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MEDICAID POLICY BRIEF

HR1 and Michigan Medicaid: Eligibility and financing impacts

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An Overview of HR1 Impacts on the State of Michigan

Introduction

The federal One Big Beautiful Bill Act (HR1), signed into law in 2025, introduces sweeping changes to the Medicaid program with profound consequences for Michigan. HR1 will reshape how Michigan's Medicaid program is funded, who can access it, and how health care providers are compensated. The law restructures Medicaid along two key dimensions: eligibility and financing. New work requirements and more frequent eligibility redeterminations are projected to significantly reduce enrollment, threatening to reverse more than a decade of coverage gains. Simultaneously, new restrictions on provider taxes and state directed payments will reduce the revenue Michigan relies on to fund the program and limit payments to health care providers. Together, these changes represent the largest federal cuts to Medicaid in the program's history. This brief explains the core policy changes embedded within HR1 and examines what they mean for Michigan's enrollees, providers, and the state budget.

Background

At a high level, the core changes made by HR1 impact the Medicaid program through two pathways: 1) eligibility and 2) revenue and payment.

1. **Eligibility changes:** HR1 will require many Medicaid expansion enrollees to do 80 hours of work or other community engagement per month and to renew their eligibility every six months to maintain their Medicaid coverage.[i] In addition to the increased frequency of redeterminations, HR1 also limits the retroactive coverage window for all Medicaid enrollees. Because of administrative barriers, these eligibility changes are expected to reduce Medicaid enrollment, even among people meeting the new requirements.
2. **Revenue and payment changes:** Michigan finances its share of Medicaid costs in part by taxing certain health care providers. HR 1 caps the use of these taxes. Nearly all states, including Michigan, use state directed payments (SDPs) to increase payments from Medicaid managed care plans to health care providers. HR1 caps the use of SDPs and places overall limits on how much Medicaid can pay providers.

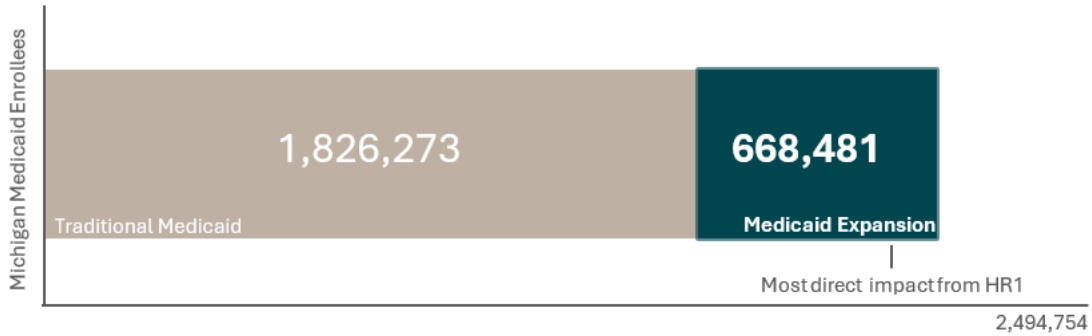
Eligibility changes

In May 2026, nearly 2.5 million Michigan residents were enrolled in the Medicaid program. Of these, roughly 668,000 are part of the Healthy Michigan Plan (HMP), Michigan's Medicaid expansion program (Figure 1).

[i] The CMS Interim Final Rule requires the completion of 80 hours of qualifying activities *or* a monthly income that is not less than the federal minimum wage multiplied by 80 hours. Because Michigan minimum wage will be $15 per hour in 2027, HMP enrollees may reach the monthly income threshold by working approximately 39 hours per month.

Figure 1

Michigan Medicaid enrollment (traditional Medicaid and healthy Michigan Plan) in May 2026 [1]



Work requirements

By January 1, 2027, many Medicaid expansion enrollees will be required to work, attend school, or perform community service for at least 80 hours each month. Some will be exempt, including those who are pregnant or postpartum, caring for a child age 13 or younger, or medically frail.[2] In the coming months, Michigan must inform beneficiaries about these requirements and implement systems to enforce them.

Mandatory outreach

States are required to implement a robust outreach process to notify Medicaid enrollees of work requirements via regular mail or email and at least one other form of communication (e.g., text or telephone). This outreach must begin by September 30, 2026.

