HEALTHCARE POLICY RESEARCH

Follow the Money

How West Virginia Finances Its Hospitals

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Executive Summary

West Virginia's Medicaid hospital financing comes down to one daunting fact: the state has built one of the most federally dependent hospital financing systems in the country, and Washington has initiated a new plan to pull some of it back.

74.25%
Federal match rate, among the highest in the nation

6%
Stacked hospital tax on inpatient receipts, at the federal cap

$1.34B
State directed payments authorized for FY2025

$5.5B
Annual cost of West Virginia's Medicaid program

This paper explains how the system operates, identifies its beneficiaries, and examines why it leaves the state dangerously exposed as federal policy moves against it.

A financing system this dependent is only as stable as the federal government's willingness to keep paying, which is now tightening. This exposure is why the issue cannot wait.

West Virginia's Medicaid match rate is 74.25%, one of the highest nationally. For every dollar the state spends, the federal government contributes about $2.88, resulting in approximately $3.88 in total spending per state dollar. This structure strongly incentivizes the state to maximize its spending to draw additional federal funds, rather than to economize.

West Virginia uses a provider tax mechanism to generate its share of financial contribution. The state taxes hospital inpatient revenue through several assessments totaling about 6%, counts this as the state Medicaid contribution, secures the federal match, and returns the funds—money received from the tax and federal government—to hospitals as increased Medicaid payments. Hospitals can receive more in return than their contribution, with federal taxpayers covering the difference.

A second mechanism, state-directed payments, does the same thing within managed care and now runs roughly $1.34 billion annually in West Virginia. Federal auditors have determined that the federal share of these payments exceeds the standard match rate, shifting additional costs to the federal government.

This system has two main consequences. First, West Virginia hospitals receive significantly more Medicaid funding than base payment rates indicate, challenging claims of financial strain from government payers. Much of the gap between base rates and hospital costs is addressed through supplemental payments. Second, these funds are concentrated in the largest hospital systems, which have the most market power and influence over policy.

These financing tools are neither unique to West Virginia nor illegal; they are a logical response to federal incentives. However, they have made the state's hospital sector and a significant portion of its budget dangerously reliant on a federal financing arrangement that is now facing restrictions. The 2025 federal reconciliation law, the One Big Beautiful Bill Act, freezes provider taxes, reduces the hospital tax safe harbor to 3.5% for expansion states like West Virginia, and caps state-directed payments at Medicare rates. These are the first substantial rule changes on a system the state has expanded over several years, and they run directly at the two mechanisms this paper describes as the core of West Virginia hospital financing. The safe harbor falls to 3.5%, below West Virginia's stacked hospital taxes of about 6%, so the financing cannot continue at its present scale.

Policymakers and health leaders must face what this means: West Virginia leans on federal matching dollars more than almost any other state. As federal policy shifts, West Virginia will also feel it more than most other states. Some hospitals will become exposed, including facilities that are the only hospital in a multi-county region. When the financing contracts, more communities will ask if they are at risk of loss. Underneath the fiscal threat is the state's anti-competitive, deformed healthcare market: a system built to chase federal money that props up the biggest players, rewards inefficiency, and squeezes out competition. That means higher costs and fewer choices for patients, with those best at gaming the system coming out ahead as taxpayers foot the bill.

This is a call for responsible planning; a reckoning West Virginia cannot avoid. The answer is not to defend the current flow of federal money or scramble for quick fixes. Instead, West Virginia must build a hospital sector in which payments reflect care delivered, patients have real choices among competing providers, and the state stops using hospital bills as a lever for federal dollars. It is time to reform this scenario: not to keep the machinery running at all costs, but to plan a deliberate strategy focused on patients before Washington forces a chaotic one. Medicaid is the clearest opportunity. Done now, on our own terms, it can be the first major step toward a system that does not depend on the federal spigot or prioritize institutional interests over West Virginia patients.

Introduction

For decades, West Virginians have wanted health care that is affordable and easy to reach. What the state built instead is a payment system that mainly protects the hospitals already in place, and the way that system is explained to the public keeps its workings hard to see.

When residents, providers, or researchers push to remove barriers to competition, such as the state's Certificate of Need (CON) laws, hospital trade groups and lobbyists respond that hospitals are already under financial strain. They warn that letting new facilities or services open would put community care at risk.

But hospital lobbies omit discussion of the complexity of their financial structures and the extent to which patients, as taxpayers, fund institutions that prioritize financial outcomes over access and quality of care.

Hospitals in West Virginia make a specific claim: "75% of hospital payments come from government programs that pay below the cost of care. Removing CON could lead to unintended consequences, such as an influx of for-profit providers focused on high-paying patients while essential services suffer.[1]" The West Virginia Hospital Association says this "payer mix" is 75% government, counting Medicare, Medicaid, and PEIA, the state's employee insurance agency.

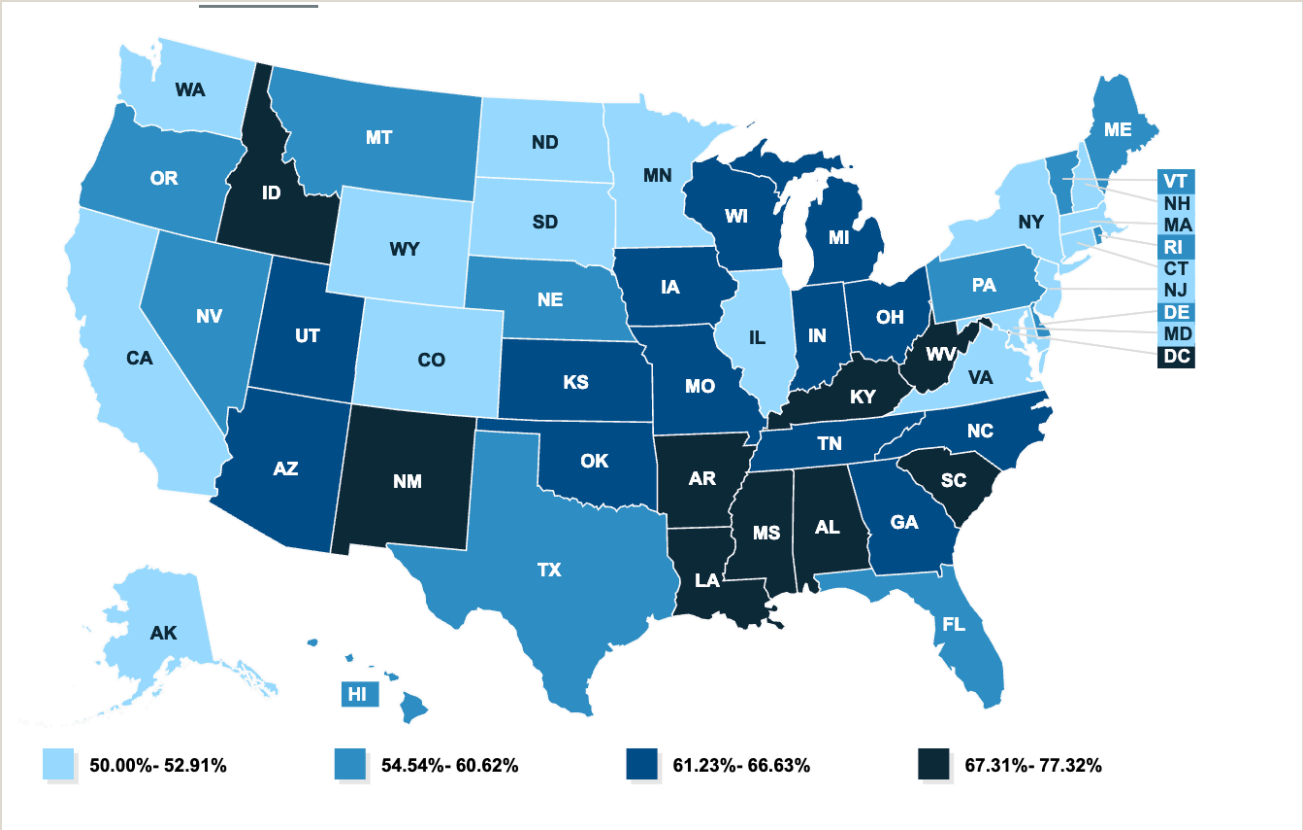
Yet more than 75% of West Virginia's hospitals are non-profits, and research shows that these same hospitals provide less than 1% of net patient revenue as charity care.[2] That raises a fair question about whether they are meeting their non-profit mission, and whether the large tax breaks and regulatory protection they receive are justified. Their claim that 75% of payments come from government programs also deserves a closer look. State law now sets a minimum payment of 110% of Medicare[3] for PEIA-covered hospital services, as a floor, with no corresponding ceiling. This allows them to keep more state money while still describing themselves as financially strained.

