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PREPARING FOR THE IMPACT OF

The One Big Beautiful Bill

Translating H.R. 1 into practical strategies for healthcare providers

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NJ and Metro Philadelphia HFMA Institute | October 21, 2026

POWER IN THE PLUS™



Overview of the Bill and its Impacts

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The issue is bigger than a “Medicaid cut”

H.R. 1 reaches providers through four interconnected channels

01

COVERAGE

Eligibility loss and administrative churn

02

ACCESS

Delayed care and disrupted continuity

03

REVENUE

Self-pay, bad debt and payment pressure

04

CAPACITY

Workload and care-setting shifts

Treat H.R. 1 as an enterprise operating-model challenge, not a single reimbursement event.

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H.R. 1 healthcare provisions at a glance

Focus on the provisions that change provider economics and patient access

MEDICAID & CHIP

Community engagement
Eligibility and renewals
Cost sharing

MEDICAID FINANCING

Provider taxes
State-directed payments
Supplemental-payment pressure

MARKETPLACE

Verification requirements
Enrollment friction
Coverage continuity

MEDICARE

Temporary 2026 physician update
No permanent inflation solution

RURAL HEALTH

$50B transformation program
State-led implementation

LONG-TERM CARE

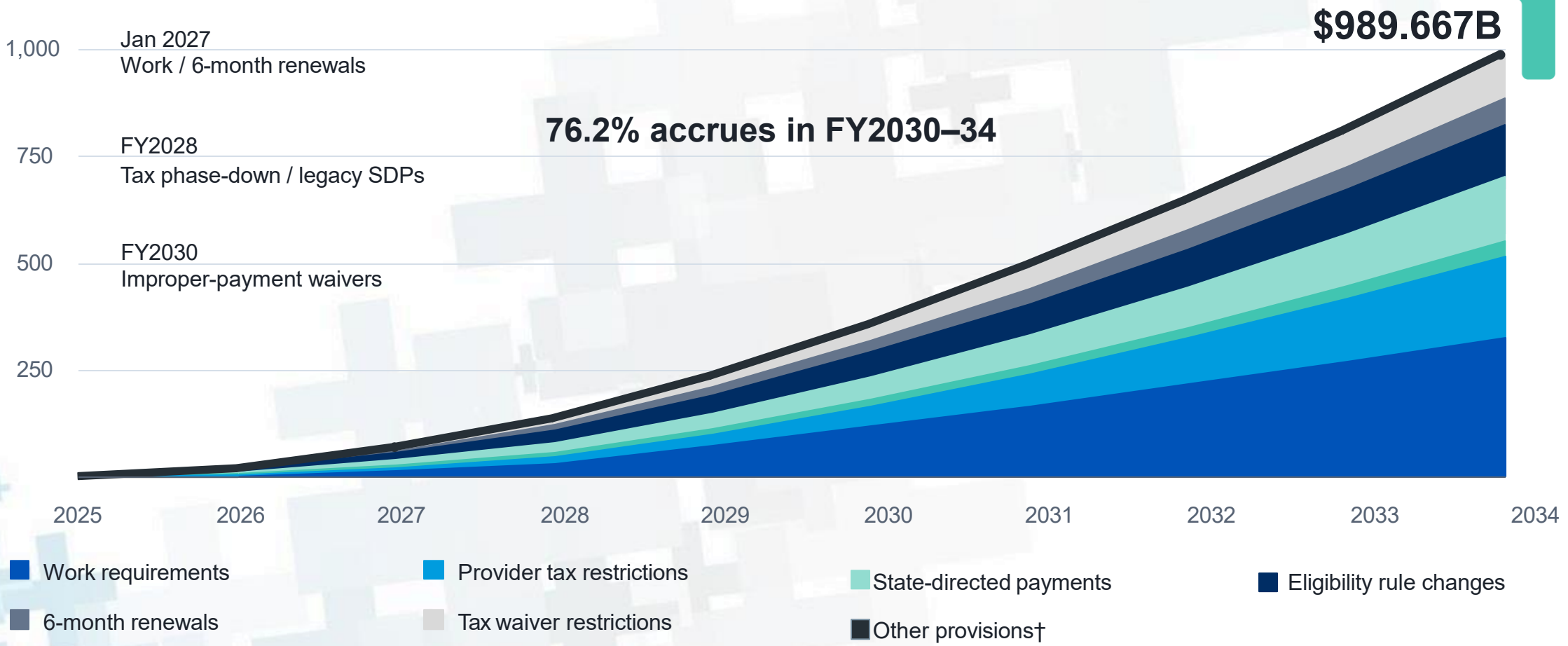
Selected regulatory delays
Operational and workforce implications

Impact varies by provider type, payer mix, state policy, patient demographics and geography.

