What the “One Big Beautiful Bill” Means for Nonprofit Medicaid Providers and Advocates in Kansas

July 31, 2025

REACH healthcare foundation®

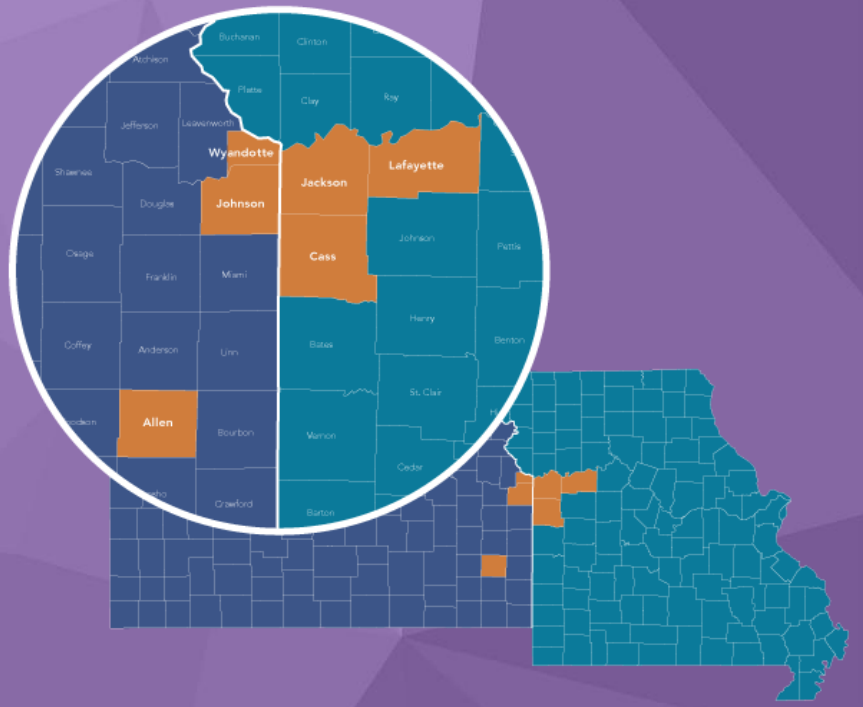
United Methodist HealthMinistryFund

ABOUT REACH HEALTHCARE FOUNDATION

Mission
To advance health equity through coverage and care for underserved people in our region.

Vision
For all people in our communities to achieve equitable health outcomes.

Service Area
Johnson, Wyandotte, and Allen counties in Kansas and Jackson, Cass, and Lafayette counties in Missouri, as well as the City of Kansas City, Missouri.



$88M in grants awarded since 2005

Approximately **$5M awarded** each year

17-member board

More than 80% of grantmaking is focused on three outcome areas

ABOUT UNITED METHODIST HEALTH MINISTRY FUND

United Methodist HealthMinistryFund

The United Methodist Health Ministry Fund works to facilitate conversation and action to improve the health and wholeness of Kansans—especially those in rural and under-served communities.

By funding programs, moving ideas to solutions, providing hands-on expertise, and convening influencers, the Health Fund works to advance innovative solutions to improve Kansans' health for generations to come. The Health Fund has provided more than $80 million in grants and program support since its inception in 1986.

Mission

Healthy Kansans through cooperative and strategic philanthropy guided by Christian principles.

Vision

All Kansans are physically, spiritually, and mentally healthy.

David Jordan
President & CEO

$80M plus in grants awarded since 1986

Approximately **$2M awarded** each year

17-member board

Grantmaking focused on three outcome areas: Access to Care, Thriving Children, and Engaged Congregations and Communities

Kansas Hospital Association

Cindy Samuelson
Senior Vice President Member and Public Relations
csamuelson@kha-net.org

Cindy Samuelson is the Senior Vice President of Member and Public Relations at the Kansas Hospital Association. Cindy has been with KHA since January 2002.

KHA is a not-for-profit association of health care provider organizations committed to the health improvement of their communities. KHA membership includes 242 member facilities, of which 124 are full-service community hospitals. Founded in 1910, KHA's vision is optimal health for Kansans and Kansas hospitals.

Cindy's role at the association is to provide leadership in the areas of member service, media and public relations, communication, strategic planning and governance. She also serves as the association's spokesperson. As part of KHA's senior management team, she works with KHA staff and members on each of KHA's strategic issues and advocacy efforts. Cindy was integral in the 2011 development of Kansas Health Matters, a web-based tool to assist hospitals, health departments, policy makers and others with community health needs assessment and improvement.

In 2019, she collaborated with national governance experts to create KHA governWell a single source for governance tools and resources to assist hospital boards in governance and ensuring quality care for Kansas communities. Prior to her work at KHA, she worked for Stormont-Vail Health, a full-service community hospital in Topeka. She has served on several local, state and national health care related boards and committees. She is a graduate of the University of Kansas

Community Care Network of Kansas

Robert Stiles
Chief Executive Officer
rstiles@communitycareks.org

Robert Stiles is a dedicated public health leader whose career has been defined by a deep commitment to supporting local solutions, building strong partnerships, and advancing advocacy efforts to ensure that every individual has access to the highest attainable standard of health.