West Virginia's Medicaid program costs about $5.5 billion a year,[4] and the state's largest hospital systems are its main beneficiaries. The way Medicaid is financed sends far more public money to these big systems than their basic claims would suggest. Recent federal law, passed as the One Big Beautiful Bill Act, has changed this picture. Understanding how the financing works now matters, because it gives policymakers and patients a chance to push for a system built around West Virginia residents rather than trade interests.

This paper lays out how that financing works, how it developed, who benefits most, and what the recent federal changes mean for West Virginia patients and policymakers.

Medicaid Claims and Payment Structure

West Virginia's Medicaid program covers approximately 504,000 enrollees—the traditional population covering roughly 344,000 individuals and expansion population of 160,000[5]—with a Federal Medical Assistance Percentage (FMAP) of 74.25% (effective FY2027) and a multiplier of 2.88.[6] That FMAP is among the highest in the country, which reflects the state's low income per person. In simple terms, for every $1 the state spends on qualifying Medicaid services, the federal government adds about $2.88, for a total of about $3.88.



Federal Medical Assistance Percentage (FMAP) by state. West Virginia sits in the highest band. Source: Kaiser Family Foundation.

Medicaid pays hospitals through two main channels: fee-for-service (FFS) and managed care organizations (MCOs). States may also operate hybrid arrangements in which both coexist, which West Virginia does.

Fee-for-Service Payments

Under fee-for-service, a hospital bills the state's Medicaid agency for each service it provides to a patient. The state pays a set rate for each service, listed in the state's Medicaid plan and approved by the federal government. Payment comes after the care is delivered, based on what was done and billed. This is a **retrospective payment model**: when payment occurs *after* the service is rendered, based on utilization and the claim.

Fee-for-service payments are direct: the hospital documents the services, sends the bill to the state, and is paid against the fee schedule. States have wide discretion to set these rates, as long as the rates are high enough to keep care available.[7] In practice, fee-for-service Medicaid rates have been considered below the cost of care for many kinds of hospital services.[8]

Patients with the highest costs, including people with chronic illness, behavioral health needs, or long-term care needs, have tended to remain in fee-for-service billing rather than move into managed care. Setting an actuarially sound payment[9] (a rate expected to cover the cost of care) is harder for these groups, and managed care plans are reluctant to take on that financial risk, which is why fee-for-service remains in states that have expanded managed care.

Managed Care Organization Payments

Under managed care, the state's Medicaid agency pays a private health plan, the MCO, a fixed monthly amount for each beneficiary. This is called **a capitation payment**, and it is set in advance: the state pays a flat per-member, per-month rate, and the plan takes on the financial risk for whatever care that member actually uses. The MCO then contracts with hospitals and other providers, negotiates rates, and is responsible for the cost of care.

From a hospital's point of view, the money now comes from the health plan rather than directly from the state. The MCO sets its payment rates through contracts, subject to federal rules. At times, MCO-negotiated rates have differed from the state's fee-for-service rates, which can mean different payment levels for patients seen at the same hospital.

Federal managed care rules state that capitation rates must be actuarially sound, meaning they are expected, on average, to cover the cost of care for enrollees.[10] States and their actuaries meet this requirement through a yearly rate-setting process, and they submit the rates for federal approval.[11]

West Virginia's Hybrid System

West Virginia operates a hybrid system in which fee-for-service and managed care payments coexist. Managed care enrollment has grown in West Virginia, with Medicaid managed care organizations serving as the primary coverage mechanism for most enrollees; fee-for-service remains important for certain populations and services, especially long-term services and supports. Whether most total Medicaid dollars still flow through fee-for-service depends on the year and the spending measure used. West Virginia's managed care materials indicate that most members are enrolled in managed care, while fee-for-service remains in use for members receiving long-term services and supports and other carved-out services.[12]

This creates a contradiction: more people are in managed care, yet a large share of dollars still moves through fee-for-service or fee-for-service-congruent arrangements. This is because the most expensive populations are often kept outside managed care and some services are carved out of capitation. States can also use state directed payments and other extra payments inside or alongside managed care to send money to specific providers, which makes the money much harder to trace than enrollment numbers alone suggest.[13]

The hybrid structure also reflects policy choices. States keep fee-for-service for groups or services where managed care oversight is less developed, and they use extra payment tools, such as disproportionate share hospital payments and upper payment limit arrangements, to support providers outside standard capitation.[14]

KEY TAKEAWAYS

- West Virginia runs a hybrid Medicaid program: most enrollees are in managed care, but a large share of the dollars still moves through fee-for-service and fee-for-service-like arrangements.
- The most expensive populations are kept outside managed care, and extra payments are layered inside it, so enrollment counts do not show where the money goes.

Federal Medicaid Matching Funds (FMAP)

How Federal Matching Works

The Federal Medical Assistance Percentage (FMAP) is the rate at which the federal government matches what a state spends on Medicaid. For every dollar a state spends on qualifying services, the federal government adds an amount set by the FMAP formula. The formula is based on a state's income per person compared with the national average, so lower-income states get a higher match. FMAP runs from a floor of 50% for wealthier states to a ceiling of 83% for the lowest-income states, with enhanced rates available for certain populations and services.

If a state spends $1.00 on Medicaid and its FMAP is 74.25%, the federal government adds about $2.88, for a total of about $3.88. Each state dollar generates multiple dollars in total program spending. This creates a highly leveraged financing environment in which each dollar of state Medicaid spending generates multiple dollars for total program resources.

West Virginia's FMAP

West Virginia's FMAP of 74.25%—among the highest in the nation—reflects low per-capita income relative to the national average. A 74.25% FMAP means that for every dollar the state spends on qualifying Medicaid spending, the federal government contributes $2.88. The state's share represents roughly $0.26 of every dollar of total Medicaid spending. That 74.25% rate applies to the traditional Medicaid population, while the expansion population of roughly 160,000 enrollees draw a higher match of 90% under the Affordable Care Act, so the state's blended federal share across all enrollees runs to roughly 79%.

This high match provides West Virginia a strong incentive to grow its Medicaid spending. Each extra dollar the state spends on Medicaid produces about $3.88 in total program spending, with the federal government covering 74.25 cents of every dollar of that total. The result is financial pressure to find financing tools that can increase the state's share while keeping the cost to the state's general budget low.

FMAP Example: If West Virginia spends $1 of qualifying Medicaid expenditure: Federal contribution = $2.88. Total program expenditure = $3.88. For every $100 million in state spending, the program generates $388 million in total Medicaid resources.

