FISCAL IMPACT REPORT

SPONSOR Brandt **LAST UPDATED** **ORIGINAL DATE** 2/18/2025

SHORT TITLE Health Care Provider Gross Receipts **BILL NUMBER** Senate Bill 249

ANALYST Faubion

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Medicaid GRT Reimbursement - HCA	$0.0	$130,320.0 to $491,200.0	$135,190.0 to $504,100.0	$995,300.0	Recurring	General Fund
Implementation - HCA	$0.0	$45.0	$0.0	$45.0	Nonrecurring	General Fund
Implementation - HCA	$0.0	$450.0	$0.0	$450.0	Nonrecurring	Federal Funds
Total	**$0.0**	**Up to $491,695.0**	**Up to $504,100.0**	**$995,795.0**	Recurring	**General Fund**

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Related to House Bill 344 and Senate Bill 295

Sources of Information

LFC Files

Agency Analysis Received From
Taxation and Revenue Department
Department of Health
Health Care Authority
NM Attorney General's Office

SUMMARY

Synopsis of Senate Bill 249

Senate Bill 249 (SB249) mandates that healthcare providers receiving Medicaid reimbursements in New Mexico must also be reimbursed for any gross receipts taxes they are required to pay. It requires an itemized list that details the services reimbursed and explicitly specifies the amount allocated for gross receipts tax compensation. The reimbursement for gross receipts taxes would be paid by the state Medicaid program.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns, or June 20, 2025, if enacted.

FISCAL IMPLICATIONS

To estimate the GRT reimbursement for Medicaid receipts, LFC applied the share of Medicaid payments—as reported by the U.S. Centers for Medicare and Medicaid Services (CMS)—to total statewide GRT healthcare receipts. This analysis was conducted separately for state, municipal, and county-level revenues and focused on the healthcare service subsectors that would require Medicaid reimbursement. These subsectors were identified using RP-80 and RP-500 reports, which detail taxable gross receipts in the healthcare industry. By integrating payer distribution data with statewide taxable healthcare receipts, LFC estimated the expected Medicaid GRT reimbursements across different levels of government. LFC identified $257 million of nonhospital healthcare gross receipts tax revenue in FY24. CMS and HCA data attribute between 30 and 50 percent of nonhospital spending to Medicaid. To account for the large deductions already offered to private-pay healthcare, LFC assumed 50 percent of taxable receipts are from Medicaid. Therefore, to reimburse Medicaid gross receipts for nonhospital Medicaid services costs the state around $130 million each year. This includes both the state GRT increment and local GRT increments. This estimate should be considered a low-end estimate. HCA and CMS data report Medicaid spending for nonhospital healthcare between $2.5 billion and $7.5 billion. If GRT applied to 70 percent of this spending to account for administrative and MCO costs, this would bring the Medicaid reimbursement costs to $180 million to $400 million.

TRD notes their methodology as follows:

> The bill provides that healthcare providers receiving Medicaid reimbursement will be compensated for all applicable gross receipts taxes they are required to pay. TRD used data from the HCA September 2024 forecast to determine the aggregate spending for services subject to GRT in FY2024. These services include fee-for-service, services for Medicaid recipients on the Traditional and Mi Via waivers and services paid through managed care. Under fee-for-services, TRD removed categories that are not subject to GRT, such as federal and Indian Health Services hospital services. For direct payments under managed care, TRD assumed that 85 percent of the managed care capitations are for direct medical services (also known as medical loss ratio). Per HCA, the current percentage is at 90 percent under Turquoise Care, which is higher than the federal required 85 percent. TRD assumed 85 percent as the portion of direct healthcare services, as the Turquoise Care 90 percent includes quality improvement expenditures which may not always be direct healthcare services for Medicaid recipients. TRD then removed the GRT portion from both fee-for-service and managed care to arrive at the base expenditures for services. This base was grown by S&P's forecasted consumer spending index through the forecast outlook. TRD applied a statewide effective GRT rate to the tax base to arrive at the total reimbursement amount.

HCA notes this bill would require the Medicaid program to provide an itemized list that includes information on the service items paid and the associated GRT amounts. The itemization would require a system change and training given to providers and the MCOs. To comply with the itemization required by this bill, a system change would be needed in addition to training providers and the Medicaid managed care organizations (MCOs) to submit claims for reimbursement with the tax amount recorded by line. The system change would be made at a cost of $450 thousand at a 90 percent federal financial participation rate; the general fund cost is $45 thousand.

In summary, if the revenue losses and costs associated with this bill were instead directed toward higher Medicaid reimbursement rates, the state could unlock up to $1.5 billion in federal matching funds, resulting in a total increase of more than $2 billion in additional Medicaid funding. This shift would significantly expand resources for healthcare providers serving Medicaid patients, enhancing access to care while maximizing federal investment in New Mexico's health system.