Exemptions

Certain individuals are exempt from the work requirements, including, but not limited to, people serving as caregivers to a disabled individual or a dependent child age 13 or younger, disabled veterans, pregnant or postpartum women, and individuals deemed to be "medically frail." The law stipulates that those who are blind or disabled, as well as those with substance use disorders, disabling mental disorders, or physical, intellectual, or developmental disabilities must be considered medically frail.[3] Beyond this, states must define medical frailty subject to federal requirements and guidance. The June 1, 2026 guidance from CMS offers a more restrictive framework for defining medical frailty than what states had expected; in particular, states cannot exempt broad groups of people with specific conditions, such as cancer or multiple sclerosis.[4] Rather, it will be necessary to show that such conditions make an individual unable to work. It remains to be seen how Michigan and other states will operationalize the definition of medical frailty in compliance with CMS requirements.

The law includes an option for states to allow short-term exceptions for economic hardship when a county's unemployment rate is higher than 8% or 1.5 times the national unemployment rate, whichever is lower. Michigan intends to implement this option, as well as exceptions for counties with a federally recognized national disaster and for individuals who are hospitalized or must travel to receive medical care. The June 1, 2026 guidance from CMS indicates that states must implement either all or none of these options.

Verification

For beneficiaries who are not exempt, states must determine if they meet the work requirement when they apply for Medicaid and then again every six months as part of each regularly scheduled redetermination. Existing rules already require states to use administrative data whenever possible for enrollment and renewal to reduce burden on enrollees; HR1 requires states to take a similar approach to verifying compliance with work requirements and exemption criteria. Although some of this can be automated with state-level data sources (such as data from the Unemployment Insurance system), the Congressional Budget Office (CBO) expects that this type of *ex parte* verification may be exceedingly difficult for certain populations, types of work, and types of exclusion criteria.[5]

Other major eligibility changes

HR1 also limits the retroactive coverage window for all Medicaid enrollees. Under current law, Medicaid covers healthcare services provided up to 90 days prior to the application date, assuming the individual would have been eligible during that time. Effective December 31, 2026, this retroactive eligibility period will be reduced to 30 days for Medicaid expansion enrollees and 60 days for traditional Medicaid and CHIP enrollees.

In addition, Michigan must increase the frequency of Medicaid eligibility redeterminations for HMP enrollees, which will occur every six months instead of once a year. The state is required to cross-reference with federal and state data sources to identify instances of duplicate enrollment and deceased enrollees and providers.

Finally, HR1 limits eligibility for lawfully residing non-citizens. These individuals will lose full Medicaid coverage and will only be eligible to Emergency Services Only (ESO) coverage, effective October 1, 2026.

Revenue and payment changes

HR1 imposes new limits on both the ways that states can raise revenue for their share of Medicaid financing and in the level of payments they can set for providers.

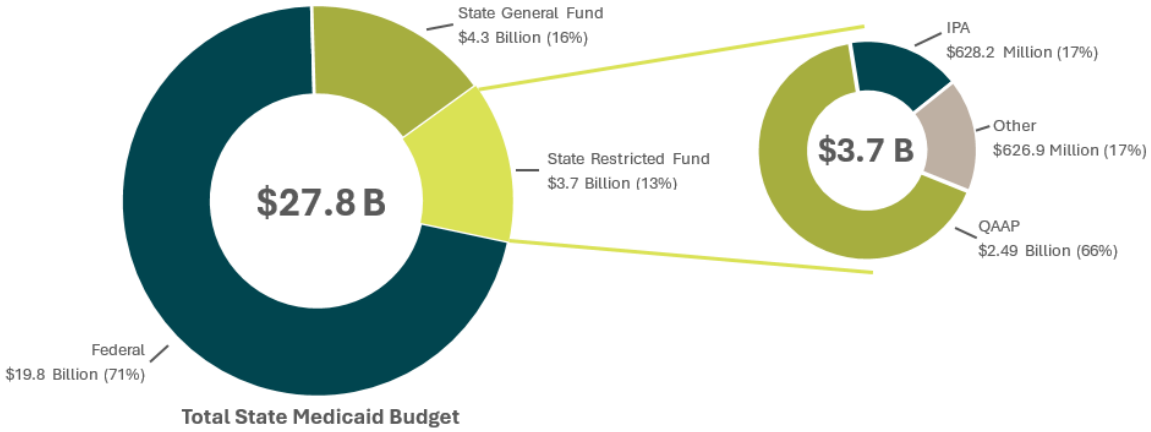
Provider tax limits

Michigan, like every state except Alaska, uses provider taxes to raise revenue for its share of Medicaid financing. Provider taxes are defined as taxes for which at least 85% of the burden falls on health care items, services, or providers, to help finance their share of Medicaid spending.[6] HR1 prohibits some currently permitted provider taxes that are used to help fund the state share of the Medicaid program. It also lowers the amount of permitted provider taxes by Medicaid expansion states by 0.5% annually starting in FY 2028 (Oct. 1, 2027) from 6% to a maximum of 3.5% of net patient revenues by FY 2032. For all states, taxes on nursing homes and intermediate care facilities are carved out of the reductions so long as they are at or below 6%.