In its 2023 review of state directed payments (SDPs), the U.S. Government Accountability Office (GAO) found that West Virginia's SDP program had a reported federal share of 83% and an actual federal share of 84%, above the state's traditional FMAP of about 74%. This elevated share reflects two things: many directed payments cover services to expansion enrollees, who draw a 90% federal match, and provider-tax financing shifts additional costs onto federal taxpayers beyond the ordinary match. In dollars, the West Virginia SDP program GAO reviewed totaled $401 million, of which only $66 million came from non-federal sources and $335 million was federally funded.[15]

State	Total number of directed payments	Total amount of directed payments	Nonfederal share from all sources	Nonfederal share from providers and local governments[a]	Net payment	Federal share	Federal share of total directed payments (pct)	Federal share of net directed payments (pct)
IN	1	407,900,000	65,300,000	52,240,000	355,660,000	342,600,000	84	96
KS	1	30,000,000	11,250,000	0	30,000,000	18,750,000	63	63
KY	3	1,194,524,634	238,140,386	188,618,749	1,005,905,885	956,384,248	80	95
MD	1	10,066,667	3,566,667	2,675,000	7,391,667	6,500,000	65	88
MI	4	2,510,616,407	605,489,471	478,404,380	2,032,212,027	1,905,126,937	76	94
MN	1	220,546,300	74,412,100	55,809,075	164,737,225	146,134,200	66	89
MO	1	42,026,933	14,284,955	10,713,716	31,313,217	27,741,979	66	89
MS	1	38,783,002	7,309,626	5,482,220	33,300,783	31,473,376	81	95
NC	10	747,867,661	214,014,644	67,517,411	680,350,250	533,853,017	71	78
NE	1	4,100,000	1,680,876	1,260,657	2,839,343	2,419,124	59	85
NH	4	90,116,817	32,193,431	0	90,116,817	57,923,386	64	64
NJ	8	696,889,804	265,314,126	196,285,595	500,604,210	431,575,678	62	86
NM	12	684,000,000	148,590,000	56,620,000	627,380,000	535,510,000	78	85
NV	3	132,648,563	48,319,153	35,857,120	96,791,443	84,329,410	64	87
NY	7	803,567,323	326,957,080	0	803,567,323	476,620,241	59	59
OH	3	1,577,529,333	435,785,467	332,850,000	1,244,679,333	1,141,743,867	72	92
OR	3	737,741,880	189,505,212	151,359,469	586,382,411	548,236,668	74	93
PA	9	831,700,000	224,698,000	32,240,000	799,460,000	607,002,000	73	76
RI	13	1,236,114,771	379,147,394	0	1,236,114,771	856,967,377	69	69
SC	1	48,000,000	14,054,400	0	48,000,000	33,945,600	71	71
TN	9	4,249,548,302	1,402,385,888	267,576,268	3,981,972,034	2,843,829,081	67	71
TX	4	6,595,742,001	2,456,142,411	1,842,106,808	4,753,635,193	4,139,599,590	63	87
UT	7	328,346,169	103,844,159	78,865,146	249,481,023	224,502,234	68	90
VA	5	2,400,440,561	715,830,081	511,300,000	1,889,140,561	1,683,610,481	70	89
VT	8	478,079,012	200,274,073	0	478,079,012	277,804,939	58	58
WA	4	195,847,000	56,943,000	18,750,000	177,097,000	138,904,000	71	78
WI	7	281,180,000	112,028,816	0	281,180,000	169,151,185	60	60
WV	2	401,304,086	66,492,445	4,804,039	396,500,047	334,811,641	83	84
Total	**169**	**$38,493,020,959**	**$12,267,513,234**	**$6,536,884,876**	**$31,956,136,083**	**$26,221,036,884**	**68%**	**82%**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-106202

Notes: Percentages rounded to the nearest whole number. Amounts of state directed payments are based on the estimates states included in their directed payment applications to CMS approved as of August 26, 2022. Directed payments that do not require CMS approval prior to implementation and directed payment applications that did not include state spending estimates are not included. In some cases, states' estimates of the nonfederal share from all sources and the federal share did not equal states' estimates for the total amount of directed payments. Since these were estimates, we did not

State directed payments by state, with reported and effective federal shares. West Virginia's $401 million program carries an 83% federal share, above the traditional 74.25% FMAP; expansion services draw a higher, 90% match. Source: GAO-24-106202, p. 45.

Why High-FMAP States Are Incentivized by Financing Mechanisms

This matching arrangement creates an uneven set of incentives. In a state with a low FMAP, say 50%, each dollar of provider tax revenue used as the state's match brings in one more federal dollar, a 2-to-1 return. In West Virginia, that same dollar brings in $2.88 in federal funds, a 3.88-to-1 return. Therefore, high-FMAP states have a stronger motive to find means to produce the state's share without using general tax revenue. This is a significant contributor to why provider taxes and extra payment programs are more common in high-FMAP states, and why West Virginia has built so much financing around them.

KEY TAKEAWAYS

- At a 74.25% match, every state dollar draws $2.88 in federal funds, for $3.88 in total spending.
- The higher the match, the stronger the incentive to find a way to produce the state's share without using general tax revenue. That is why provider taxes and supplemental payment programs cluster in high-FMAP states.

Provider Tax

What is a Provider Tax?

A provider tax is a charge a state places on health care providers, usually a percentage of gross revenue from certain services. Federal Medicaid law allows this under rules covering how it is structured, how broadly it applies, and scope. Provider taxes are widely used across state Medicaid programs.

West Virginia stacks several assessments on hospital inpatient receipts—a 2.5% broad-based tax (§11-27-9), a 3.37% directed-payment assessment (§11-27-38), and a 0.13% practitioner assessment (§11-27-39)—together about 6%, the federal safe-harbor maximum.[16]

Despite the name, a provider tax does not work like a traditional tax. Here, the providers, mainly hospital systems, help design the tax, working with state agencies so it produces an acceptable return through higher Medicaid payments. In effect, the state collects the tax, at an agreed upon rate, uses it to draw down federal matching funds, and returns the money to providers as higher Medicaid payments.

Why Do States Use Provider Taxes?

For a state budget, provider taxes produce the state's share of Medicaid spending without tapping into the general fund. States must pay part of every Medicaid cost, and a provider tax allows them to cover that share with money from providers instead of from appropriations.

From a provider's perspective, the logic is this: hospitals pay the tax and usually receive more in higher Medicaid payments back than they paid in. The tax is not a net cost because the matching payment increases are set up to offset it. The gain comes from the federal match that the tax unlocks; the federal government, not the state, funds the amount returned above what providers paid. So, providers have reason to support taxing themselves, because of how the matching system is built—they are getting money in return.

Federal Regulation

Federal law imposes three rules on provider taxes to keep states from using them purely as a financing scheme:

- Broad-based: the tax must apply to all providers in a defined class. A state cannot tax only the Medicaid-heavy providers and exempt the rest, which would make the tax self-funding at federal taxpayers' expense.
- Uniform: the tax must be the same for all providers in the class.
- No hold-harmless: the state cannot promise that providers will get back the full cost of the tax through higher Medicaid payments. There are three tests for determining this. The "guarantee test" is triggered when the tax rate goes above 6% of net patient revenue.

The Secretary of Health and Human Services can waive[17] the first two rules if a tax is "generally redistributive," meaning the tax burden falls more heavily on providers with smaller Medicaid shares and the tax amount is not tied directly to Medicaid payments. West Virginia's broad-based 2.5% tax needs no such waiver, but its directed payment assessment relies on one.[18]

Each of West Virginia's individual assessments falls below the 6% guarantee-test threshold, though stacked they sit near the 6% ceiling.

How the Provider Tax Moves: Step-by-Step

1. Hospitals pay the provider tax to the state, based on share of gross inpatient receipts. In West Virginia, the directed-payment assessment (3.37%) on a hospital with $500 million in gross inpatient revenue is about $16.85 million.

