



KEYNOTE · REVENUE CYCLE LEADERSHIP

The New Medicaid Reality

Navigating H.R. 1 and Protecting Revenue Cycle
Performance Through 2027

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Six Parts to This Conversation

Every segment below ends with something you can act on Monday morning.

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The New Medicaid Landscape

What H.R. 1 actually changed, and why now

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CBO, Urban Institute & hospital margin data

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The Revenue Cycle Leader's Playbook

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Key Takeaways & Open Discussion

Your 90-day action plan, then your questions

The Clock Is No Longer Theoretical

\$1T+

in federal Medicaid cuts
over 10 years under H.R. 1 /
the “Working Families Tax
Cut”

17MM+

more people projected
uninsured nationwide,
combining Medicaid and
ACA subsidy changes

Jan 1, 2027

the federal deadline — but
Nebraska, Georgia, and
Montana are already live

This month

Pennsylvania and Nevada
began mailing 700K+ and
250K+ enrollee notices,
respectively

PART 1

The New Medicaid Landscape

What H.R. 1 actually changed, and why the pressure is arriving now

One Law, Two Names, One Reality

H.R. 1 • P.L. 119-21

Signed into law July 4, 2025. Known throughout 2025 as the “One Big Beautiful Bill Act” (OBBBA).

CMS now calls it the “Working Families Tax Cut” (WFTC)

CMS Administrator Dr. Mehmet Oz used this framing when launching the nationwide work-requirement rule on June 1, 2026 — both names refer to the same statute.

For revenue cycle leaders, the name doesn't matter.

The mechanics do — and five of them will touch nearly every eligibility, verification, and reimbursement workflow you run.

SIGNED

July 4, 2025

CBO SCORED SAVINGS

\$1T+ / 10 years (Medicaid)

STATES REQUIRED TO COMPLY

50(incl. DC)

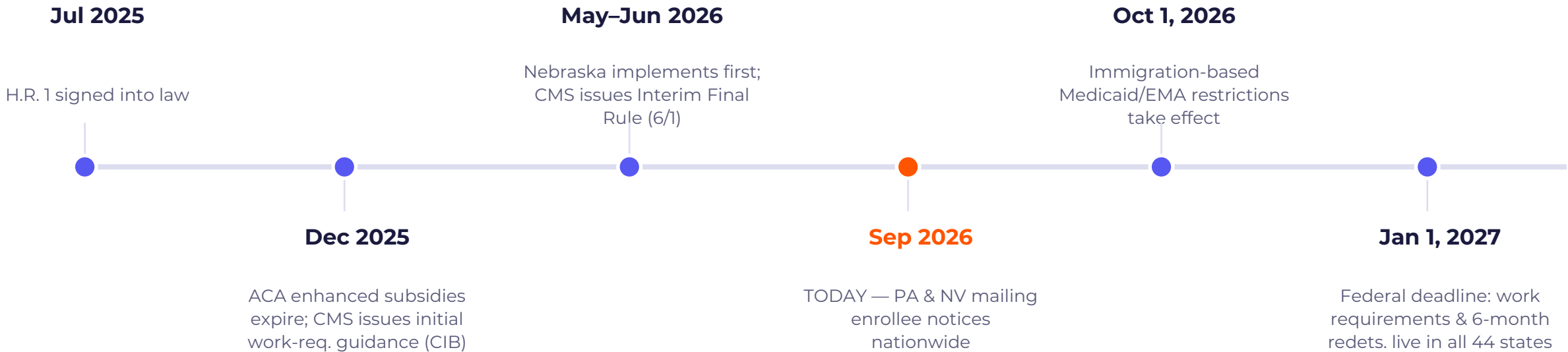
FULL IMPLEMENTATION

2026 – 2028

Where the Pressure Is Coming From

				
Work Requirements	Faster Redeterminations	Shorter Retroactive Coverage	Immigration & EMA Limits	ACA Subsidy Expiration
80 hrs/month community engagement for expansion adults, effective Jan 1, 2027	6-month eligibility reviews for expansion adults vs. 12 months prior	3 months cut to 1 month (expansion) / 2 months (all others)	Full-scope FFP narrowed to a small set of statuses, effective Oct 1, 2026	Enhanced premium tax credits expired 12/31/25; premiums and deductibles spiked

From Signing to Full Enforcement



You are here — outreach is already landing in patients' mailboxes

Why DSH & 340B Are Ground Zero

Coverage loss doesn't just cost individual claims — it moves a threshold percentage that determines whether a hospital keeps two major funding streams.

