hpio health policy institute of ohio

Policy explainer
Changes to Medicaid financing in Ohio

March 2026

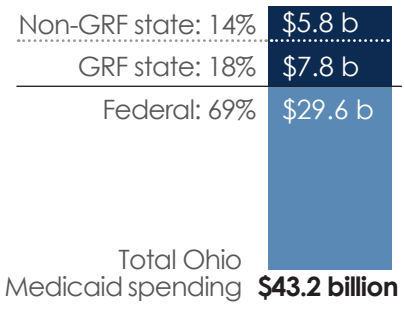
Ohio's Medicaid program provides health insurance to nearly 3 million Ohioans, covering more than a quarter of the state's population.[1] Medicaid coverage has been shown to improve access to care, health outcomes and financial security.[2] For example, Medicaid expansion is associated with improvements in cancer survival rates.[3]

As the second most common form of health insurance in the state,[4] Ohio's Medicaid budget exceeded $43 billion in state fiscal year (SFY) 2025.[5] The program is jointly funded by states and the federal government; in Ohio, the federal government paid 68.5% of total costs in SFY 2025 ($29.6 billion) and the state paid the remainder ($13.6 billion).

States have flexibility in how they finance their share of Medicaid spending. Funding sources include both general revenue funds (GRF), as well as non-general revenue sources like funding from local governments and specific fees on healthcare entities, which are called provider taxes.[6] The federal government then matches state Medicaid dollars using the federal medical assistance percentage (FMAP), which varies between states, as well as across different coverage categories and services.[7]

In Ohio, each dollar of state Medicaid spending draws down multiple dollars of federal funds. For more information on Ohio's Medicaid program and how it is financed, see HPIO's **Ohio Medicaid Basics**.

Figure 1. **Ohio Medicaid spending by revenue source, SFY 2025**



Source: Legislative Budget Office Analysis of Ohio SFY 2025-26 Budget

3 Key findings for policymakers

1. **HR 1 restricts the ability of states to raise revenue for their Medicaid programs through provider taxes.** These provisions will significantly impact two of Ohio's provider taxes, which currently generate billions of dollars in state revenue, along with additional matching federal funds.
2. **HR 1 caps the amount that states can enhance provider reimbursement through state directed payments**, which may impact the financial stability of providers and care access for Medicaid enrollees.
3. **States will need to account for the loss of Medicaid funding from provisions in HR 1.** Ohio can mitigate some of the cuts by modifying its provider tax on health insurers. States may pursue reducing Medicaid expenditures, however, doing so is likely to have negative health and economic consequences for Ohioans.

Inside

HR 1, the federal reconciliation bill sometimes referred to as the "One Big Beautiful Bill Act" or the "Working Families Tax Cuts Act," includes provisions that will have major impacts on Medicaid financing in Ohio. These provisions affect provider taxes, as well as one of the ways that states increase payments to providers who treat Medicaid patients and invest in quality improvement efforts. While the exact impacts of these changes to financing are not yet fully known, they will reduce Medicaid funding in Ohio by billions of dollars. Ohio policymakers will need to make important decisions to mitigate these funding cuts. States may consider cutting Medicaid expenditures in response to HR 1, however these decisions will have negative impacts on residents and the broader health care system.

Total Medicaid funding impacts in HR 1

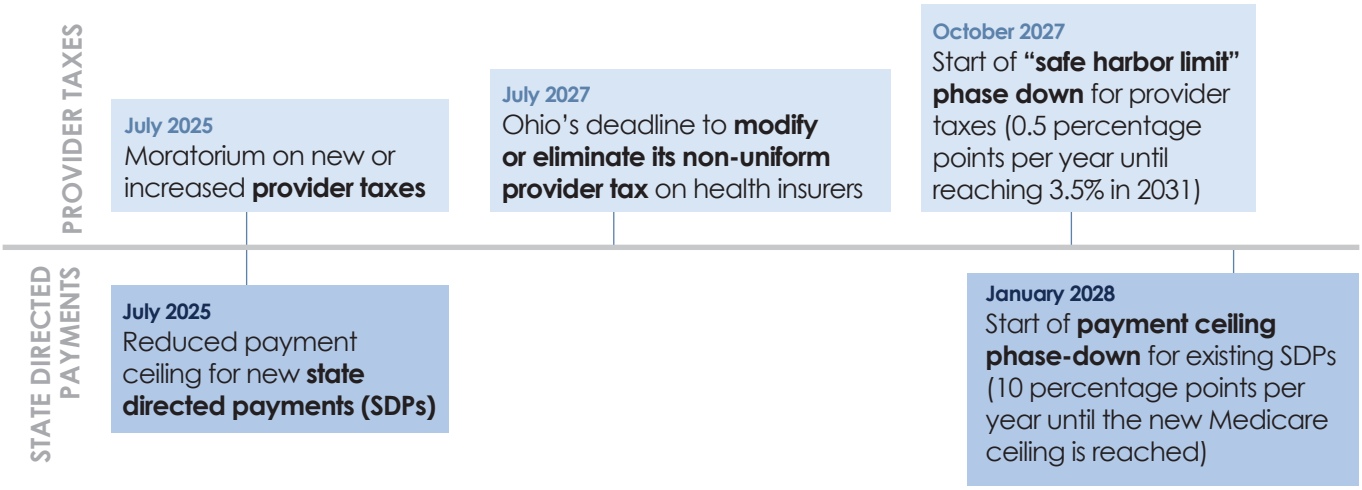
The total funding losses expected to Ohio's Medicaid program, including from the provisions that are the focus of this brief, were originally estimated to be **$33 billion** over the next decade, according to KFF's analysis of Congressional Budget Office estimates. The actual impact may differ based on a variety of factors.