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Medicaid spending reductions grow over time

Cumulative spending reductions • $ billions • FY2025–2034



Enacted July 4, 2025; CBO July 2025 spending estimates. Combined estimates; overlapping effects not deducted.

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Impact of each provision

Work requirements

Work or qualifying activities; exemptions apply.

Provider tax restrictions

Limits taxes; expansion phase-down FY2028–32.

Tax waiver restrictions

Closes non-uniform tax loopholes; dates vary.

State-directed payments

Caps additional managed-care provider payments.

Eligibility rule changes

Blocks enrollment simplification, including MSPs.

6-month renewals

Checks expansion adults' eligibility twice yearly.

Retroactive coverage

Shortens coverage before an application.

Expansion incentive

Ends new-expansion bonus—not the regular 90%.

Cost sharing

Adds specified charges above 100% of poverty.

Address / duplicate checks

Verifies residency and cross-state enrollment.

FMAP: improper-payment waivers

Limits good-faith waivers for erroneous payments.

Immigration

Narrows eligibility and emergency-care matching.

Additional provisions

Smaller provisions, net of spending increases.

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Varied Impact Across the Continuum

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How Medicaid coverage disruption reaches providers

Administrative friction can become clinical and financial disruption

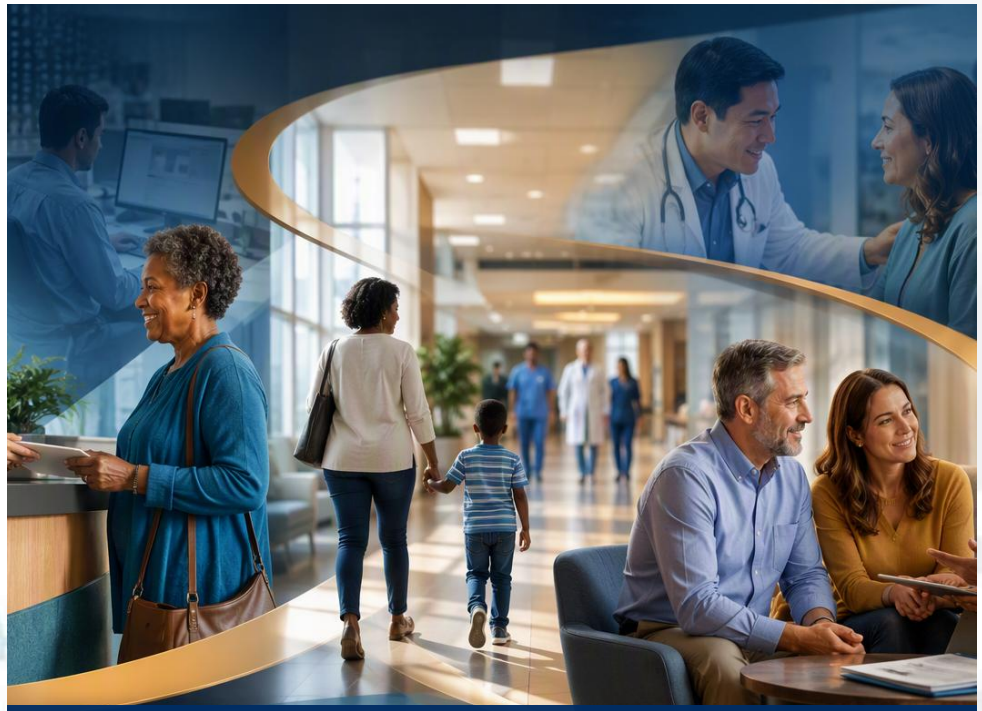


Coverage loss is not only an eligibility outcome. It changes patient behavior and provider operations.