2. The state puts revenue into a Medicaid fund and treats it as state Medicaid spending, or the non-federal share. This is the point where the tax money becomes the state's share and triggers federal matching.
3. The federal government matches the state expenditure at the FMAP rate: 74.25%. For every $1 of provider tax revenue used as state share, the federal government provides $2.88.
4. This combined pool of tax money and federal match goes back to hospitals as Medicaid payments. These can be base rate increases, supplemental payments, or State Directed Payments.
5. Hospitals can get back more than they paid in tax, partly funded by federal matching.

Provider Tax Recycling Example:

The directed-payment assessment (3.37%) on $1 billion in gross inpatient receipts generates $33.7 million in state share. At 74.25% FMAP, the federal government contributes approximately $97.1 million. Total redistributable pool: approximately $130.8 million. Hospitals receive back approximately $130.8 million, well above the $33.7 million they paid.

Federal taxpayers fund the $97.1 million increment.

KEY TAKEAWAYS

- The state's directed-payment assessment (3.37%) is counted as its Medicaid share, draws the federal match, and returns the pool to hospitals.
- On $1 billion in inpatient receipts, that yields $33.7 million; the pool returns roughly $130.8 million. Federal taxpayers fund the $97.1 million difference.

Supplemental Medicaid Payments

Supplemental payments are lump-sum Medicaid payments paid to hospitals, and other providers, in addition to the regular base per-service payment for claims. They are a separate tier of hospital payment within Medicaid. Rather than paying for patient encounters, they

reflect policy choices about how much providers should be paid in total under Medicaid. As of FY2023, 53% of all Medicaid payments to inpatient and outpatient hospitals outside of managed care were supplemental, up more than 10 percentage points since FY2011.[19]

Nationwide, hospitals receive an overwhelming majority of supplemental payment money. About 84%, or $47.8 billion, of the $57.1 billion in total supplemental payments in FY2023 went to inpatient and outpatient hospital services.[20] That concentration reflects the political weight of hospital systems in Medicaid policy and the way the financing system is built to send these payments to hospitals.

Upper Payment Limit (UPL) Payments

Under an upper payment limit (UPL) arrangement, a state can increase the total Medicaid it pays a "class" of providers up to a ceiling, beyond the base rates. For hospitals, that ceiling is the amount Medicare would have paid for the same services. The limit applies as a whole: total payments across all hospitals in the class must remain below the ceiling, but an individual hospital's payments can go above Medicare rates.

Because the limit is set at a class level, states have room to move money around. A state can pay some hospitals below Medicare rates per claim while making large UPL payments to others, as long as the class total stays under the ceiling. In the past, states used this flexibility to steer extra payments to politically favored facilities.[21] In FY2022, the federal government spent $15.8 billion in UPL payments.[22]

Notably, UPL applies only to fee-for-service Medicaid payments; it does not apply to money flowing through managed care. That is one reason state directed payments, which work within managed care, became important as states shifted from the fee-for-service model to managed care.

Disproportionate Share Hospital (DSH) Payments

Disproportionate share hospital (DSH) payments are supplemental payments that go to hospitals that, as the name implies, treat a disproportionate share of low-income and uninsured patients. DSH payments are the only Medicaid supplemental payments that are explicitly authorized to support uncompensated care. Each state gets a yearly DSH amount and decides how to split it among qualifying hospitals. (e.g., A 2012 GAO study found 41 states made Disproportionate Share Hospital (DSH) payments to 717 hospitals that exceeded the hospital's cost of uncompensated care, and 9 states did not accurately calculate uncompensated care

cost of 206 hospitals in those states. 39 states also made non-DSH payments to 505 DSH hospitals that, with Medicaid payments, exceeded their total cost of providing Medicaid care by $2.7 billion.)

Unlike most Medicaid payments, DSH amounts are capped at the federal level. In 1993, the Omnibus Budget Reconciliation Act locked federal allotments at 1992 levels, with yearly inflation adjustments.[23] Because that is written into federal law, states that had built the most aggressive supplemental payment programs by 1992 kept a larger share of federal DSH money. That has created a lasting structural imbalance. West Virginia's DSH allotment is fairly small compared with states like New York and California.

Paragon Health Institute research found that West Virginia's DSH per uninsured person ($667) ran well above the national average ($432), while its DSH per low-income person ($143) fell slightly below the $155 average.[24]

Other Supplemental Mechanisms

Other Supplemental Mechanisms

- Uncompensated Care Pools (UCPs): run under Section 1115 waivers, meant to pay providers for the cost of unreimbursed care
- Delivery System Reform Incentive Payments (DSRIPs): meant to fund changes in how care is delivered, though some states have used them as additional supplemental payments
- Graduate Medical Education (GME): payments that help teaching hospitals cover the cost of training physicians

Nationally, uncompensated care pools totaled about $10 billion in FY2022.[25] These pools have been criticized for weak federal oversight,[26] including by the HHS Inspector General in Tennessee, over documented failure and overpayment risk.[27]

KEY TAKEAWAYS

- Supplemental payments are a separate tier of hospital payment, set by policy rather than by patient encounters.
- They are heavily concentrated in hospitals: 84% of the $57.1 billion paid nationally in FY2023 went to inpatient and outpatient hospital services.

State Directed Payments (SDPs)

Origin and Legal Authority

State directed payments (SDPs) are authorized under 42 C.F.R. § 438.6, which is the rule, formalized in 2016 under the Centers for Medicare & Medicaid Services (CMS), covering contracts with Medicaid managed care plans. The rule phased out "pass-through payments," where states had inflated MCO capitation rates and told the MCOs to pass the extra money to specific providers without formal rules, and authorized a replacement that allows states to direct MCO payments to provider, subject to specific criteria.

SDPs are the managed care version of the supplemental payments states had long made under fee-for-service. As states moved Medicaid enrollment into managed care, they lost the fee-for-service supplemental tools, because DSH and UPL payments do not apply in managed care, putting financial pressure on hospitals that had relied on them. SDPs were developed in an effort to fill that gap, giving states a way to increase hospital payments within the managed care model.

How SDPs Work

SDPs involve three actors: the state's Medicaid agency, the managed care plan, and the hospitals. The state designs the SDP program, setting (1) which providers get directed payments, (2) the amount or formula, (3) which services the payments cover, and (4) the timing and conditions. The SDP is built into the MCO's capitation rate, and the plan is then required by contract to pass those amounts through to providers.

This preserves the formal shape of managed care, with the MCO sitting as an intermediary, between the state and the hospitals, while letting the state decide how much hospitals are paid. Minimum fee schedule SDPs act as price floors inside managed care contracts, requiring MCOs to pay specific hospitals at least a specified amount regardless of what they may have negotiated.

Federal rules recognize three broad types of state directed payments:

- Minimum or maximum fee schedules, which set floors or ceilings on what MCOs pay providers. These require plans to pay at least the fee-for-service Medicaid rate or a specified Medicare rate.

- Uniform rate increases, which require plans to pay a set dollar amount or percentage above base rates. These are the managed care equivalent of fee-for-service supplemental payments and are the most common SDP type nationwide, making up about 74% of all SDP spending in 2024.[28]
- Value-based payments, which require plans to use payment models tied to performance.

West Virginia's SDP Program

West Virginia's FY2025 State Directed Payments were authorized at $1.34 billion.[29]

In the GAO's review of approved SDPs, West Virginia's $401 million in directed payments carried an effective federal share of 83%, above the state's roughly 74% FMAP, partly because expansion services draw a 90% match, and partly because provider-tax financing shifts cost onto federal taxpayers.[30]

SDPs have grown since they were first authorized, passing $110 billion in 2024, more than four times the 2020 level.[31] West Virginia has followed, helped by its high FMAP and by provider tax revenue to fund the state share.