In addition to provisions impacting Medicaid financing, HR 1 contains other major changes to Medicaid that will also affect program funding. For example:

- Implementing work requirements and more frequent eligibility redeterminations will require developing and paying for new administrative systems.
- New eligibility restrictions may reduce program enrollment, which would in turn reduce program expenditures.

For more information on other important HR 1 provisions impacting aspects like program eligibility, see HPIO's **Healthcare access and affordability series**.

Figure 2. **Timeline of HR 1 provisions impacting Medicaid financing**



MEDICAID PROVIDER TAXES

Summary

Provider taxes are assessments on healthcare entities, such as hospitals and insurers, that states use to generate revenue to fund their Medicaid programs. Revenue from provider taxes draws down federal matching dollars, which enables states to pursue program initiatives, such as providing health coverage to more people.

HR 1 Changes

HR 1 alters the federal requirements for provider taxes, including:

- Prohibiting any new or increased provider taxes as of July 2025
- Restricting the use of waivers for some requirements
- Gradually lowering of the maximum allowable tax rate in future years

Ohio Impacts

- Ohio's **health insuring corporation (HIC) franchise fee** must be modified or eliminated before July 1, 2027. This would result in annual state revenue losses of $640 million starting in SFY 2028, along with $1.5 billion in matching federal dollars.
- Ohio's **hospital franchise fee** was increased shortly before passage of HR 1 (July 2025), making the tax rate high enough that it must be phased down as the safe harbor limit (i.e., maximum tax rate) is lowered beginning in October 2027. ODM estimates that the phase down of this tax will reduce state funds by $1.2 billion through 2032 ($220 - $280 million annually), along with matching federal dollars.

Provider taxes are "state-imposed taxes or fees on certain health care providers (like hospitals, nursing facilities or managed care organizations)."[8] For example, a state may tax nursing homes based on the number of patient beds they have, or tax hospitals as a percentage of their total facility expenditures. These taxes are one of the most common sources of revenue that states use to fund their share of Medicaid programs, comprising approximately 17% of all state Medicaid funds nationally, which is second only to general revenue dollars.[9]

When used as the state share of Medicaid expenditures, provider taxes draw down additional federal matching funds. This revenue gives states financial flexibility to pursue important program initiatives like increasing Medicaid payment rates, initiating new payment and delivery reforms and expanding eligibility categories to cover more people.[10] Providers are generally supportive of these taxes because they ensure funding for Medicaid programs, reducing uncompensated care from uninsured patients and oftentimes supplementing reimbursement rates.[11]

There is wide variation across states in the number and types of provider taxes. Alaska is the only state with no provider taxes, while 41 states and DC have at least three provider taxes.[12] As of January 2026, Ohio has four provider taxes, described starting on page 4.

States must structure provider taxes to adhere to specific federal guidelines to receive matching federal dollars.[13] The three main requirements are:

1. **Broad-based**: The tax must apply to all providers in a specific class/type (e.g., all hospitals, all insurers, etc.). For example, the tax cannot only apply to specific hospitals in a state.
2. **Uniform**: The tax must apply equally across all members of that class. For example, the tax cannot have different rates for different hospitals.
3. **No hold harmless**: The taxpayers (i.e., providers) cannot be directly or indirectly guaranteed to receive their tax payments back through boosted reimbursement rates or other types of payments.

Historically, the Centers for Medicare and Medicaid Services (CMS) allowed states to submit waivers to circumvent broad-based and uniform requirements, as long as the tax did not impose excessively higher rates on Medicaid providers (determined by a mathematical test).

Under current federal law, there is an exception to this requirement if the tax rate is 6% or less of a provider group's net patient revenue. This is called the "safe harbor limit." Practically, taxes are only permissible if they remain below 6% of the provider group's aggregate net patient revenue.

HR 1 changes

HR 1 made significant changes to the federal requirements for provider taxes. Some changes went into effect when the bill was enacted in July 2025, while others have effective dates in the coming years.

Provision	Ohio context (see following section for more detail)	Effective date
Prohibits new or increased taxes on providers	Provider taxes must have been "enacted and imposed" before the passage of HR 1, meaning Ohio cannot create new provider taxes or increase existing ones to generate additional Medicaid revenue.	Upon enactment (July 4, 2025)
Gradually reduces the hold harmless safe harbor limit for provider taxes by 0.5 percentage points annually from current level of 6% to 3.5% • **Does not include taxes on nursing homes and intermediate care facilities** • **Applies to Medicaid expansion states only**	Because Ohio is a state with Medicaid expansion, any provider tax above the phased down safe harbor limit in a given year will need to be gradually reduced beginning in federal fiscal year (FFY) 2028. This will specifically affect Ohio's hospital tax.	Reduction occurs from FFY 2028 through FFY 2032
Restricts waivers for broad-based and uniformity requirements, specifically for taxes where providers are assessed at different rates depending on their Medicaid revenues or number of Medicaid patients	Ohio's tax on health insurers has historically received a waiver because it is not uniform. A **final federal rule** clarified that Ohio will have until the end of SFY 2027 (June 30, 2027) to make this tax uniform or eliminate it.	Upon enactment (July 4, 2025), with up to three years to transition.

