27th Annual Revenue Cycle and Finance Conference

Building Beyond: Leading the Future of Revenue & Finance

UNDER PRESSURE: MEDICAID IN THE WAKE OF THE ONE BIG BEAUTIFUL BILL ACT

Tom Barker &
Caroline Farrell

January 15, 2026

hfma
massachusetts-rhode island chapter

hfma
massachusetts-rhode island chapter

The information in this presentation is for general informational purposes only and is not legal advice. It may not reflect the most current legal developments and may not apply to your jurisdiction or situation.

OVERVIEW

- Medicaid Overview
- How does Medicaid operate?
  - Who is covered?
  - What is covered?
  - How is Medicaid financed?
- How is Medicaid changing with the Big Beautiful Bill?
- Where will the impacts be felt and when?
- How will these changes affect revenue cycle management?

MEDICAID OVERVIEW

- Medicaid provides health coverage to almost 78 million Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities.

- Medicaid covers more lives than any other health coverage program or payer in the United States.
  - Covers over 37 million children, more births, behavioral health services and long-term care services (in facilities and at home) than any other health coverage program.

- **After implementation of the Big Beautiful Bill, 7.5 million people are estimated to lose coverage.**

WHAT IS AT STAKE? MEDICAID NUMBERS & TRENDS

- Medicaid eligibility and enrollment: over 78 million individuals were enrolled in Medicaid and CHIP and receiving a comprehensive benefit package in June 2025
  - Almost 17 million additional people are receiving Medicaid and CHIP coverage today as compared to October 2013 when the initial Marketplace/Exchange open enrollment period began

- A shift to managed care - states generally pay health plans a fixed prospective monthly payment for each enrolled beneficiary:
  - 2021: almost 68 million Medicaid beneficiaries (87% of all beneficiaries) get comprehensive coverage through a managed care plan
    - States have expanded managed care programs to increasingly cover seniors, persons with disabilities and persons receiving long-term services and supports (LTSS).

- Many enrollees may not realize they receive Medicaid
  - E.g.,MassHealth & RIte Care
  - Often, enrollees have private insurance cards as their "Medicaid" card

MEDICAID ELIGIBILITY BASICS

- States set individual eligibility criteria within federal minimum standards
- Federal law mandates who states must cover and permits states the option to cover additional groups
  - All mandatory groups have maximum income thresholds, and some groups have limits on resources (assets)
    - Examples: pregnant women, children, individuals receiving SSI, very low-income parents
  - Currently 20+ optional groups (often same categories of people who are mandatorily eligible, but with higher income limits)
  - Medically needy: persons whose income exceeds the state's regular Medicaid eligibility limit but who have high medical expenses (e.g., nursing home care) that reduce their disposable income below the eligibility limit
- Additional eligibility requirements beyond categorical and financial requirements (i.e., immigration status), including **new mandatory work and other procedural requirements as well as new limits on immigrant eligibility under the Big Beautiful Bill**

WHAT DOES MEDICAID COVER?

Mandatory and Optional Benefits → State Variability

- Mandatory Benefits Examples:
  - Hospital and Physician Services
  - Federally Qualified Health Center and Rural Clinic Services
  - Laboratory and X-ray services
  - Nursing facility services
  - Early and Periodic Screening, Diagnostic, and Treatment services for persons under 21
  - Emergency and non-emergency transportation
- Optional Benefit Examples:
  - Home- and Community-Based Services and Personal Care Services
  - Prescription Drugs
  - Dental
  - Hospice

The Big Beautiful Bill does not eliminate services, but states may be forced to stop covering some optional benefits.

MEDICAID FINANCING BASICS

- Federal government matches state spending generally without any limit or cap:
  - Payments to providers for services rendered and supplemental provider payments
  - Payments to health plans who assume risk of covering eligible beneficiaries
  - Other state costs (e.g., administrative, systems, etc.)

