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Federal Budget Reconciliation Overview

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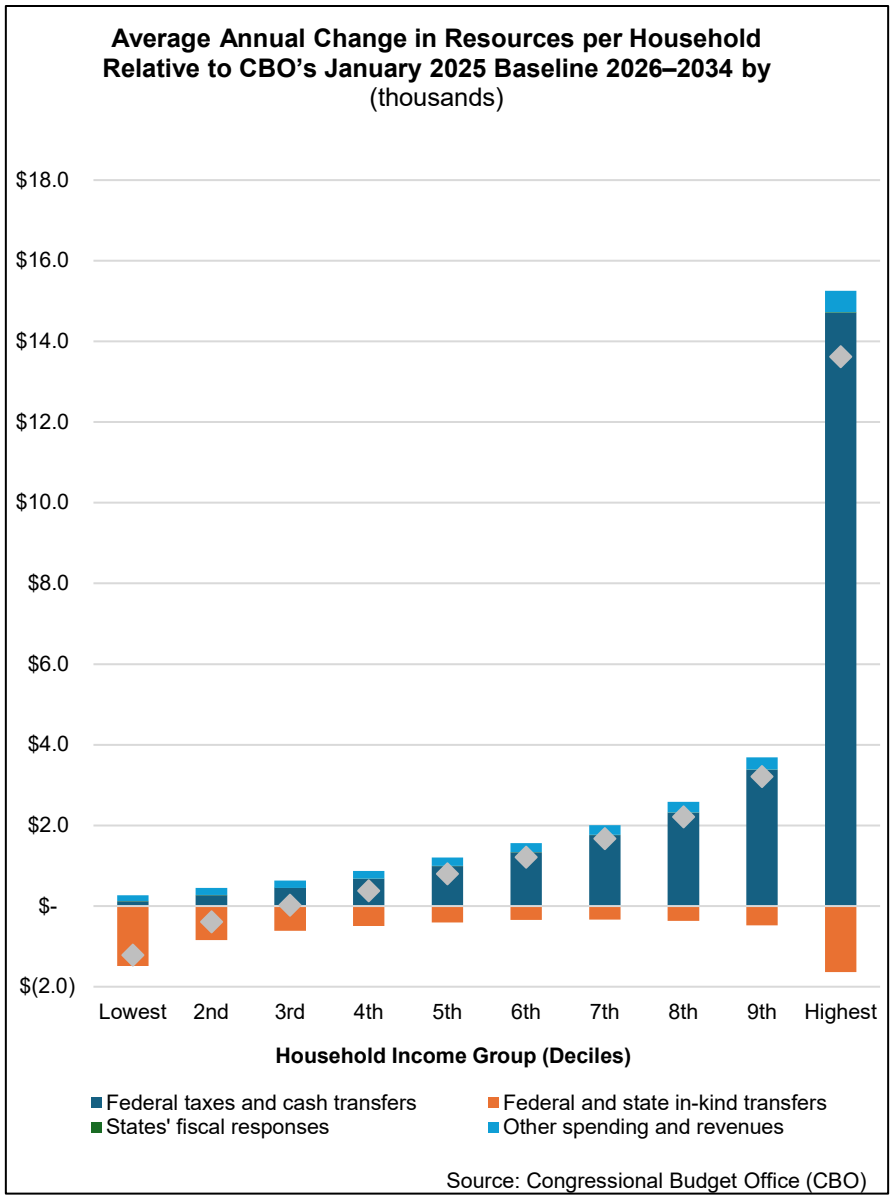
Possible PAYGO Sequestration Under Reconciliation

- Pay-As-You-Go (PAYGO) was enacted in 2010 to prevent new tax and spending legislation from increasing the federal budget deficit.
  - Requires the Federal Office of Management and Budget to offset any increase in spending under new legislation by ordering annual across-the-board cuts to mandatory and direct spending programs.
  - The reconciliation bill increases deficits by $3.4 trillion and will trigger these cuts, unless congress acts to override PAYGO at the beginning of 2026.
  - According to the Congressional Budget Office, required reductions would exceed sequestrable resources for covered programs
  - Exempt mandatory programs include Social Security, veteran's benefits, Medicaid, SNAP, TANF, Unemployment Insurance, and SSI.
  - Medicare cuts are capped at 4 percent.
  - Sequestrable programs include the crime victims fund, Maternal, Infant, and Early Childhood Home Visiting Programs, Promoting Safe and Stable Families, Housing Trust Fund and many others.