- 1 Medicaid Coverage Loss**
Work requirements + 6-month redeterminations + shorter retroactive windows push more patients into uninsured or self-pay status.
- 2 Medicaid DSH Percentage Falls**
Fewer Medicaid patient days shrink the hospital's Medicare DSH adjustment percentage — the metric that gates both DSH and 340B eligibility.
- 3 Two Funding Streams at Risk**
DSH payments phase out below threshold; 340B drug-discount eligibility requires >11.75% (DSH/CAN/PEDS) or ≥8% (SCH/RRC).
- 4 Margin & Access Impact**
Lost 340B savings and DSH payments compound with rising uncompensated care — hitting safety-net and rural hospitals hardest.

PART 2

Work Requirements Deep Dive

CMS's June 2026 rule, who is exempt, and where states stand today

What CMS's June 2026 Rule Actually Requires

80 hrs

of qualifying activity per month — or \$580/month in earnings at minimum wage

6 months

redetermination cadence for the expansion population (was 12 months)

30 days

cure period after a noncompliance notice before disenrollment

Guidance Trail

- **Dec 8, 2025** CMS issues initial Informational Bulletin (CIB) to states
- **Jun 1, 2026** Interim Final Rule with Comment (IFC) released — defines exemptions, verification, and reporting in detail; comment period opens
- **Jul 31, 2026** Comment period closes; IFC becomes effective
- **Sep 2026 (now)** States actively notifying enrollees (PA: 700K+, NV: 250K+ letters)
- **Jan 1, 2027** Federal enforcement deadline in all 44 required states

Applicable Individuals vs. Exempt Populations

MUST DEMONSTRATE COMPLIANCE

- Adults ages 19–64 in the ACA Medicaid expansion group
- Enrolled via a Section 1115 waiver offering expansion-like coverage
- Not pregnant, not entitled to / enrolled in Medicare Part A or B
- Applies in 41 expansion states + 3 waiver states (GA, TN, WI)

EXEMPT / EXCLUDED

- Pregnant & postpartum individuals
- Medically frail (narrowly defined by CMS's June 2026 rule)
- Disabled individuals receiving SSI / SSDI
- Parents / caregivers of a child under 13–14
- American Indian / Alaska Native (fully exempt)
- Full-time students; those already meeting SNAP/TANF work rules
- Incarcerated individuals; residents of high-unemployment areas

State Implementation Status — September 2026

State	Status	Effective / Notes
Nebraska	LIVE	First state to enforce — began May 1, 2026 via state plan amendment
Georgia	LIVE	Operating since 2023 under a Section 1115 waiver (non-expansion)
Montana	LIVE (early)	Enforcing since July 2026 via waiver authority
Iowa	Dec 1, 2026	Announced early start — four weeks ahead of federal deadline
Pennsylvania	Notifying now	700,000+ enrollee letters mailed starting Sept. 2026
Nevada	Notifying now	250,000+ letters; texts & emails to follow through September
Wisconsin	Jan 1, 2027	~200,000 BadgerCare Plus childless adults affected
All other req. states	Jan 1, 2027	Federal deadline — 37 additional states + DC

Source: KFF Medicaid Work Requirements Tracker (updated 9/9/26); state health agency announcements

The Verification Burden Lands on Everyone



01

Data Matching First

States must cross-check payroll, SNAP, and TANF data before requesting documentation from enrollees.



02

Self-Attestation, For Now

Allowed initially, but CMS signaled tightening restrictions on self-attestation beginning in 2027.