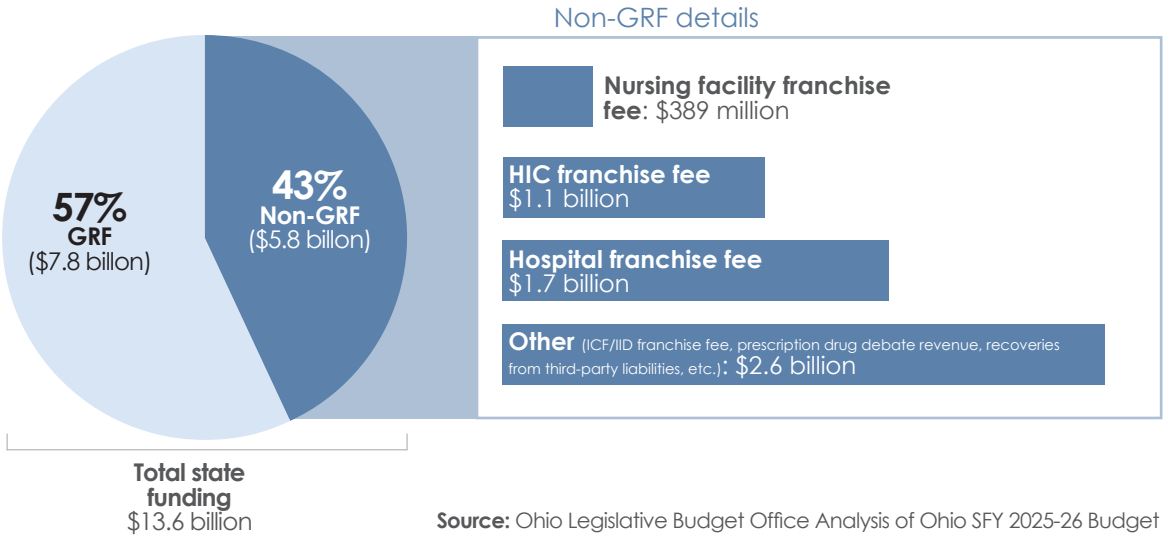
The Congressional Budget Office (CBO) estimates that these changes to provider taxes will cut federal Medicaid spending nationally by **$226 billion** over the next decade.[14] This loss of funding will restrict state Medicaid program budgets and force difficult financial decisions, which the CBO estimates will lead to 1.2 million people losing their insurance nationally by 2034.[15]

For more details on the impact of HR 1 on provider taxes, see the following resources:
- **How Medicaid Provider Taxes Work: An Explainer** (National Association of Medicaid Directors)
- **CMS Issues New Guidance on H.R. 1's Restrictions on State Use of Provider Taxes to Finance Medicaid** (Georgetown University Center for Children and Families)

Impacts on Ohio's provider taxes from HR 1

Ohio uses revenue from taxes on four classes of providers to fund a portion of its Medicaid program. These provider classes are hospitals, health insurers, nursing homes/long-term care (LTC) units and intermediate care facilities for individuals with intellectual disabilities (ICF/IID). The three largest taxes (on hospitals, health insurers and nursing homes/LTC units) together raised $3.2 billion in state revenue in SFY 2025, comprising 24% of the state's total share of the Medicaid budget (figure 3).

Figure 3. **Breakdown of state share of Medicaid funding, Ohio SFY 2025**



Source: Ohio Legislative Budget Office Analysis of Ohio SFY 2025-26 Budget

Two of Ohio's existing taxes are impacted by provisions in HR 1:

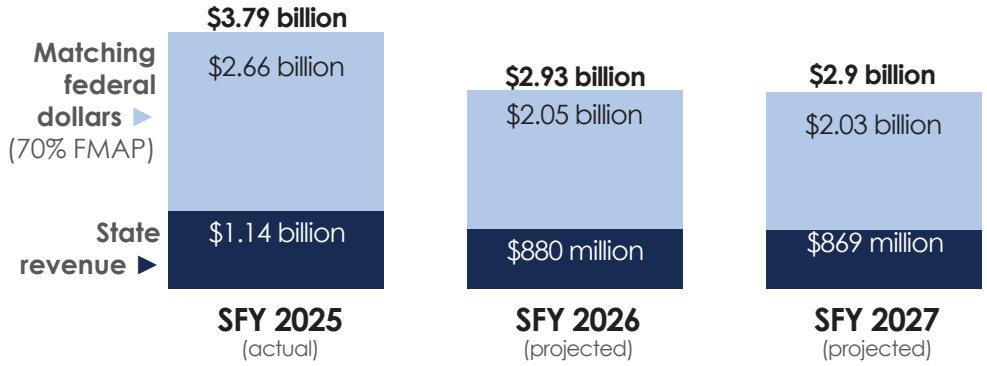
- **The health insuring corporation (HIC) franchise fee**—a tax on health insurers—that previously received a uniformity waiver.
- **The hospital franchise fee**—a tax on hospital systems—that is now above 3.5% of net patient revenues, which must be phased down in future years.

