Federal Impacts to Hospital Funding

Federal Funding Stabilization Subcommittee

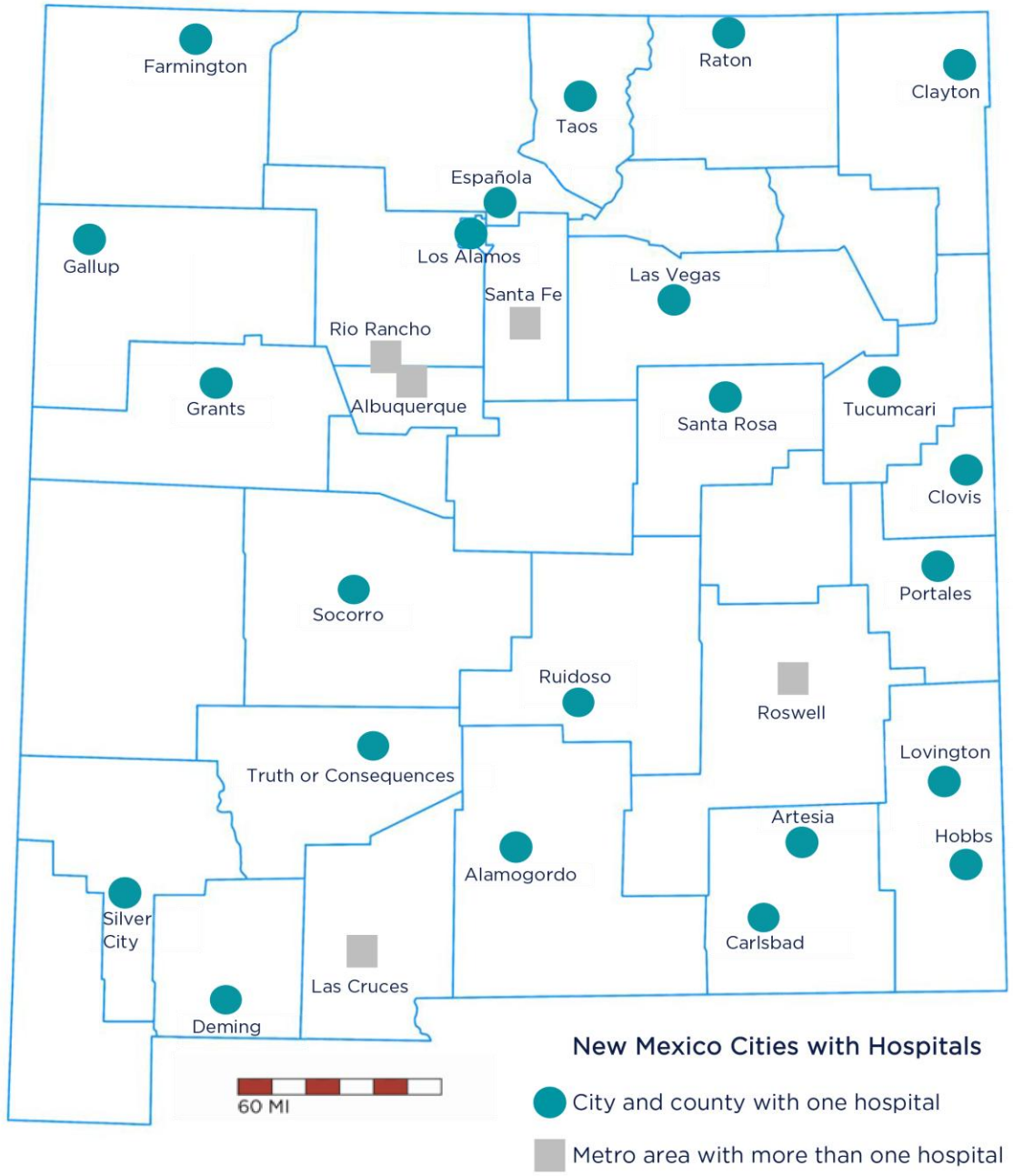
July 1, 2025

New Mexico Hospital Association

NMHA is the advocate and supporter of 48 community hospitals and the patients and communities they serve—and of hospital healthcare champions in public office.

