Information Briefing:

Impact of Changes to the Medicaid Program Required by H.R. 1 (2025) on Virginia's Hospitals

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Study purpose

- This information brief examines two questions:
  - How changes to the Medicaid program required by H.R. 1 (2025) affect Virginia's acute care hospitals
  - The extent to which the Rural Health Transformation Program (RHTP) addresses those effects
- Most major provisions of H.R. 1 take effect between October 2026 and October 2031, so findings describe anticipated rather than observed effects

H.R. 1 = An act to provide for reconciliation pursuant to title II of H. Con. Res. 14. Public Law 119-21 (7/4/2025)

Findings in brief

- Medicaid is a federal-state partnership that provides access to health care for individuals and funding for health care providers
- H.R. 1 limits two mechanisms states use to fund hospitals that provide services to Medicaid enrollees
- New Medicaid eligibility and administrative requirements will reduce Medicaid enrollment, likely decreasing hospital revenue and increasing rates of uncompensated care
- H.R. 1 created the Rural Health Transformation Program to strengthen rural health care

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Medicaid as a federal-state partnership

H.R. 1 limits on hospital funding mechanisms

New eligibility and administrative requirements

The Rural Health Transformation Program

State Medicaid programs must follow federal rules to receive matching funds

- Federal law and CMS rules set minimum requirements, and states design programs within those guidelines
- Federal match (FMAP) is about 50% for most Virginia services and 90% for expansion adults
- About 1.5 million Virginians are enrolled in Medicaid
  - 976,000 are enrolled in traditional Medicaid
  - 566,000 are enrolled in Medicaid expansion

CMS = Centers for Medicare & Medicaid Services; FMAP = Federal Medical Assistance Percentage

Nonfederal share may be collected through health care provider taxes

- States raise the nonfederal share from sources including health care provider taxes, and only qualifying amounts earn a federal match
- Health care provider taxes must be broad-based, uniform, and free of hold-harmless arrangements
- Virginia has two health care provider taxes: a coverage assessment and a provider rate assessment

States may deliver services through different payment and delivery models

- Fee-for-service (FFS) models pay providers directly for each service provided to a Medicaid enrollee
- Managed care models provide coverage to enrollees through contracts between the state agency and MCOs
  - State Medicaid programs pay MCOs capitated payments for each enrollee to cover the cost of health care services
  - MCOs pay providers who participate in approved networks negotiated rates for delivery of covered health care services to enrollees

MCO = Managed care organization

Medicaid programs provide base and supplemental payments to providers

- Base payments reimburse providers for services delivered to eligible individuals
  - FFS methodology is included in the state plan and approved by CMS
  - Managed care rates are negotiated by MCOs with individual providers
- States may provide additional payments to providers to supplement low base payments, subject to federal rules
  - State directed payments (SDPs) require MCOs to provide additional payments to a defined group of providers

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H.R. 1 caps the payment rate on some state directed payments

- Prior to H.R. 1, payment rates for SDPs for certain health care services were capped at the average commercial rate:
  - inpatient and outpatient hospital services
  - nursing facility services
  - qualified practitioner services at an academic medical center
- H.R. 1 caps payment rates for SDPs at 100% of Medicare in expansion states and 110% in non-expansion states

H.R. 1 temporarily grandfathers certain SDPs, delaying rate reductions

- Existing SDPs above the new cap may be grandfathered if approved by or submitted to CMS before July 4, 2025
- Grandfathered SDPs are frozen as of July 4, 2025, and reduced by 10 percentage points each year thereafter until they reach the cap
- In Virginia, reductions begin July 1, 2028

