ATI Advisory

EXECUTIVE BRIEF

The Hospital Margin Crisis: Disrupting the Payer-Provider Relationship

Margin compression is accelerating as uncompensated care and rate pressures loom. Sustainable growth can be found in premium dollar control when paired with managed care reinvention.

Executive Summary

There has not been a public policy moment as consequential to the future of American hospitals since the passage of the Affordable Care Act 15 years ago. HR1—One Big Beautiful Bill Act (OBBBA) will have significant direct and indirect impact on hospital systems as the legislation goes into effect over the next several years. Driven by funding shifts, policy restrictions, and cost containment goals, the bill's effects are expected to ripple across hospital finances, operations, and care transitions. Executives are particularly focused on the following challenges now seen on the healthcare horizon:

Financial strain from state and plan-level pass through:

- → Hospitals may experience greater financial stress as states and managed care plans absorb cost pressures and pass them down to providers.
- → Directed payments and other supplemental funding mechanisms that support safety-net hospitals may be reduced or eliminated.
- → Underpayment issues may worsen as hospitals are asked to shoulder more costs without corresponding rate increases.

Rising uncompensated care and emergency department strain from eligibility changes:

- → Changes to Medicaid expansion population eligibility requirements, including new work requirements and redetermination processes, will increase coverage loss and churn.
- → Hospitals may face spikes in uncompensated care, especially for formerly covered individuals.

The One Big Beautiful Bill Act marks the most significant policy shift for hospitals since the ACA—threatening to deepen financial strain and exacerbate uncompensated care burdens across the nation's health systems.

Emergency departments may see increased utilization by patients unable to access primary or preventive care, or SUD/BH services. System bottlenecks and throughput challenges from capacity and behavioral health gaps:

- Post-acute and Home and Community Based Services (HCBS) workforce shortages and financial pressures may reduce access to these supports and constrain upstream inpatient throughput by means of delayed discharges and care transitions due to limited post-acute and HCBS capacity.
- At the same time, shifting demographics, immigration policy, and work requirements will strain unpaid family caregiving capacity necessary to support hospital-to-home transitions—leading to readmissions, longer inpatient stays, and patient dissatisfaction.
- The closure or withdrawal of community-based behavioral health and SUD providers will potentially increase operational and quality challenges on the inpatient side related to discharge challenges, including boarding, readmissions, and emergency department over-utilization. Hospitals with inpatient psychiatric units could be particularly affected.

These disruptions are not theoretical—as health systems worked tirelessly to return to positive margins in the post-COVID era, they must again re-examine respective strategies considering OBBBA's provisions and the magnitude of its ripple effects. While the challenges are clear, more sophisticated systems will identify the opportunity to stabilize upstream revenue, which can most directly be achieved through value-based care and premium-dollar influence. Health systems that evolve into the payer space will be better able to protect margins while also expanding influence and positive community impact. To help health systems make that leap, ATI Advisory (ATI) brings deep expertise in Medicare and Medicaid strategy, and we welcome the opportunity to brief your executive team on the implications of OBBBA and ongoing policy developments. Our clients are scenario planning, and today will be remembered as the decisive moment when forward thinking leaders defined new strategic pathways to financial stability, operational resilience, and community impact.

As OBBBA reshapes the care landscape, hospitals face a perfect storm of capacity constraints, behavioral health gaps, and strained discharge pathways—making strategic adaptation not just necessary, but urgent.

Policy Highlights & What It Means

Rural Health Transformation

OBBBA created a “Rural Health Transformation” grant for states to develop a transformation plan and secure federal funding, with funding made available to rural providers.

Impact: $50B will be allocated to states over five years (2026-2030) to benefit rural health providers who will improve priority areas identified within OBBBA, but tight deadlines for this one-time grant award require rapid state and provider action before Dec 31, 2025.

Action: Health systems should engage with their state and associations to confirm their status meeting rural requirements, advocate for inclusion within the state’s application, align on strategic priorities, and prepare to demonstrate value, unmet needs, and readiness to address long-term rural health goals.