We work with others to advance public policy to create a healthier New Mexico by protecting and expanding access to quality care.

New Mexico Hospital Association
1945-2025



Few and Far Between

In New Mexico, our hospitals are interconnected in the care they provide.

Rural, urban, academic, specialty (i.e., behavioral health, long-term care)

Private, nonprofit, independent, governmental hospitals serve ALL patients (Medicaid, Medicare, commercially insured, uncompensated)

Range of services, service lines emergency, inpatient and outpatient procedures, surgery, primary care clinics, school-based health clinics, behavioral health and substance use treatment, long-term care

Thank You

Recent Investments in Hospitals & Providers

SFY 2024 –

- **~$312.1 million**, including Medicaid provider and facility rate increases, Rural Health Care Delivery Fund, Health Professional Loan Repayment Fund increase

SFY 2025 –

- **~$241.5 million**, including bridge funding for independent rural hospitals, supplemental payments for 20 smallest rural hospitals, support for hospitals in McKinley, Quay, and Colfax counties
- Enactment of the Health Care Delivery and Access Act (HDAA)

SFY 2026

- **~$230.3 million**
- Medicaid Trust Fund & State Supported Fund
- Behavioral Health Trust Fund, Behavioral Health Reform & Investment Act

Health Care Delivery & Access Act

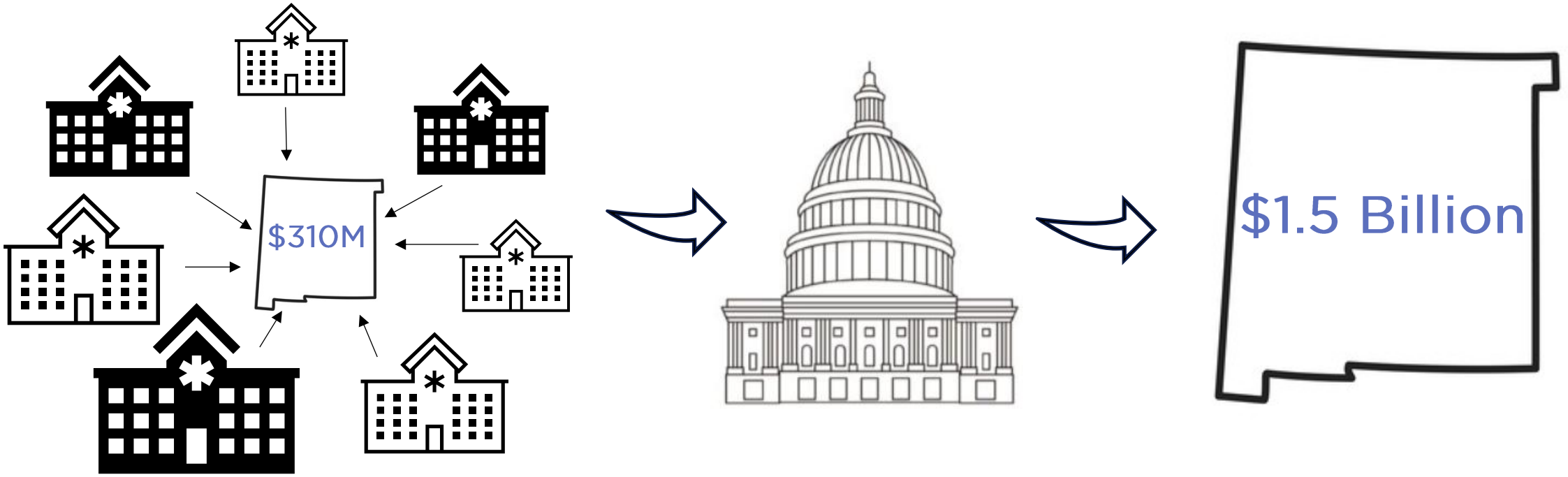
Background

- In 2022, 2/3 of hospitals' expenses exceeded revenue
- HDAA was developed to utilize new rules adopted by Centers for Medicare & Medicaid Services (CMS) to stabilize hospital operations
- Enacted by the Legislature and Governor & approved by CMS in 2024
- Hospitals received first payments in March
- Requires annual CMS renewal; CMS approved CY 2025