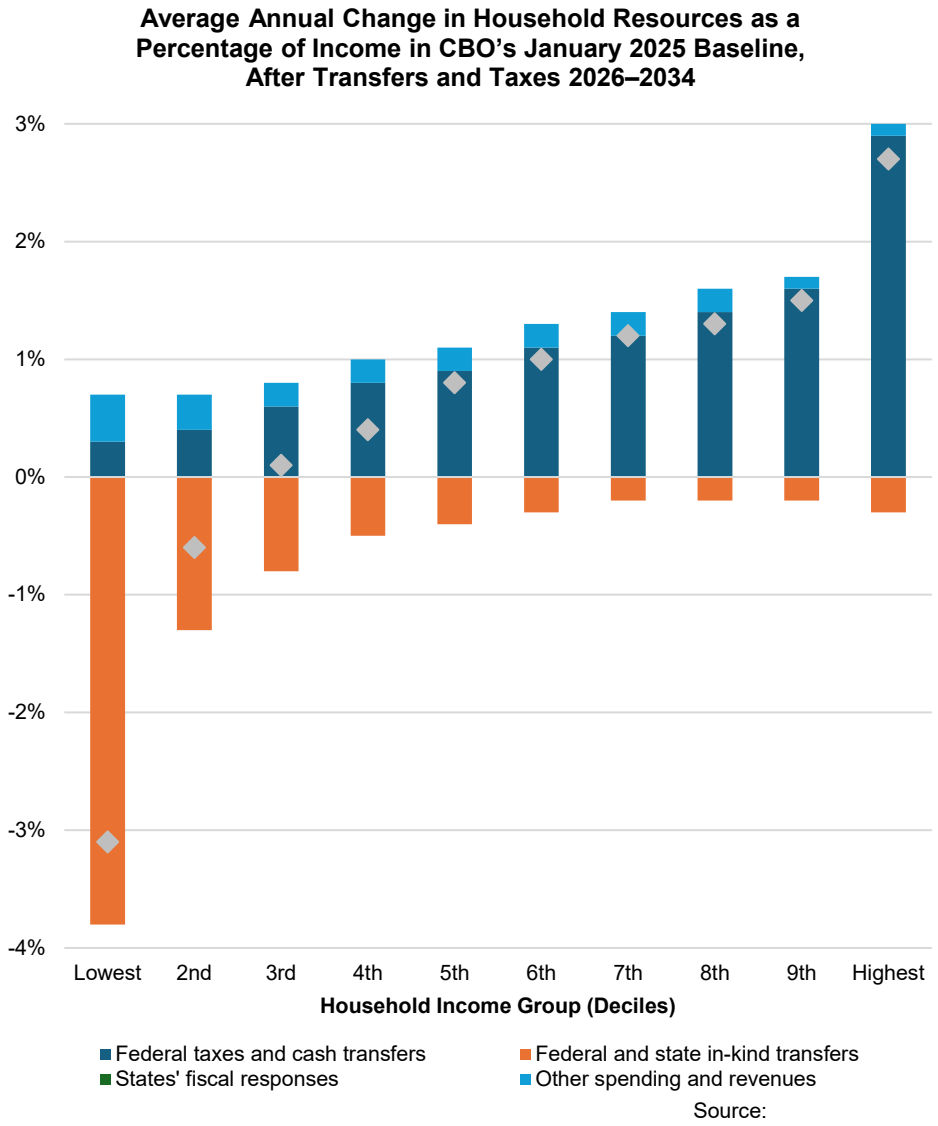
How Reconciliation Impacts the Distribution of Resources to Households

The Congressional Budget Office Estimated that the legislation will affect household resources through several channels:

- Federal taxes and cash transfers (such as Social Security benefits);
- Federal and state in-kind transfers (such as Medicaid benefits);
- States' fiscal responses (that is, changes in state taxes and spending resulting from changes in state spending on program benefits); and
- Other spending and revenues (which CBO allocates as if they were public goods).