Michigan has two types of provider taxes— one, levied through the Quality Assurance Assessment Program (QAAP) and another, the Insurance Provider Assessment (IPA). These taxes account for approximately $3 billion of the state's share of Medicaid spending in 2026 (Figure 2).[7]

Figure 2

Total Michigan Medicaid budget (left) and state restricted fund breakdown (right), fiscal year 2026[7]



QAAP

Michigan's QAAP levies provider taxes to support Medicaid on three categories of health care providers: hospitals, skilled nursing facilities and ambulance providers. Based on current CMS guidance, the most relevant provider tax impact in Michigan is on the hospital provider tax which is currently approximately 5.5% of net patient revenues. Because the current hospital provider tax is equal to the 5.5% maximum allowed rate for FY 2028, the phase down required by HR1 will not begin to affect revenues for Michigan until FY 2029. The ambulance provider tax in Michigan is currently at or below the 3.5% maximum. Full CMS guidance on skilled nursing facilities has not been released by CMS, so a future impact is possible.

Insurance Provider Assessment

The IPA went into effect in Michigan on October 1, 2018, replacing an earlier Health Insurance Claims Assessment (HICA). The IPA created a fixed and variable rate structure for certain insurance providers, including Medicaid managed care organizations (MCOs)[ii] and health insurers. As a result of HR1, certain variable assessments like those established by the IPA are impermissible. [iii]

Public Act 25-25, which was signed into law with immediate effect by Governor Whitmer on October 7, 2025, replaced the IPA's variable assessment structure with a uniform or flat tax rate structure for all payers.[8] Whereas certain variable assessments like those established by the IPA in 2018 are impermissible under HR1, the new law is federally compliant and will result in the same level of revenue for the state as under the original IPA statute.

[ii] Medicaid MCOs are health care entities that contract with state Medicaid programs and providers to coordinate the delivery of medical care for their members.
[iii] The fixed and variable rate structure of the IPA was designed to meet the requirements of the CMS statistical test for non-uniform taxes demonstrating the tax is generally redistributive – meaning it does not place a disproportional burden on certain providers. HR1 prohibits these non-uniform or variable tax structures for the Medicaid program.

State directed payments

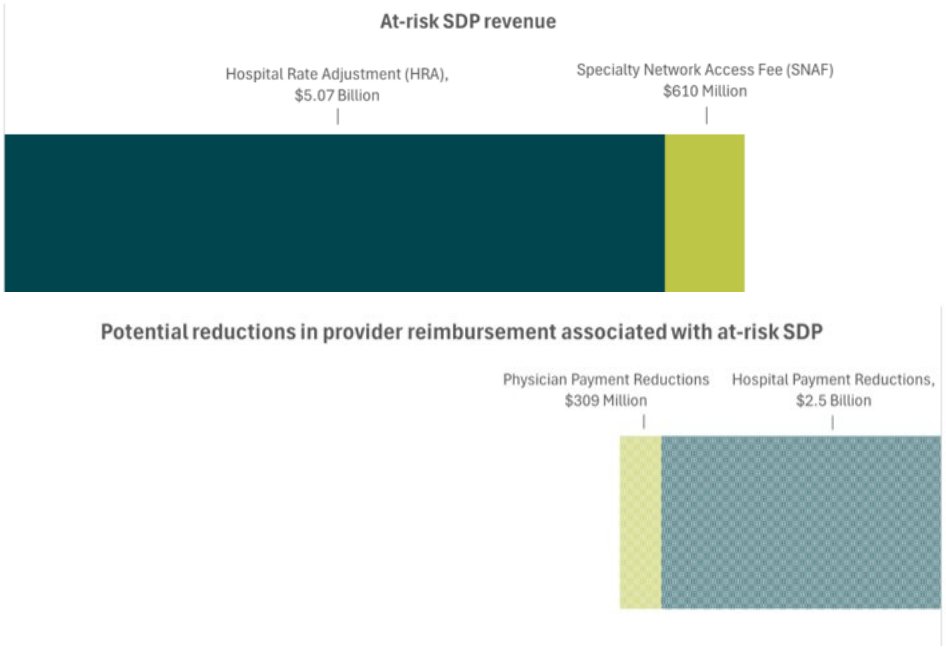
SDPs are a mechanism which most states, including Michigan, use to help fund payments to health care providers. In Michigan, the SDP applies revenue from hospital provider taxes to draw down additional federal funds that are used to enable Medicaid managed care plans to pay hospitals based on average commercial rates (ACR). Michigan transitioned to an ACR-based SDP for hospitals in FY24 (10/1/23 – 9/30/24).