How It's Funded

Provider Tax

- Provides a portion of the state share of Medicaid funding
- Paid by each hospital, funds are pooled, sent to Feds & matched (~1:4)
- Used in 49/50 states



How Hospitals Receive Funds

Supplemental Payments

- Quarterly, hospitals receive an additional payment per Medicaid patient served
- Annually, one payment (40% of funds) made based on clinical quality performance
- The total Medicaid reimbursement (base + supplemental) is capped at the average commercial insurance reimbursement rate
  - For hospital services, averages 175% of Medicare
    - (blends rates for inpatient and outpatient & several state directed payments)

Mark Wilson / Getty Images

Changes on the Horizon

Federal Uncertainty

H.R. 1 – One Big Beautiful Bill Act

- Makes changes to provider tax and hospital funding reimbursement cap that limit higher reimbursement and threaten the HDAA's impact

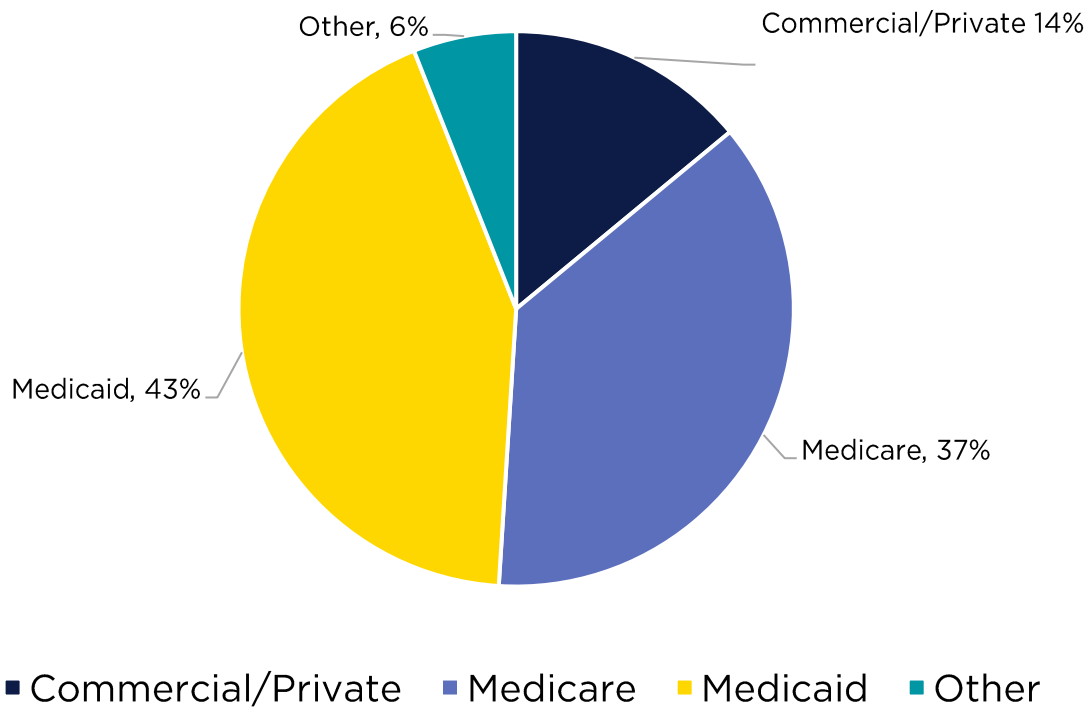
Presidential Memoranda: Eliminating Waste, Fraud, and Abuse in Medicaid