Together, these two taxes are projected to generate **$3.9 billion** in state revenue in SFY 2027. Because of this, changes to provider taxes from HR 1 are likely to have a major impact on Ohio's Medicaid budget in the coming years, potentially resulting in a loss of billions of state and federal dollars.

Health insuring corporation (HIC) franchise fee

Unit assessed	Enrollee member-months (total number of individuals enrolled in an insurance plan multiplied by the number of months they are covered)	
Tax rate	**Medicaid MCOs:** Tiered rate ranging from $26 - $56 per member per month (PMPM)	**Other health insurers:** Tiered rate ranging from $1 - $2 PMPM
HR 1 issues	Tax rate is not uniform across Medicaid and non-Medicaid member months	

Figure 4. **HIC franchise fee all-funds impact, SFY 2025-2027**



Source: HPIO analysis of Ohio Legislative Budget Office data

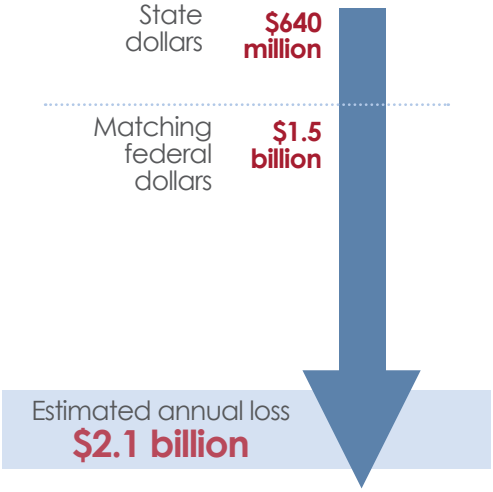
The HIC franchise fee was first enacted in Ohio in July 2017, after the federal government stopped permitting previous forms of taxation that had been used to finance Ohio's Medicaid program.[16] The HIC franchise fee assesses health insurers based on the number of people they cover.[17] Most Medicaid enrollees in Ohio are covered through managed care organizations (MCOs), which are privately-operated health insurance companies contracted by ODM.[18] Importantly, the HIC franchise fee taxes these Medicaid MCOs at a higher rate than other health insurers in the state, meaning it does not meet the uniformity requirement. Only six other states have taxes on MCOs that work in this manner. Since its inception, CMS has waived the uniformity requirement for Ohio's HIC franchise fee.[19]

HR 1 no longer permits the waivers that Ohio and six other states have relied on for these non-uniform taxes on health insurers. Based on a **final federal rule**, Ohio will have until the end of SFY 2027 (June 30, 2027) to either make this tax compliant or eliminate it. This is shorter than the maximum transition period of three years described in HR 1.[20]

In SFY 2025, the HIC franchise fee accounted for 8.4% of the state's share of Medicaid revenue, with a total funds amount of nearly $3.8 billion after accounting for the federal match (figure 4). ODM projects that the elimination of the HIC franchise fee would result in an annual $640 million loss in state Medicaid funding starting in SFY 2028, which reflects anticipated decreases in Medicaid enrollment.[21] When accounting for subsequent federal matching dollars, the total funding loss would be approximately $2.1 billion (figure 5).

The seven states with non-compliant MCO taxes can make their tax uniform rather than eliminate it entirely.[22] For example, a state could choose to assess the same tax rate on all enrollee-months, rather than a differential rate for Medicaid vs. non-Medicaid insurers. Some states already have a tax on insurers to raise state Medicaid revenue that meets uniformity requirements.[23]

Figure 5. **Potential Medicaid funding loss if non-uniform HIC franchise fee is not resolved, beginning in SFY 2028**

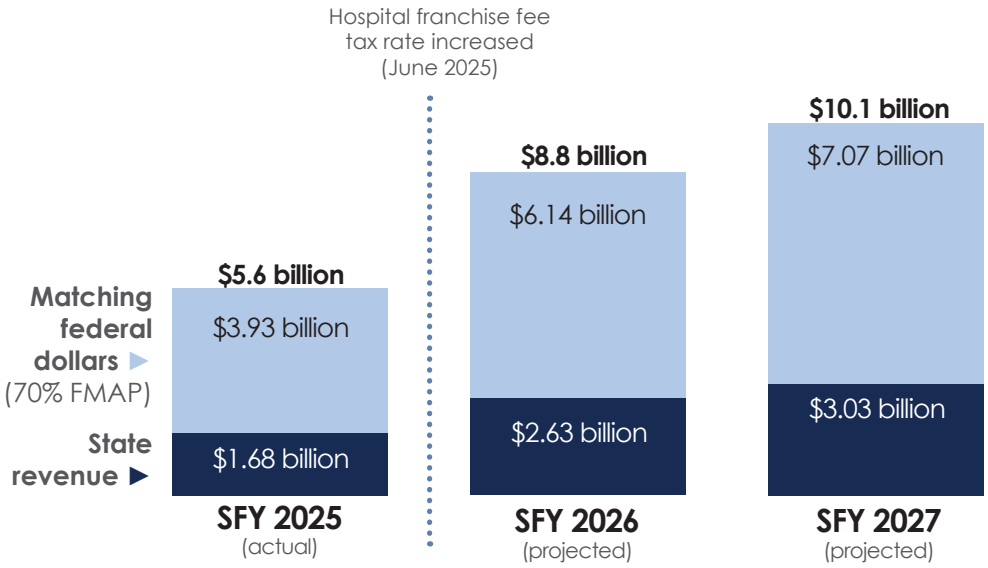


Note: Federal matching estimates calculated using a 70% overall blended FMAP. Funding loss estimates may differ based on Medicaid enrollment changes and other policy developments.
Source: HPIO analysis of Ohio Department of Medicaid projections