Robert Stiles holds a master's degree in public health from the University of Kansas and brings extensive experience in advancing community health initiatives across state and federal levels. Most recently, he served as director of Telehealth ROCKS (Regional Outreach for Communities, Kids and Schools) through the University of Kansas Department of Pediatrics. His previous roles include CEO of a Federally Qualified Health Center in Missouri, director of the Primary Care Office at the Kansas Department of Health and Environment, and earlier work at a Kansas FQHC. Stiles has also served as a grant reviewer for the Health Resources and Services Administration and provided formal technical assistance on behalf of HRSA, SAMHSA and CMS to grantees across the country, particularly in the areas of telehealth and school-based health services. He has delivered numerous presentations and contributed to publications at both the state and federal level, underscoring his commitment to improving access to care through practical, community-driven solutions.

Aaron Dunkel
Vice President, Regulatory & External Affairs
adunkel@communitycareks.org

Aaron Dunkel brings more than 25 years of public service and health care leadership to Community Care, with deep expertise in regulatory policy, legislative affairs and health care finance. He spent 17 years at the Kansas Department of Health and Environment (KDHE), where he served as Chief Financial Officer and later as Deputy Secretary. He also led the Kansas Pharmacists Association as Executive Director for six years and most recently served as Plan President for Molina Healthcare of Kansas, where he played a key role in developing the organization's KanCare 3.0 strategy and request for proposal (RFP).

At Community Care, Aaron focuses on Medicaid agency relations, regulatory strategy, and engagement with managed care organizations and payors. A lifelong Kansan, he is committed to strengthening health systems that serve the state's most vulnerable populations. Aaron lives in Kansas with his wife, Audrey, and remains driven by a deep-rooted dedication to improving health care for all Kansans.

Manatt Health

Cindy Mann
Partner
CMann@manatt.com

With more than 30 years of experience in federal and state health policy, Cindy Mann works with clients to develop and implement strategies around federal and state health reform, Medicaid, the Children's Health Insurance Program, and delivery and payment system transformation. Her clients include states, providers, plans, consumer organizations and foundations.

Before joining Manatt, Cindy was deputy administrator at the Centers for Medicare & Medicaid Services and director of the Center for Medicaid and CHIP Services where she led the administration of Medicaid, CHIP and the Basic Health Program for more than five years during the implementation of the Affordable Care Act. Cindy set and oversaw the implementation of federal policy relating to all aspects of the Medicaid program including delivery and payments, eligibility, benefits, waiver policy and long term services and supports. Throughout her time at CMS, she was deeply involved in supporting state program implementation and innovation, and coordinating policy and program operations with the Marketplace.

Prior to her appointment at CMS, Cindy was a research professor at the Georgetown University Health Policy Institute. There, she was the founder and director of the Center for Children and Families, focusing on health coverage, financing and access issues affecting low-income populations.

Previously, Cindy was a senior advisor at the Kaiser Commission on Medicaid and the Uninsured. She also was director of the Family and Children's Health Program group at the Health Care Financing Administration, now CMS.

Cindy joined the HCFA from the Center on Budget and Public Policy, where she directed the center's federal and state health policy work. Previously, she worked on these issues in Massachusetts, Rhode Island and New York.

United Methodist HealthMinistryFund

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Changes to Medicaid and Affordable Care Act (ACA) Marketplaces in the One Big Beautiful Bill Act (H.R.1)

Thursday, July 31, 2025

Agenda

- **Overview of Kansas Medicaid (KanCare) and the State Marketplace**
- **One Big Beautiful Bill Act's Projected Impacts on Kansas**
  - Key Medicaid Provisions Impacting Kansas
  - Key ACA Marketplace Provisions Impacting Kansas
- **Takeaways: What's at Stake for Kansas**
- **Discussion / Q&A**

Overview of Kansas Medicaid (KanCare) and the State Marketplace

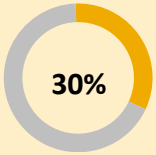
Coverage

KanCare and the federal Marketplace impact individuals, families, communities, the economy, and undergird the healthcare system in Kansas.

Medicaid

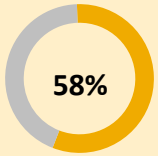
Provides coverage to over 437,000 Kansans

Covers



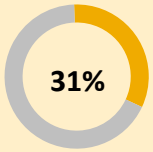
of Kansas' children

Covers



of nursing home residents

Pays for



of all births in the state

Among all Kansas Medicaid enrollees, 3 in 10 (34%) live in rural areas.

Marketplace

Provides coverage to over 200,000 Kansans

For Plan Year (PY) 2025, 7 insurers offered 81 health plans on the Kansas Marketplace

In 45 counties at least 7% of Kansans are enrolled in Marketplace coverage.

Many counties with the highest Marketplace enrollment are in rural areas.

Kansas has not taken up the ACA Medicaid expansion for adults.