How Reconciliation Impacts the Distribution of Resources to Households



How Reconciliation Impacts the Distribution of Resources to Households

Federal Budget Reconciliation – Medicaid Rural Health Transformation Program

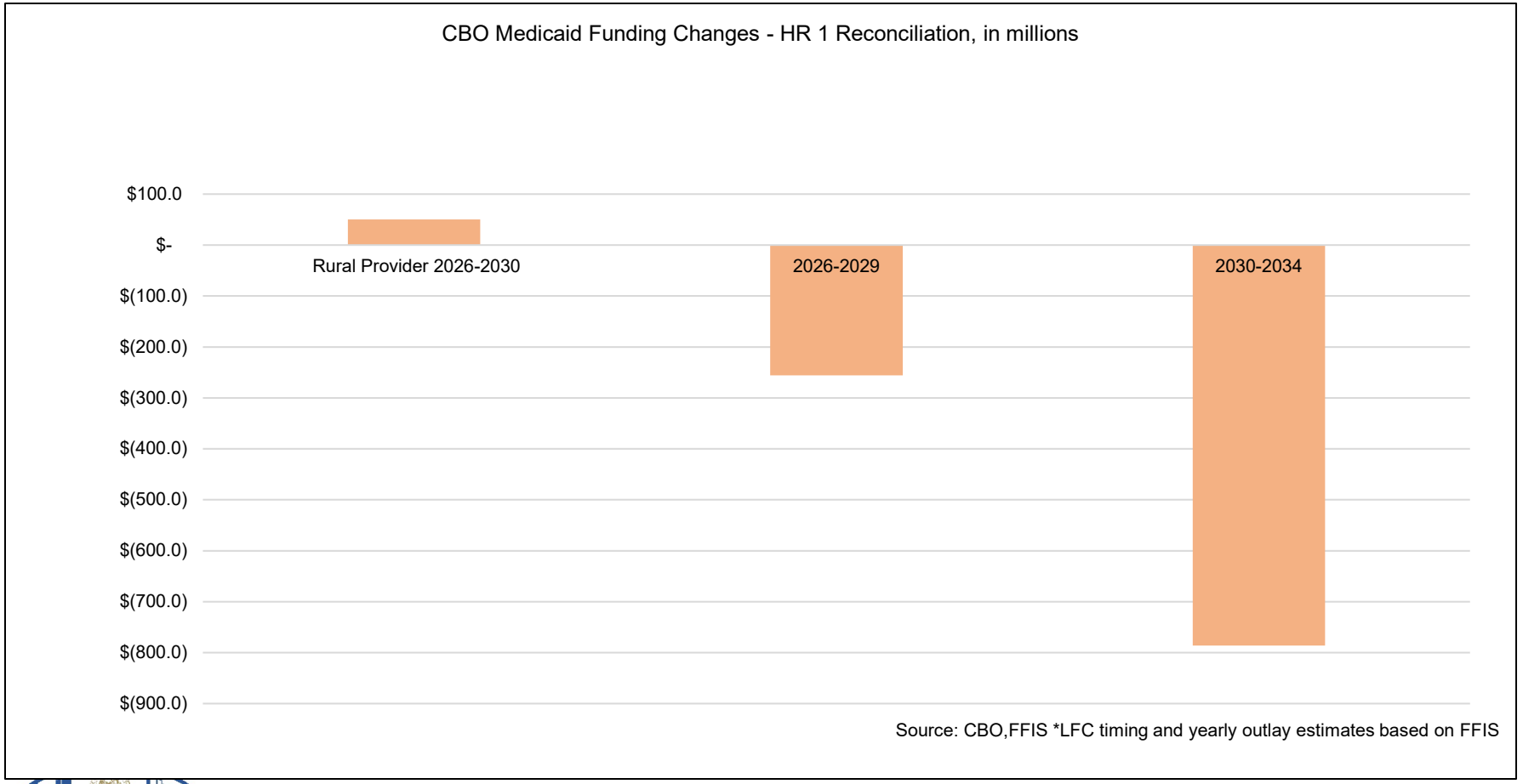
- Reconciliation created the rural health transformation program with $50 billion nationally over five years to:
  - Improve access to hospitals and other healthcare providers to rural residents in the states,
  - Improve healthcare outcomes,
  - Strengthen local and regional partnerships,
  - Enhance the supply of clinicians through enhanced recruitment and retention,
  - Prioritize data and technology driven solutions that help rural hospitals, and
  - Other improvements
- The Legislature may want to consider creating a fund to allow for the appropriation of the transformation grants in a similar way to how the Legislature appropriated American Rescue Plan Act (ARPA) funding. The transformation program includes:
  - A minimum of $100 million distributed to each state annually for five years and
  - Additional amounts determined through an application process based on a state's rurality, share of rural hospitals, and other factors that the Medicaid administrator deems appropriate
- Applications are expected to be distributed to states in early September, applications are to be returned to CMS the same month, CMS will process the applications in November, and the first distributions are expected by the end of the year