Action: Providers should form comprehensive partnerships, develop rural workforce recruitment and retention strategies, and assess technology and data readiness (especially for telehealth and cybersecurity) to position themselves for funding and meet rigorous oversight and accountability standards.

Consideration: Rural health providers are not well defined, and hospitals should consider that, if their state is awarded funds, those funds will be distributed by the state amongst other care providers within rural settings.

State Directed Payments

Previously, State Directed Payments were a mechanism by which states increased payments for Medicaid services relative to either Medicaid, Medicare, or commercial benchmarks. OBBBA placed limits on State Directed Payments relative to Medicare (at either 100% or 110%), which will likely cause some states to walk back rates currently in place.

Impact: Medicaid payments could be reduced to certain providers, especially hospital providers, in states where these payments are currently implemented.

Action: Health systems should work with their finance departments to project revenue at risk after assessing their payer mixes, high volume and dollar services provided to Medicaid beneficiaries, and their states' policies—including quantifying payment above Medicare rates.

Action: Health systems should work closely with their state and associations to continue to quantify impacts to the community, jobs, and patient well-being.

Consideration: Nursing facilities may also be affected, as well as physician payments, and margin compression could be anticipated by all affected provider types. These provider types are new partners in broader and more effective coalitions to mitigate OBBBA's multi-faceted impacts on health systems.

Provider Taxes

Previously, states used Provider Taxes to help fund Medicaid services, and this revenue was commonly matched by the federal government. To decrease federal dollars spent, OBBBA has placed limits on certain provider taxes. This will likely decrease Medicaid funding in states who had significantly leveraged this mechanism previously.

Impact: Providers, particularly hospitals, could see lower provider taxes in coming years. However, hospitals and nursing homes may face lower reimbursement rates from Medicaid as funding sources are potentially reduced and/or restricted relative to previously planned growth.

Action: In addition to research and advocacy with state and federal policy officials, health systems should work with Medicaid managed care organizations and other local healthcare providers to advance value-based care delivery and payment to reduce reliance on volume-based payment and reward efficiency and quality.

Consideration: Some states may need to redesign their provider tax and associated payment structures as the limits on provider taxes gradually go into effect over the next five years.

Redeterminations

Previously, Medicaid eligibility for expansion populations was redetermined every 12 months. OBBBA now requires redetermination every 6 months.

Impact: Providers may discover coverage loss as beneficiaries seek care, resulting in uncompensated care and increased rates of uninsurance.

Action: Health systems and plans should partner together, engaging support services which could potentially include social work and onsite eligibility liaisons to help beneficiaries navigate redetermination processes.

Consideration: Health systems can also collaborate with states and other managed care organizations to develop streamlined eligibility processes to minimize unnecessary disenrollment and preserve access to care.

Retroactive Coverage and Work Requirements

Previously, Medicaid would cover up to three months preceding the month of application. OBBBA shortens this to two months for traditional Medicaid applicants, and to just one month for expansion adults.

Impact: Uncompensated care burdens may increase, affecting hospitals but also rippling out to nursing facilities and home care providers.

Action: Health systems should collaborate with the state Medicaid agency regarding exploration of different policy levers such as presumptive eligibility and other means of improving application processing. Health systems should also partner more closely with HCBS/LTSS and post-acute care partners to reduce the potential impact of hospital throughput and ED overcrowding challenges.

Consideration: OBBBA additionally stops federal funding for emergency Medicaid care to people whose immigration status has not been verified, which could compound impact to states with relatively higher immigrant populations. This could also restrict access to preventative and primary care in Community Health Centers and other community services that historically served all individuals in a community, regardless of immigration status.

Consideration: OBBBA puts forward work requirements for beneficiaries, which is expected to also increase coverage losses and uncompensated care.