Source: KanCare, Spending and Enrollment Reports; KFF, Medicaid in Kansas; KFF, Marketplace Enrollment ; KHI, 2025 Affordable Care Act Health Insurance Marketplace

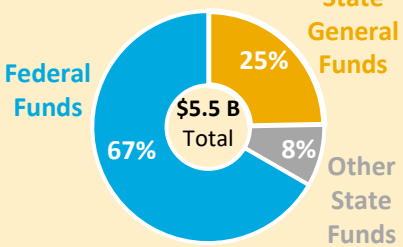
Financing

Currently, the federal government shares the cost of Medicaid spending without any pre-set limit. Individuals buying Marketplace plans may receive federal premium tax credits (PTC) if they meet income and eligibility standards.

Medicaid

Kansas Medicaid Budget (FY 2023)

- Kansas spent nearly **$5.5 billion on Medicaid, over two-thirds of which was federal funds.**
- Medicaid is **the largest source of federal funds in the state.**

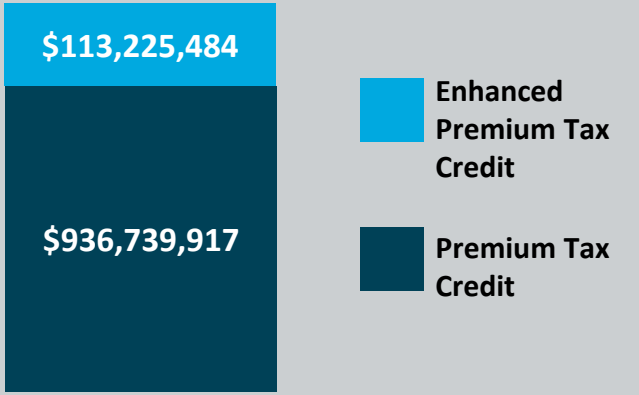


Federal Share of Costs (2026)

Type of Cost	Federal Share
Most Medicaid Services	60.67%
Children's Health Insurance Program (CHIP) (In Medicaid and Kansas' separate CHIP program)	72.47%
Administrative Costs*	50%

Marketplace

Marketplace Premium Tax Credit Breakdown, Kansas 2024



The Marketplace provided over $1 billion in total premium tax credits to Kansans in 2024; $113 million is slated to expire at the end of the year.

*Federal match for administrative activities does not vary by state and is held at 50%. States may receive a higher match rate for certain administrative activities.

Source: NASBO, 2024 State Expenditure Report; Federal Register, Fiscal Year 2026 FMAP; KFF, IRA Subsidies: What is Their Impact and What Would Happen if They Expire; KFF, Estimated Total PTC Received by Marketplace Enrollees

One Big Beautiful Bill Act's Projected Impacts on Kansas

Implications of One Big Beautiful Bill Act's Provisions for Kansas: Medicaid

On July 4, the President signed the budget reconciliation legislation, the One Big Beautiful Bill Act (H.R.1), making sweeping changes to Medicaid and ACA Marketplaces. Key Implications for Kansas:

- Hospital payments recently approved by the Kansas legislature will be **significantly constrained over time.**
- **Future opportunities for Kansas to shape payment policy is sharply curtailed,** while mechanisms Kansas has used to finance the state's share of Medicaid costs **would no longer be available.**
- Other provisions will **restrict certain payments, stop planned enrollment simplification, add new administrative requirements for the state, and result in a drop in enrollment.**
- To the extent Kansas policymakers seek to replace lost federal funding and bolster the fragile rural health sector through new state investments, **Kansas may need to reduce payment rates to other providers or eliminate/reduce optional benefits and eligibility.**

The Congressional Budget Office (CBO) estimates that nationwide the law would reduce federal spending by over a trillion dollars, including $911 billion in reduced federal Medicaid expenditures over the next 10 years.*

*After accounting for interactions that produce overlapping reductions across different provisions of the law.

Implications of One Big Beautiful Bill Act's Provisions for Kansas: Marketplace

Various bill provisions will make it **harder for individuals to enroll or reenroll in subsidized coverage through Marketplaces,** with most provisions effective starting in PY 2026.

Other Pending or Potential Marketplace Changes:

- **Unless Congress acts, enhanced premium tax credits will expire at the end of 2025**, which will lead to higher costs for Marketplace enrollees and an increase in the uninsured.
- On June 20, the Centers for Medicare & Medicaid Services (CMS) **also issued a final rule that restricts eligibility, reduces benefits, and imposes new paperwork burdens**, with most provisions taking effect in 2025 or 2026.

The Congressional Budget Office (CBO) estimates that nationwide Marketplace enrollment will drop sharply through a combination of this bill and other federal actions/inactions.

One Big Beautiful Bill Act's Projected Fiscal Impact on Kansas

Policies enacted through the passage of this bill will lead to deep cuts to government subsidized health care in Kansas, creating increased strain on hospitals and rural providers.

Kansas will see a cut of **$3.9 billion** in total Medicaid funds over 10 years (FFY 2025 – 2034)

Federal	State	Total
-$2.4 B	-$1.5 B	**-3.9 B**

Hospitals will see a cut of **$2.7 billion** in total Medicaid funding over 10 years (FFY 2025 – 2034)

Federal	State	Total
-$1.6 B	-$1.0 B	**-2.7 B**

Funding reductions under this bill will require Kansas to make difficult decisions on whether to offset the federal cuts with state dollars or pass on the cuts in the form of provider rate reductions, eligibility and/or benefit limitations.