Federal Budget Reconciliation – Medicaid Timeline

LFC Analysis of CBO Estimates for Impact of 2025 Budget Reconciliation Bill												
	Actual - 2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025-2034
Medicaid - Federal	618	$ 656	$ 695	$ 738	$ 767	$ 803	$ 837	$ 871	$ 910	$ 948	$ 986	$ 8,211
Baseline Growth Rate		6%	6%	6%	4%	5%	4%	4%	4%	4%	4%	
Medicaid Changes From Baseline		$ (1)	$ (22)	$ (54)	$ (73)	$ (106)	$ (127)	$ (146)	$ (157)	$ (170)	$ (186)	$ (1,043)
Percent Change from Baseline		0%	-3%	-7%	-10%	-13%	-15%	-17%	-17%	-18%	-19%	-13%
Rural Healthcare Initiative*			$ 10	$ 10	$ 10	$ 10	$ 10					$ 50
New Baseline		$ 655	$ 683	$ 694	$ 704	$ 707	$ 720	$ 725	$ 753	$ 778	$ 800	$ 7,218
Percent Change YOY New Baseline			4%	2%	1%	0%	2%	1%	4%	3%	3%	

Source: CBO,FFIS *LFC timing and yearly outlay estimates based on FFIS

Federal Budget Reconciliation – Medicaid Timeline



Federal Budget Reconciliation – Medicaid Economic Effects

- LFC used REMI, an economic impact modeling software, to understand the economic impacts lower federal payments will have once the provisions of H.R.1 are fully in place
- LFC identified other recent economic impact analyses and calculated the economic impact implied in that work. Those researchers had differing assumptions about the reduction in federal spending and used different modeling techniques.

Estimated Economic Impact of H.R.1 Medicaid Components by 2034

	LFC Analysis	Other National Estimates	
		Low end	High end
Total Employment	(9,000)	(2,700)	(11,300)
GDP Impact (millions)	$ (847)	$ (718)	$ (997)

Note: LFC analysis was calculated using LFC and HCA estimates of decreased state revenues. To produce a range, this analysis calculated the implied impact on New Mexico from two recent national analysis: Basu, Patel, and Berkowitz 2025 (low end); Ku et al. 2025 (high end). LFC and the Basu, Patel, and Berkowitz (2025) scenarios assume full impacts by 2034. Ku et al. 2025 assumes full impacts in 2029.

Source: LFC analysis of LFC and HCA estimates

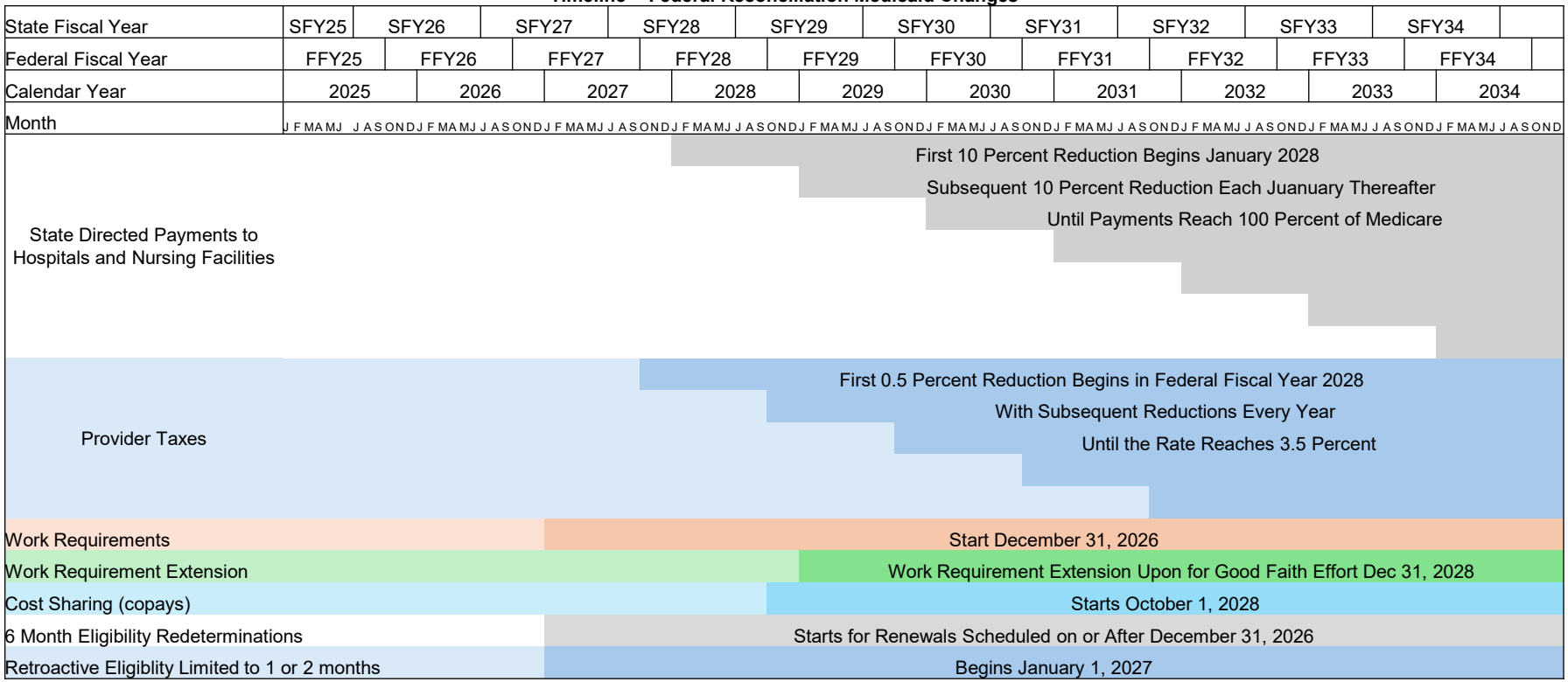
Federal Budget Reconciliation - Medicaid

