AMERICA'S ESSENTIAL HOSPITALS

April 27, 2026

Mr. Alan Skelton
Director of Research and Technical Activities
Governmental Accounting Standards Board
801 Main Avenue
P.O. Box 5116
Norwalk, CT 06856-5116
Via email: director@gasb.org

Ref: Project No. 3-25, Governmental Accounting Standards Board (GASB) Exposure Draft, Proposed Implementation Guide on Financial Reporting Model Improvements—Subsidies

Dear Mr. Skelton:

America's Essential Hospitals appreciates the opportunity to submit comments on GASB's Proposed Implementation Guide's proposed treatment of Medicaid supplemental payments in proprietary fund statements of state and local governmental health care providers. Medicaid is a crucial payer for care provided by our members but is also complex and different from the commercial payer relationship. **We urge GASB to retract its mischaracterization of certain Medicaid payments as subsidies, rather than reimbursement for services provided to patients, to avoid confusion and potential negative impact for essential hospitals**.

America's Essential Hospitals is the leading association and champion for hospitals dedicated to high-quality care for all, including those who face social and financial barriers to care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health and access to health care. We support our more than 400 members with advocacy, policy development, research, education, and leadership development. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health, and other services. Supported by Essential Hospitals Institute, the association's research and education arm, essential hospitals innovate and adapt to lead all of health care toward better outcomes and value.

Essential hospitals are committed to serving people in all communities that need access to quality care. Although essential hospitals account for only 6% of acute-care hospitals nationwide, they provided 29% of the nation's charity care in 2023. About three-quarters of the patients our members serve are uninsured or enrolled in Medicaid or Medicare. In 2023, essential hospitals reported aggregate operating margins of -7.1%, but without Medicaid

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disproportionate share hospital (DSH) payments and other Medicaid supplemental payments, the margins for essential hospitals would have been -12.4%.[1]

Because Medicaid supplemental payments are an important component of essential hospital finances, it is important that they are characterized appropriately in financial statements as operating revenue related to patient care. Unfortunately, the question and answer (Q&A) 4.1 of the Proposed Implementation Guide demonstrates a fundamental misunderstanding of Medicaid supplemental payments and mischaracterizes these payments as subsidies rather than as payments for services provided to Medicaid beneficiaries. **We therefore urge GASB to withdraw Q&A 4.1.**

Below, we outline the statutory and regulatory structure governing these payments, as well as our insights from decades of experience working with governmental providers and the federal and state agencies that implement the Medicaid program, all of which demonstrate that these payments are payments for services.

Background on Exposure Draft Q&A 4.1

GASB's proposed guidance broadly and incorrectly characterizes Medicaid supplemental payments as "subsidies" rather than operating revenues under Statement No. 103, known as "GASB 103." GASB 103 defines "subsidies," in part, as "resources received from another party or fund (a) for which the proprietary fund does not provide goods and services to the other party or fund and (b) that…keep the proprietary fund's current or future fees and changes lower than they would be otherwise . . . . ." To provide clarification on the application of the standard, GASB proposes the following addition to its Q&A:

> 4.1. Q—A government provides supplemental payments to hospitals in addition to the standard contractual Medicaid base payments made on a fee-for-service or managed-care basis. In this circumstance, the supplemental payments **are not part of any contractual relationship between the patient and the government for healthcare coverage.** Do those supplemental payments received by a hospital that reports as a BTA or an enterprise fund meet the definition of subsidies in paragraph 14a of Statement 103?
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> A—Yes. In contrast to a circumstance in which there is **a contractual relationship between the patient and the government for healthcare coverage**, **the patient has no contractual relationship for healthcare coverage associated with supplemental payments**. Therefore, in this circumstance, the supplemental payments would meet the definition of subsidies because the payments **(a) are not related to the goods or services provided by the hospital** as part of the contractual relationship with the patient and (b) **allow the hospital's current or future charges to be lower than they would be otherwise**.