Anticipating These Changes

The path ahead won't unfold overnight—but the window for understanding impact and responsive strategic positioning is now. Most OBBBA provisions will phase in gradually, with major implementation milestones stretching over the next five years. However, states will interpret and operationalize these changes on differing timelines, with varying levels of clarity and readiness.

Congress is expected to revisit Medicare and Medicare Advantage reforms this fall, with possible attention to risk adjustment, star ratings, site-neutral payment, and even Medicaid restructuring. These additional reforms could accelerate or compound pressures on hospitals. With this uncertainty, health systems must prepare for multiple scenarios—starting now.

Fiscal Year (FY) 2025

July 2025 (Enactment)

- Prohibition on new provider taxes and increases for existing provider taxes (71115)
- Revising the payment limit for certain state directed payments (71116)
- Requirements regarding waiver of uniform tax requirement for Medicaid provider tax (71117)

FY 2026

Jan 2026

- Sunsetting increased Medicaid expansion FMAP incentive (71114)

FY 2027

Oct 2026

- Removal of enhanced federal match for emergency Medicaid services provided to undocumented immigrants (71110)

Jan 2027

- Codifying 1115 demonstration budget neutrality (71118)

FY 2028

Oct 2027

- 5.5% safe harbor limit on provider taxes for expansion states goes into effect (71115)

Jan 2028

- 10 percentage point decrease for grandfathered state directed payments that exceed new allowable limit, with an annual 10 percentage point decrease thereafter until the total payment rate is equal to the allowable limit (71116)

FY 2029

Oct 2028 — 5% safe harbor limit on provider taxes for expansion states goes into effect (71115)

FY 2030

Oct 2029 — 4.5% safe harbor limit on provider taxes for expansion states goes into effect (71115)

FY 2031

Oct 2030 — 4% safe harbor limit on provider taxes for expansion states goes into effect (71115)

FY 2032

Oct 2031 — 3.5% safe harbor limit on provider taxes for expansion states goes into effect, for fiscal year 2032 and all subsequent fiscal years (71115)

What to anticipate later this year:

Summer 2025

Congress focused on H.R.1: OBBBA with impacts to Medicaid, Exchanges

Reduces federal outlays for safety net:

- → Reduces Medicaid, SNAP funding
- → Modifies eligibility processes
- → Exchange tax credits expire in 2025 without additional legislative action

Fall 2025

Congress expected to revisit Medicare and Medicare Advantage reform

Potential focus areas may include:

- → Risk adjustment modifications
- → Star rating quality bonus reevaluation
- → Site neutral payment proposals
- → Potential to revisit Medicaid

Unprecedented Headwinds Operating Within an Increasingly Fragile Healthcare System

U.S. Healthcare Executives are Facing Unprecedented Headwinds Operating Within an Increasingly Fragile Healthcare System

→ Although hospital and health systems' financial performance improved in 2024, many providers continue to struggle, and despite positive margins for the industry on average, there is considerable variability in providers' financial health.

→ The traditional hospital business model has historically supported health systems' margins and adequately served communities, which is no longer sustainable or sufficient.

40% Hospitals operating in the red (with negative margins) in 2024	Workforce shortages and high turnover rates are impeding productivity and driving up labor expense	Demographic and site-of-care optimization are increasing the medical complexity & throughput of hospital patients	Rising tariffs and potential supply chain disruptions are escalating costs and impacting care delivery
-2% Projected shortfall in operating cash margin compared to pre-pandemic	Investment market downturns are contributing to decreased cash reserves and putting additional pressure on margins	Care delivery shifts outward, driving the need for care team redesign and investments in network adequacy	Legislative & regulatory activity, and the growth in Medicare Advantage, will continue to impact reimbursement

Strategic Challenges & Pathways Forwards

Challenge: Rate compression and limited Medicare Advantage leverage

Without a deeper managed care strategy, health systems risk ceding premium control and margin opportunity to external plans—while absorbing growing uncompensated care and administrative burden.