Impacts of the proposed rule may extend beyond scope of H.R. 1

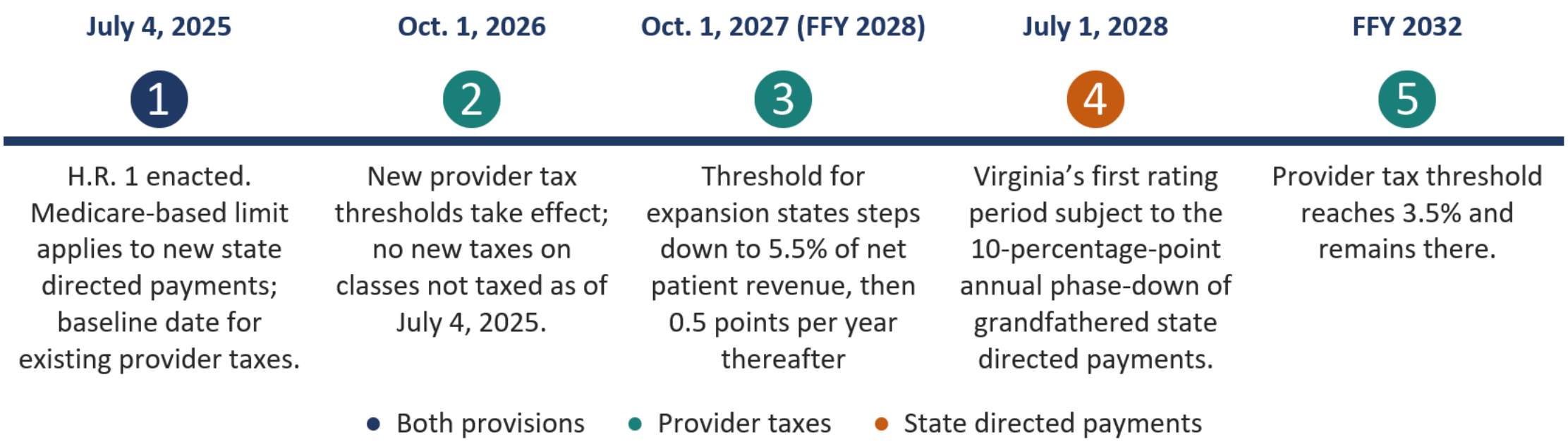
- CMS's proposed rule is not final but suggests phase down of grandfathered payments would be faster than anticipated and, beginning in 2029, would extend the Medicare limit to all services rather than just those specified in H.R. 1
- DMAS, HHR, VHHA, and individual hospitals have provided comment to CMS indicating the proposed rule exceeds the statutory text

DMAS = Department of Medical Assistance Services; HHR = Secretary of Health and Human Resources, VHHA = Virginia Hospital & Healthcare Association

H.R. 1 restricts provider taxes that yield portion of states' nonfederal share

- H.R. 1 narrows the scope of the "generally redistributive" exception to the requirement that health care provider taxes be broad-based and uniform
  - Virginia does not appear directly affected
- H.R. 1 reduces the threshold for determining whether a health care provider tax constitutes an impermissible hold-harmless agreement from 6% to 3.5% of net patient revenue over 5 years
  - Virginia's current health care provider taxes total about 5.96% of net patient revenue

H.R. 1's financing provisions take effect over the next five years



CMS rules implementing both provisions were proposed, not final, as of October 2026. The proposed state directed payment rule would also extend the Medicare-based limit to all services for rating periods beginning on or after January 1, 2029.

H.R. 1 will likely have compounding, negative effects on hospitals in Virginia

- SDP caps limit what MCOs currently pay hospitals, reducing hospital revenue
- A shrinking revenue base and declining safe harbor threshold reduce what Virginia can collect through health care provider taxes
- Lower health care provider tax limits reduce funds available for the nonfederal share of Medicaid expansion and enhanced payments to hospitals including SDPs

Virginia's acute care hospitals anticipate significant, negative impacts

- Comment letters from VHHA and hospitals in every region anticipate substantial reductions in revenue
- SDPs were about 20% of hospital net patient revenue statewide in SFY 2026 and up to 43% for certain rural and safety-net hospitals
- VHHA estimates $34.7 billion in reduced funding to hospitals from 2027 through 2036

SFY = state fiscal year

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H.R. 1 eliminates Medicaid coverage for some lawfully present noncitizens