HR 1 limits the supplemental payments that can be made beyond the Medicaid base rates. The reduction lowers the maximum rate of all SDPs down to 100% (for expansion states) or 110% (for non-expansion states) of the equivalent Medicare published payment rate for relevant services. SDPs approved or submitted in good faith before May 1, 2025, were permitted to remain above the new caps (grandfathered) temporarily. In grandfathered states, the rates must begin to be phased down by 10% annually beginning with rating periods starting on or after January 1, 2028, until they reach the new Medicare-based cap (by 2037 at the latest).

When fully phased in in Michigan, Medicaid managed care payments to hospitals will be reduced by about 27% from current levels.[iv] Because Michigan is a grandfathered state and based on Michigan's managed care rating period (October 1 – September 30), these changes will not begin to affect provider payments until FY 2029.

Figure 3

Current at-risk SDP revenue and HR1's potential impacts on provider reimbursement [9]

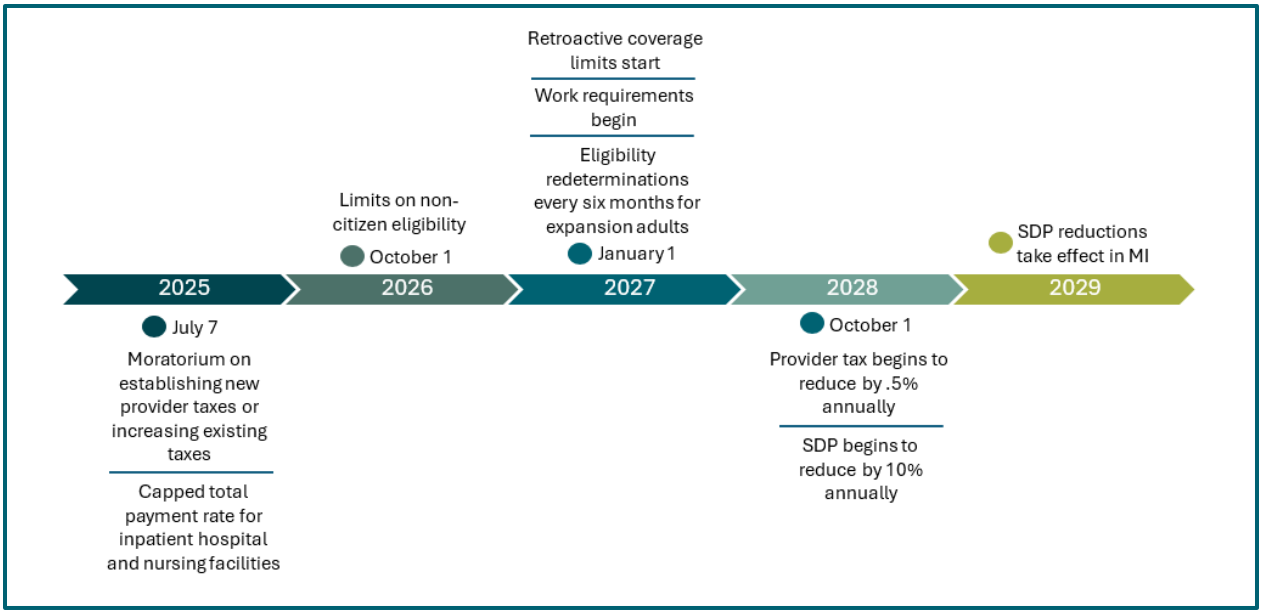


[iv] The reduction in payments results from reducing supplemental managed care hospital payments by 10% a year for four years (i.e., a 40% reduction in these supplemental payments yields a 27% reduction in total managed care hospital payments). These percentages are based on "total computable" amounts (federal dollars + the non-federal/state share).

The SDPs in Michigan that will be impacted by HR1 are the $5.07 billion Hospital Rate Adjustment (HRA) and the $610 million the Specialty Network Access Fee (SNAF), which supplement Medicaid payments to hospitals and physicians, respectively.[10] The at-risk SDP payments and the potential impacts on reimbursement to hospitals and providers is depicted in Figure 3, using estimates provided by MDHHS on the impact SDP caps will have on payments.[11]

Figure 4

Timeline of Medicaid-related HR1 provision implementation dates.