Federal Fiscal Year (millions)	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025-2029	2025-2034
Medicaid Work Requirements	0	250	-13,080	-19,030	-39,840	-46,280	-48,440	-50,690	-53,100	-55,550	**-71,700**	**-325,760**
Provider Taxes	0	-2,790	-4,743	-7,604	-12,294	-18,585	-26,724	-34,099	-39,317	-44,976	**-27,431**	**-191,132**
State Directed Payments	0	-5,450	-7,471	-9,269	-13,334	-16,552	-19,598	-22,845	-25,861	-29,035	**-35,524**	**-149,415**
Delay Rule on Eligibility and Enrollment in Medicare Savings Programs	-115	-2,688	-7,037	-9,415	-9,789	-10,280	-10,733	-11,205	-11,785	-12,234	**-29,044**	**-85,281**
Delay Rule on Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program	-600	-6,283	-8,378	-8,627	-9,043	-9,018	-9,382	-9,744	-10,142	-10,529	**-32,931**	**-81,746**
Eligibility Redeterminations	0	0	-5,115	-7,089	-7,472	-7,816	-8,180	-8,560	-8,978	-9,392	**-19,676**	**-62,602**
Uniform Tax Requirement for Medicaid Provider Tax	0	-3,158	-3,426	-3,518	-3,684	-3,828	-3,969	-4,172	-4,345	-4,506	**-13,786**	**-34,606**
Expansion FMAP for Emergency Medicaid	0	0	-2,493	-3,166	-3,342	-3,526	-3,721	-3,924	-4,141	-4,370	**-9,001**	**-28,683**
Other Provisions												**-84,100**
Total Medicaid												**-1,043,325**

Source: Congressional Budget Office

Federal Budget Reconciliation – Medicaid Timeline

Timeline -- Federal Reconciliation Medicaid Changes



Notable Reconciliation Changes to Medicaid: State Directed Payments and Provider Taxes

- Historically, hospitals and Medicaid MCOs would negotiate rates and states could not direct how or how much to pay. States could make supplemental payment arrangements, not always tied to actual utilization, with hospitals to offset uncompensated care.
- CMS shifted and began disallowing supplemental payment but issued a rule allowing states to direct payments through managed care.
- Medicare rates have served as a "ceiling" or upper payment limit for hospital payments, but CMS issued a rule allowing commercial market rates as the new upper payment limit.
- State's often use specific taxes or fees only directed to those providers who would then receive compensation for the tax plus rate increases from the federal match. CMS limits the amount to six percent of the provider's revenue called "safe harbor."
- In 2024, NM hospitals reported almost $7.5 billion in net patient revenue, with about $1.6 billion coming from Medicaid. Reported net income was $575 million, with six hospitals reporting a combined loss of almost $88 million.
- NM implemented the new upper payment limits this calendar year after federal approval last year. NMHA estimated hospitals would gain an additional $1.1 billion in federal matching funds and for some hospitals more than doubling their Medicaid revenue. *Figures exclude specialty and BH facilities

Notable Reconciliation Changes to Medicaid: State Directed Payments and Provider Taxes

