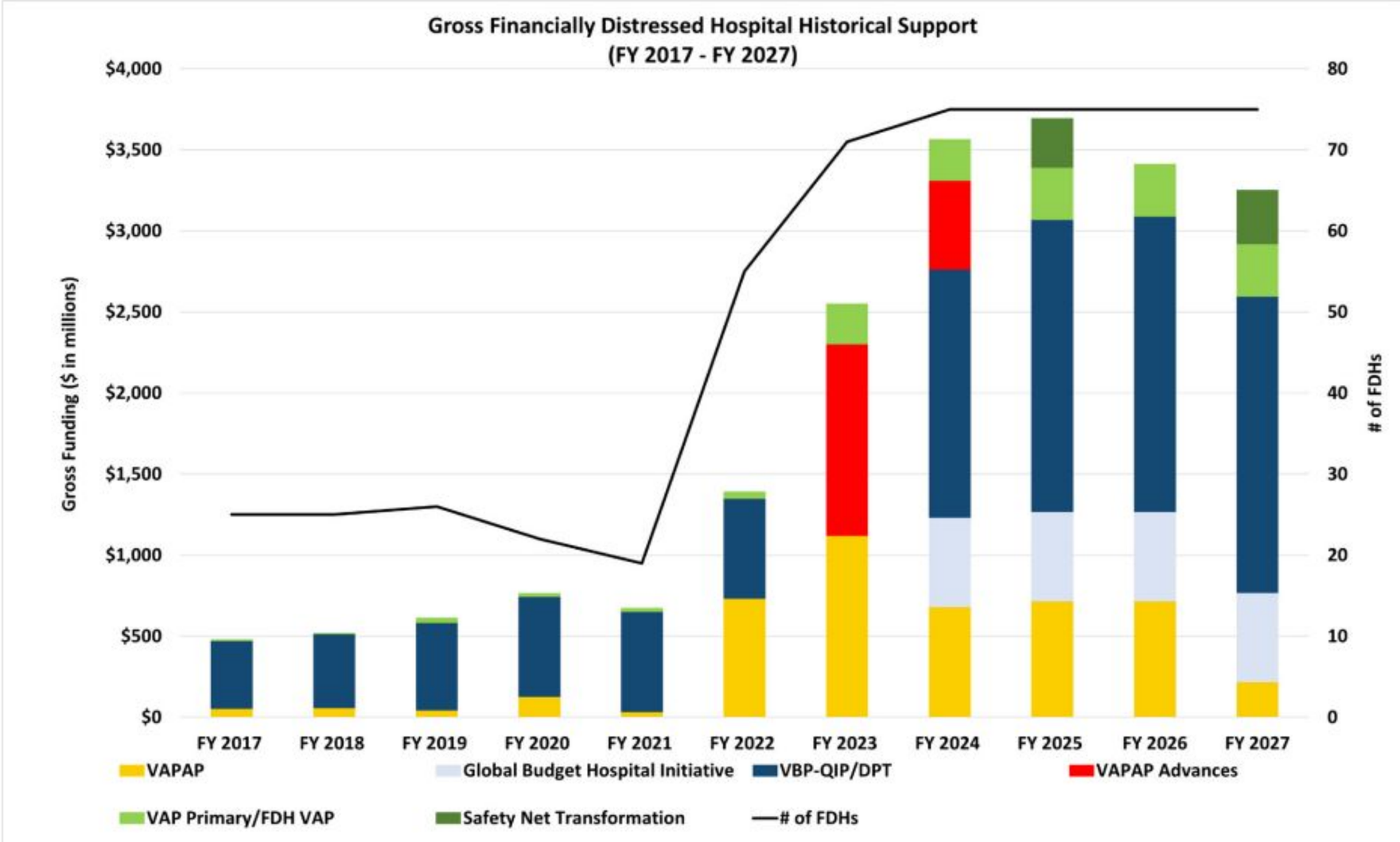
DSH, UPL, ICP: 2025

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Payment Type	Private	State Government	Non-State Government	4/1/25-3/31/26 Gross Total
Indigent Care Pool/Voluntary UPL $339M Guarantee	$727M	$5M	$93M	$825M
Indigent Care Pool Adjustment	$0	$150M	$262M	$412M
Disproportionate Share Program	$0	$605M	$933M	$1,538M
Vital Access Program	$0	$0	$0	$0
State Public Inpatient UPL	$0	$72M	$0	$72M
Non-State Government Inpatient UPL	$0	$0	$564M	$564M
Total	**$727M**	**$832M**	**$1,508M**	**$3,410M**

Supplemental Payments Today

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Supplemental Payments Today

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- Three dynamics have caused shifts in supplemental payments:
  - Growing need and flat Medicaid rates during the Cuomo administration
  - Post-Covid distress among hospitals.
  - The shift to managed care, which limits the use of UPLs.
  - Expanded State-Directed Payment (SDP) authority.

Major Supplemental Payment Programs

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- **DPT ("Directed Payment Template"):** $4B (all-funds)
- **VAPAP (Vital Access Provider Assistance Program):** $1.3B, no federal match (or it's complicated)
- **Hospital Global Budget Initiative:** $500M
- **Vital Access Program:** $300M
- **Safety Net Transformation Fund:** $300M

DPT Funding

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- Remember, UPL only works for **fee-for-service** spending.
- This became an obstacle to state transition to managed care.
- The federal government authorized **state-directed payments (SDP)** – the state can **direct** MCOs to pay more.
  - Originally up to the Medicare level (like UPL)
  - Under Biden – up to *commercial rates!!!* Hallelujah.
  - Under Trump: Back down to Medicare, starting in 2028.
  - H+H alone has $2.3B-ish in SDPs at commercial rates
- It's called "DPT" in New York for some stupid reason.

VAPAP (and VAP)

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- VAPAP: Highly discretionary payments to highly distressed hospitals.
  - This is keeping hospitals “on life support.”
  - The Governor threatens to cut it every year.
  - Currently quasi-matched through the 1115 waiver (see next week) but unlikely to continue.
- VAP: Similar but for mostly rural hospitals, likely more stable.

Hospital Global Budget Initiative

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- $500M for downstate, private safety net hospitals.
- See next week!

Safety Net Transformation Program

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- $300M for hospitals that partner with a larger system to "transform."
- Reflects the Executive's views on what needs to happen to safety net hospitals:
  - Partnership with big systems.
  - Service line changes and reductions.
- Political challenge of hospital closures.

Provider Taxes

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- A frequent mechanism to increase federal reimbursement historically.
- Heavily restricted by H.R. 1.
- New York has several, but the most famous is our short-lived MCO tax (2025-2026 – RIP!)

How to Structure a Provider Tax

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1. Tax your local hospital $100.
2. Spend $50 of the money paying the hospital for Medicaid stuff.
3. The federal government will kick in another $50.
4. Now:
    a. The hospital broke even. ($100 in taxes, $50 in state money, $50 in federal money).
    b. The federal government spent $50.
    c. You're left with $50 ($100 in taxes collected minus $50 in repayment).
5. If you spent the $50 on Medicaid you can get another $50 of federal match!

Restrictions on Provider Taxes

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- The federal government regulated this in the early 1990s, but didn't eliminate it.
  - Taxes must be uniform on a class of providers, must not hold providers harmless, etc.
  - New York's HCRA tax is "carved out" by statute.
- Regulations led to a "cat and mouse" game.
- H.R. 1 eliminated most of the mice.