MCO Pass-Through and Accountability

MCOs are required to pass SDP money to the designated providers on a per-service basis, tied to the delivery and utilization of Medicaid services. But oversight and auditing of SDP compliance is limited. Federal rules require states to report payments financed through intergovernmental transfers (IGTs) at the provider level, but they do not require the same provider-level reporting for SDP payments financed by provider taxes. This gap makes it difficult for researchers, legislators, and auditors to confirm where money actually goes.

Medicaid and CHIP Payment and Access Commission's (MACPAC) review of SDP programs found that as of 2024, 87% of uniform-rate-increase SDP spending was paid through "separate payment terms" that sit outside standard capitation accounting, meaning they were added on top of the base rate rather than built into it.[32] A 2024 CMS rule requires directed-payment amounts to be incorporated into base capitation rates beginning with the first rating period on or after July 9, 2027, with existing arrangements generally phased down starting in 2028.[33]

KEY TAKEAWAYS

- West Virginia's FY2025 directed payments were authorized at $1.34 billion, and the effective federal share of the program GAO reviewed ran above the state's FMAP.
- Provider-level reporting is not required for SDPs financed by provider taxes, so where the money lands is hard to verify.

How Provider Taxes and SDPs Work Together

Provider taxes and state directed payments do not work in isolation. Rather, they form a single financing system where each reinforces the other. To understand West Virginia's Medicaid financing for hospitals, consider how they connect:

1. Hospitals pay the provider tax, about 6% of gross inpatient receipts (stacked), which produces state-share revenue.
2. The state counts that revenue as Medicaid spending and draws federal matching funds at the 74.25% FMAP rate.
3. The combined pool is built into MCO capitation rates as SDP funding.
4. MCOs are required to send those SDP amounts to hospitals.
5. Hospitals get back, through SDPs, more than they paid in provider tax.

THE FINANCING LOOP

01 Hospitals pay the tax
≈6% of gross inpatient receipts (stacked)

02 The state counts it as its own share
The revenue becomes the non-federal share of Medicaid spending

03 Federal matching applies
A 74.25% FMAP adds $2.88 for every state dollar

04 The pool enters capitation
The combined amount is built into MCO rates as SDP funding

05 Hospitals are paid back
Through SDPs, more than they paid in provider tax

This creates a financial loop. Hospitals contribute to the state through the tax, the federal government amplifies the contribution through matching, and the amplified returns are sent to hospitals through the SDP mechanism. The financial beneficiary of this loop is the hospital sector, with the increment funded primarily by federal taxpayers.

How this Raises Total Hospital Payments

This interaction between provider taxes and SDPs pushes total hospital payments above what base Medicaid rates would produce. Without provider taxes and SDPs, a West Virginia hospital's Medicaid revenue would come only from fee-for-service or managed care rates, which can be below hospital costs. Supplemental payments add a monetary layer that can shrink or close the gap between Medicaid rates and hospital costs.

Among large SDP programs covering inpatient, outpatient, and behavioral health services, Barclays found that at least 24 states set their SDP payment levels as a share of average commercial rates (ACRs), the rates commercial insurers pay.[34] The average level was 85% of those commercial rates for programs in fiscal years 2024 and 2025. A 2024 CMS rule made

clear that SDPs can be set at or below 100% of commercial rates, meaning Medicaid hospital payments made through SDPs can approach what private insurers pay.[35] Because commercial rates for inpatient hospital care average about 254% of Medicare rates nationally,[36] and above 300% in West Virginia, Medicaid hospitals may end up being paid far above the Medicare benchmark. West Virginia does not set its SDP level as a share of ACR. Instead, it uses the ACR as a benchmark, requiring that total reimbursements after directed payments stay below 100% of ACR.

West Virginia's $1.34 billion in SDP authorization for FY2025, in addition to Medicaid payments, makes the state's hospital financing much larger than a base rate suggests. Thus, these mechanisms increase the total amount of public money flowing to state hospital systems.

Shifting Cost from the State to the Federal Government

One effect of provider taxes and SDPs is that they move a large share of the cost from the state to the federal government, beyond what FMAP implies. By using provider taxes as the state's share, the state keeps its general-fund spending low while still generating federally matched payments. When an SDP's effective federal share is higher than the FMAP, it means the provider tax arrangement has shifted extra cost to federal taxpayers, more than what the FMAP was meant to do.

Nationwide, the GAO's 2023 review found that among SDPs above $1 billion, 21 states reached an effective federal share of 80% or higher, and 9 reached 90% or higher.[37]

Fee-for-Service vs. Managed Care Financing

Structural Differences

The choice between fee-for-service and managed care affects how supplemental payments are layered, how financial risk is split between the state and insurers, and how hospital payment is determined.

Under fee-for-service, the state carries the financial risk for all Medicaid claims; there is no insurer in between. Supplemental payments under fee-for-service, namely UPL and DSH payments, go straight from the state to hospitals, funded by the state and federal combination. The state can see the payment flows directly and is directly accountable for total spending.

Under managed care, the state shifts risk to the MCO through capitation. The MCO is responsible for keeping total spending within its capitation payment, but SDPs built into capitation rates work as pass-throughs: the plan bears no risk for the SDP amounts, because they are added into the rate and then handed to hospitals as the state directs. In this respect, SDPs inside managed care look like the fee-for-service supplemental payments they were meant to replace, with the state setting the amount and the plan acting as a conduit.

Who bears the risk?

In theory, managed care moves the risk of higher use from the state to the MCO: if patients use more care than expected, the plan absorbs the shortfall, not the state. In practice, for SDP amounts, which are a large and growing share of managed care hospital spending, the plan bears no risk, because the amounts are set in advance and must be passed through. The plan's risk applies to base-rate services, not to the supplemental layer.

For West Virginia, with $1.34 billion in SDP authorization, a large part of total managed care hospital payments is effectively risk-free for the MCO. That weakens the risk-shifting that managed care is supposed to provide.

State Incentives Under Each Model

Fee-for-service and managed care give states different incentives for controlling Medicaid spending. Under fee-for-service, each additional claim directly increases state spending (matched by federal funds), so the state has a direct stake in controlling utilization. Under managed care, the risk of higher use shifts to the MCOs, and the state's main obligation is the capitation payment. SDPs funded through provider taxes add a parallel channel in which the state's own contribution from general revenue is small: the provider tax produces the state share, and the federal match multiplies it.

As states move to managed care and stack SDPs on top of capitation, the state's direct accountability for total Medicaid hospital spending fades. Most of the cost of large SDP authority falls on federal taxpayers, offset only by the state's FMAP share.

Why Payments Concentrate in Large Hospital Systems

Base-claims data show payments concentrated in the largest systems because CAMC and WVU Medicine own most of the state's hospital capacity. West Virginia Medicaid data from 2018 through 2024 shows this: the top institutional recipients took a large share of total program dollars.

Charleston Area Medical Center (CAMC) in Charleston received about $259 million in Medicaid payments over this period. West Virginia University Hospitals in Morgantown and the affiliated WVU Medical Corporation together received roughly $315 million. (These are separate billing entities within WVU Medicine, not separate hospitals.) These systems, the largest in the state, took a sizable portion of the total institutional Medicaid payments identified in a dataset totaling $8.56 billion in documented payments for 2018 through 2024.

Provider	Total Paid, 2018–2024
Charleston Area Medical Center (all CAMC entities)	$259,388,909
WVU Hospitals, Inc. (all WVU Medicine entities)	$315,295,504

Source: HHS Open Health Data Hub, queried April 2026. Figures reflect base FFS and partial managed care claims only and do not include State Directed Payments or other supplemental payments

Volume and Acuity as Drivers

The simplest cause for this concentration is volume: large systems treat more Medicaid patients, file more claims, and earn more base payment. West Virginia's biggest systems, CAMC and WVU, serve as regional referral centers with broad inpatient services and high patient volumes. Because base Medicaid payments are per-claim, higher volume means proportionally higher base payment totals.