State Directed Payments

- Caps the total payment rate for inpatient hospital and nursing facility services at 100 percent of Medicare for expansion states
- Grandfathers current directed payments implemented prior to enactment
  - ***Effective Date:*** For grandfathered payments, reduces payment rates by 10 percent per year starting January 1, 2028, until they reach 100 percent of Medicare payment rate
    - However, each year CMS adjusts Medicare payment rates – so the new upper payment limit will grow over time
  - ***Impact to the state:*** Directed payments are expected to reach $1.1 billion for hospitals in FY26, which would be reduced by 10 percent annually until they reach 100 percent of Medicare rates
    - Preliminary estimates would reduce hospital patient revenue by less than 2 percent annually. The hospital tax burden would come down over time as well

Provider Taxes

- Prohibits new provider taxes and eliminates some types of provider taxes all together
  - ***Effective Date:*** Reduces the current 6 percent provider tax limit by 0.5 percent per year starting in Federal Fiscal Year 2028 through 2032 to 3.5 percent
  - ***Impact to the state:*** Provider tax revenue funds the state's directed payments for hospitals and federal reconciliation exempted nursing facilities taxes

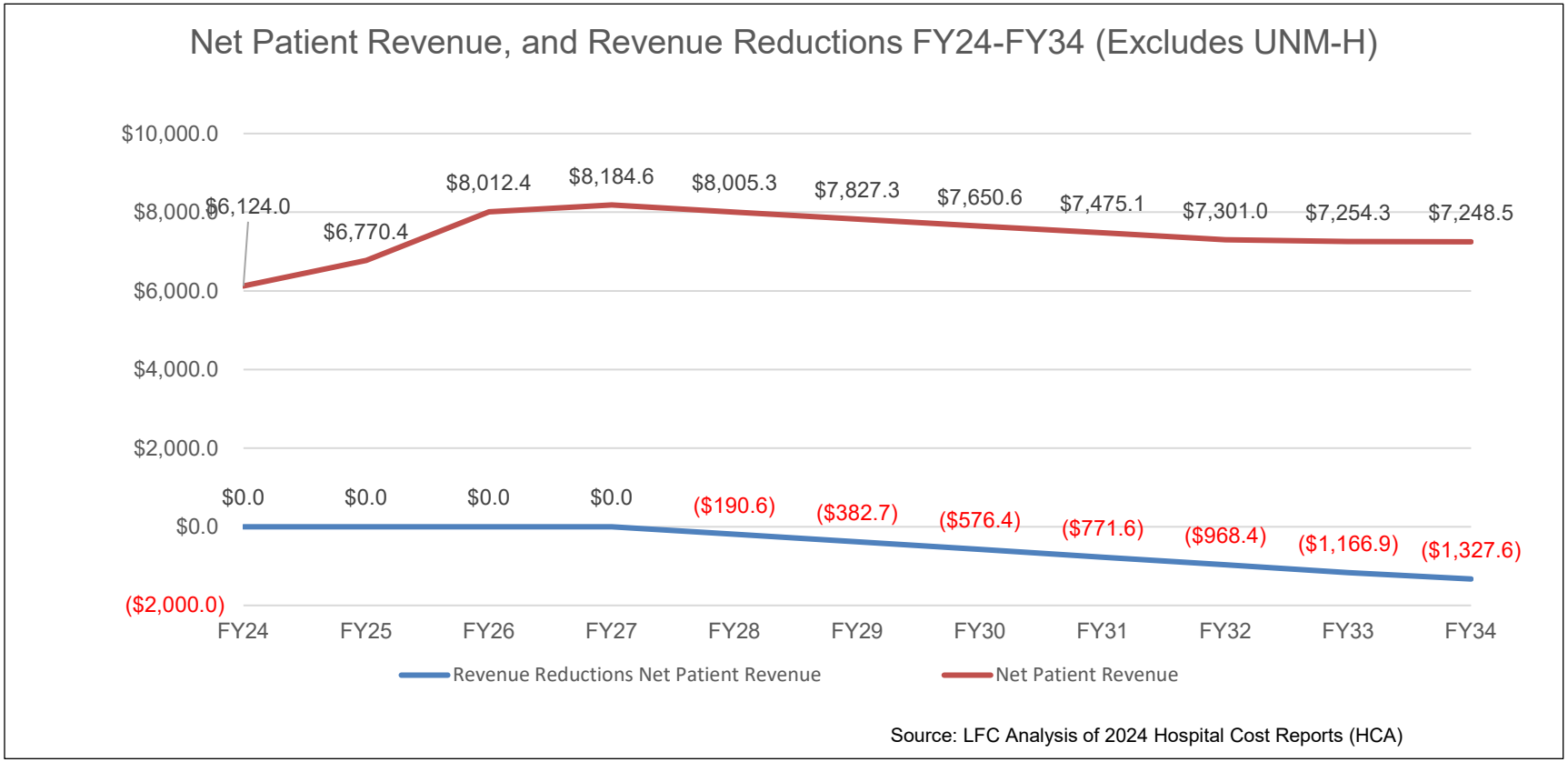
Notable Reconciliation Changes to Medicaid: State Directed Payments and Provider Taxes