- Beginning October 1, 2026, certain previously eligible refugees, asylees, and other lawfully present noncitizens are no longer eligible for Medicaid coverage
- DMAS notified about 5,800 enrollees that their coverage might be affected
  - Temporary state funding will provide coverage for about 270 through June 30, 2027
- FMAP for Emergency Medicaid also reduced from 90% to 50%, shifting $25.5M in costs of care to the state in FY27

FY = fiscal year

H.R. 1 requires work or community engagement activities for eligibility

- Beginning January 1, 2027, adults in the expansion population must engage in 80 hours per month of work, education, job training, community service or some combination thereof
- Exemptions exist for: caregivers, pregnant or postpartum individuals, former foster youth, and individuals who are “medically frail”
- Applicants must meet the requirement before applying, and current enrollees by their first renewal in 2027

H.R. 1 requires more frequent eligibility renewals for expansion adults

- Beginning January 1, 2027, adults in the expansion population must renew their Medicaid eligibility every six months, twice as often as before
- At each renewal, applicants must show they meet all eligibility criteria, including community engagement criteria
- States must add death-record and address checks in 2027, and a multistate enrollment check in 2029

New requirements may result in loss of Medicaid coverage

- New administrative requirements may create procedural barriers that cause eligible people to abandon the application process
  - About 53% of Virginians who lost coverage during Medicaid unwinding in 2023-2024 were disenrolled for procedural reasons
  - About 25% of adults subject to work requirements in another state lost Medicaid coverage

Estimates of the impact of H.R. 1 on Medicaid enrollment in Virginia vary

- A Virginia analysis estimates about 260,000 Virginians could lose coverage within nine years, and about 188,000 by 2034 from community engagement alone
- RAND projects about 183,000 fewer Medicaid enrollees in Virginia by 2034

Coverage losses from H.R. 1 may increase rates of uncompensated care

- Changes to Medicaid eligibility criteria and administrative requirements that create barriers to enrollment may result in fewer Virginians obtaining or maintaining Medicaid coverage
- When patients lose Medicaid coverage, hospitals experience increased rates of uncompensated care, with the effect often most significant for rural and safety-net hospitals
- National estimates suggest that uncompensated care resulting from coverage loss due to H.R. 1 and expired premium tax credits could total $466 billion by 2034

Virginia hospitals anticipate more self-pay patients and uncompensated care

- Top concern across stakeholders is coverage loss from new eligibility requirements and procedural disenrollment
- One health system estimates about $60 million in added annual uncompensated care
- Another reports already caring for 177 patients a day who cannot pay and notes that uninsured patients present later, often in emergency departments

Virginia is taking steps to minimize administrative challenges

- The General Assembly provided about $124.0 million over the biennium for Cover Virginia call center operations
- DMAS is notifying expansion enrollees and has raised call center staffing by more than 50%
- Executive Order 20 (August 2026) sets a “Keep Virginia Covered” policy to minimize administrative barriers
- New Virginia United Coalition engages health partners

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The RHTP provides funding to states to strengthen rural health care