Patient acuity adds to this. Tertiary and quaternary referral hospitals, which handle the most complex cases, generate higher payments per claim even at the same rates, because the procedure and diagnosis codes reflect higher-cost care. WVU Medicine's status as an academic medical center, and CAMC's role as the state's second-largest system, produce acuity-related concentration that would exist even without supplemental payments.

Provider Tax Base and Supplemental Payment Design

The provider tax ties hospital revenue to Medicaid supplemental payments in a way that favors larger systems. Because the tax is a percentage of gross inpatient receipts, larger hospitals with higher revenue pay a larger tax in absolute terms. If supplemental payments are redistributed in proportion to what providers paid in tax, the larger hospitals that paid more get more back.

This creates a risk of concentration: large systems pay more in provider tax, which produces more state-share funding, which supports a larger SDP authorization, which flows back to those same large systems. How strongly this happens depends on the SDP design.

Commercial Rate Benchmarks in SDP Design

Where SDP programs aim to bring Medicaid payments toward average commercial rates, hospitals that have negotiated higher commercial rates gain an advantage. Commercial rates are set in contracts between hospitals and insurers, and larger systems, especially those with regional dominance or academic medical center status, usually negotiate higher commercial rates than smaller competitors.[38] If Medicaid SDPs are set as a share of commercial rates, the hospitals with the highest commercial rates get the largest share of state payments.

At least 24 states have built SDP programs around commercial rate benchmarks.[39] In West Virginia, where the hospital market is concentrated, these benchmarks could reinforce payment concentration in the state's largest facilities.

Scale Advantage in the Regulatory System

Large hospital systems also benefit from their size in navigating administrative and regulatory work of Medicaid supplemental payment programs. Designing SDPs, complying with the provider tax, and contracting in managed care all take significant administrative capacity. Dominant systems are best positioned to build that capacity, hire consultants who know Medicaid financing, and take part in the policy process that shapes SDP programs.

Concentration in large systems does not by itself mean money is being wasted or misused. West Virginia's directed payments are distributed by utilization and provider class, not weighted for the intensity of need or community served, so a high-volume system captures more even where the care isn't going to the highest-need patients. Whether the money is distributed in line with actual care and Medicaid need is a fair policy question.

> A narrative of fiscal fragility justifies supplemental payment increases, while increasing payments undercut the idea of continual fragility.

Legislative History

The financing design described thus far was no accident. It was built through deliberate advocacy—nationally by the American Hospital Association and, in West Virginia, by the West Virginia Hospital Association—the same organizations that reliably argue government reimbursement leaves hospitals financially vulnerable.

In 2011, West Virginia established a hospital assessment tied to upper payment limit supplemental payments. This allowed provider tax revenue to be used to generate federal matching funds, then redistributed to hospitals as UPL payments. The West Virginia Hospital Association supported continuation and expansion of this.

Then, when West Virginia expanded managed care, traditional UPL payments were less practical as DSH and UPL do not apply. Rather than allow supplemental payments to decline, WVHA secured a conversion to the Directed Payment Program, adapting the same financing mechanics to the managed care environment through Senate Bill 486, passed in 2017.

SUMMARY OF SB 486 – CONTINUATION OF THE ACUTE CARE HOSPITAL TAX

ceobulletin

May 12, 2017

TO: Chief Executive Officers
WVHA Member Hospitals and Health Systems

FROM: Carol Haugen
Vice President, Financial Policy

SUBJECT: SUMMARY OF SB 486 – CONTINUATION OF THE ACUTE CARE HOSPITAL TAX

SB 486 is effective July 1, 2017.

SB 486 impacts only eligible acute care Inpatient Prospective Payment Hospitals (IPPS). The bill excludes psych IPPS, Critical Access Hospitals (CAH), and state owned or designated hospitals.

The legislation continues the acute care hospital tax, which has been in effect since July 1, 2011 for another year. The tax proceeds are dedicated to Medicaid Supplemental payments formerly known as Upper Payment Limit (UPL) and are now converted to Directed Payment Program (DPP) payments. The UPL program was a Medicaid Supplement allowable exclusively for Fee for Service payments. WV Medicaid, effective January 1, 2017, has moved much of the Medicaid populations utilizing hospital services to managed care. With this shift, SB 486 renamed the payment to DPP for SFY 2018.

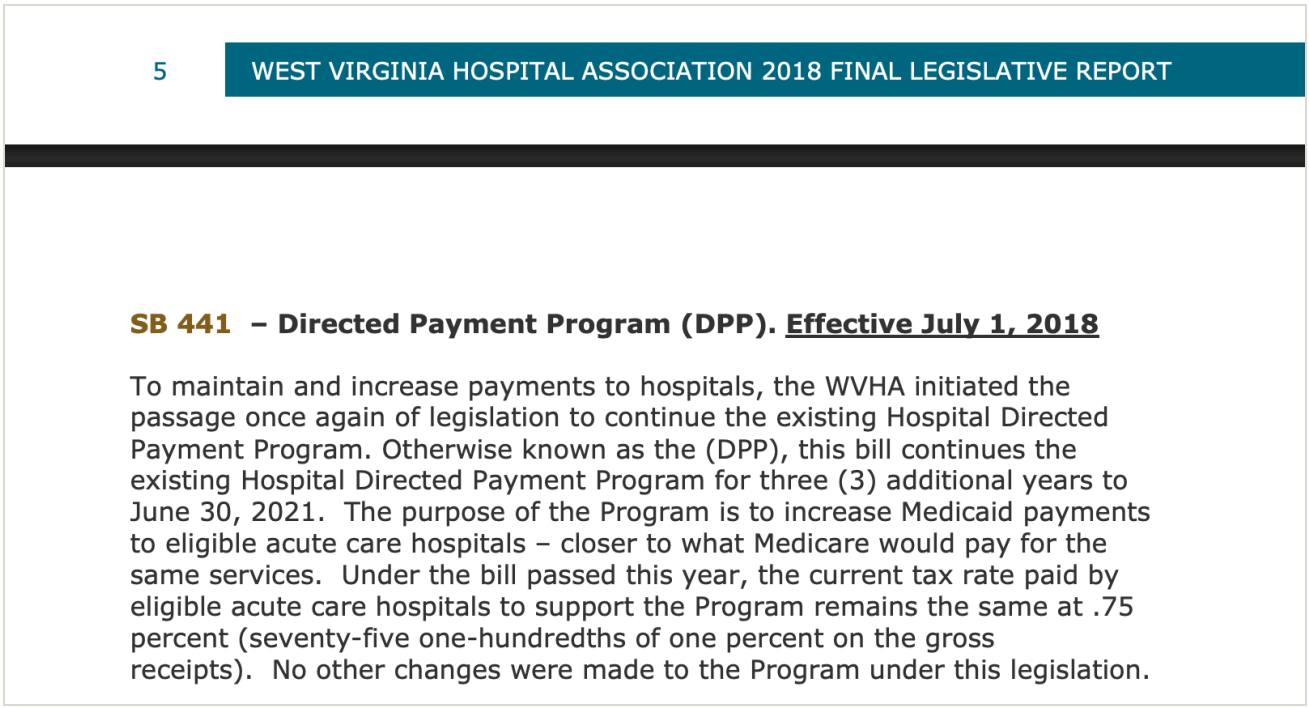
SB 486 adjusted the tax rate from the current 0.74 percent to 0.75 percent.

SB 486 also expanded the definition of taxed hospitals. Effective July 1, 2017 Non-State Government Owned Hospitals (NSGO) hospitals are subject to the tax. In previous years, the NSGO utilized an intergovernmental transfer program to participate in the UPL program. Under current rules, that funding methodology is excluded in an MCO environment.