millions

	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	FY32	FY33	FY34
Net Patient Revenues - Base (UNMH not included)	$6,189.6	$6,480.0	$6,480.0	$6,480.0	$6,480.0	$6,480.0	$6,480.0	$6,480.0	$6,480.0	$6,480.0	$6,480.0
Add: Growth Factor - Inflation	$6,313.4	$6,609.6	$6,741.8	$6,876.6	$7,014.2	$7,154.4	$7,297.5	$7,443.5	$7,592.4	$7,744.2	$7,899.1
Growth Factor - Uncompensated Care	3.0%	3.0%	3.0%	3.0%	3.5%	4.0%	4.5%	5.0%	5.5%	6.0%	6.0%
Total Uncompensated Care	($189.4)	($198.3)	($202.3)	($206.3)	($245.5)	($286.2)	($328.4)	($372.2)	($417.6)	($464.7)	($473.9)
Uncompensated Care Growth	$16.9	$8.0	$4.0	$0.0	($39.2)	($79.9)	($122.1)	($165.9)	($211.3)	($258.4)	($267.6)
Subtotal NPR	**$6,124.0**	**$6,411.3**	**$6,539.5**	**$6,670.3**	**$6,768.7**	**$6,868.3**	**$6,969.1**	**$7,071.3**	**$7,174.8**	**$7,279.5**	**$7,425.1**
HDAA Revenue - Assessment	$0.0	$79.8	$327.3	$336.5	$308.5	$280.4	$252.4	$224.3	$196.3	$196.3	$196.3
Add FMAP (3.5x Multiplier)	$0.0	$279.3	$1,145.6	$1,177.8	$1,079.6	$981.5	$883.3	$785.2	$687.0	$687.0	$687.0
Subtotal HDAA Adjusted Revenue	$0.0	$359.1	$1,472.9	$1,514.3	$1,388.1	$1,261.9	$1,135.7	$1,009.5	$883.3	$883.3	$883.3
Net Revenues from Medicaid - Base (less UNMH)	$1,081.6	$1,081.6	$1,081.6	$1,081.6	$1,081.6	$1,081.6	$1,081.6	$1,081.6	$1,081.6	$1,081.6	$1,081.6
Provider Assessment	6.0%	6.0%	6.0%	6.0%	5.5%	5.0%	4.5%	4.0%	3.5%	3.5%	3.5%
Less: Provider Tax Cap Reduction	$0.0	$0.0	$0.0	$0.0	($126.2)	($252.4)	($378.6)	($504.8)	($630.9)	($630.9)	($630.9)
Directed Payment Reduction	$0.0	$0.0	$0.0	$0.0	($151.4)	($302.9)	($454.3)	($605.7)	($757.1)	($908.6)	($1,060.0)
Total Deductions	**$16.9**	**$8.0**	**$4.0**	**$0.0**	**($190.6)**	**($382.7)**	**($576.4)**	**($771.6)**	**($968.4)**	**($1,166.9)**	**($1,327.6)**
Total Adjusted Patient Revenue	**$6,124.0**	**$6,770.4**	**$8,012.4**	**$8,184.6**	**$8,005.3**	**$7,827.3**	**$7,650.6**	**$7,475.1**	**$7,301.0**	**$7,254.3**	**$7,248.5**

Source: LFC analysis of Hospital Cost Reports and HDAA

Notable Reconciliation Changes to Medicaid: State Directed Payments and Provider Taxes



Source: LFC Analysis of 2024 Hospital Cost Reports (HCA)

Notable Reconciliation Changes to Medicaid: State Directed Payments to UNMH

- The University of New Mexico Hospital (UNMH) sends an intergovernmental transfer of about $150 million to the state's Medicaid program, where it is matched with Medicaid revenue and sent back in the form of a directed payment.
  - Unlike other hospitals, UNMH does not participate in the Healthcare Delivery and Access Act, but its arrangement is similar.
  - UNMH will not be affected by the provider tax change but will be affected by the state directed payment change.
  - The state directed payment will decrease by 10 percent annually from the current average commercial rate, until it reaches 100 percent of Medicare, like other hospitals' directed payments, according to HCA
  - The HCA projects that the directed payment to UNMH will decrease from $274 million to about $64 million over the course of 10 years.