Hospital franchise fee

Unit assessed	Adjusted total facility costs (excludes skilled nursing, hospice, home health, ambulance, durable medical equipment, and care for Medicare recipients)
Tax rate	**Before July 2025:** Approximately 4.5% of adjusted total facility costs **After July 2025:** 8% of adjusted total facility costs, which will decrease to approximately 7% by SFY 2027. These new tax rates remain below 6% of hospital net patient revenues
HR 1 issues	Increased tax rate is subject to the gradual phase down of the safe harbor limit

Figure 6. **Hospital franchise fee all-funds impact, SFY 2025-2027**



Note: Revenues from the hospital franchise fee will begin decreasing in later years due to the safe harbor limit phase down.
Source: HPIO analysis of Ohio Legislative Budget Office data

Ohio's hospital franchise fee, which was enacted in 2009,[24] assesses all hospitals in the state at a uniform rate based on their adjusted facility costs.[25] ODM has increased the tax rate frequently since the hospital franchise fee was first enacted, including most recently in June 2025 before HR 1 was signed into law. A substantial portion of the revenue generated from this tax is used to increase Medicaid payments to hospitals (see State Directed Payments on page 8), as is permitted by federal law if the tax remains under the safe harbor limit.

Figure 7. **Anticipated Medicaid funding loss from hospital franchise fee due to safe harbor limit phase down, beginning in FFY 2028**

Note: Federal matching estimates calculated using a 70% overall blended FMAP. Funding loss estimates may differ based on Medicaid enrollment changes and other policy developments.
Source: HPIO analysis of Ohio Department of Medicaid projections

The hospital franchise fee accounted for approximately $1.7 billion in state Medicaid revenue in SFY 2025 and is projected to increase significantly given the July 2025 rate increase (figure 6). The Ohio Legislative Budget Office estimates that the hospital franchise fee rate increase will generate *additional* state revenues of $912 million in SFY 2026 and $1.0 billion in SFY 2027.[26] More than half of this additional revenue would go towards increased hospital payments, while the rest would go towards other Medicaid initiatives such as behavioral health care and rate increases for home and community-based service providers.[27]

In prior years, Ohio's hospital franchise fee was well below the safe harbor limit of 6% of net patient revenues. The increased rate remains below 6% but is now high enough that it will be subject to the upcoming gradual safe harbor phase down, which begins in FFY 2028. The phase down is estimated to first impact Ohio in FFY 2029. Each half percentage point decrease in the safe harbor limit will reduce the revenue available to Ohio to fund the state's share of the Medicaid program and pursue higher hospital payment rates. ODM estimates that the safe harbor phase down will result in state funding losses of $1.2 billion through 2032, or $220-$280 million per year.[28] When accounting for federal matching dollars, the funding impact on Ohio's Medicaid program will total **$4 billion** over this 5-year period, or up to **$933 million** annually (figure 7).

STATE DIRECTED PAYMENTS

Summary

State directed payments (SDPs) allow Medicaid programs to boost provider payments and support care quality initiatives. These payments can address low Medicaid reimbursement rates and improve care access for program enrollees. The revenues generated by provider taxes and other sources, along with matching federal dollars, are used to fund these additional payments.

HR 1 Changes

HR 1 places restrictions on SDPs, capping payments at Medicare reimbursement levels rather than commercial insurance levels. Existing SDPs can remain at higher rates for now but will be phased down in coming years.

Ohio Impacts

Many of Ohio's SDPs currently reimburse services at rates higher than the Medicare level, meaning they will need to be lowered in the future. These provisions will cost Ohio providers approximately $200 million annually in upcoming years, which could impact access to care for Medicaid enrollees.

Revenues generated from provider taxes (and subsequent matching federal dollars) can be used towards a variety of Medicaid program initiatives.[29] Medicaid payments for healthcare services tend to be significantly lower than Medicare and commercial rates. This can produce fiscal pressures for providers who see many Medicaid patients and can lead to some providers limiting their Medicaid patient volume.[30] Thus, one common and important use of provider tax revenue, along with other state funding sources, is to increase provider reimbursement rates for Medicaid services.[31]

To account for the transition towards Medicaid managed care in many states, CMS developed a mechanism in 2016 called state directed payments (SDPs) that allows states to enhance provider reimbursement and pursue new care delivery arrangements. SDPs can apply across a full set of services in the state (e.g., inpatient hospital care) or to a specific subset of providers and services (e.g., physician services in a group of hospitals). Each SDP is tied to specific quality measures.[32]

The most common type of SDP is a uniform rate increase, allowing states to boost the amount that Medicaid MCOs reimburse providers for a set of services by a specific percentage or amount. SDPs can also be used to pursue value-based payment initiatives, where reimbursement rates are tied to quality metrics or outcomes.[33] States' usage of SDPs has grown in recent years, with a 2024 analysis finding that the total amount of payments exceeded $110 billion.[34] Prior to HR 1, SDPs could not exceed an upper payment limit of the average commercial rate. SDPs must also be renewed by CMS each year.