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Hospitals and health systems

Move beyond enterprise payer mix to pinpoint concentrated exposure



Where vulnerability often concentrates

UNCOMPENSATED CARE

Self-pay and bad debt

FRONT-END FRICTION

Inactive coverage and Medicaid pending

UTILIZATION SHIFT

Emergency and acute care

FINANCING PRESSURE

Supplemental payments and service-line margin

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Physician practices, ASCs and nursing facilities

Different operating models, different pressure points

PHYSICIAN PRACTICES

Uninsured and self-pay encounters
Volume erosion due to care avoidance
Eligibility verification workload
Appointment and referral disruption
Temporary Medicare relief

AMBULATORY SURGERY

Elective-volume sensitivity
Pre-service verification and authorization
Estimates, deposits and financing
Lower-cost site-of-service opportunity

NURSING FACILITIES

Long-term-care eligibility delays
Medicaid-pending cash exposure
Resident-liability workflows
Persistent workforce pressure

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The rural health opportunity and limitation

Transformation funding can accelerate change, but it is not a blanket revenue replacement



$50B **Rural Health Transformation Program**

- Workforce and access
- Technology and digital health
- Regional collaboration
- Preventive and chronic care
- Sustainable delivery models

Position as an implementation partner, not a passive recipient.

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Preparing a Response

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A five-part H.R. 1 readiness framework

Turn uncertainty into a coordinated management response

01	02	03	04	05
QUANTIFY	**PROTECT**	**STRENGTHEN**	**MODEL**	**REDESIGN**
Exposure	Coverage	Controls	Scenarios	Access & capacity

Accountability • Early warning • Practical mitigation • Paradigm shift

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1 | Quantify exposure

Build an H.R. 1 dashboard that reveals where disruption matters most

ENTITY

Hospital, practice, ASC, facility

SERVICE LINE

ED, maternity, behavioral health, elective

POPULATION

Eligibility category and vulnerability

GEOGRAPHY

State, market and community

FINANCIAL

Revenue, payments, denials, cash

OPERATIONS

Visits, pending accounts and workload

The goal is not one perfect estimate. The goal is to identify where management attention is most urgent.

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2 | Protect coverage at the point of care

Create multiple opportunities to identify risk before an account becomes self-pay



1. **SCHEDULE** — Initial eligibility check
2. **PRE-SERVICE** — Recheck near date of care
3. **REGISTRATION** — Resolve inactive or uncertain coverage
4. **PRE-BILL** — Investigate before self-pay conversion

A Medicaid-to-self-pay change should trigger investigation, assistance and navigation, not only a bill.

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3 | Strengthen revenue-cycle defenses

Protect legitimate coverage across the entire patient journey

FRONT END	DURING CARE	BACK END
Eligibility verification Coverage discovery Authorization Estimates and counseling Medicaid pending workflow	Coverage-status documentation Medical necessity support Communication of payer changes	Denial segmentation Retroactive eligibility Rebilling and assistance conversion

Preserve coverage first. Collect from the patient only after every legitimate coverage path is resolved.

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4 | Model relative risk, not one forecast

Separate what can be measured now from what should be monitored and stress-tested

QUANTIFIABLE DISRUPTORS

- Renewal and retroactivity changes
- Cost sharing and financing phase-downs
- Current Medicaid exposure baseline
- State directed payment reductions

LIKELY DISRUPTORS

- Coverage churn and eligibility denials
- Self-pay and uncompensated-care growth
- Higher financial counseling and administrative workload

DIFFICULT TO QUANTIFY RISKS

- Concentrated service-line volume shock
- Rapid liquidity deterioration
- Access or capacity constraints

Assess probability • quantify exposure • establish triggers • assign a response

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5 | Prepare the operating model: Medicaid disruption

Monitor leading indicators before the impact reaches monthly financial statements

ELIGIBILITY

Failure rate

SELF-PAY

Medicaid conversions

DENIALS

Eligibility-related

PENDING

Medicaid inventory

ACCESS

Coverage cancellations

COST

Uncompensated care



Ask where deferred demand will reappear and whether teams have the capacity to respond.