Note: These projections represent an understatement of funding cuts since Manatt has not modeled all of the provisions of H.R.1 due to data limitations. For example, Manatt's estimates do not reflect (1) the impact of changes to provider taxes and SDPs for providers other than hospitals, (2) changes, if any, are needed to ensure that provider taxes are "generally redistributive," nor (3) provider tax losses for any new, future taxes Kansas would have adopted. Additionally, Manatt's hospital estimates do not consider impacts from the Rural Health Transformation Fund (see slide 18).
Source: Manatt Health Modeling on H.R.1

Projected Coverage Impact on Kansas

Policies enacted through the passage of this bill, plus the potential loss of the enhanced Marketplace subsidies, will lead to major health insurance coverage losses for Kansans.

Medicaid

Some Kansans, including children, seniors, and people with disabilities, will lose out on coverage due to the bill's "moratorium" of recently issued rules.

Marketplace

Approximately 108,000 Kansans are projected to lose Marketplace coverage over 10 years (FFY 2025 - 2034).

Manatt estimates are based on Urban Institute analysis of House-passed H.R.1 and enhanced PTC expiration using the Urban Institute's Health Insurance Policy Simulation Model.

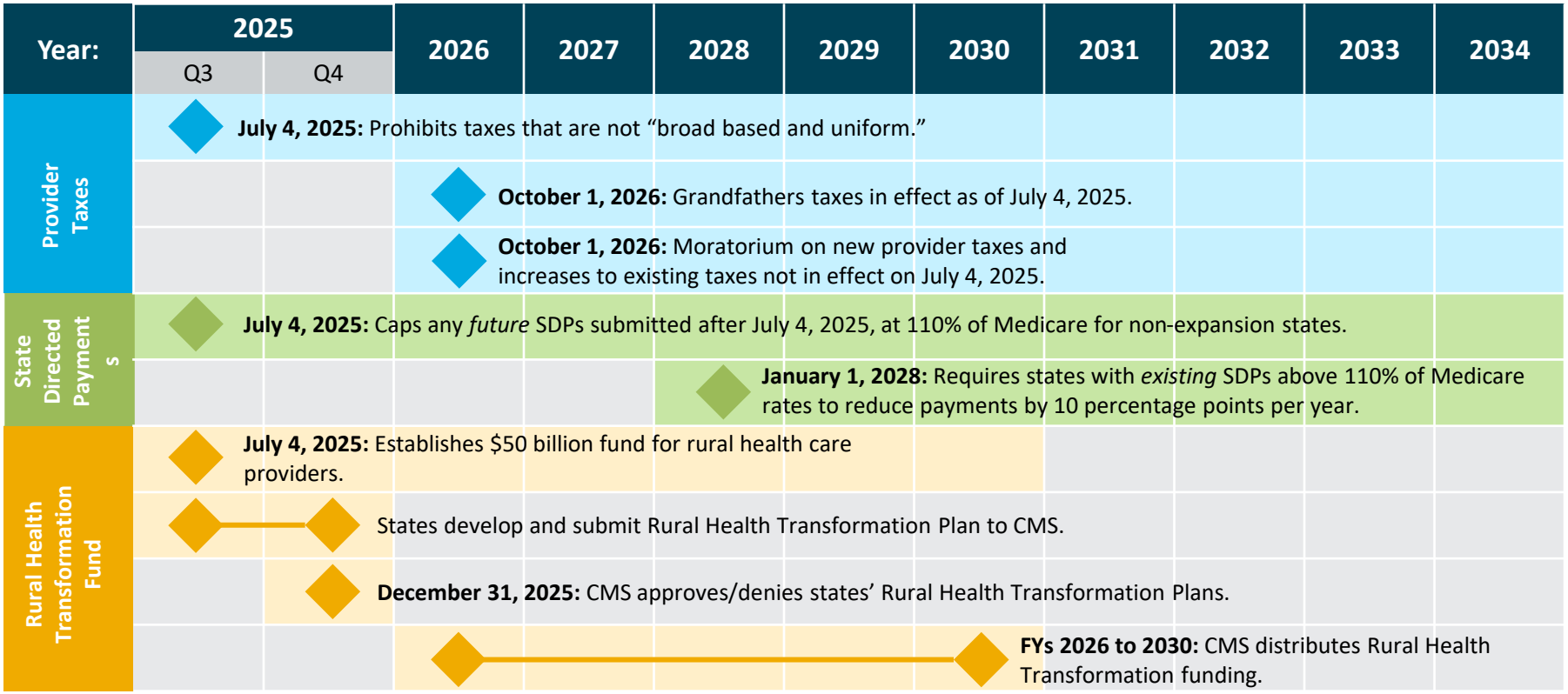
Medicaid enrollment changes will depend on the state's responses to the federal funding cuts.