Ohio uses SDPs to boost reimbursement for multiple provider types, including academic medical centers, community health centers and rural hospitals, as well as to implement care delivery mechanisms for certain Medicaid populations.

Examples of SDPs in Ohio

► Hospital Additional Payments (HAP)

Ohio's HAP SDP provides supplemental payments to hospitals for inpatient and outpatient care provided to Medicaid patients.[35] Hospitals receive quarterly payments based on the amount of services rendered. The additional payments from this SDP are directly tied to Ohio's hospital franchise fee and the associated federal dollars that this revenue draws down.[36]

The most recently approved version of this SDP for 2025 totaled $3.9 billion in payments to hospitals around the state, which cannot increase any further due to HR 1. These additional payments boost reimbursement to hospitals above typical Medicaid rates but are set to levels that are below the average commercial rate. The HAP SDP prioritizes quality improvement metrics related to follow-up rates after hospitalization for mental illness.

► Care Innovation and Community Improvement Program (CICIP)

CICIP is an SDP created in 2018 that focuses on improving access to high-quality care for low-income communities at four participating academic medical centers and safety-net hospitals across Ohio.[37]

The systems receive quarterly payments in a uniform rate increase to their combined average commercial rate, but 10% of the annual payments are withheld and paid out based on achieving specific quality measures.[38] The clinical areas addressed by the measures include substance use disorder, emergency department utilization, perinatal care, mental health and opioid prescribing rates.

The most recently approved version of this SDP for 2025 totaled over $290 million in payments for participating hospitals. The health systems provide state funding for the program through intergovernmental transfers, which are funds from government entities such as counties or public academic medical centers that can draw down federal dollars similar to provider taxes.[39]

► SDPs for professional services

Some of Ohio's current SDPs specifically target enhancing reimbursement rates for the services of physicians and other medical professionals (such as psychologists, nurse practitioners, dentists, etc.) within certain health systems. These payments can address reimbursement rates that lag other payers like commercial insurers, helping to increase the number of providers who accept Medicaid patients. For example, one recently renewed SDP increases reimbursement rates at participating academic medical centers for certain professional services up to average commercial rates.[40]

HR 1 changes

As with provider taxes, HR 1 restricts the use of SDPs, which is likely to have important impacts on provider reimbursement for Medicaid.

Provision	Ohio context	Effective date
Caps upper payment limit of SDPs at 100% of Medicare payment rates (110% for non-expansion states)	Any new SDP in Ohio will need to adhere to this new upper payment limit.	Upon enactment (July 4, 2025) for new SDPs
Gradually reduces existing SDP amounts by ten percentage points annually until they reach the new upper payment limit of Medicare payment rates (110% of Medicare rates for non-expansion states)	Existing grandfathered SDPs in Ohio can continue at rates that exceed Medicare levels, but will gradually decrease in the coming years, which will lower payments to providers.	Reductions begin January 1, 2028

The CBO estimated that these provisions will reduce federal Medicaid spending by **$149 billion** in the next decade.[41] Given that Medicaid reimbursement levels are often insufficient to cover the cost of care[42], restrictions on SDPs may impact service availability for Medicaid enrollees.

For more details on the impact of HR 1 on SDPs, see the following resources:

- **How Medicaid State-Directed Payments Support Critical Health Care Providers** (Commonwealth Fund)
- **New CMS Guidance on H.R. 1's Restrictions of State Directed Payments** (Georgetown University Center for Children and Families)

Impacts on Ohio's state directed payments from HR 1

Ohio uses many different SDPs to not only boost reimbursement rates for specific providers but also pursue value-based care initiatives. One key component of the HR 1 provisions affecting SDPs is the criteria used to determine whether a payment is grandfathered by CMS, which would allow it to continue at reimbursement levels that are higher than Medicare rates. As of February 2026, 16 of Ohio's 24 SDPs have received notification from CMS that they are preliminarily grandfathered, according to ODM.[43] This includes the large HAP SDP.

Grandfathered SDPs cannot increase any further and will be subject to the reimbursement ceiling phase down starting in 2028.[44] However, it is not yet clear how this phase down will occur or how long it will take for all Ohio SDPs to reach Medicare equivalent levels.

Overall, ODM estimates that the reimbursement ceiling phase down will cost providers approximately **$200 million per year** until the new Medicare payment levels are reached.[45]

POTENTIAL STATE RESPONSES TO MEDICAID FUNDING LOSSES IN HR 1

Summary

Changes to Medicaid financing from HR1 will have significant implications for Ohio's Medicaid budget, requiring the state to make important financial decisions for the Medicaid program. States have options they can pursue to make up for this deficit. For example, Ohio can mitigate some of these funding cuts by modifying the HIC franchise fee to meet new uniformity requirements. States can also consider raising additional revenue or reallocating funding from other sources.