- Federal match rate varies across states based on a formula
  - Ranges from a minimum of 50% to much higher levels in "poorer" states
  - The lower a state's per capita income, the higher the federal match rate it receives
  - Enhanced FMAP under the ACA for newly eligible individuals (i.e., adults)

- **The One Big Beautiful Bill Act is expected to reduce federal Medicaid spending by $911 billion over the next 10 years, with major cuts affecting supplemental payments and coverage of adults.**

MEDICAID AND THE BIG BEAUTIFUL BILL

- Major Changes on the Horizon After the One Big Beautiful Bill Act
  - **Financing** – less money for states and ultimately providers and plans
    - Attempts to mitigate losses for rural providers through the $50 billion Rural Transformation Fund
  - **Eligibility** – more "paperwork" and eligibility restrictions, especially for adults
    - Work requirements and more frequent eligibility renewals will be responsible for the majority of coverage losses
    - Questions about downstream consequences for children of newly uninsured parents
    - Reduced access for legal immigrants (plus additional agency action to limit immigrant access)

BIG BEAUTIFUL BILL: PROVIDER TAXES

- **Provider Taxes**: A state can provide its share of Medicaid funding with revenues derived from taxes imposed on providers so long as the tax does not contain a "hold harmless" provision (i.e., a provision that guarantees that the hospital does not suffer an economic loss from paying the tax).
  - A hold harmless guarantee is deemed not to exist so long as the revenues derived from the tax are less than 6% of the revenues received by the provider.
  - The legislation generally lowers this safe harbor threshold to 3.5%;
  - Effective starting October 1, 2026, but the requirement does not become effective until 2028 for expansion states.

The Big Beautiful Bill allows provider taxes that predated the law to remain in effect if, as of the date of the law's enactment (July 4, 2025), the state "has *enacted* such tax and *imposes* such tax on such class," and "the Secretary determines that the tax is within the hold harmless threshold as of that date."

- Preliminary CMS guidance issued on November 14, 2025 contains restrictive interpretations of "enacted" and "imposes" that would invalidate state healthcare–related taxes implemented shortly before the law's enactment:
  - States must have received CMS approval of the waiver by July 4, 2025 for the tax to be considered "enacted"
  - States must have been actively collecting tax revenues on July 4, 2025 for the tax to have been "impose[d]"

These changes mean less revenue for health care providers, with more significant reductions depending on CMS's final interpretations.

MORE CHANGES: FINANCING & PAYMENT

- **State-Directed Payments**: States generally cannot direct the terms of Medicaid managed care payments but can adopt a minimum fee schedule. Under present law, payments under such a fee schedule cannot exceed the average commercial rate for managed care payments in the state.
  - State-directed payments will now be limited to 100% of the total established Medicare rate in the state (in the case of states that have expanded Medicaid eligibility under the ACA) or 110% of that amount (for non-expansion states). Rural hospitals are grandfathered for a limited period.
- **"Reducing State Medicaid Costs"/Retroactive Coverage**: Medicaid currently pays bills for claims Medicaid would have paid if the person were eligible for the three months prior to eligibility. Under the Big Beautiful Bill, the period of retroactive Medicaid eligibility for expansion adults will be one month prior to application, and to two months for all other Medicaid enrollees. CHIP is similarly limited to two months of retroactive coverage.

These changes mean even less revenue for health care providers.

BIG BEAUTIFUL BILL: MEDICAID ELIGIBILITY

- Work Requirements - effective on January 1, 2027 (or earlier at state option)
  - Adults under age 65 will now generally be required to show that they are working or performing other qualified activities for 80 hours/month to be eligible for Medicaid
  - All states must implement this new feature of Medicaid, but there will be state by state variability in what implementation looks like
  - Beneficiaries can satisfy requirement through work, community service, work/training programs
  - States may require compliance for up to three consecutive months prior to application and for one or more months between eligibility renewals.
  - Exempt populations
    - Mandatory: children under 19, Medicare beneficiaries, pregnant and some postpartum women, caregivers to young children or disabled dependents, medically frail individuals, and those already meeting work requirements under other federal programs (i.e., TANF and SNAP).
    - States have the option to grant exemptions for short-term hardships, like hospitalization or needing to travel for complex medical care.
  - States are developing programs now, but awaiting CMS guidance (required by June, 2026)