WVHA will sponsor a conference call for DPP eligible hospitals soon. In the interim, please direct your questions or comments to me at (304) 353-9721 or by email at chaugen@wvha.org.

CH/kw

Source: 2017 CEO Bulletin Summary of SB 486, p.6



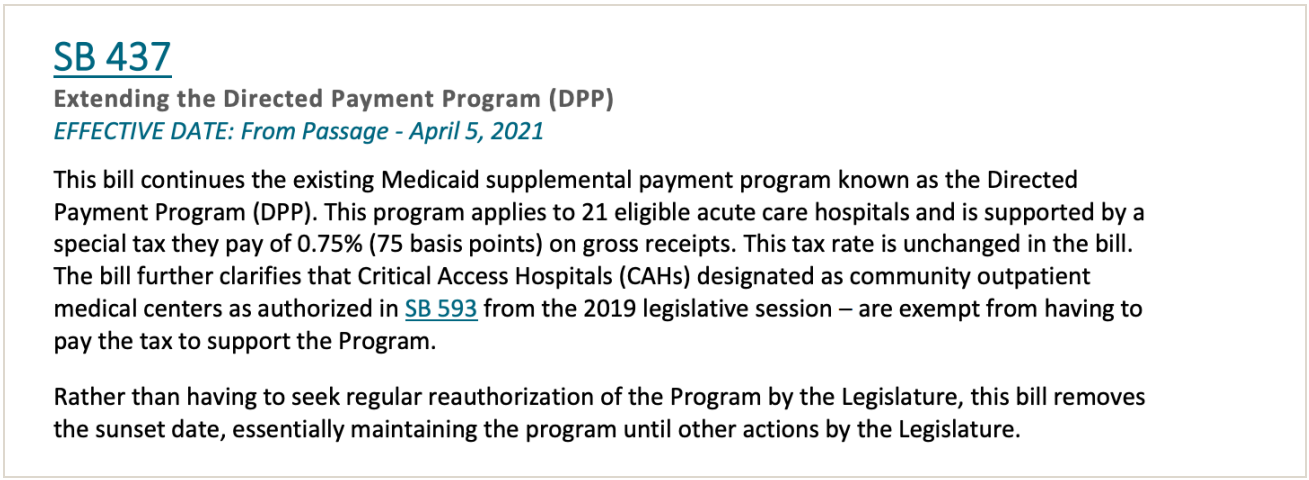
5 WEST VIRGINIA HOSPITAL ASSOCIATION 2018 FINAL LEGISLATIVE REPORT

SB 441 – Directed Payment Program (DPP). Effective July 1, 2018

To maintain and increase payments to hospitals, the WVHA initiated the passage once again of legislation to continue the existing Hospital Directed Payment Program. Otherwise known as the (DPP), this bill continues the existing Hospital Directed Payment Program for three (3) additional years to June 30, 2021. The purpose of the Program is to increase Medicaid payments to eligible acute care hospitals – closer to what Medicare would pay for the same services. Under the bill passed this year, the current tax rate paid by eligible acute care hospitals to support the Program remains the same at .75 percent (seventy-five one-hundredths of one percent on the gross receipts). No other changes were made to the Program under this legislation.

Source: 2018 Final Legislative Report, p.6

In 2021, WVHA advocated to remove sunset provisions from the Directed Payment Program, shifting the financing structure to permanency rather than through reauthorization. What had been originally legislated as a temporary supplemental payment arrangement has become a standing feature of West Virginia Medicaid.



SB 437

Extending the Directed Payment Program (DPP)

EFFECTIVE DATE: From Passage - April 5, 2021

This bill continues the existing Medicaid supplemental payment program known as the Directed Payment Program (DPP). This program applies to 21 eligible acute care hospitals and is supported by a special tax they pay of 0.75% (75 basis points) on gross receipts. This tax rate is unchanged in the bill. The bill further clarifies that Critical Access Hospitals (CAHs) designated as community outpatient medical centers as authorized in SB 593 from the 2019 legislative session – are exempt from having to pay the tax to support the Program.

Rather than having to seek regular reauthorization of the Program by the Legislature, this bill removes the sunset date, essentially maintaining the program until other actions by the Legislature.

Source: 2021 WVHA Legislative Summary, p.4

In 2024, as CMS rule changes opened the door to SDPs benchmarked against average commercial rates, with the potential of reaching 2.5x Medicare rates nationally, WVHA then pursued expansion of West Virginia's payments toward these higher ceilings. This aggression is

reflected in the mid-year amendment to the SFY2023–24 SDP preprint, in which West Virginia initially submitted $270 million for hospital SDPs and then amended it up to $344 million within the same rating period.

"Top 3" WVHA Priority Bills- WVHA Legislative Agenda

HB 5157

Relating to the Facility Directed Payment Program (DPP)

EFFECTIVE DATE: From Passage – February 14, 2024, and upon approval by CMS

This bill was a top priority of WVHA. HB 5157 continues the existing Facility Directed Payment Program (DPP) which provides targeted funding to West Virginia hospitals. Since 2011, West Virginia has utilized a Directed Payment Program (DPP) to maximize federal matching dollars to increase Medicaid payments for hospitals.

- The purpose of the DPP Program is to support lower Medicaid payments with supplemental funds to support hospital financial stability.
- The DPP Program was put in place to comply with Federal supplemental payment initiatives under Medicaid. The Federal rules outline the types of Medicaid payment arrangements that states may use to direct managed care expenditures.
- CMS recently made programmatic changes to the formula calculating the limit of funding a state can request and provide to hospitals through the DPP. While the program ceiling has historically been limited to what Medicare would have paid for a service (which does not cover the cost of care), the recent changes raise the ceiling to the average commercial rate (ACR).
- In response to the CMS policy changes, the WVHA partnered with national DPP experts to evaluate West Virginia's current arrangements and assess the potential for additional federal funding. WVHA has discussed programmatic changes with the Commissioner for the West Virginia Bureau for Medical Services and the West Virginia Tax Department.
- This specific program has benefited the hospitals and helped Medicaid draw down federal matching dollars. For every $1 that West Virginia invests in our DPP, it is matched with approximately $3 from the federal government.
- The program does not require any state budget appropriation; rather all eligible hospitals pay an assessment (provider tax) as the state contribution toward drawing down additional federal matching dollars for Medicaid to pay hospitals rates as allowable under such a Program.
- Historically, the Facility DPP has been limited to participation of 23 acute care hospitals. In addition to the change in funding calculations, this bill expands the eligible participating hospital population to include critical access hospitals (CAH) and specialty hospitals.
- The modeling shows **57** total hospitals. This includes the current 23 acute care hospitals and 34 anticipated new hospitals that would be eligible to participate in the Facility DPP through changes in this bill.
- Before implementation, West Virginia Medicaid must submit an updated plan document to CMS that must be subsequently approved.

For additional information or questions regarding implementation, please contact Melanie Dempsey, Vice President Financial Policy at mdempsey@wvha.org

Source: 2024 WVHA Legislative Summary, pp.4

The same document also notes WVHA "prevented" HB 5530, a bill that would have required hospitals to disclose price and fee information for certain services.

> In addition to successfully advancing the WVHA legislative agenda, the hospital community also prevented negative legislation from moving forward. Some of these bills included **HB 4320** – relating to access for minor children's medical records; and **HB 5530** – requiring a hospital to disclose price and fee information for certain health care services, among many other bills/amendments that were introduced.

