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Healthcare Alert

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One Big Beautiful Bill Act poised to reshape Medicaid program

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President Trump recently signed a sweeping budget law that marks the most significant shift in federal health policy since the Affordable Care Act.

What's the impact?

- Codifies Medicaid work requirements for certain adults, with no waiver authority under Section 1115
- Imposes re-enrollment and redetermination limits that could increase procedural terminations
- Restricts provider taxes and financing mechanisms used to increase federal Medicaid funding
- Caps Medicaid provider payments in expansion states at Medicare levels and limits payments in non-expansion states
- Establishes a $50 billion rural hospital grant fund with broad flexibility in use and no state match requirement

On July 4, 2025, President Donald Trump signed into law H.R. 1, or the One Big Beautiful Bill Act, a sweeping law that spans a wide range of tax, spending, and regulatory priorities. Title VII,

Subtitle B—Health includes significant reforms to the Medicaid program that build on proposals introduced earlier this year.

The changes are expected to have far-reaching implications for State Medicaid agencies, Medicaid managed care plans, hospitals and other healthcare providers, and millions of low-income Americans who rely on Medicaid for their health coverage.

Below, we outline some of the key healthcare provisions in the final legislation, with a focus on anticipated impacts for stakeholders, Medicaid agencies, hospitals, payers, and Medicaid.

Medicaid eligibility, enrollment changes, and cost sharing

MEDICAID WORK REQUIREMENTS (EFFECTIVE JANUARY 1, 2027)

State Medicaid agencies will be required to condition Medicaid eligibility for certain adult beneficiaries on compliance with a new federal "community engagement requirement." Under the law, individuals must work, participate in job training or community service, or attend school for at least 80 hours per month. Alternatively, those who earn at least the monthly equivalent of 80 hours at minimum wage may also qualify.

Some groups are automatically exempt—including individuals under age 19, pregnant women, people who are medically frail, or those caring for a dependent. States may also approve short-term hardship exceptions in cases such as hospitalization, family crisis, or displacement due to natural disaster.

States must check whether individuals are meeting the requirement during routine eligibility reviews. While states can seek temporary implementation exemptions during the rollout period, those flexibilities must end by the close of 2028. These rules are expected to increase the number of individuals who lose Medicaid coverage—not necessarily because they don't meet the criteria, but because they face barriers documenting compliance. Previous state-level efforts along similar lines have shown that paperwork requirements alone can cause large numbers of eligible individuals to be disenrolled.

RE-ENROLLMENT AND ELIGIBILITY REDETERMINATION RESTRICTIONS (EFFECTIVE JANUARY 1, 2027)

The new law delays recent federal efforts to simplify Medicaid renewal processes. Specifically, it blocks implementation of new Centers for Medicare & Medicaid Services (CMS) rules meant to make it easier for people to stay enrolled through automated renewals, standardized forms, and streamlined eligibility checks. Those changes are now paused until at least 2034.

In addition, state Medicaid agencies will soon be required to verify eligibility for certain Medicaid users twice per year instead of once. The law provides that "a State shall conduct a

redetermination of eligibility every 6 months" for individuals covered under the adult expansion group or certain demonstration programs. The law directs the Department of Health and Human Services (HHS) to issue guidance to assist with this requirement, and $75 million is allocated to support state system changes.

The law also rolls back tools designed to facilitate smoother renewals, including pre-populated forms, automatic processing, and longer renewal intervals. Without these tools, beneficiaries—particularly those with unstable housing or limited access to documentation—may experience disruptions in coverage despite ongoing eligibility. States are further directed to use "available sources of information, including data matching" to verify eligibility criteria like income and residency. If inconsistencies are found, state Medicaid agencies must reach out to the individual by mail, phone, or electronic communication and give them at least 10 days to respond. Importantly, state Medicaid agencies may delegate or contract with third parties for imposing these new mandates.

Taken together, these changes reflect a shift toward more frequent and documentation-heavy eligibility reviews. They are expected to increase the administrative workload for states and create new barriers to coverage for many enrollees.

COST SHARING REQUIRED (TO BEGIN IN 2027 FOR EXPANSION POPULATIONS)

Historically, Medicaid enrollees had little or no cost sharing obligations. The new law establishes cost-sharing obligations for certain Medicaid expansion enrollees, allowing states to charge up to $35 per item or service. The HHS Office of the Inspector General (HHS-OIG) has historically expressed longstanding and consistent concerns regarding routine waivers of enrollees' cost-sharing amounts. Accordingly, the new law will require healthcare providers to revamp their financial assistance policies and ensure that cost sharing waivers for Medicaid beneficiaries are not routine, not advertised, and made on the basis of a good-faith, individualized assessment of financial need.

Medicaid payment and financing changes

PROVIDER TAXES AND MEDICAID FINANCING RESTRICTIONS (*EFFECTIVE IN PHASES STARTING FY 2026*)

The bill narrows the type of healthcare-related taxes states may impose to generate matching Medicaid funds. Prior to the bill's passage, states were permitted to finance the non-federal share of Medicaid spending through multiple sources, including state general funds, healthcare-related taxes (or provider taxes), and local government funds. The law adds new definitions for "Medicaid taxable unit" and "non-Medicaid taxable unit," and prohibits redistributive tax structures that vary tax rates based on the volume or percentage of Medicaid-related businesses. Under the new law, a tax is not considered generally redistributive (and thus not permissible for

federal matching purposes) if it imposes a lower tax rate on entities with a lower volume or percentage of Medicaid taxable units, or if it imposes a higher tax rate on Medicaid taxable units compared to non-Medicaid taxable units within the same class of taxpayers.