- Issued June 6
- Directs the Health and Human Services Department (over CMS) to "take appropriate action to eliminate waste, fraud, and abuse in Medicaid, including by ensuring Medicaid payments rates are not higher than Medicare…"

Why It Matters

- Supplemental Medicaid payments fill the gap of lower base reimbursement rates and aid in stabilizing hospital operations
- Helps address access to care crisis for all New Mexicans

2020-NM



Medicaid

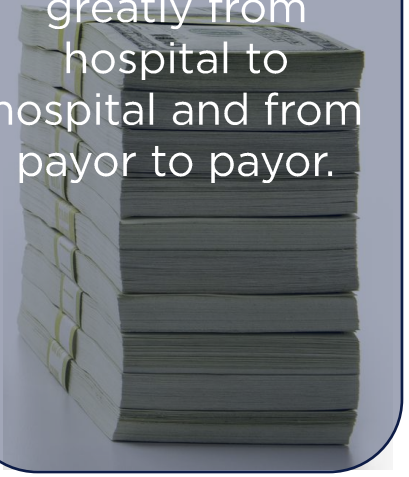
Reimburses **80-90% of COST** without supplemental payments.

Medicare

Reimburses **90-100% of COST**

Commercial

Reimbursement usually exceeds cost but varies greatly from hospital to hospital and from payor to payor.



Broader Medicaid Changes

- All raise concerns about disruption to Medicaid and Exchange enrollment, at varying degrees

- Increase amount of hospital **uncompensated care** with more uninsured New Mexicans

- Proposed changes:
  - Medicaid community engagement/work requirements
  - Increase frequency of redeterminations for Medicaid expansion enrollees
  - Modifying retroactive eligibility under the Medicaid and CHIP programs
  - Medicaid cost-sharing requirements for certain expansion individuals

- Changes to Exchange enrollment and programs also

Potential Impacts

Felt Across the State

- Limited fraud, waste or abuse addressed by the changes. Hospitals, doctors, patients, and the State bear the weight and responsibility of changes.

- More difficult for New Mexicans to enroll and stay enrolled in Medicaid & Exchange plans

- Increased pressure on hospital ERs, increased uncompensated care provided by hospitals, escalates chances of hospital closure(s)

Possible Hospital Impact

- Loss of **$3.6B** (across all H.R. 1 policy changes as passed House)*

Possible State Impacts

- Loss of **$9.2B** (across all H.R. 1 policy changes as passed House)*

*Source: Urban Institute & Robert Wood Johnson Foundation

Impacts, continued…

Possible HDAA Impacts

- Reduce the funds and reimbursement to a degree where it no longer supports hospitals and access to care
  - U.S. Senate Finance Committee proposal shrinks the program by $566M (more than one-third)
- Hospitals could pay more into the program than they could receive in reimbursement under 100% of Medicare cap

Economic Impacts of Each $1B Reduction in Medicaid Spending**

- **1,380:** Annual average hospital jobs lost
- **14,632:** Annual average total jobs lost
- **$1.6B:** 10-year reduction in statewide economic activity
- **$56.9M:** 10-year loss of federal, state, local tax revenue

**Economic impact modeling conducted by American Hospital Assoc. using Lightcast (lightcast.io), as of 5/2025

Thank You!

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Appendix

H.R. 1 OBBBA – Provisions passed by U.S. House + Potential Impacts

- **Section 44132: Moratorium on new or increased provider taxes (effective upon enactment)**
  - Disallows federal matching funds for state provider taxes imposed after the date of enactment or any provider taxes that were increased (in amount or rate) after the date of enactment. Also prohibits states from increasing the tax base by expanding items or services, or expanding the tax base to include providers that were previously not included. This would effectively cap provider taxes at the amount in place on the date of enactment.
  - Potential Impact: The provider tax portion of HDAA was approved (for three years) in mid 2024 and should be grandfathered in under this provision. Unknown is how renewal applications would be treated.