03

30-Day Cure Window

A noncompliance notice triggers a 30-day period to demonstrate compliance or claim an exemption before disenrollment.



04

Where Providers Feel It

Verification gaps surface as coverage denials at registration — often for patients who were actually compliant or exempt.

PART 3

Quantifying the Financial Exposure

What CBO, Urban Institute, and hospital-specific data actually project

Coverage Loss Projections, By the Numbers

\$1T+

10-year federal Medicaid spending reduction (CBO score of H.R. 1)

4.9–10.1M

people projected to lose coverage by 2028 from work requirements + faster redeterminations alone (Urban Institute)

\$326B

10-year federal savings attributed specifically to the work-requirement provision (CBO)

10M

additional uninsured Americans projected by 2034 from Medicaid provisions alone (CBO)

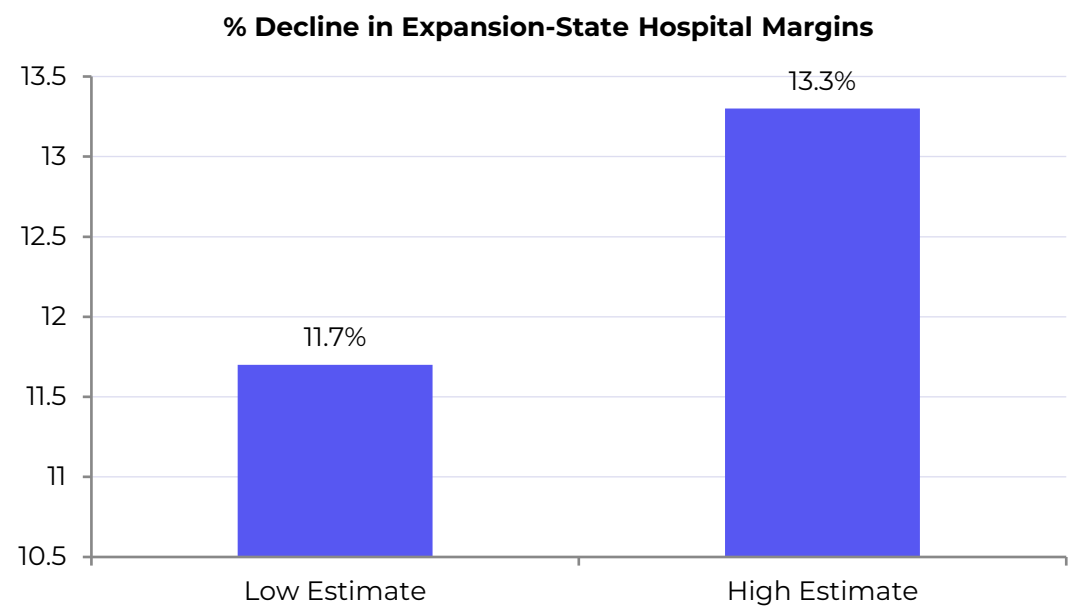
\$466B

cumulative rise in hospital uncompensated care, 2025–2034, from Medicaid cuts + ACA subsidy expiration (America's Essential Hospitals)

2.9M

HHS ASPE's own estimate of a possible poverty reduction from work requirements — the administration's stated rationale

Hospital Operating Margins Take a Direct Hit



Source: Qualify Health analysis of Urban Institute modeling, based on projected Medicaid coverage losses under H.R. 1

\$8B

projected national spike in uncompensated care from work-requirement disenrollment alone

36–42%

of the current Medicaid expansion population estimated to be at risk of procedural disenrollment

\$27.4B

increase in uncompensated care costs for uninsured individuals in 2034 alone (America's Essential Hospitals)

Rural and safety-net hospitals — already thin on margin — absorb a disproportionate share of this impact.

DSH & 340B Eligibility at the Brink

HRSA 340B Eligibility Thresholds

DSH / Children's / Free-Standing
Cancer Hospitals **>11.75%**

Sole Community Hospitals & Rural
Referral Centers **≥8%**

These thresholds are measured against the Medicare DSH adjustment percentage — a direct function of how many Medicaid patient days a hospital has.

