

What H.R.1 means for non-Medicaid expansion states

Only ten states have not expanded Medicaid to a broader population of low-income adults than those eligible under traditional Medicaid. Although many provisions of H.R.1 (such as Medicaid community engagement requirements and eligibility redeterminations) impact primarily states that have expanded Medicaid, select provisions related to Medicaid financing will impact all states to varying degrees.

The most relevant H.R.1 provisions for non-expansion states include:

- **Provider Taxes (Sec. 71115):** For non-expansion states, existing provider taxes may remain in place if they stay under the preexisting 6% “hold harmless” threshold, but all new provider taxes are prohibited.¹ All states also cannot propose new provider taxes effective July 4, 2025. This limits states' ability to generate Medicaid financing revenue. 49 of 50 states currently use provider taxes to finance significant portions of the state share of Medicaid.
- **State-directed payments (SDPs):** H.R.1 caps certain SDPs (to inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center) are capped at 110% of the equivalent Medicare rate in non-expansion states, compared with 100% in expansion states, with a mandatory phasedown of grandfathered SDPs. Prior to H.R.1, states were required to cap SDPs at 100% of the Average Commercial Rate, which is typically higher than the Medicare equivalent rate. Notably, [a rule proposed by CMS](#) in May would extend the limits above to all SDPs in nearly all provider settings beginning Jan. 1, 2029, with no phasedown period, which could have a significant impact on behavioral health services financed in part by SDPs.
- **Retroactive coverage reductions:** H.R.1 shortens the retroactive coverage period from the current three months to one month for individuals enrolled through Medicaid expansion and two months for those in traditional Medicaid. This may

¹ CMS originally established 6% as the maximum allowable tax amount because it aligned with averages of other taxes imposed on goods/services in states.

increase uncompensated care for providers serving individuals who delay enrollment and may increase medical debt for patients newly applying for Medicaid.

- **Recoupment of erroneous Medicaid payments:** Beginning Oct. 1, 2029, states that make erroneous Medicaid payments for ineligible individuals or overpayments for eligible individuals must allow CMS to recoup federal funds if the state's "error rate" is over 3%. While a similar rule is currently in place, it has largely been unenforced because of "good-faith" administrative waivers. H.R.1 removes these waivers and could further strain state shares of Medicaid financing
- **Noncitizen Medicaid eligibility:** H.R.1 narrows the definition of qualified immigrants eligible for Medicaid and CHIP in all states.
- **Budget neutrality for Section 1115 waivers:** H.R.1 includes new budget-neutrality requirements for Medicaid Section 1115 demonstrations, potentially limiting state flexibility to finance or sustain certain waiver programs. For more information, access the National Council's [hub resource](#).

What do these changes mean for non-expansion states?

As a result of these changes to Medicaid financing, both expansion and non-expansion states may experience reduced Medicaid revenue due to financing restrictions, greater fiscal pressure on state Medicaid programs, and potential increased uncompensated care resulting from eligibility changes.

The National Council is prepared to help states and providers identify strategies to address uncompensated care in light of these Medicaid changes. For more information, reach out to the National Council Policy and Advocacy team at policy@thenationalcouncil.org.