Source: Manatt Health Modeling on H.R.1; Urban Institute, Reconciliation Bill Would Cut Marketplace Enrollment by Over 5 Million People; Urban Institute, Who Benefits from Enhanced Premium Tax Credits in the Marketplace

Key Medicaid Provisions Impacting Kansas

Effective Dates of Select Bill Provisions Impacting Kansas

Q3 = Jul – Sept; **Q4** = Oct – Dec



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State Directed Payment (SDP) Limits

Kansas mostly uses SDPs to offset hospital shortfalls in Medicaid base payments and sustain access to vital services in communities where health care options are scarce. The law sharply limits any future SDP levels.

Existing, "Grandfathered" SDPs

- Requires that Kansas reduce its existing SDPs (including the one pending federal approval) **by "10 percentage points" per year** beginning in 2028 until they are no greater than 110% of Medicare payment levels.
- **SDPs submitted to CMS prior to July 4, 2025, will be grandfathered.**

Limiting hospital payments to 110% of Medicare reduces those payments nearly by half. Kansas' pending SDP is currently estimated at 190% of Medicare for inpatient services and 244% of Medicare for outpatient services.

New SDPs

- Effective immediately, requires that **any new SDP in Kansas must be capped at 110% of Medicare rates** instead of average commercial rates (ACR).

Actions for State Consideration:

- Assess the fiscal impact on providers, and the impact of reducing SDP on access to and quality of care.
- Closely monitor and potentially engage with federal policymakers on the distribution of the Rural Transformation Fund. *(See Slide 18)*
- Consider mitigations for providers and beneficiaries.

Source: Manatt Health Modeling on H.R.1. The estimated Medicare rates leverage estimates from Milliman of the difference between Medicare and commercial rates by region.

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Provider Tax Limits

Kansas primarily uses provider taxes to help finance state directed payments for hospitals. The law limits use of this mechanism, effective immediately and going forward.

Provider Tax Limits

- Effective immediately, **sets a new standard for prohibiting any tax that CMS finds is not "broad-based and uniform"** in a class of providers (e.g., inpatient hospitals).
- Effective October 1, 2026, **prohibits any new Medicaid provider tax or increases to existing tax rates*** (for both local- and state-imposed taxes).
- *Note:* Last year, the Kansas legislature enacted an increase in the state's hospital provider tax to 6%. **This pending provider tax increase will be grandfathered.**

In Kansas, more hospitals are at risk of closing than anywhere else in the nation. Limits on SDPs and provider taxes will exacerbate hospital closures and hospital service cuts across the state, particularly in rural areas. Other providers could also be affected.**

*Increases to "existing tax rates" refers to existing provider taxes enacted prior to July 4, 2025.
**66 rural hospitals in Kansas are at risk of closure, and 29 are at immediate risk of closure.

Source: Center for Healthcare Quality & Payment Reform. Rural Hospitals at Risk of Closing.

Actions for State Consideration:

- Assess the need for additional sources of non-federal share to meet current or emerging needs.
- Track CMS rulemaking and guidance.
- Confer with CMS to gauge the availability of a transition period if the uniformity rule impacts Kansas.

Rural Health Transformation Fund

The law establishes a $50 billion fund for rural health care providers. To qualify for funding, states will need to apply and submit a plan to CMS. CMS is required to approve or deny applications by December 31, 2025.

Rural Health Transformation Fund

- Funds distributed in **$10 billion annual allotments from 2026 to 2030:**
  - 50% **distributed equally among states with an approved transformation plan.**
  - 50% **distributed at CMS's discretion,** with Congressional direction to consider factors such as the percent of rural residents and rural health care facilities relative to the nation.
  - The funds are potentially **available to a range of rural health providers**.
- **Only states may apply for awards**. Each state will submit one application for funding for the five-year period.
- **Statute gives CMS broad discretion; CMS is directed to issue program instructions or other forms of program guidance**