314 hospitals are projected to be at risk of losing 340B eligibility as coverage losses compress DSH percentages nationwide.

CASE STUDY

A 9-Hospital System's EBITDA Swing

TODAY

+\$11M

IF 340B LOST

-\$42M

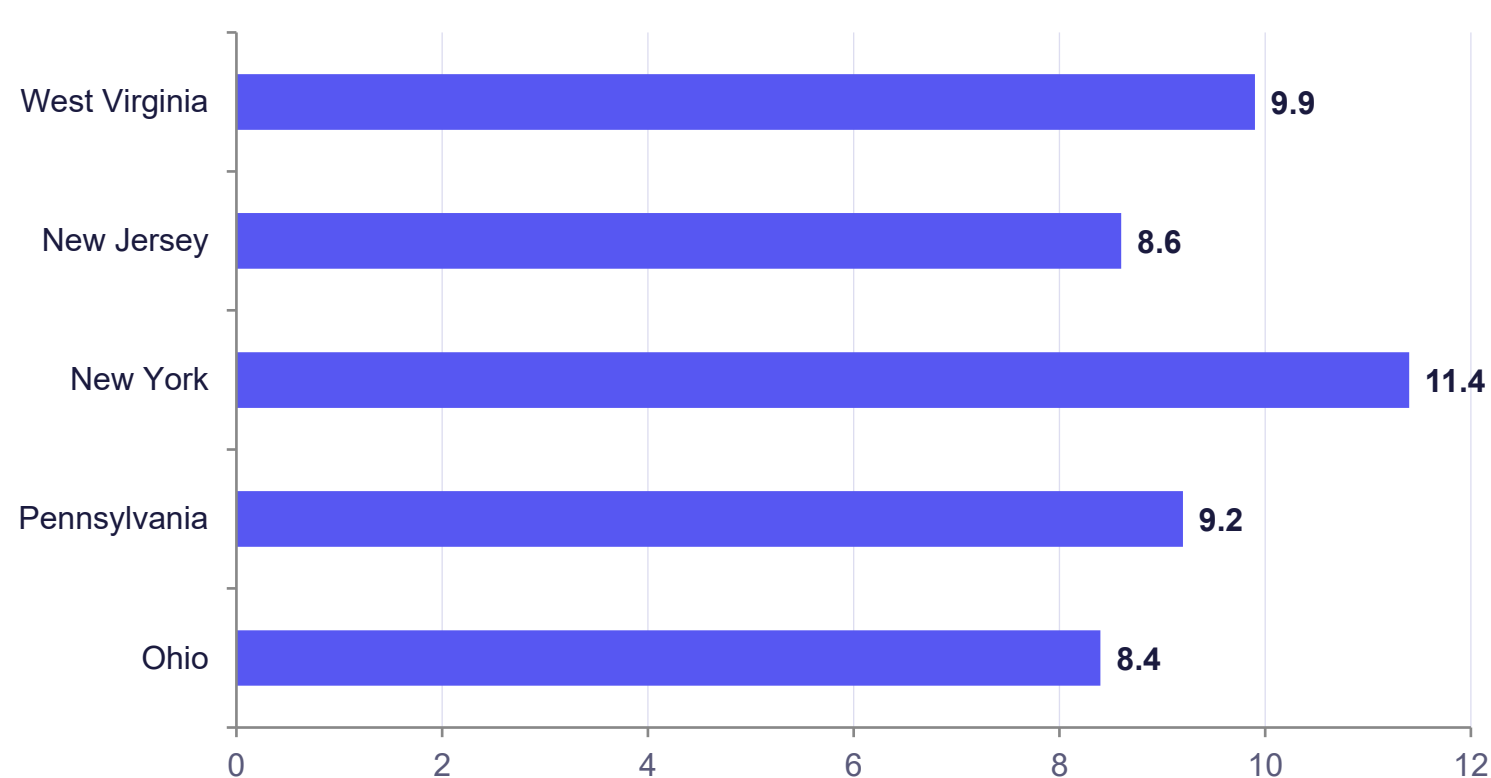
A modeled \$53M EBITDA swing on a single eligibility metric

Illustrating why Medicare DSH percentage must become a board-level KPI — not a back-office reporting line item.