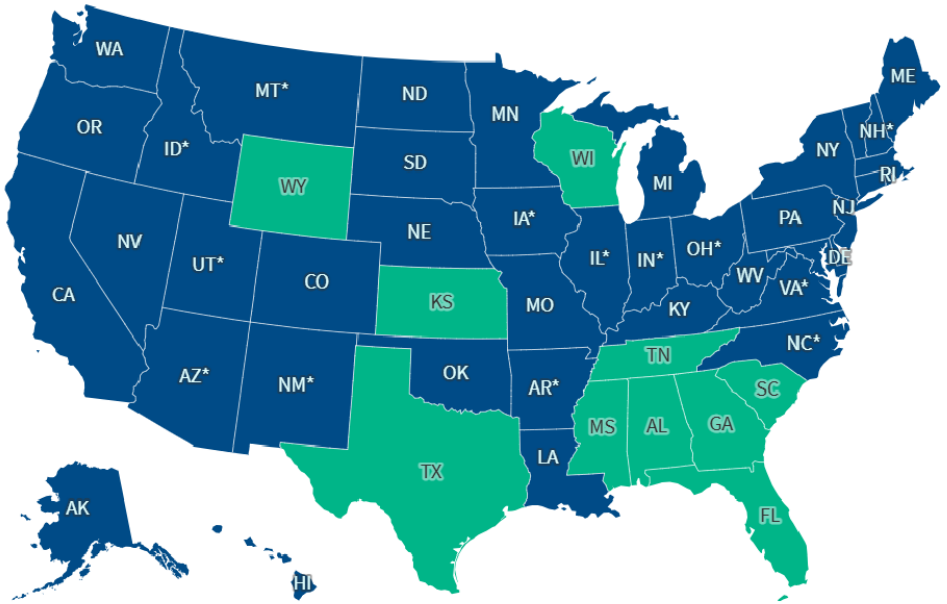
BIG BEAUTIFUL BILL: ELIGIBILITY RENEWALS

- Currently, most Medicaid beneficiaries renew their eligibility annually.
- The Big Beautiful Bill requires that states must verify Medicaid eligibility for adults under age 65 every 6 months starting on January 1, 2027.
- These bi-annual eligibility checks do not apply to certain individuals who are excluded from statutory work requirements.
- We are awaiting guidance about how this requirement will be implemented.
- Coupled with the work requirements, these changes will be responsible for the vast majority of coverage losses attributable to the Big Beautiful Bill. These changes disproportionally apply to "expansion" enrollees and will be felt the most in expansion states.

WHERE THE IMPACT WILL BE FELT MOST

Status of State Action on the Medicaid Expansion Decision

Adopted and implemented (41 states including DC) Not adopted (10 states)



Note: * State has a trigger law that would end expansion coverage or require states to take steps to mitigate increases in state costs if federal funding for the expansion is reduced.

Source: KFF tracking and analysis of state actions related to adoption of the ACA Medicaid expansion and Searing, Adam. "Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States." Say Ahhh! Georgetown Center for Children and Families, November 27, 2024 • Get the data • Download PNG

KFF

BIG BEAUTIFUL BILL: COST SHARING

- Beginning October 1, 2028, the 50 states and D.C. must impose cost-sharing (deductibles, copayments, or similar charges) greater than $0, up to $35 for covered services, on Medicaid expansion adults with income above 100% of the federal poverty line.
- This is a significant change for Medicaid expansion/adult group populations, who have generally had minimal cost-sharing.
  - Certain services (e.g., preventive services, primary care, mental health, substance use disorder services, FQHC, CCBHC, and rural health clinic services) are excluded from cost-sharing.
- This provision could mean Medicaid beneficiaries forego necessary care, further reducing provider visits, or cost-sharing amounts go unpaid.

BIG BEAUTIFUL BILL: MEDICAID TIMELINE

- January 1, 2026
  - Eligibility limits on lawful immigrants who are not permanent residents
- October 1, 2026
  - Provider tax limitations
- January 1, 2027
  - Work requirements
  - 6-month redeterminations/renewals required for adults under 65
  - Retroactive coverage limitations
- January 1, 2028
  - State directed payment limits
- October 1, 2028
  - Cost-sharing expansions

KEY TAKEAWAYS

- **Staggered and complex rollout:** Multi-year phase-in requires close coordination with federal and state agencies.
- **Funding and payment pressure:** Federal cuts and capped payments strain health systems – especially rural and safety-net settings.
- **Tightened eligibility and increased disruption:** Work requirements and six-month renewals reduce coverage and increase churn (cost-sharing begins in 2028).
- **Start preparing:** Understand state implementation plans and operational impacts on providers and patients to mitigate risk.

REVENUE CYCLE MANAGEMENT IMPLICATIONS

- Providers need to know more than just that a person was recently enrolled in Medicaid
  - Regular insurance verification
  - Understanding renewal dates and whether patients are subject to work requirements will be key
    - Awareness of not only the substantive eligibility rules, but the specific procedural requirements is important
  - Patient education to avoid churn
    - Awareness of new deadlines but also technologies to facilitate patient compliance with new requirements
- Expect more self-pay patients and uncompensated care
- Reduction in Medicare DSH payments
- Potential loss of access to 340B status

hfma
massachusetts-rhode island chapter

THANK YOU!

FOLEY HOAG