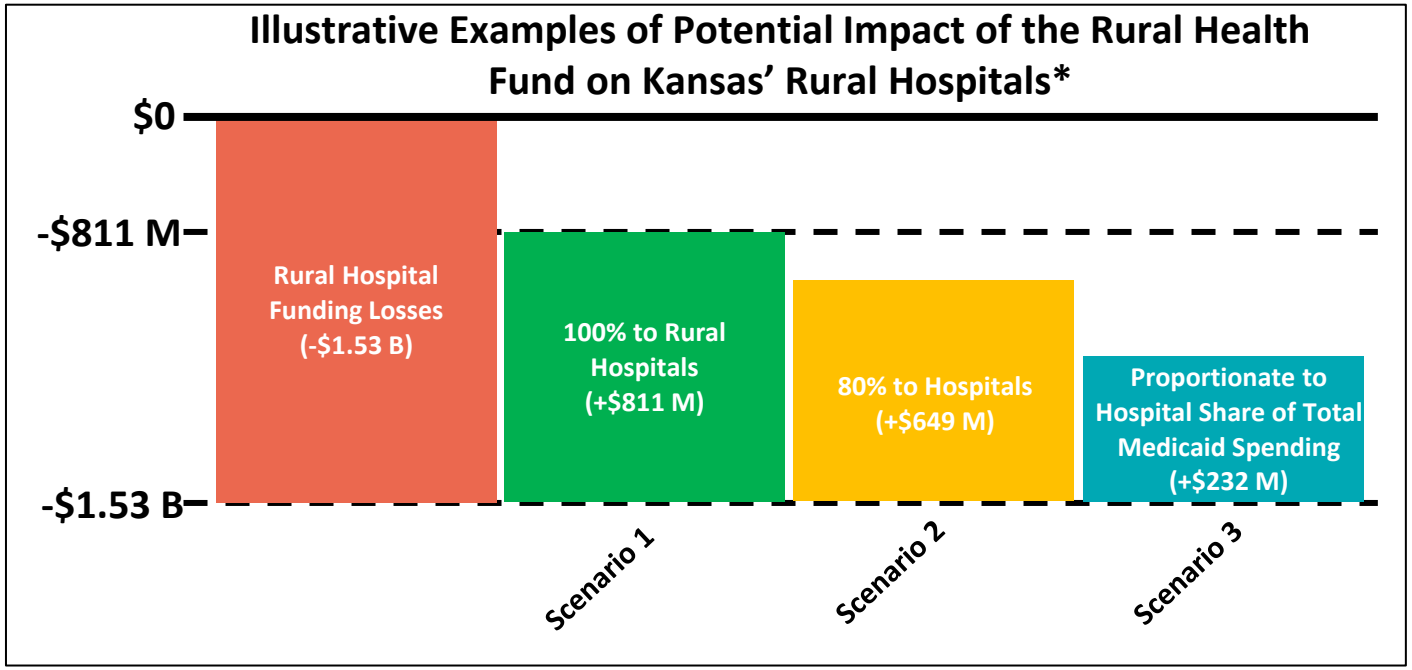
Actions for State Consideration:

- Develop a process and solicit input for the Transformation Plan from key partners and providers.
- Compile and submit the Transformation Plan to CMS. States must apply this year, and CMS must approve or deny applications by the end of the year.

See Appendix, slide 28 for description of H.R.1's considerations and parameters for states and CMS relating to the Rural Health Transformation Fund.

Impact of Rural Health Fund on Kansas – *Pending Additional Updates*

The amount of funding Kansas' rural providers receive from the fund – and its uses – will depend on decisions made by CMS and the state. While rural health funds will be distributed from FFY 2026–2030, H.R. 1's cuts extend longer.



The bill does not limit the fund to rural hospitals and permits many uses of the fund, at CMS and state discretion.

*These estimates show the extent to which the rural health fund might address rural hospital funding losses in Kansas, under 3 scenarios for how Kansas' funds might be shared among rural providers. These scenarios are for illustrative purposes only and do not consider any restrictions on the uses of these funds. CMS program guidance and state decision-making will determine the amount different providers receive and the allowable uses.

Source: Manatt Health Rural Health Impact Analysis, which describes the parameters for each scenario.

Moratorium on Eligibility and Enrollment Final Rules

Effective immediately, the law imposes a 10-year delay until October 1, 2034, on the implementation and enforcement of select provisions of two CMS eligibility and enrollment final rules.

Maintains E&E rule provisions, for example:	E&E rule provisions subject to moratorium, for example:
• Remove access barriers for CHIP-eligible children (e.g., prohibit premium lockouts/ waiting periods). • Improve Medicaid/CHIP transitions. • Remove requirement to apply for other benefits. • Deem certain Medicare and Social Security Income enrollees eligible for Qualified Medicare Beneficiary coverage, without requiring an application.	• Requirements to reduce barriers to enrollment in Medicare Savings Programs (MSPs).* • Simplifies enrollment and renewal policies for the elderly and people with disabilities, in alignment with policies already in effect for other Medicaid populations.* • Establish new timeframes for processing renewals and changes in circumstances. ** = Provisions that may be implemented at state option.*

Actions for State Consideration:

- Continue with or begin systems and operational work to implement provisions that remain in effect.
- Evaluate whether to take up provisions that are delayed at state option.

Source: "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" and "Medicaid Program; Streamlining Medicaid, CHIP, and Basic Health Program (BHP) Application, Eligibility Determination, Enrollment and Renewal Processes."

Other Medicaid Policy Changes

Effective January 1, 2027, Medicaid retroactive coverage will be shortened from three to two months for all Medicaid applicants. This will impact medical debt, uncompensated care (particularly for hospitals) and nursing home admissions.

Effective January 1, 2028, the home equity limit used to determine financial eligibility for Medicaid long-term services and supports will be adjusted by: (1) allowing states to set a cap ($750,000) for homes on agricultural land (with a max of $1 million based on the Consumer Price Index); (2) permitting states to adopt cap of up to $1 million for non-agricultural homes; and (3) prohibiting use of asset disregards to modify these limits.

Effective January 1, 2028, creates new section 1915(c) Home and Community Based Services (HCBS) waiver option, that allows states to provide HCBS to individuals who meet a state-designed standard of need that is less restrictive than current waiver authority.