Source: Chartis Group modeling, April 2026

IT'S NOT UNIFORM

Coverage-Loss Exposure Varies Sharply by State



Medicaid Coverage-Loss Estimate

Ohio	~253K (8%)
Pennsylvania	~275K (9%)
New York	~832K (11%)*
New Jersey	~159K (9%)
West Virginia	~52K (10%)

*NY's own 2026 post-enactment estimate (NYSAC) projects ~1.3M — see Appendix for full methodology.

Source: Joint Economic Committee (Minority Staff), "State-by-State Data on Health Insurance Losses," May 15, 2025 (CBO-based). Percentages vs. each state's current Medicaid enrollment. Full sources & state-specific corroborating estimates in Appendix.

PART 4

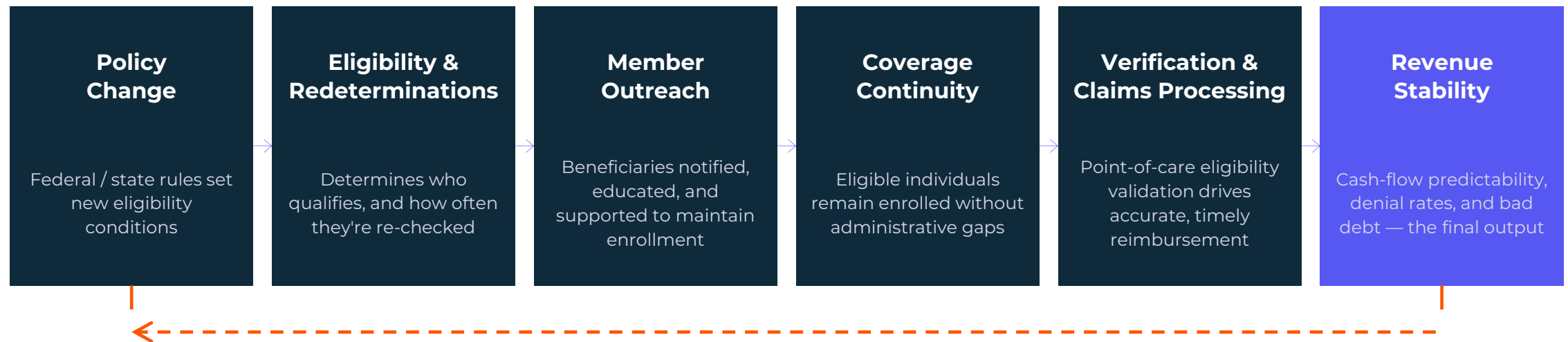
The Eligibility-to-Revenue Framework

Denials, bad debt, and cash-flow volatility are lagging indicators of failures that occurred weeks or months earlier — in eligibility processing, redetermination handling, and member outreach.

Leaders who focus exclusively on back-end revenue cycle fixes will keep absorbing preventable losses. The fix starts upstream.

The Medicaid Eligibility-to-Revenue Flow

Revenue is not a back-end function — it is the final output of a multi-stage operational system.