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5 | Prepare the operating model: Enterprise Transformation

THE CHALLENGE

Pressure from multiple directions

- Loss of Medicaid coverage and associated increase in self-pay
- Reduction in state directed payments
- Shorter retroactive coverage periods
- Cost sharing requirements for certain Medicaid beneficiaries
- Potential loss of DSH days and impact on 340b
- Staffing shortages, burnout and increased labor costs
- Continued expense growth

THE ANSWER

A Transformation Management Office

Scattered initiatives will not close the gap. One enterprise office will.

- Quantifies the business imperative over a 3- to 6-year horizon
- Connects executive sponsors and the board to every team
- One named owner per initiative — multiple owners means no owner
- Standard value calculation, workplan and realization schedule
- Dedicated project managers, analytics and embedded Information Technology

THE RESULTS

What health systems achieve

Margin improvement that lands in the GL
Value is credited only when it reaches the income statement

Operational gains you can see weekly
Length of stay, ED throughput, block utilization, Medicaid pending days, denials and bad debt

Intentional service line strategy
Capital and capacity concentrated in the lines the system can win, and exited where it cannot

A workforce and cost structure back in balance
Improvement initiatives impacted by human capital supported by targeted recruiting and retention

A durable culture of accountability
Discipline that carries into every future budget cycle

THE FIVE-STEP APPROACH

1. Establish the business imperative
2. Define executive oversight
3. Identify value
4. Drive accountability
5. Measure success

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Four takeaways

01	PARADIGM SHIFT	This will dramatically change how you operate
02	CROSS-SECTOR IMPACT	Every provider will feel downstream effects differently.
03	ACT NOW	Quantify exposure and strengthen front-end workflows.
04	PLAN FOR FUTURE	Establish systems and structures to support organizational transformation

Providers cannot eliminate the disruption. They can choose whether to encounter it reactively or manage it proactively.

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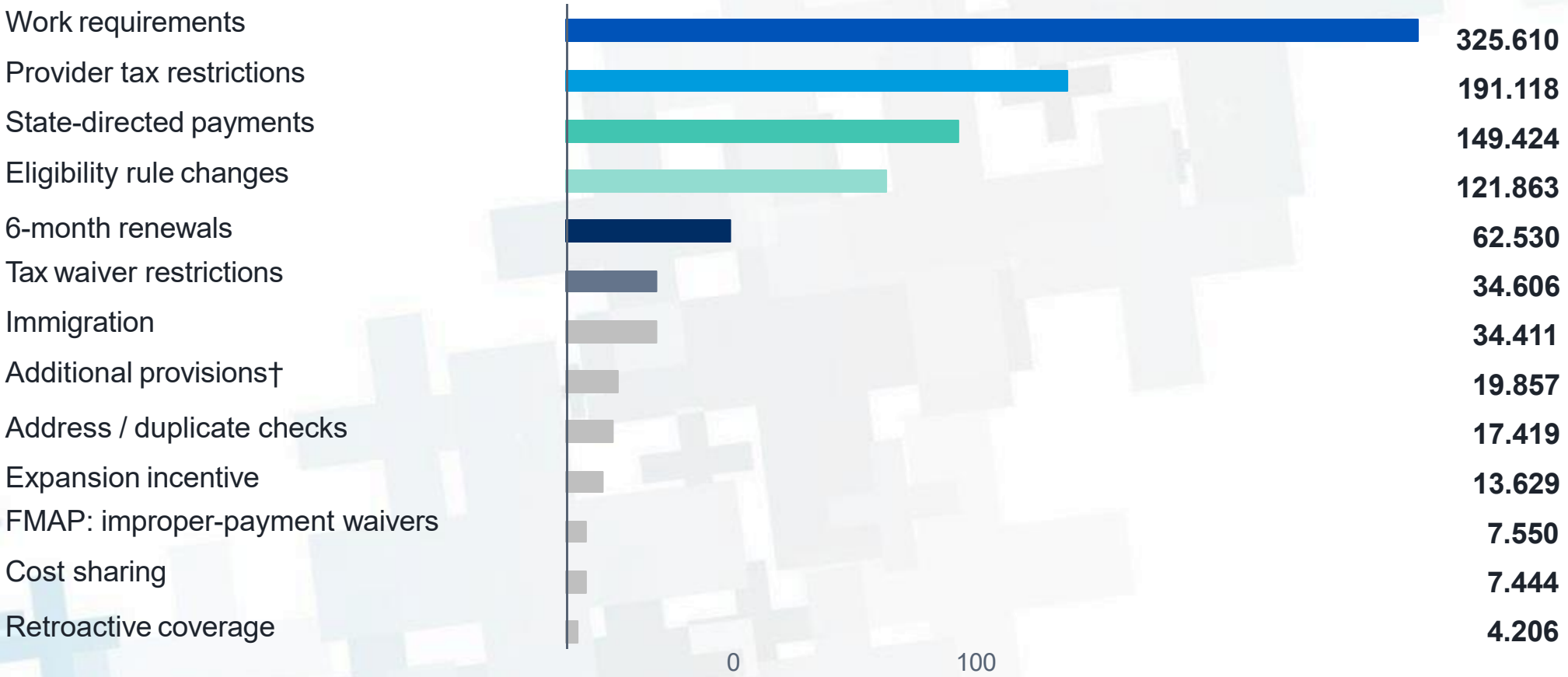
Questions?