- **Section 44133: Revising the payment limit for certain state directed payments (effective upon enactment)**
  - States that state directed payment programs (e.g., HDAA) that have been approved or submitted for approval to CMS by the time OBBBA goes into effect will be allowed to have total reimbursements over 110% of Medicare but will be capped at the current percentage of average commercial rate that is approved or submitted for approval. If a state submits a state direct payment for approval by CMS after the enactment date of OBBBA, then the total reimbursement would be capped at 100% of Medicare for adult expansion states.
  - Potential Impact: The CY 2025 HDAA program was approved by CMS on June 23, so HDAA should be grandfather in at least the CY 2025 HDAA program. The narrowest reading of this section raises the question of what will be the reimbursement cap for the required annual renewal applications that are submitted after the effective date of OBBBA (possibly impacting CY 2026 of HDAA and future years of the program)?

Appendix

H.R. 1 OBBBA – U.S. Senate Bill Language + Potential Impacts*

- **Section 71117: Medicaid provider taxes**
  - The section freezes in place hospital provider taxes as of the date of enactment. For expansion states, beginning in federal fiscal year (FY) 2028 (beginning October 1, 2027) and continuing through 2032, their threshold will be reduced by 0.5% annually until the threshold reaches 3.5% in FFY 2032. Non-expansion states will remain frozen at their provider tax rate as of enactment.
  - Potential Impact: This would freeze in place the provider tax that funds the HDAA. The provider tax for HDAA is approximately 6% (of net patient revenue), so the provider tax percentage would be reduced by .5% beginning in FFY 2028 to a final cap of 3.5% by FFY 2032. Our modeling shows that **this would reduce the total funds in the HDAA program by approximately $566 million dollars, or more than one third** (without considering the impacts of the second provision below).
  - Note: On Thursday, June 26, the Senate Parliamentarian ruled that the original language submitted by the Senate Rules Committee did not meet the Byrd Rule and would need 60 votes to pass the Senate. The language above is the replacement to address the Parliamentarian ruling.

*As of Monday, June 30 at 2 pm MT.

Appendix

H.R. 1 OBBBA – U.S. Senate Bill Language + Potential Impacts*

- **Section 71118: Medicaid state directed payments**
  - This would set the payment limit for state directed payments (SDPs) (e.g., HDAA) at 100% of Medicare in expansion states (and 110% of Medicare in non-expansion states). States with approved SDPs (or where there was a good faith effort to be approved) by May 1, 2025, will be temporarily grandfathered. Beginning on January 1, 2028, the total SDP amount for all hospitals in all states would be reduced by 10 percentage points annually until the specified Medicare payment rate limit is achieved.
  - Potential Impact: We anticipate the 10% per year reimbursement cap reduction to begin with the CY 2028 HDAA program and that it could take several years for the 100% of Medicare cap to be reached. Currently, the reimbursement cap for HDAA is the average commercial insurance reimbursement rate (referred to as ACR). Between several SDPs that hospitals are beneficiaries of, the blended (between inpatient and outpatient) reimbursement rate is approximately 175% of Medicare.
    - While we do not have an exact financial impact to the HDAA if this is implemented, we anticipate that **reducing the total program reimbursement to no more than 100% of Medicare would result in some hospitals paying more in their provider tax than they could possibly receive in additional payments.**

*As of Monday, June 30 at 2 pm MT.

Appendix

H.R. 1 OBBBA – U.S. Senate Bill Language + Potential Impacts*

- **Section 71401: Rural Health Transformation Program**
  - The legislation would create a $25 billion rural stabilization fund, to be paid out as follows: $10 billion in federal FYs 2028 and 2029, $2 billion in FYs 2030 and 2031, and $1 billion in FY 2032. Of that total amount, half is distributed equally among all states, and half is distributed based on CMS' discretion, with it targeted at states with more rural areas.
  - Potential Impact: We anticipate the rural hospitals in New Mexico would be beneficiaries of this funding, but there's the potential that this funding ends at the same time that the provider tax and distribution caps are finalized at lower amounts.

*As of Monday, June 30 at 2 pm MT.