CHILDREN'S HOSPITAL ASSOCIATION

Implications of Budget Reconciliation Legislation on Children's Hospitals

Based on Enacted Law on State Directed Payments & Provider Taxes

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Background and Summary

On July 4, President Trump **signed** reconciliation legislation, **H.R. 1**, which includes numerous actions to reduce federal Medicaid spending through new restrictions on Medicaid eligibility and coverage rules, payments, and non-federal share financing. Manatt Health modeled the impact of the legislation based on survey responses from 64 children's hospitals across 27 states. Given the critical role that Medicaid provider taxes and state-directed payments (SDPs) have for sustaining the finances of children's hospitals, the Children's Hospital Association focused its survey on the impact of limitations on Medicaid provider taxes and SDPs. The budget reconciliation law establishes the following limitations:

- Prohibiting increases to existing provider taxes in all states and grandfathering existing tax rates, regardless of expansion status, and reducing the hold harmless threshold to 3.5% in expansion states by FY32 (Section 71115)
- Establishing the upper limit on **new** SDPs as 100% of Medicare in expansion states and 110% of Medicare in non-expansion states (Section 71116)
- **Existing** SDPs would be reduced by 10 percentage points annually starting in FY28 until the allowable Medicare-related payment limit is achieved (Section 71116)

Implications of H.R. 1 for Children's Hospitals

As permitted under federal law and subject to federal approval/regulations, virtually all states have implemented taxes on health care providers—supplementing state general fund appropriations—to finance the non-federal share of their Medicaid programs. These provider taxes are critical in funding supplemental payments that offset low Medicaid reimbursement and support investments in improved access for millions of children.

Supplemental payments, such as SDPs, are critical for ensuring access for children in the Medicaid program. Children's hospitals represent less than 5% of the nation's hospitals and account for nearly half of states' hospital days for Medicaid-enrolled children[1], while base payments cover less than 70% of children's hospitals' costs of providing care on average.[2] Since their inception in 2016, SDPs have represented an increasing and now predominant share of Medicaid supplemental payments to providers nationwide and provide an essential lifeline for children's hospitals in particular.

New restrictions on states' ability to maintain and renew provider taxes and SDPs will limit states' ability to finance enhanced Medicaid payments. This will have a devasting impact on children's hospitals in their ability to access payment levels needed to sustain and promote access to care for children and their families in the Medicaid program.

[1] Children's Hospital Association's Analysis of Kids' Inpatient Database (KID), Healthcare Cost and Utilization (HCUP), Agency for Healthcare Research and Quality, 2019.

[2] Annual Benchmark Report Fiscal Year 2023, Freestanding and Children's Hospital in Hospital Cohort, Children's Hospital Association. 2025

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Key Takeaways Based on CHA's Analysis of Survey Results

- Of the 64 hospitals that submitted survey data, 53 hospitals had SDPs that amounted to $5.3 billion of payments during a 12-month period. SDPs are a significant source of funding for these hospitals, making up 38% of total Medicaid funding and 13% of all overall operating resources. The average SDP per hospital was approximately $105 million.

- Because existing SDPs will be capped at Medicare levels over time, children's hospitals in states with existing SDP arrangements will receive 44% less in SDP funding relative to current state at year 10. If SDPs were to remain as they currently are, during year 10, survey respondents are projected to receive $7.2 billion in SDPs. However, because of the enacted legislation, they will experience a $3.2 billion reduction in SDPs.[3]

- In states pursuing a new SDP arrangement after enactment of the legislation, children's hospitals would receive SDPs that are 58% below total Medicaid reimbursement (base payments and SDP) levels in place today. Today, states have the flexibility to pay SDPs up to the average commercial rate to support children's care. This flexibility will no longer be available. Across the country, commercial payors pay 2 – 2.5 times more than what Medicare pays. Therefore, by setting the limit of SDPs at Medicare rates, the legislation imposes a major opportunity cost on children's hospitals and limits the ability of new states to use SDPs to stabilize financing of pediatric care.[4]

- Of the 64 hospitals that submitted survey responses, 56 hospitals currently report paying provider taxes totaling $1.8 billion (averaging $32 million per hospital), which finance nearly $4.5 billion in Medicaid payments today. While the impact of the provider tax legislation will depend on whether a state is a Medicaid expansion state, the final enacted bill allows the tax rate in all states with existing provider taxes to trend with inflation. For expansion states, the hold harmless threshold would be reduced to 3.5% by 2032. Of the 56 hospitals with provider taxes, 26 have taxes greater than 3.5% and of these, half (13 hospitals) are in expansion states[5]. Based on the enacted bill (and absent new state funding), survey respondents would pay $1.7 billion less in provider taxes over 10 years and this would in turn eliminate $4.4 billion in Medicaid funding that would otherwise be available in these states under current regulations.[6]

Conclusion

The modeling results provided by Manatt Health consider provisions in the enacted reconciliation bill, H.R. 1, related to SDPs and provider taxes, indicating significant cuts in federal Medicaid funds for children's hospitals. Given the limited scope and timing of the survey (which preceded the Senate legislation), these estimates almost certainly understate the total impact of the bill.

[3] Manatt leveraged the Congressional Budget Office's (CBO) June 2024 **Medicaid Baseline** and additional analysis from its January 2025 **Budget and Economic Outlook** to establish 10-year medical inflation trends for Medicaid-enrolled children. For existing SDPs and Medicaid managed care base payments, analysis assumes that they would be able to continue to trend with inflation consistent with CBO estimates.

[4] Based on hospitals' survey responses and publicly-available SDP preprint approval letters, Manatt identified SDP amounts as a percentage of Medicare or the average commercial rate (ACR) for children's hospitals responding to CHA's survey. For hospitals with SDP amounts expressed as a percentage of ACR, Manatt utilized Milliman 50-state commercial-to-Medicare reimbursement benchmarks to translate SDP amounts to a percent of Medicare. The aggregate reduction in payments is based on the aggregate SDP amount above the upper limit for new SDP arrangements in the House reconciliation bill (i.e., 100% of Medicare for non-expansion states, 110% of Medicare for expansion states). This is intended to provide directional insight on the opportunity cost for children's hospitals in states that have not yet implemented SDPs relative to those receiving SDPs today under current regulations.

[5] Tax percentage has been calculated based on hospital-provided data. Equals provider taxes paid divided by total net patient service revenue.

[6] Manatt relied on the CMS market basket inflation rate to trend aggregate provider taxes included in CHA survey responses to FFY 2034.