Pathways: A deliberate managed care strategy—focused on capturing the value with existing service lines and assets—can help hospitals reclaim leverage in federal programs. With MA enrollment continuing to grow, health systems already offering a plan have an opportunity to broaden their portfolio by launching Chronic Condition Special Needs Plan (C-SNP) or Dual Eligible Special Needs Plan (D-SNP). These targeted products offer not only enhanced care coordination and benefit design for complex patients but also demonstrably higher margins—nearly double that of general MA plans between 2019–2022. Leading health systems like Sentara, Henry Ford, Intermountain, and Banner have already made this move.

Challenge: Throughput and Discharge Bottlenecks

Workforce shortages in community care will create gaps that restrict patient flow across the care continuum, including increasing inpatient length of stay and driving ED overcrowding.

Pathways: Hospitals need to align discharge strategy with post-acute network development, home-based care models, and policy levers like HCBS or state sponsored services. ATI brings cross-setting insights into how hospitals can lead care transitions—not just absorb the system failures.

Challenge: Fragmented Value-Based Arrangements Across the Continuum

Hospitals are often caught between upstream health plan expectations and downstream provider capacity—limiting their ability to coordinate care, manage risk, or drive shared savings. Without alignment, value-based contracts become administrative burdens rather than strategic tools.

Pathways: Building or joining integrated value-based networks—with clear roles across acute, post-acute, and community providers—positions hospitals to lead on cost, quality, and population health. ATI helps hospitals craft multi-directional VBP strategies that connect payer contracts with real delivery system readiness.

Challenge: Behavioral Health Gaps and Dual Eligible Complexity

Hospital EDs and inpatient units are absorbing rising demand from patients with unmet behavioral health needs—often dual eligible individuals with complex, fragmented coverage and limited community supports.

Pathways: A proactive dual eligible and behavioral health strategy—including evaluation of SNPs, behavioral health networks, transition of care partnerships with health plans, and community based organizations—can reduce avoidable utilization and stabilize care transitions. ATI specializes in dual eligible integration and behavioral health delivery models that connect hospitals to the upstream solutions their patients need.

Refresh Your Strategies Post-OBBBA to Redefine Your Role in Value-Based Care

As OBBBA reshapes the operating environment, hospitals must take proactive steps to redefine their role in managed care and strengthen their influence in value-based arrangements. Start by revisiting the fundamentals—and then build toward advanced capabilities like SNP expansion.

Evaluate your current Medicare and Medicaid managed care positioning:

→ What are the characteristics of the population you serve today?

→ How has your payer mix evolved over time?

→ Which plans dominate in your market?

→ Are there unmet coverage needs that, if filled, could expand access to care?

Map your value-based footprint:

→ Do you have outcomes data to prove your value in payer partnerships?

→ Are you sharing savings or operating in a fee-for-service environment?

→ How integrated is your care delivery across acute, post-acute, and community partners?

Explore Medicare Special Needs Plans as a Growth Strategy:

→ For health systems already offering an MA plan—or considering one—SNPs represent a path to greater alignment and stronger returns. ATI Advisory brings national expertise in SNP strategy and execution, including full-service Model of Care (MOC) support, analytics, and implementation planning.

Evaluate opportunities to realign primary care assets and behavioral health partnerships to create ED alternatives:

→ Pair existing or new health plan capabilities with owned primary care capabilities to create new community-based care capacity to reduce overcrowding in the ER.

Hospitals that reassess their managed care strategies in the wake of OBBBA—and expand into models like SNPs—can unlock new value-based revenue streams while improving access and outcomes for the populations they serve.

Let's talk about your next moves. ATI Advisory supports hospitals and health systems at every stage of the managed care journey—from plan evaluation and board alignment to SNP applications and value-based network design.

ATIAdvisory.com

About ATI Advisory

ATI Advisory is a healthcare research and advisory services firm dedicated to system reform that improves health outcomes and makes care better for everyone. ATI guides public and private leaders in solving the most complex problems in healthcare through objective research, deep expertise, and bringing ideas to action. For more information, visit **atiadvisory.com**.