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Additional Reference Materials

Spending reductions by provision

FY2025–34 • $ billions • enacted-law outlays



DSH: no verified separate score plotted. Citizenship: within eligibility; no separate score.
† Additional provisions are net of spending increases.

Enacted July 4 2025 law; CBO July 2025 spending estimates. Combined estimates; overlapping effects not deducted.

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Detailed implementation dates

Statutory / CMS implementation dates • CY = calendar year; SFY = state fiscal year

JUL 4, 2025 · Eligibility + staffing
Medicaid / MSP rule moratoria through Sept. 30, 2034.

JUL 4, 2025 · State-directed payments
Limits for new rating periods; legacy phase-in: Jan. 2028.

JUL 4, 2025 · Prohibited entities
Original one-year period; legal enforceability unverified.

JAN 1, 2026 · Expansion incentive
New-expansion bonus ends; regular 90% match remains.

OCT 1, 2026 · Provider tax restrictions
New thresholds; July 4, 2025 tax baseline.

OCT 1, 2026 · Immigration
Eligibility and Emergency Medicaid matching changes.

2026–2028 · Tax waiver transitions
MCO: end CY2026 / SFY2027; other taxes: end SFY2028.

JAN 1, 2027 · Work requirements*
Earlier state option; possible delay through Dec. 31, 2028.

JAN 1, 2027 · Renewals + retroactive coverage
6-month expansion renewals; retro: 1 month / 2 months†.

JAN 1, 2027 · Address + enrollee death checks
State address process and deceased-enrollee checks.

JAN 1, 2027 · Section 1115 neutrality
Certification for new applications, amendments, renewals.

JAN 1, 2028 · Home equity + provider checks
Home-equity cap and deceased-provider checks begin.

JAN 1, 2028 · Legacy state-directed payments
Grandfathered limits phase in by applicable rating period.

FY2028–FY2032 · Provider tax phase-down
Expansion states: 5.5% → 3.5%; specified exceptions.

JUL 1, 2028 · HCBS waivers
CMS may approve the new HCBS waiver option.

OCT 1, 2028 · Cost sharing
Specified charges for expansion adults begin.

OCT 1, 2029 · Duplicate enrollment
Federal multistate enrollment system begins.

OCT 1, 2029 (FY2030) · Improper payments
FMAP good-faith waiver limits begin.

* Exemptions apply. † Retro: expansion / other groups. FY = federal fiscal year; SFY = state fiscal year.
Sources: CMS guidance / tax-waiver rule; CRS R48633. Details in notes. DSH: no verified rollout date.

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Implementation at a glance

Key implementation waves

Immediate
2025–2026

- Eligibility & immigration rules
- New SDP limits
- Expansion bonus ends
- Tax restrictions begin

Near term
2027

- Work requirements
- 6-month renewals
- Address checks
- Shorter retro coverage

Long term
2028–2032

- Provider-tax phase (FY2028–32)
- Grandfathered SDP phase-down
- Expansion cost sharing
- Duplicates / FMAP limits (2029+)

Changes begin early; major financing restrictions phase in over several years.

Implementation timing—not the year CBO savings first appear. See slide 4 for dates. Tax-waiver compliance deadlines vary across 2026–2028.

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