Each of the bolded statements above are inaccurate. In short, both the question and the answer appear to reflect a misunderstanding of the relationship between a Medicaid beneficiary, the

[1] Miu R, Kelly K, Nelb R. Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey. America's Essential Hospitals. November 2025. essentialdata.info. Accessed April 16, 2026.

state Medicaid agency, its managed care organizations (MCOs) (where applicable), and Medicaid providers. The proposed answer draws on this misunderstanding to make a broad conclusion that supplemental payments "are not related to goods or services provided by the hospital." Further consideration of the authorities that allow for these supplemental payments would reveal that they are the same authorities that allow for the base payments that GASB does not consider subsidies, and that there are only a few examples of non-service-based payments. Finally, we disagree with the assertion that hospitals change their charges for a service based on receipt of Medicaid supplemental payments that are intended merely to offset the otherwise unsustainably low base rates paid by most states. Upon further consideration, **we believe GASB would conclude, consistent with past practice and financial accounting standards board (FASB) principles, that supplemental payments do not meet the GASB 103 definition of subsidies.**

1. **Medicaid does not involve a contractual relationship between a patient and a government for health care coverage.**

The framing of the question and answer reflects a fundamental misunderstanding of the legal basis for Medicaid payments. Medicaid is not traditional insurance, but rather a joint federal-state entitlement program for eligible beneficiaries to receive covered services from identified providers. In some cases, the state Medicaid agency directly manages and pays for services delivered by providers to its beneficiaries, known as fee-for-service (FFS) Medicaid. In other cases, the state contracts with MCOs to deliver the Medicaid benefit and pay providers for services to Medicaid enrollees. There is not a contract between an individual and a payer as in traditional insurance. Nonetheless, there are binding arrangements under which providers agree to provide services to Medicaid beneficiaries and to receive payments—base and supplemental—for the services.

Each state has a formal agreement with the federal government, known as a Medicaid state plan, that outlines the state's Medicaid program and the expenditures for which the federal government will agree to provide matching funds. Among the program details outlined in the state plan are provider payment rules and the requirements that providers must meet to be eligible for payments. States must submit and receive federal approval for any changes to their Medicaid programs, including provider payment. Like a contract, the terms of the Medicaid state plan are binding on the state.

In states implementing their programs through managed care, the state enters contracts with MCOs The contract outlines the state plan requirements to be fulfilled by the MCOs, including the services to be provided, the per member rates to be paid by the state to the plan, and certain requirements on the plans in making payments to providers for services to plan enrollees.

There are also agreements between the state and any provider that wants to serve Medicaid, known as a provider agreement— under which the provider agrees to follow state Medicaid requirements and to accept state payment rates as consideration for those services. For states with managed care plans, plans also enter into network provider agreements with the subset of providers that will be part of their network. These agreements reflect the requirements in the contract between the state and the plan, as well as payment rates negotiated by the plan and provider, within the state's rules, for service for which the plan has contracted with the provider.

As an entitlement program, the relationship between the state Medicaid program and beneficiaries is relatively unique. Beneficiaries must apply to the state to be determined eligible for the state's Medicaid program pursuant to the state plan and the applicable scope of coverage. The individual might be assigned to a managed care plan for delivery of care. Once eligible and enrolled, the individual is entitled to eligible services and responsible for any cost-sharing defined in the state plan.

Note that in some cases, states obtain approval from the federal government to administer certain aspects of their Medicaid programs under demonstration authority, most typically under the authority provided in section 1115 of the Social Security Act, through which a state can receiver a waiver of certain federal requirements or the authority to make certain expenditures not otherwise permitted under Medicaid and receive federal matching funds. To implement such demonstrations, the federal government and state Medicaid agency will enter into a Special Terms and Conditions document defining the agreement between the agencies.

While not in the form of a typical commercial insurance contract between a plan and an individual**, the various agreements between the state and state-contracted MCOs result in providers agreeing to provide services to Medicaid beneficiaries in exchange for reimbursement at rates set pursuant to state rules designed within federal requirements. Both the base payments made to a provider for a service as well as any supplemental payment to increase the rate for that service are authorized under these same agreements**.