Effective January 1, 2027, states must use data sources to regularly update enrollee addresses and check the Social Security Administration Death Master File, or another database, quarterly, treat the information as factual, disenroll deceased individuals from Medicaid, and retroactively reenroll anyone incorrectly removed.

Effective January 1, 2026, repeals the American Rescue Plan Act (ARPA) increased FMAP for states that newly expand Medicaid. States expanding Medicaid after this date will no longer be eligible for the temporary five-percentage-point increase in the FMAP.
Note that the 90% FMAP for expansion remains in place.

Key ACA Marketplace Provisions Impacting Kansas

Marketplace Changes

The law makes significant changes to the Marketplaces that shrink enrollment, primarily by making it harder to enroll and reenroll. This will result in coverage losses for Kansans enrolled in the Marketplace and increase medical debt and uncompensated care.

Marketplace Changes

- **Removes the limitation on Advanced Premium Tax Credits (APTC) repayment**, meaning that enrollees will be responsible for repaying all APTC in excess of the PTC calculated based on projected income.
- **Requires enrollees receiving APTC to file taxes and reconcile the credit.** Enrollees who did not file and reconcile in the applicable tax year will lose APTC, ending the current two-year grace period.
- **Ends tax credits for income-based Special Enrollment Periods (SEP),** unless the SEP is also tied to a life change.
- **Ends automatic reenrollment**. All enrollees must verify information on their application (e.g., household income, family size, immigration status, enrollment in or eligibility for other health coverage) and enroll in a health plan, even if nothing has changed.
- **Prevents enrollees from using their APTC until all verification is complete.** This requirement may be waived for individuals enrolling through a SEP for a change in family size.
- **Considers all bronze and catastrophic Marketplace plans to be high-deductible health plans (HDHPs),** making them eligible to be paired with a health savings account (HSA).

Noncitizen Eligibility Limitations

The law limits immigrant eligibility for the Marketplaces. This will lead to more individuals seeking care in acute care settings, exposing them to higher medical expenses/medical debt and increasing uncompensated care costs for providers.

Limit Noncitizen Eligibility for Financial Assistance

The law limits eligibility for financial assistance for immigrants, though it does not explicitly say that lawfully present immigrants cannot enroll in qualified health plans (QHPs).

- **Effective in PY 2026:** The law ends PTC eligibility for people who are ineligible for Medicaid due to immigration status and have income less than 100% of the FPL.
  - This includes lawfully present residents and individuals with other lawful statuses.
- **Effective in PY 2027:** The law layers on new limitations on the immigrant groups who qualify for PTC to:
  1. Lawfully present residents;
  2. Certain Cuban and Haitian entrants; and
  3. Compact of Free Association (COFA) migrants

***Statuses newly denied assistance include:** Refugees, asylees, and victims of human trafficking.

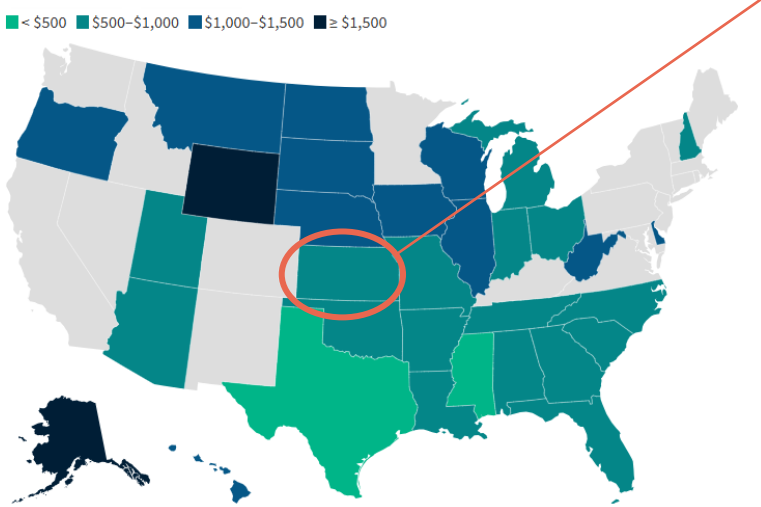
Beyond the Bill: Expiration of Premium Tax Credits

Increasingly, Kansans are relying on the Marketplace for coverage, but, if Congress does not extend the enhanced credits, Kansans will face sharply higher costs and coverage losses.

Enhanced Premium Tax Credits Scheduled to Expire

- Passed by Congress in March 2021, **the enhanced PTCs increased the subsidies available for people to buy insurance in the Marketplace.**
- If Congress allows the PTC enhancements to expire, **average annual net cost of coverage will rise, Marketplace enrollment will drop, and Kansans will lose health coverage.**

Average Dollar Change in Premium Payments Among HealthCare.gov States Without Enhanced PTC



Average premium payments would increase 77%, or $708 annually, from $924 to $1,632 per year without the enhanced PTC.

Higher costs will lead to coverage losses, more medical debt and rising uncompensated care for health providers

Source: KFF, IRA Subsidies: What is Their Impact and What Would Happen if They Expire

What’s at Stake for Kansas

What's at Stake for Kansas?