Notable Reconciliation Changes to Medicaid: Work Requirements and Cost Sharing

Work Requirements

- Expansion adults 19 to 64 must be enrolled in a qualifying activity for 80 hours per month
- Certain exemptions such as dependent children under 14 and medically frail
- If disenrolled for not meeting work requirements also would not qualify for subsidized marketplace coverage
  - ***Impact to the state:*** Would reduce Medicaid spending by $513 million in federal revenue and $57 million in state general funds, due to an estimated 83 thousand reduction in enrollment.
  - ***Effective date:*** December 31, 2026, with state exemptions granted until December 31, 2028, for states showing good faith efforts to implement

Cost Sharing

- $35 per service on expansion adults except primary care, mental health, and substance use disorder services. Also exempts services provided at federally qualified health centers, behavioral health clinics, and rural health clinics.
  - ***Impact to the state:*** Reduces spending by $8 million in federal revenue and $890 thousand in general fund revenue, due to an estimated 254 thousand enrollees that would now be subject to copays.
  - ***Effective date:*** October 1, 2028

Notable Reconciliation Changes to Medicaid: Eligibility

Eligibility

- Requires states to conduct eligibility redeterminations at least every 6 months for Medicaid expansion adults, current practice is annual, secretary of HHS to issue guidance within 180 days of enactment
  - ***Impact to the state****:* Reduces spending by $158 million in federal revenue and $17 million in general fund revenue because of expected enrollment churn. Also has interaction effects with retroactive coverage limitation.
  - ***Effective Date:*** For renewals scheduled on or after December 31, 2026

Retroactive Eligibility

- Limits retroactive coverage to one month prior to application for coverage for expansion enrollees and two months for traditional enrollees, current practice is three months.
  - ***Impact to the state:*** $8.2 million in federal revenue and $2.3 million in general fund revenue because of a projected decrease of 18.4 thousand months of member enrollment annually.
  - ***Effective Date:*** January 1, 2027

Federal Budget Reconciliation – SNAP Timeline

Timeline -- Federal Reconciliation SNAP Changes

State Fiscal Year	SFY 25	SFY26	SFY27	SFY28	SFY29	SFY30	SFY31	SFY32	SFY33	SFY34	
Federal Fiscal Year	FFY25	FFY26	FFY27	FFY28	FFY29	FFY30	FFY31	FFY32	FFY33	FFY34	
Calendar Year	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	
Month	J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D										
State Match Requirement				Begins in October 2027							
State Match Requirement Delayed Implementation					If Payment Error Rate is Too High Begins in FFY29						
State Match Requirement Delayed Implementation						If Payment Error Rate Continues to Be High Begins FFY30					
Administrative Match Reduction			Federal Share for Administrative Expenses Reduces from 50 Percent to 25 Percent								

Federal Funds Framework Options

- Still a significant amount of uncertainty on status of specific programmatic federal funding, for things like workforce training and education. Many of the bigger fiscal impacts from reconciliation are not in next year's budget cycle, nor are they traditional "backfill." What would/should a framework look like for analysis to help with recommendations?
- Draft LFC budget guidelines suggest treating requests for replacement the same as if an agency was asking for new/expansion funding. That framework would include:
  - Is the program addressing a priority of the committee?
  - Legislating for Results Budget Development Tool – Program Premise, Needs Assessment, Program Description, Research and Evidence, Implementation & Fidelity Plans, Measurement and Accountability (how will we know it is working)
  - Presumably, the federal program would have robust information about its effectiveness.
  - Is the program funding reduced or eliminated and permanently or temporarily?
  - Does the state need to replace the program to address the need using the existing federal format, or could it free itself from regulatory barriers by developing a New Mexico specific approach?

Federal Funds Policy Options for Consideration

- Create fund to allow for federal rural health transformation program grants to be appropriated by the Legislature.
- Should the state subsidize certain rural hospitals' revenue with 100 percent general fund revenue as rural health transformation program grants run dry in five years?
- The Legislature appropriated a total of $176 million for rural health delivery grants over the past three years. Of that amount, $63 million is expended, $34 million is encumbered, and about $79 million remains unspent.
  - LFC staff requested detailed information about grants, uses, outcomes with minimal information to date.
- Should the state repeal the Healthcare Delivery and Access Act? Should 25 percent be allowed to flow out of the state? Or what are the risks of modifying the act to preempt future reductions?

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For More Information

- http://www.nmlegis.gov/lcs/lfc/lfcdefault.aspx
  - Session Publications
  - Performance Report Cards
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