Source: 2024 WVHA Legislative Summary, p.3

The result of these policies is a program that grew from $379 million in combined hospital and physician SDPs in SFY2022–23 to $1.376 billion in SFY2024–25—a 263% increase in two years.[40] In October 2025 testimony, the Commissioner for the West Virginia Bureau for Medical Services, Cindy Beane, confirmed that SFY2025 was the first year all West Virginia hospitals joined the Directed Payment Program, driving the jump from $335 million to $1.3 billion in one cycle.[41]

The association's documents use the phrase "no state budget appropriation" to describe the directed payment program, framing provider tax recycling as cost-free to the state, accurate as far as the state general fund goes, but it does obscure who pays: federal taxpayers, whose matching dollars fund the increment above what hospitals paid. The means in which these financing arrangements operate were designed to be generally invisible to state budget scrutiny, and hospital association messaging has kept it that way.

Together, this is an important timeline worth inspecting alongside the Medicaid financing mechanics. WVHA has historically argued the state's hospitals are financially fragile, underpaid, and dependent on regulatory protection to survive; meanwhile, the association was simultaneously, and successfully, pursuing the largest expansion of government supplemental payments in state Medicaid history. These positions are not contradictory, but complementary. A narrative of fiscal fragility justifies supplemental payment increases, while increasing payments undercut the idea of continual fragility. Both serve institutional interests over patients.

KEY TAKEAWAYS

- The financing structure was built deliberately, through legislation the hospital association pursued in 2011, 2017, 2021, and 2024.
- Combined hospital and physician directed payments grew from $379 million in SFY2022–23 to $1.376 billion in SFY2024–25, a 263% increase in two years.

Strategy for Reform

State Medicaid financing is being reshaped through federal rule changes, implemented through "One Big Beautiful Bill." The ultimate question now present for policymakers and healthcare leaders is whether West Virginia will use this moment to redesign the system with emphasis on patients and rural health or absorb the changes reactively while leaving underlying structure intact. The following could help reorient finance structures towards patients and away from politically powerful systems:

1. **Design state directed payment distribution criteria toward rural access and outcomes**

   Current SDPs distribute dollars proportional to utilization and institutional classification creating a system where the largest systems with the highest volume receive the most share. Currently, program design does not include any requirement that SDPs flow to hospitals with the greatest Medicaid need, access gaps, or the most underserved populations. West Virginia should redesign SDP eligibility and distribution through a weighted system, which includes rural access, Health Professional Shortage Area designations, and, most importantly, patient outcomes.

2. **Require public reporting of state directed payment distribution by hospital**

   The Centers for Medicare & Medicaid Services lacks any mandate for states to disclose SDP payment amounts by hospital. West Virginia should. Policymakers can require public reporting of SDP payment amounts by hospital as a condition of payment participation, a transparency recommendation: markets, however limited, function best with price and payment information. Moreover, policymakers cannot currently evaluate whether public dollars are well spent without knowing where they flow.

3. **Condition state directed payment eligibility on access and quality metrics**

   West Virginia should establish state-level quality and access conditions tied to SDP eligibility. Hospitals receiving directed payments should be required to demonstrate measurable charity care contribution relative to the value of their tax exemption and access for Medicaid patients. Importantly, the CMS 2024 managed-care final rule has a 2027 evaluation requirement, mandating that SDPs exceeding 1.5% of managed care costs submit evaluation reports every three years, as a floor, not a ceiling. West Virginia policymakers could go further, binding SDP eligibility to outcomes on access and quality. This connects directly to Cardinal's prior findings on charity care showing that West Virginia's non-profit hospital systems provide less than 1% of net patient revenue, on average, as charity care despite receiving substantial public subsidies.

4. **Use the provider tax compliance window strategically**

   West Virginia has already taken the first step. HB 5459, passed in the 2026 legislative session and effective June 9, 2026, converts the state's tiered MCO tax to a uniform 2.5% tax on gross premiums, bringing West Virginia into compliance with new federal uniformity requirements ahead of the deadline. But harder work remains. West Virginia's stacked hospital taxes of about 6% sit above the 3.5% cap that "One Big Beautiful Bill's" safe harbor phase-down requires by FY2032; phase-down begins in FY2028. Rather than treating that deadline as a compliance obligation to be managed, policymakers can use the window proactively. Deliberate and well-designed reduction in the provider tax rate paired with redesigned distribution weighted toward rural access and patient outcomes is better than a scramble when federal pressure arrives. States that are able to get ahead of this will have more flexibility in reshaping their Medicaid financing; states that wait will have less room to protect populations that depend on it most.

Summary

Medicaid financing is a layered system. Base payments, fee-for-service and managed care, all heavily supplemented through provider taxes, federal matching, and state directed payments, leave total payments well above what base rates alone produce. In short, these five layers build in sequence:

1. Base Medicaid payments through fee-for-service and managed care

2. Provider tax charges on hospital inpatient receipts, which produce the state-share Medicaid funding without general fund appropriations
3. Federal matching at West Virginia's 74.25% FMAP, which turns each dollar of provider tax revenue into $3.88 of total program spending
4. Supplemental payments under fee-for-service, funded by the provider tax and federal match
5. State Directed Payments built into MCO capitation rates and required to be passed through to hospitals, funded mainly by provider taxes and federal matching

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What This Means for West Virginia's Hospital Market

Looking at this structure as a whole has several implications for better understanding West Virginia's hospital market and for the policy debates that follow.

First, total Medicaid hospital payment in West Virginia is much higher than base Medicaid rates imply. The $1.34 billion in SDP authorization is hospital revenue stacked on top of base payments. Any look at hospital finances that counts only base Medicaid rates, or that takes the sector's "below cost" framing at face value, understates what hospitals receive through Medicaid.

Second, financial-distress arguments behind the hospital lobby's case for anti-patient policies such as Certificate of Need and non-profit tax exemptions must be read against this supplemental payment structure. Claiming government payers reimburse below cost holds for base rates seen in isolation, but provider taxes, federal matching, and state directed payments exist precisely to close that gap. A hospital can show a low base Medicaid rate and still collect supplemental payments that lift its total Medicaid compensation well above those rates.

Third, current financing distribution concentrates benefits in the state's largest systems. Because provider taxes scale with gross revenue, and because commercial-rate-based SDPs reward hospitals with the highest negotiated rates, the dominant systems (CAMC and WVU Medicine) are positioned to capture the largest returns. Moreover, financing does not just pay for care; it strengthens market position. Rules meant to shield "community infrastructure" end up steering public money to the systems with the most market power, rather than the hospitals that may need it most.

Fourth, most of the cost for this financing lands on federal taxpayers as whole rather than the state. Provider taxes supply the state share, the federal match multiplies it, and the effective federal share of West Virginia's SDPs runs above the state's nominal FMAP. This arrangement works less like state spending decisions than like a federally supported transfer to hospitals, with the state's general revenue shielded. This distribution of cost is what recent federal reforms, through the "One Big Beautiful Bill" is intended to target.

> For West Virginia, the question is no longer how far this can grow, but how the state and its hospital systems adjust as it contracts.

Foundation for Policy Reform

These mechanisms are now being reined in. The 2025 Reconciliation bill, or "One Big Beautiful Bill Act," freezes provider taxes at their mid-2025 levels and, for states that expanded Medicaid, West Virginia among them, phases the provider-tax safe harbor down from 6% to 3.5%, starting in FY2028.[42] West Virginia's stacked hospital taxes (about 6%) sit above that forthcoming cap, so the state will be required to shrink them. The law also caps state directed payments for expansion states at 100% of Medicare,[43] and 110% for non-expansion states, removing the commercial-rate benchmarking that let SDPs climb toward private-insurer levels. Together, these changes narrow two channels described here as the core of West Virginia's hospital financing: provider taxes and state directed payments.

For West Virginia, the question is no longer how far this can grow, but how the state and its hospital systems adjust as it contracts. This supplemental layer that has quietly enlarged hospital Medicaid revenue is being capped and pared back, and the systems that gained the most from it have the most to lose as it unwinds. Understanding how it has operated is a valuable starting point as West Virginia considers fiscal health policy moving forward, and for an honest accounting of what West Virginia's hospitals receive, and from whom.

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