SIGNIFICANT ISSUES

This bill mandates that healthcare providers receiving Medicaid reimbursements in New Mexico will also be directly reimbursed for any GRT they are required to pay. Currently, GRT is included in the reimbursement rates paid to Medicaid managed care organizations (MCOs), which then negotiate contracts with providers to determine how GRT is covered. The state does not directly pay GRT but factors it into MCO payments, leaving providers responsible for paying the tax to the state and negotiating reimbursement through their MCO contracts.

Current MCO contract requirements cite the following provisions regarding GRT:

- [In capitation rate] The contractor's capitation rate will be established by HCA. HCA's actuaries will develop components of the capitation rates, to include the medical services components, premium tax, gross receipts tax for provider payments, and the administrative expense portion of the capitation rates.
- [In provider agreements] Address how GRT will be accounted for when reimbursing providers (i.e., whether the GRT will be built into the negotiated contract rate or paid separately and identify the amount of GRT that will be paid on Medicaid claims);
- [In provider payments] The contractor shall negotiate with providers on how the GRT will be accounted for when reimbursing providers and consider GRT when establishing reimbursement rates (i.e. whether the GRT will be built into the negotiated contract rate or paid separately and identify the amount of GRT that will be paid on Medicaid claims)
- [In special reimbursement] The contractor shall be reimbursed for paid claims at either the established Medicaid fee schedule or the contracted rate in the provider agreement, whichever is greater, as of the date of service, plus GRT as applicable. HCA shall reimburse the contractor with state funds for state-funded services and state funds and federal match for federally funded services via invoicing methodology
- Unless otherwise noted in … this agreement, the contractor shall reimburse all providers at or above the state plan approved fee schedule for all services reimbursed at a fee-for-service payment methodology exclusive of applicable taxes and negotiated amounts.

HCA oversees MCO compliance with these contractual provisions, including through provider rate audits to ensure conformance with the contract.

The bill aims to standardize GRT reimbursement by ensuring providers are directly compensated, regardless of contract terms. However, this could lead to the state effectively paying GRT twice—once in the capitated payments to MCOs and again through direct reimbursement to providers—unless capitation rates are adjusted. This double payment would increase Medicaid costs without additional federal matching funds. Maintaining GRT on Medicaid services benefits the state because it shifts part of the tax burden to the federal government, with New Mexico's federal Medical assistance percentage (FMAP) matching rate covering approximately 73.47 percent of Medicaid costs in FY24. Removing GRT from the

MCO reimbursement rate would reduce the state's ability to leverage federal funds and increase the Medicaid program's reliance on state revenues.

The Attorney General's Office notes, because the bill proposes to reimburse healthcare providers for the gross receipts taxes that the providers are required to pay, at least insofar as the state portion of Medicaid is concerned, this may implicate the Anti-Donation Clause.

TRD notes New Mexico is one of the few states that taxes medical services, including those funded by Medicaid. Federal law, though, allows for federal match, federal financial participation, of the GRT that is included in payments to healthcare providers and in negotiated service rates paid through Managed Care. So, while medical professionals accepting patients in New Mexico under the Medicaid program must file GRT returns and pay the GRT, that GRT portion of the payment along with the service portion is subsidized by the federal FFP and state reimbursement match. In reimbursing healthcare providers for the GRT portion as proposed in this bill, the general fund loses revenue without compensation from a federal match. The GRT FFP subsidization allows for increased revenue to the state general fund which aids in increasing healthcare service rates to healthcare providers. Increasing the overall service rates to healthcare providers through appropriations to HCA would represent a more efficient use of state funds and make it more attractive for medical professionals to practice in New Mexico.

ADMINISTRATIVE IMPLICATIONS

The Health Care Authority notes the Medicaid program currently factors in GRT when calculating capitation rates for MCOs and pays providers GRT on fee-for-service (FFS) claims. However, in accordance with federal regulations, HCA is not legally allowed to be involved in provider reimbursement negotiations between MCOs and Medicaid providers who are subject to collecting and remitting the GRT to the state.

For most provider types and services, the Medicaid paid amount includes GRT, but this amount is
not identified separately on the claim. The GRT is generally calculated and remitted to providers at the header paid amount. The itemization required by this bill could be challenging and complex
to achieve for Mi Via providers and institutional services. The Medicaid program reimburses providers rendering services to Medicaid recipients at either a line level or header level, depending on reimbursement methodology.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

SB249 relates to House Bill 344 and Senate Bill 295, which include similar provisions for Medicaid GRT reimbursement.

TECHNICAL ISSUES

TRD notes the proposal states that the "health care provider shall be reimbursed …" but does not state by whom, or the source of those reimbursements. TRD also notes that there are no definitions of "health care provider" and "health care services". As noted in the revenue impact, certain populations of Medicaid recipients receive a variety of special needs services which may or may not fall under the intended scope of this bill. These terms may further clarification and definition to establish the scope of the reimbursement.

JF/rl/hg