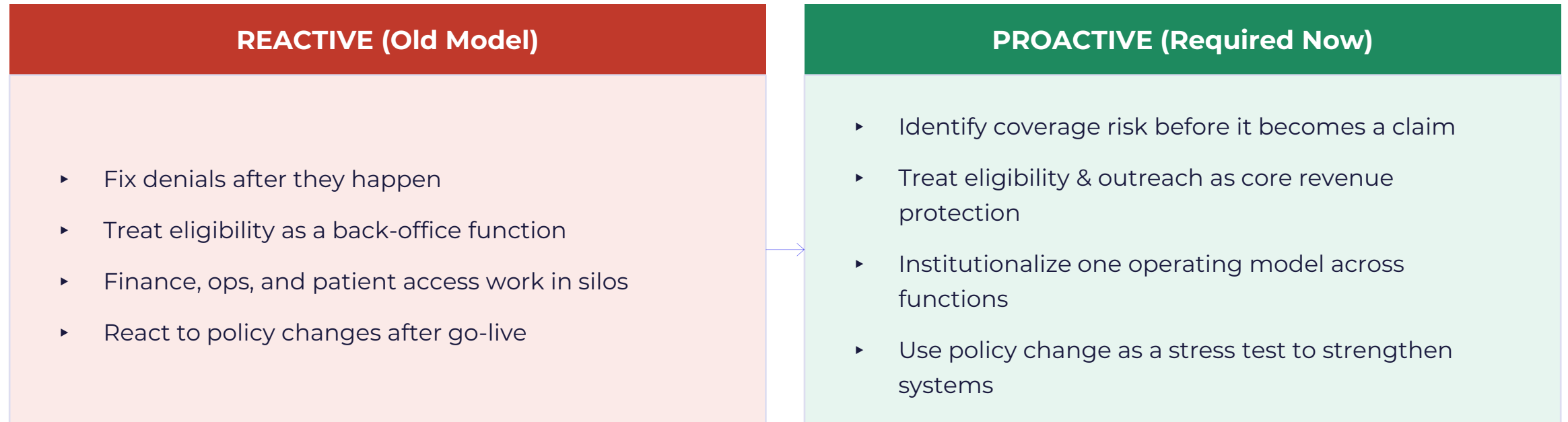


Feedback loop: rising denials or self-pay balances should trigger root-cause analysis upstream — in eligibility and outreach, not just denial appeals

Where H.R. 1 Provisions Apply Pressure

Flow Stage	H.R. 1 / WFTC Pressure Point	Operational Consequence
Eligibility & Redeterminations	6-month cycles; documentation-heavy work-req. verification	Shortened timelines + more paperwork raise risk of coverage loss from administrative error
Member Outreach & Continuity	Work-requirement reporting adds a compliance burden	Disenrollment increases whenever outreach fails to reach or engage members in time
Verification & Claims	Increased verification exposes state-system data inconsistencies	Claims get denied at the point of service due to eligibility data mismatches
Reimbursement	Retroactive coverage cut to 1–2 months; DSH/340B thresholds tighten	Lower reimbursement amplifies the financial impact of every upstream failure

From Reactive Revenue Cycle to Proactive Eligibility



Executives should institutionalize this flow as a shared operating model — with KPIs aligned to each stage, and explicit feedback loops back to eligibility and outreach.

PART 5

The Revenue Cycle Leader's Playbook

A readiness checklist, technology enablers, and lessons from live states

Four Pillars to Get Ahead of January 1, 2027



Technology

- › Predictive risk models flag likely disenrollment before it happens
- › SAVE / Federal Data Hub integration for real-time verification
- › Automated portal-based outreach & reminders



Staffing & Training

- › Expand enrollment assistance & financial counseling teams
- › Train intake staff to log exemptions before patients fall off rolls
- › Standardize scripts for work-requirement conversations



Outreach & Engagement

- › Multi-channel: mail, text, email, portal, app alerts
- › Prioritize patients nearing 6-month redetermination windows
- › Partner with community organizations for hard-to-reach populations



Governance & KPIs

- › Track Medicare DSH % as a standing board-level metric
- › Align KPIs across finance, ops, compliance, and patient access
- › Build feedback loops from denials back to eligibility root cause

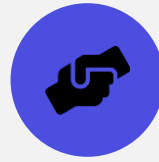
Identify → Engage → Support



IDENTIFY

Flag patients needing reenrollment or new coverage options

- Predictive analytics on historical disenrollment patterns
- Focus on managed-care patients with chronic care needs
- Prioritize by redetermination date proximity



ENGAGE

Proactive, omnichannel outreach before coverage lapses

- Letters, texts, emails, portal & app alerts
- Technology-driven reminders tied to recert timing
- Reach members where they actually are



SUPPORT

Expanded enrollment assistance through the transition

- Help patients reapply or transition to Marketplace
- Track outcomes to ensure continuity of care
- Feedback loop refines targeting and messaging

The Tools Are Arriving — Faster Than Expected

On September 9, 2026, CMS and GSA announced continued partnership fast-tracking Medicaid technology vendors onto the GSA Schedule — letting states (and their RCM partners) skip lengthy procurement.