KanCare and the ACA Marketplace are the backbone of Kansas' health care system. The One Big Beautiful Bill Act will result in deep cuts to these coverage programs, with major ripple effects on people and providers further weakening rural health care.

Depending on how Kansas responds to federal funding reductions and Marketplace coverage losses, Kansas could see sharp reductions in access to care, rising medical debt, and uncompensated care.

Increased uncompensated care puts more financial strain on already financially unstable hospitals and other providers. Coverage losses challenge providers' ability to keep their doors open, which is especially concerning in rural communities.

The depth of cuts means that children, seniors in need of long-term care, people with disabilities, and pregnant women will all be impacted. Because of the fragility of rural health care in Kansas, rural communities may be hit the hardest.

Discussion Panel and Q&A

Appendix

Effective Dates of One Big Beautiful Bill Act's Medicaid Provisions (1/2)

Medicaid Provisions		Section	Effective Date
Payment and Financing	Prohibits any tax that: imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes; or that taxes Medicaid units of service at a higher rate than non-Medicaid units of service (also prohibits taxes that have the "same effect")	71117	July 4, 2025
	Caps any future state-directed payments (SDPs) submitted after July 4, 2025, at 100% of Medicare payment levels for expansion states and 110% of Medicare for non-expansion states	71116	
	Establishes a $50 billion rural health transformation fund for rural healthcare providers	71401	December 31, 2025
	Ends the temporary FMAP increase for states that newly adopt Medicaid expansion	71114	January 1, 2026
	Prohibits states from implementing any new provider taxes and increasing existing tax rates (tax must be in effect as of July 4, 2025)	71115	October 1, 2026
	Codifies CMS' requirement that section 1115 waivers not cost the government more than the state's Medicaid program would cost absent the demonstration	71118	January 1, 2027
	Requires states with existing SDPs above Medicare rates to reduce payments by 10 percentage points per year until the SDPs are no greater than 100% of Medicare payment levels for expansion states or 110% of Medicare payment levels for non-expansion states	71116	January 1, 2028
	Eliminates the waiver authority permitting CMS to waive states' disallowance of its federal funds associated with "excess" improper payments	71106	October 1, 2029

Effective Dates of One Big Beautiful Bill Act's Medicaid Provisions (2/2)

Medicaid Provisions		Section	Effective Date
Eligibility and Enrollment	Prohibits implementation or enforcement of select provisions in the eligibility and enrollment (E&E) final rules	71101, 71102	July 4, 2025 – October 1, 2034
	Requires states to modify retroactive coverage under Medicaid; state option under CHIP	71112	January 1, 2027
	Requires states to establish standardized processes to regularly update address information	71103	
	Requires states to verify eligibility against a Death Master file on a quarterly basis to ensure deceased individuals are not enrolled	71104	
	Codifies states' ceiling for the home equity limit allowable for individuals seeking long term care for homes zoned for agricultural use and homes not zoned for agricultural use	71108	January 1, 2028
	Creates a new section 1915(c) home and community-based services (HCBS) waiver option	71121	July 1, 2028
	Requires a new national federal database to be built that will identify individuals simultaneously enrolled in Medicaid in more than one state	71103	October 1, 2029
Provider Participation and Oversight	Bars Medicaid participation by certain providers of abortion services (including Planned Parenthood) for one-year (temporary restraining order was in effect through July 21, 2025)	71113	July 4, 2025 – July 4, 2026
	Delays implementation and enforcement of the nursing home staffing final rule	71111	July 4, 2025 – October 1, 2034
	Codifies certain existing requirements for states to screen Medicaid providers	71105	January 1, 2028
Noncitizen Coverage	Provides states with their regular federal medical assistance percentage (FMAP) for all emergency Medicaid services	71110	October 1, 2026
	Ends federal Medicaid/CHIP funding for refugees, asylees, and certain other noncitizens	71109	

Rural Health Transformation Fund Plan

To access funding, states must submit a detailed transformation plan to CMS. The deadline to submit a plan has yet to be established by CMS but will fall before December 31, 2025.

Required Plan Components	Activities Eligible for Funding
States must specify how they will: • Improve access to hospitals and other health care providers • Improve health outcomes for rural residents • Prioritize the use of new and emerging technologies, including artificial intelligence (AI), emphasizing prevention and chronic disease management • Foster local and regional strategic partnerships between rural hospitals and other providers • Enhance supply of clinicians via recruitment and training • Prioritize data and other technology-driven solutions for rural hospitals and other rural providers • Outline strategies to manage long-term solvency of rural hospitals • Identify specific causes of stand-alone rural hospital closures or conversions	✓ Promoting chronic disease management interventions ✓ Providing payments to health care providers ✓ Promoting consumer-facing, technology-driven solutions for prevention and managing chronic disease ✓ Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals ✓ Recruiting and retaining clinical workforce to rural areas, with commitments to serve rural communities for at least five years ✓ Technical assistance, software and hardware for information technology ✓ Assisting rural communities to right-size their delivery systems ✓ Supporting access to behavioral health treatment ✓ Supporting innovative models of care that include value-based care arrangements and alternative payment models

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