Conclusion

The Medicaid provisions of HR1 represent the largest cuts in the program's history. The projected reduction in federal spending arises mainly from reduced enrollment due to work requirements and more frequent eligibility redeterminations. The budget released by Governor Whitmer in February 2026 assumes a reduction in HMP enrollment of about 40,000 in FY2027. This projection was made before recent federal guidance suggesting that exemptions based on medical frailty would be more narrowly defined than had been expected. In light of this new guidance, the decline in enrollment will likely be even greater than 40,000.

The implications of declining enrollment depend entirely on what becomes of former HMP enrollees. It is expected that the large majority of Michiganders who lose HMP coverage will become uninsured. In 2013, before the Medicaid expansion and other coverage provision of the Affordable Care Act went into effect, more than 1 million Michiganders were uninsured and hospitals reported more than $1 billion in uncompensated care.[12] Following the implementation of HMP and the Health Insurance Exchange Marketplace in 2014, both the uninsured rate and hospital uncompensated care in Michigan were cut in half.[13] The increase in the uninsured population caused by HR1 can be expected to increase the

uncompensated care burden on hospitals and other health care providers to levels closer to what we saw in 2013 than any year since 2014.

Other provisions of HR1 will magnify this negative financial impact on providers. Limits on how Michigan can finance its share of Medicaid spending and limits on the amount that the program can pay providers will also reduce hospital revenues. These provisions of the law will not be effective immediately but will have a significant financial impact once fully implemented.

We thank the Michigan Health Endowment Fund for supporting this work.

[1] MDHHS, Fact Sheet May 2026 (PDF). https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Reports-and-Statistics---Health-Services/MDHHS_Fact_Sheet.pdf?rev=efa4ec6a9a624e858aa6909e8c3eea32&hash=BA8BE20B94EACF23FD49C73B3363A90D.

[2] CMS, "Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule with Comment Period (CMS-2454-IFC). https://www.cms.gov/newsroom/fact-sheets/medicaid-community-engagement-requirement-certain-individuals-interim-final-rule-comment-period-cms

[3] Federal Register. "Medicaid Program; Community Engagement Requirement for Certain Individuals". https://www.federalregister.gov/documents/2026/06/03/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals

[4] KFF, "CMS Requires More Restrictive Definition of Medical Frailty in New Medicaid Work Requirements Rule". https://www.kff.org/quick-insights/cms-requires-more-restrictive-definition-of-medical-frailty-in-new-medicaid-work-requirements-rule/

[5] Congressional Budget Office, PL-119-21 Medicaid (PDF). https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

[6] Social Security Act, Title XIX, Section 1903. https://www.ssa.gov/OP_Home/ssact/title19/1903.htm; KFF, "5 Key Facts About Medicaid and Provider Taxes". https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/

[7]MDHHS, Executive Directive ED-2025-3 (PDF). https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Newsroom/ED-2025-3-FINAL.pdf

[8] Act No. 25, Public Acts 2025. State of Michigan 103rd Legislature, Regular Session of 2025. https://www.legislature.mi.gov/documents/2025-2026/publicact/pdf/2025-PA-0025.pdf

[9] CMS, State Directed Payment Preprint: Primary Care and Specialty Physicians (PDF). https://www.medicaid.gov/medicaid/managed-care/downloads/MI_Fee_PC.SP_Renewal_20241001-20250930.pdf; CMS, State Directed Payment Preprint: Inpatient and Outpatient Hospital Services (PDF). https://www.medicaid.gov/medicaid/managed-care/downloads/MI_Fee_IPH.OPH_Renewal_20241001-20250930.pdf

[10]MDHHS, SNAPMA HR1 presentation (PDF). https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid/MDHHS-Presentation---SNAPMA---HR1.pdf

[11] MDHHS, Michigan Medicaid Program Updates Presentation (Feb. 27, 2026).

[12] Barnett, Jessica C. and Edward R. Berchick, Current Population Reports, P60-260, Health Insurance Coverage in the United States: 2016, U.S. Government Printing Office, Washington, DC,2017. https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf.

[13] Buchmueller, Thomas, Helen Levy, Sayeh Nikpay, and Jordan Rhodes. The Healthy Michigan Plan PA 107 §105(d)(8-9) 2016 Report on Uncompensated Care and Insurance Rates. 2017. https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder3/Folder81/Folder2/Folder181/Folder1/Folder281/2013_PA_107_Section_105d8-9_Required_Report_2017.pdf?rev=e20c494ec4614732a3e0f5e59aa1dabf&hash=F03A39172A3E587ED49FB1FB9A11B336.