2. Medicaid supplemental payments are payments for services governed by these agreements.

The Medicaid statute requires states to develop payment policies that are consistent with the statutory principles of efficiency, economy, quality, and access, and also requires states to consider the situation of hospitals that serve a disproportionate number of low-income patients with special needs.[2] Consistent with these goals, many states have chosen to increase payments to a subset of hospitals that serve a safety-net role to reduce Medicaid shortfall, which is the gap between a hospital's cost of care and the payments that it receives. States also choose to make increased payments for services contingent on hospitals meeting specified quality goals or for services provided by hospitals that maintain access to essential services in their communities. These increased payments for services are often referred to by policymakers as supplemental payments to distinguish them from the base payment rates that are used as the starting point for calculating payments for Medicaid services.

The term supplemental payments has been used to refer to a variety of different types of payment adjustments that vary based on the state's Medicaid delivery system (FFS versus managed care), the service, and the state's selected payment methodology and frequency. The predominant payment types, each with their own federal authority, are state directed payments (SDPs), upper payment limit (UPL) payments, Medicaid DSH payments, and section 1115 demonstration payments.

Critical to GASB's analysis, **the federal Medicaid authorities under which states implement supplemental payments explicitly define these payment adjustments**

[2] §§ 1902(a)(30)(A) and 1902(a)(13)(A)(iv) of the Social Security Act

as reimbursement for specific services delivered to Medicaid beneficiaries by the eligible providers. Below we summarize each of these authorities in more detail.

State-Directed Payments.
SDPs are payments that states require Medicaid MCOs to make to an identified group of network providers for specific services delivered to their enrollees. SDPs typically take the form of a minimum fee schedule or a uniform dollar or percentage increase over the MCO's base rate for a particular service, but they can also include incentive payments for the achievement of quality goals.

Federal regulations specifically require that SDPs "[b]e based on the utilization and delivery of services."[3] The state uses the claims reported by Medicaid managed care plans to determine the SDPs that should be made to eligible providers. Where SDPs are paid in lump sums separate from base payments, the SDPs are made for the same services for which the providers received the base payments. Other SDPs may be paid as an adjustment to a base rate before any payment is made for the service.

As additional evidence that SDPs are treated under Medicaid rules as payment for underlying service, to receive federal approval, states must demonstrate that the base rate paid for the eligible service plus the SDP rate for the service result in a total payment rate for the service that does not exceed the reference limit (e.g., Medicare or commercial rates).

Consistent with federal regulations at 42 C.F.R. § 438.6, SDPs are required to be included in the contract between the state and MCO and are also covered in the contracts between the plans and their network providers; the same contracts that define base payment rates for the services.

Upper Payment Limit (UPL) Payments.
Within the Medicaid FFS program, state base rates and supplemental payments are subject to upper payment limits. Both base rates and supplemental payments, which are commonly known as UPL payments, must be specified in the section of the Medicaid state plan that governs reimbursement for the particular service type (e.g. inpatient hospital services, outpatient hospital services, practitioner services) and are subject to federal regulations at 42 C.F.R. Part 447, titled "Payments for Services". Pursuant to state design in its Medicaid state plan, UPL supplemental payments can be paid as adjustments to base payments by claim or separately from base payments, typically on a lump sum basis. However, like base payments, they are paid according to a payment methodology for a particular service outlined in the Medicaid state plan.

Medicaid Disproportionate Share Hospital (DSH) Payments.
Medicaid DSH is authorized under federal statute as an adjustment in payment for Medicaid inpatient hospital services furnished by hospitals that serve a disproportionate share of low-income payments. Each state must specify its payment methodology for DSH in its Medicaid state plan. Like UPL payments, DSH is typically paid on a lump sum basis; however, these payments are specifically for hospital services, as opposed to other provider types. Hospitals may receive DSH payments up to a hospital-specific limit that accounts for hospitals' cost of providing inpatient hospital and outpatient hospital services to Medicaid patients and the uninsured. States must determine these limits, which are ultimately subject to independent audits, using a combination of claims data from their Medicaid Management Information System (MMIS) and hospital cost reports and backup data—again reinforcing the tie to provision of services to Medicaid beneficiaries.

[3] 42 C.F.R. § 438.6(c)(2)(A).