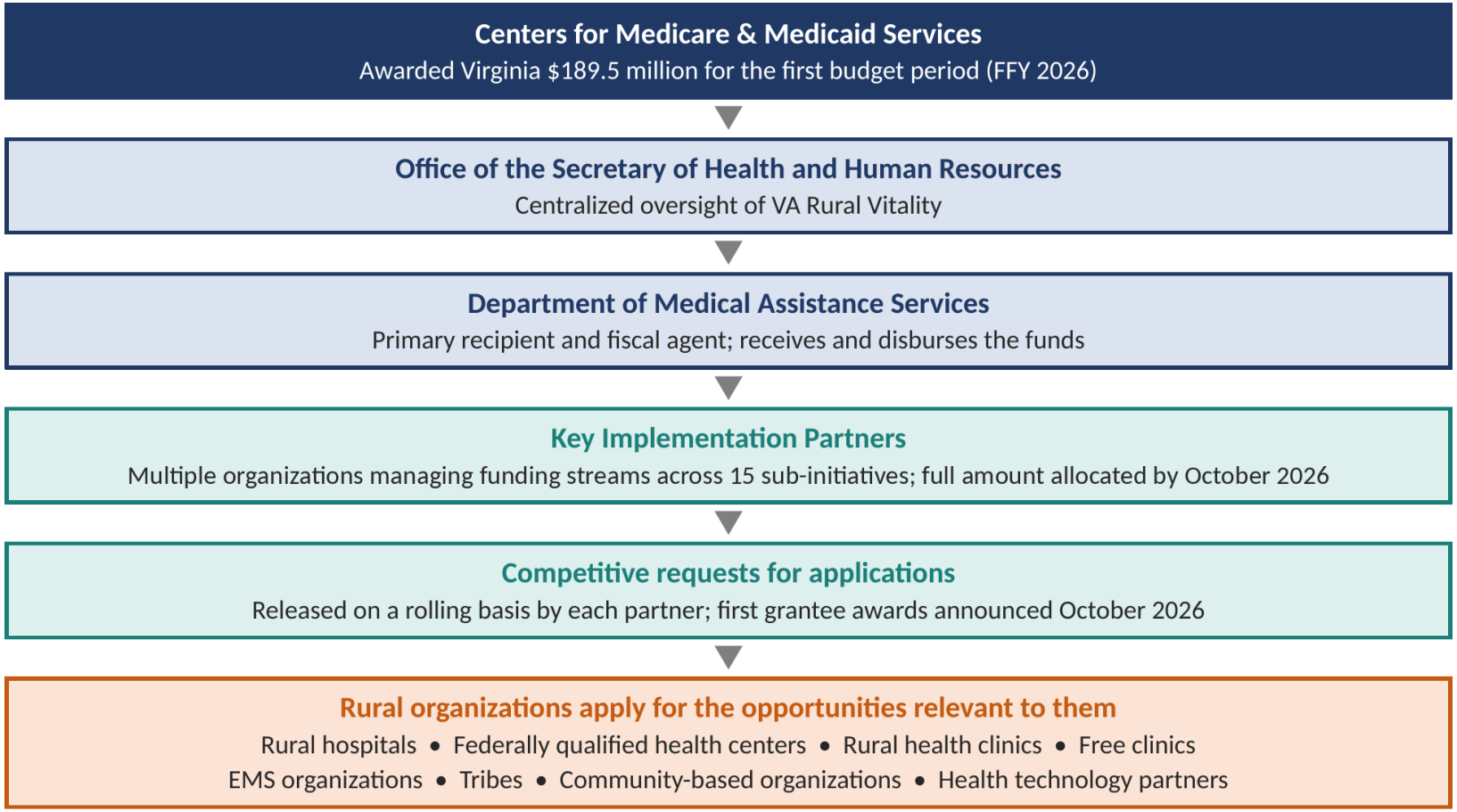
- H.R. 1 created the RHTP and appropriated $10 billion per year for five years beginning FFY 2026
- States submitted one-time applications in November 2025, including proposed initiatives, timelines, and budgets
- Awards must be used consistently with approved applications, and CMS may withhold, reduce, or recover funds from states that use them for other purposes

FFY = federal fiscal year

Virginia's RHTP plan includes four health initiatives

Initiative	Description	Total	First-Year
Connected Care, Closer to Home	Expands access through mobile clinics, telehealth, community paramedicine, and maternal care	~$412 million	$85.9 million
CareIQ	Modernizes rural health technology, including electronic health records, interoperability, and cybersecurity.	~$283 million	$53.7 million
Homegrown Health Heroes	Builds the rural health workforce through residencies, apprenticeships, and career pathways	~$132 million	$32.5 million
Live Well, Together	Promotes prevention and community health through nutrition, food-as-medicine, and wellness initiatives	~$124 million	$16.5 million
	TOTAL	~$1 billion	$189.5 million

Virginia administers the RHTP through a distributed model



RHTP enhances rural health financing but will not offset Medicaid losses

- Federal rules bar using RHTP funds to replace payments for services Medicaid otherwise covers
- Awards are not guaranteed to be the same each year, which limits hospitals' ability to plan staffing, capital, and clinical capacity
- Grants generally reach only federally designated rural areas, while the Medicaid changes apply statewide

Questions?