Automated Eligibility Checks

Big Interview, Optum

Fraud Detection

CITIZ3N

Social Services Connection

Findhelp, Fleet Health

Beyond off-the-shelf vendors, three capabilities matter most for revenue cycle teams specifically:



Predictive Risk Modeling

Use historical disenrollment patterns to flag at-risk patients before their redetermination date arrives



Real-Time Data Hub Integration

Connect to SAVE / Federal Data Hub for point-of-service verification instead of after-the-fact denials



Workflow Automation

Automate reminders, document collection, and exemption logging to reduce staff burden at scale

What Nebraska, Georgia & Montana Are Teaching Us

Pacing Beats Speed

States succeeding in prior Medicaid unwinding prioritized automation and beneficiary support over rushing the timeline.

NEBRASKA (LIVE SINCE 5/1/26)

Ex Parte Renewal Automation

High ex parte (automatic) renewal rates, powered by existing data matches, dramatically cut procedural disenrollments.

BEST-PRACTICE STATES

Over-Communicate, Repeatedly

Multiple touchpoints — mail, text, email — sent well before the compliance deadline reduce surprise disenrollment.

PENNSYLVANIA, NEVADA (9/26)

Assume Most Are Exempt or Compliant

Nevada expects most letter recipients to already qualify — but they still won't know it without clear communication.

NEVADA DHHS MESSAGING

KPIs Every Revenue Cycle Leader Should Track Now



Redetermination Completion Rate

% of expansion-population redeterminations completed on time, by month



Ex Parte / Auto-Renewal Rate

Share of renewals completed via data match without member action



Self-Pay Conversion Rate

Volume of Medicaid-to-self-pay conversion at registration & discharge



Medicare DSH Percentage

Tracked monthly, not annually — the gatekeeper for DSH & 340B eligibility



Eligibility-Related Denial Rate

Denials tied specifically to coverage/eligibility issues, trended over time



Time-to-Verification

Speed of point-of-service eligibility confirmation via SAVE/Data Hub

Five Things to Remember on Monday Morning

1

The deadline isn't January — it's now

Nebraska, Georgia, and Montana are already enforcing; PA and NV are actively mailing notices this month.

2

Revenue instability is a symptom, not the disease

Denials and bad debt trace back to eligibility and outreach failures weeks or months earlier.

3

Watch your Medicare DSH percentage like a KPI

It single-handedly gates both DSH payments and 340B eligibility — a modeled \$53M swing on one number.

4

Technology can outrun the timeline

GSA-accelerated vendor access, predictive analytics, and Data Hub integration are available now, not in 2027.

5

Pacing and communication beat speed

The states succeeding are over-communicating early and automating renewals — not rushing compliance.

A 90-Day Action Plan

NOW (Days 1–30)	NEXT (Days 31–60)	BY JAN 1, 2027
➤ Pull your current Medicare DSH % and model 340B/DSH exposure ➤ Audit outreach data for accuracy (addresses, phone, email) ahead of notices ➤ Identify your state's work-requirement start date — don't assume Jan. 1	➤ Stand up predictive risk model for upcoming redetermination cohorts ➤ Train intake & financial counseling staff on exemption documentation ➤ Integrate real-time eligibility checks with SAVE / Federal Data Hub	➤ Multi-channel outreach cadence live for all at-risk populations ➤ Board-level DSH %, ex parte rate, and denial-rate KPI dashboard live ➤ Cross-functional governance model (finance, ops, compliance) operating

The organizations that treat this as an operational stress test — not just a compliance exercise — will come out with stronger systems and more stable revenue.



Thank You

"Adaptation is the key to survival."

Let's Discuss

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Questions & Open Discussion