In addition, the law lowers the "hold harmless" or safe harbor threshold for provider taxes over time, i.e., the threshold at which states can recoup taxes paid by providers through increased Medicaid payments, which payments are returned to providers through Medicaid reimbursements. The lower threshold reduces states' flexibility to use these tax mechanisms for enhanced Medicaid funding to support state Medicaid agencies. The law sets new limits on the safe harbor threshold for existing hold harmless provider taxes in place in states that have expanded Medicaid, gradually lowering the threshold from 6 percent to 3.5 percent between fiscal years 2028 and 2034. The law precludes states that have not expanded Medicaid from increasing the provider tax rate beyond the current level. Nursing homes and intermediate care facilities in expansion states are exempt from the phase-down of the "hold harmless" threshold. In all states, beginning October 1, 2026, no safe harbor will be available for any new provider tax that does not exist on the provision's enactment date. These changes are expected to impact provider tax models commonly used to bolster hospital and managed care rates, with potential significant impact on safety net hospitals.

LIMITS ON MEDICAID MANAGED CARE AND STATE-DIRECTED PAYMENTS (EFFECTIVE IN FY 2027, WITH SOME GRANDFATHERING FOR EXISTING PROGRAMS)

The law limits the ability of states to use directed payments to boost managed care provider rates. The law directs HHS to revise state-directed payment regulations to cap the total payment rate for inpatient hospital and nursing facility services at 100 percent of the specified total published Medicare payment rate for expansion states and 110 percent of the Medicare payment rate for non-expansion states. If no Medicare rate exists, the cap defaults to the Medicaid fee-for-service payment rate. Existing arrangements approved before enactment may continue temporarily but will be phased down. These limits may require states to revise or unwind supplemental payment structures and will likely lead to reduced reimbursement in states that had used managed care directed payments to address workforce shortages, rural access, or other policy objectives.

Rural health investment

RURAL HEALTH TRANSFORMATION GRANT PROGRAM (APPLICATIONS DUE BY END OF 2025; GRANTS ISSUED FY 2026–2030)

As Congress negotiated the extensive cuts contemplated in the legislation, lawmakers recognized the potential for financial distress and service disruption, particularly in rural communities. To help offset, at least temporarily, the impact of new eligibility restrictions, provider tax limitations, and payment caps, the law establishes a $50 billion Rural Health

Transformation Grant Program over five years. This short-term initiative is designed to provide immediate support to rural hospitals and health centers, enabling them to invest in facility upgrades, workforce recruitment, digital infrastructure, and innovative care delivery models. By prioritizing rural health investment, lawmakers aimed to cushion the blow of broader Medicaid changes.

Eligible facilities include:

- Critical access hospitals,
- Rural emergency hospitals,
- Low-volume hospitals,
- Federally qualified health centers,
- Community mental health centers, and
- Opioid treatment programs in rural areas.

States must submit a transformation plan to access funding, identifying at least three areas of investment such as chronic care, telehealth, or cybersecurity improvements. No state match is required. Applications are due by the end of 2025, with federal decisions to follow within six months.

The program allows states to use funds to "improve access to care and health outcomes" and "modernize or restructure delivery systems" in response to local needs. This includes the ability to consolidate or repurpose services in low-utilization areas.

Additional provisions at a glance

The 870 page comprehensive budget reconciliation legislation includes various other significant changes to federal healthcare programs, including Medicaid, Medicare, and health insurance marketplaces.

- **Sunsets the FMAP bump**. (*Applies to Medicaid expansion occurring after January 1, 2026*) Ends the enhanced Federal Medical Assistance Percentage (FMAP) for states that newly expand Medicaid after January 1, 2026, removing the financial incentive for late expansion.
- **Budget neutrality for waivers**. (*Applies to all new or renewed waivers submitted after January 1, 2026*) Requires all Section 1115 demonstration projects to be budget-neutral and certified as such by the CMS actuary prior to approval.
- **Immigration restrictions**. (*Effective October 1, 2026*) Limits Medicaid eligibility to US citizens, lawful permanent residents, and specific humanitarian groups, narrowing the pool of eligible non-citizens.
- **Error-related payment penalties**. (*Effective FY 2026*) Reduces federal payments to states that

have high levels of payment errors or improper Medicaid expenditures, creating a financial disincentive for noncompliance.

- **Moratorium on Biden rulemaking**. (*Effective FY 2026*) The law issues moratoriums on CMS rulemaking promulgated under the Biden administration related to minimum staffing standards for long-term care facilities, and eligibility and enrollment in Medicare Savings Programs, Medicaid, the Children's Health Insurance Program, and Basic Health Program.
- **Prohibits funding for certain entities**. Prohibits federal payments, including Medicaid payments, to "prohibited entities" for a one-year period. Prohibited entities include tax-exempt entities, and their affiliates, that are essential community providers "primarily engaged in family planning services, reproductive health, and related medical care," that provide abortions beyond cases of rape, incest, and life-endangering situations, and received at least $800,000 in Medicaid funding in 2023.

How can healthcare stakeholders prepare for policy changes?

These policy changes represent one of the most significant federal shifts to federal healthcare programs, especially Medicaid, since the 2009 Affordable Care Act. With more frequent eligibility checks, new documentation requirements, and major rural funding opportunities, the stakes are high for both Medicaid providers and enrollees. The budget reconciliation package is anticipated to result in nearly $930 billion in Medicaid cuts over the next decade.

Federal implementation guidance is expected in the coming months. In the meantime, providers, managed care organizations, and state Medicaid agencies should begin assessing how these changes may affect enrollment, operations, and strategic planning.

Nixon Peabody's Healthcare team is actively tracking developments and is ready to support clients navigating the path forward.

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