Section 1115 Demonstration Payments.
Some states have demonstrations that include authorization for certain provider payments. The special terms and conditions must define the expenditure, particularly where the payment is newly created and made eligible for federal matching funds by the demonstration. The most common waiver-based payments, such as uncompensated care pool payments, are explicitly authorized as payments for the unreimbursed costs of certain services provided to certain individuals. While a more nuanced review of the expenditure authority for any particular payment might be warranted, these demonstration payments nonetheless must be made in exchange for delivery of a service by the particular provider, subject to rates and methodologies to which the provider, the state, and the federal government have agreed. The terms of the waiver are binding, as they would be under a contract.

In many ways, Medicaid supplemental payments are no different than Medicare supplemental payments. This includes, for example, Medicare DSH payments. In contrast to Medicaid DSH payments, which are generally paid on a lump sum basis, Medicare DSH payments are paid as an adjustment to a hospital's inpatient hospital payments. However, whether the payments are made on a lump sum or claims adjustment basis, both Medicaid DSH and Medicare DSH are types of supplemental payments made for hospital services. There is no legal or contractual basis for treating Medicaid and Medicare supplemental payments differently, as GASB's guidance would do.

3. Medicaid supplemental payments do not meet the definition of "subsidies" under GASB 103.

GASB 103 defines "subsidies", in part, as "Resources received from another party or fund . . . for which the proprietary fund does not provide goods and services to the other party or fund . . . . ." As discussed above, Medicaid supplemental payments are payments for services to which health care providers are entitled pursuant to the state Medicaid plan, as referenced in the provider agreement, the MCO contract, or demonstration special terms and conditions outlining rules agreed to under the provider agreement. **Providers must furnish the services for which the supplemental payments are available to receive the payments. Thus, these payments do not appear to meet the first part of the definition of subsidy.**

While it is thus unnecessary to address the second part of the definition, we also question GASB's assertion that supplemental payments "allow the hospital's current or future charges to be lower than they would be otherwise." As outlined above, Medicaid payment rates are defined by states within federal regulatory requirements. Providers have minimal-to-no discretion in pricing Medicaid services because the FFS rates are set administratively in the state plan and managed care payment rates are constrained by health plan capitation payments that are developed based on state plan rates and SDPs that are set by the state.

More importantly, supplemental payments do not affect the underlying cost of care for the services that they provide to Medicaid patients. **Hospitals cannot afford to lower the price of a service where they are receiving reimbursement that likely does not cover the cost of that service.** Essential hospitals have small if any operating margin even with supplemental support due to their provision of uncompensated care across a range of

needy patients. In 2023, essential hospitals reported a $9.8 billion Medicaid shortfall, even after accounting for supplemental payments.[4]

4. The guidance is inconsistent with our understanding of historical and current practice under GASB and FASB.

The draft guidance is a departure from how such payments have been treated under GASB and FASB standards, which will result in a separate set of standards applicable to governmental providers. Yet, the payment authorities and Medicaid agreements implementing provider payment rules are the same whether the payments are for governmental or private providers. **If GASB moves forward with its proposed guidance, governmental providers will be subject to a different set of rules than non-profit and other non-governmental providers. This differential treatment will reduce the ability to compare financial data across governmental and private health systems and create challenges when evaluating entities across reporting frameworks.**

5. GASB should withdraw Q&A 4.1 to avoid potentially significant negative impact for governmental providers.

Most critically, treating Medicaid supplemental payments to governmental providers as subsidies for accounting purposes has the potential to negatively impact governmental providers' overall financing position. The change will result in reclassifying what would have been operating revenues as subsidies, reducing operating revenues. While specific impact might vary by financial institution, the change has the potential to affect governmental providers' existing covenants with lenders, which typically include financial ratio requirements. While it may vary by rating agency, the change could also affect their ability to obtain financing moving forward. Because of these potential negative effects, **we urge GASB to withdraw Q&A 4.1.**

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America's Essential Hospitals appreciates the opportunity to submit these comments and welcomes the opportunity for engagement with GASB on this issue. If you have questions, please contact Director of Policy Robert Nelb, at 202-585-0127 or rnelb@essentialhospitals.org.

Sincerely,

Jennifer DeCubellis
President and CEO

[4] Miu R, Kelly K, Nelb R. Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey. America's Essential Hospitals. November 2025. essentialdata.info. Accessed April 16, 2026.