Some states may cut Medicaid expenditures in response to HR 1. However, these decisions would have critical impacts on the health and well-being of both Medicaid enrollees and Ohio more broadly, including the state's healthcare infrastructure.

HR 1 is expected to result in an estimated $33 billion decrease in federal funding for Ohio's Medicaid program in the next decade.[46]

A large portion of these cuts come from provisions affecting financing mechanisms such as provider taxes and state directed payments, which impact both state and federal Medicaid funding.[47] Ohio and other states will need to make budgetary decisions to account for these funding cuts.[48] Many of the major financing changes will occur after the 2026 elections, meaning implementation decisions will be made by Ohio's next governor and legislature.

Mitigating funding losses in Ohio

Although the funding losses anticipated from HR 1 are significant, Ohio has options to avoid more difficult decisions related to cutting state expenditures. First, the state can address resolvable components of the HR 1 financing changes. Most notably, the potential elimination of the HIC franchise fee due to non-uniformity would cost the state billions of state and federal dollars starting in SFY 2028. However, the state can alleviate this funding loss by making the HIC franchise fee uniform (i.e., assessing the same tax rate on all health insurers). States like New Jersey already have uniform insurer provider taxes that can continue to raise revenue for their Medicaid program going forward.[49]

Ohio could also consider developing a smaller set of SDPs targeting providers with the highest level of need for additional funding so that they can continue serving the Medicaid population. The state took steps towards consolidating their SDPs in the SFY 2025 – SFY 2026 state budget.[50]

Some states may shift spending from other departments or programs to pay for Medicaid services or raise additional revenue through taxes or fees. Either of these options would have other consequences and require significant political will.[51]

In response to funding losses, states may consider cutting Medicaid expenditures. However, these decisions would have significant negative impacts on Medicaid enrollees, including worsened care access and health outcomes. Importantly, the consequences of these cuts would extend beyond the Medicaid program itself, potentially leading to increased strain on Ohio's healthcare infrastructure and even higher premiums for people with employer-sponsored insurance, according to some studies.[52]

Potential consequences of cutting Medicaid expenditures in Ohio

►Reducing provider reimbursement

Although Medicaid reimbursement rates to providers already tend to lag Medicare and commercial rates, some states such as North Carolina have begun cutting provider payment rates in response to HR 1.[53] Ohio's SFY 2024-2025 state budget enacted substantial provider rate increases, including for home and community-based services providers, which amounted to over $3.4 billion.[54] These increases were designed to address workforce shortages and increase the availability of Medicaid providers.[55] Rate increases maintained in the most recent budget could be subject to future cuts in response to upcoming HR 1 impacts.

Consequences for Medicaid enrollees:

- **Exacerbated care access issues.** Providers (physicians, clinics, dentists, etc.) may choose to no longer take Medicaid patients in response to reduced payment rates.
- **Potential lower quality care.** Studies have indicated that lower Medicaid reimbursement rates can lead to issues such as reduced staffing levels in nursing homes, which increase the risk of adverse medical events.[56]

►Eliminating optional covered services

The federal government requires that all state Medicaid programs cover a set of mandatory services that includes hospital/physician services, nursing facility and home health care, family planning, and more. States can also choose to cover certain optional benefits. Ohio's Medicaid program covers optional services such as dental and vision care, prescription drugs and certain behavioral health interventions.[57] In response to HR 1 funding shortfalls, states may opt to restrict optional services that are covered by their Medicaid programs.

Consequences for Medicaid enrollees:

- **Loss of important services.** If Medicaid programs restrict the availability of services, enrollees will lose access to important types of care, potentially leading to worsened health outcomes. For example, loss of Medicaid dental coverage in other states resulted in more dental problems and emergency department visits.[58]
- **Increased out-of-pocket costs.** If programs stop covering benefits like prescription drugs, enrollees will need to pay for these services themselves, which would be difficult given low income levels amongst program enrollees.

►Restricting eligibility groups

Another area where states have discretion with their Medicaid programs is by expanding program eligibility beyond the statutory minimum levels. For example, the federal government requires that all states cover pregnant women with incomes at or below 133% of the federal poverty level (FPL).[59] However, almost every state, including Ohio, have higher income eligibility limits than this required minimum (up to 205% FPL in Ohio).[60]

As of February 2026, 40 states and DC have implemented Medicaid expansion, which allows for coverage of low-income adults (up to 138% FPL) who do not qualify for Medicaid through other avenues[61], including in Ohio where it covers over 730,000 low-income adults.[62] Medicaid expansion reduced Ohio's uninsured rate by half between 2012 and 2023 and helps ensure access to care for a population that has limited alternative sources of health insurance.[63]

Cuts to Medicaid funding could lead states to roll back program eligibility for some categories, which would have major consequences. Eliminating Medicaid expansion in Ohio, for example, could lead to an 80% increase in the state's uninsured rate.[64] These impacts would extend beyond those losing insurance; economic studies suggest that higher uninsured rates reduce access and quality of care even for people with insurance due to higher premiums and increased strain on healthcare infrastructure.[65]

Because the federal government pays most Medicaid expansion expenditures, dropping expansion would result in minimal savings for the state.[66]

Consequences for Medicaid enrollees:

- **Loss of care access.** If optional eligibility is reduced, enrollees who lose coverage will be unlikely to access health services, including cost-effective preventative care.[67]
- **Worse health outcomes.** Research evidence suggests that Medicaid expansion has led to improvements in cancer survival rates[68], maternal and infant health, and self-reported health.[69] Restrictions to coverage may result in the loss of these positive outcomes, which can also affect workforce availability and productivity.
- **Financial vulnerability.** People who lose or lack health insurance are at risk of facing large medical bills if they do seek care, which will strain their budgets and potentially lead to long-term medical debt.[70]

Notes

1. "Caseload Reports," Ohio Department of Medicaid, accessed Feb. 9, 2026, https://medicaid.ohio.gov/stakeholders-and-partners/reports-and-research/caseload-reports/caseload-reports.
2. "Medicaid: The Health and Economic Benefits of Expanding Eligibility," Office of the Asisstant Secretary for Planning and Evaluation, Sept. 26, 2024, http://aspe.hhs.gov/reports/benefits-expanding-medicaid-eligibility.
3. Elizabeth J. Schafer et al., "Association between Medicaid Expansion and 5-Year Survival among Individuals Diagnosed with Cancer," *Cancer Discovery* 15, no. 12 (2025): 2431–36, https://doi.org/10.1158/2159-8290.CD-25-1244.
4. Health Policy Institute of Ohio, "Ohio Medicaid Basics 2025," Feb. 4, 2025, https://www.healthpolicyohio.org/our-work/publications/ohio-medicaid-basics-2025.
5. Nelson V. Lindgren, "LBO Analysis of Enacted Budget, Ohio Department of Medicaid," Legislative Service Commission, July 2025.
6. Akeissa Coleman, "How Do We Pay for Medicaid?," Commonwealth Fund, March 14, 2025, https://doi.org/10.26099/t28v-s666.
7. "Ohio's Medicaid Financial Landscape and FMAP," Ohio Legislative Service Commission, January 2025.
8. Hannah Kim, "How Medicaid Provider Taxes Work: An Explainer," *National Association of Medicaid Directors*, Sept. 25, 2025, https://medicaiddirectors.org/resource/how-medicaid-provider-taxes-work-an-explainer/.
9. Coleman, "How Do We Pay for Medicaid?"
10. Kim, "How Medicaid Provider Taxes Work."
11. "Medicaid Provider Taxes: A Critical Source of Medicaid Funding for States," *Center For Children and Families*, Feb. 4, 2025, https://ccf.georgetown.edu/2025/02/04/medicaid-provider-taxes-a-critical-source-of-medicaid-funding-for-states/.
12. Alice Burns et al., "5 Key Facts About Medicaid and Provider Taxes," *KFF*, Dec. 1, 2025, https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/.
13. Kim, "How Medicaid Provider Taxes Work."
14. "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline," Congressional Budget Office, July 21, 2025, https://www.cbo.gov/publication/61570.
15. "Distributional Effects of Public Law 119-21," Congressional Budget Office, Aug. 11, 2025, https://www.cbo.gov/publication/61367.
16. Wendy Patton, "Medicaid Provider Tax Fix Must Not Hurt Counties, Transit Agencies," *Policy Matters Ohio*, June 12, 2016, accessed Feb. 17, 2026, https://policymattersohio.org/research/medicaid-provider-tax-fix-must-not-hurt-counties-transit-agencies/.
17. Ohio Revised Code, Section 5168.76.
18. Health Policy Institute of Ohio, "Ohio Medicaid Basics 2025."
19. Health Policy Institute of Ohio, "2025 Ohio Medicaid Expansion Study," May 2025, https://www.healthpolicyohio.org/our-work/publications/2025-ohiomedicaid-expansion-study.
20. "CMS Shuts Down Massive Medicaid Tax Loophole, Saving Billions for Federal Taxpayers and Restoring the Federal-State Partnership," Centers for Medicare and Medicaid Services, Jan. 29, 2026, https://www.cms.gov/newsroom/press-releases/cms-shuts-down-massivemedicaid-tax-loophole-saving-billions-federal-taxpayersrestoring-federal
21. Scott Partika, "H.R. 1 (OBBBA) Updates," Ohio Department of Medicaid, Feb.19, 2026.
22. "CMS Issues New Guidance on H.R. 1's Restrictions on State Use of Provider Taxes to Finance Medicaid," *Georgetown University Center For Children and Families*, Nov. 18, 2025, https://ccf.georgetown.edu/2025/11/18/cms-issues-new-guidance-on-h-r-1s-restrictions-on-state-use-of-provider-taxes-to-finance-medicaid/.
23. New Jersey Human Services, "Meeting of the Medical Assistance Advisory Council," July 17, 2025, https://www.nj.gov/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentation_7-17-25.pdf.
24. "Ohio Hospital Franchise Fee," Ohio Hospital Association, accessed Feb. 9, 2026, https://www.ohiohospitals.org.
25. Ohio Administrative Code, rule 5160-2-30.
26. Lindgren, "LBO Analysis of Enacted Budget," *Ohio Department of Medicaid*.
27. Ibid.
28. Scott Partika, "H.R. 1 (OBBBA) Updates," Feb. 19, 2026.
29. Burns et al., "5 Key Facts About Medicaid and Provider Taxes"
30. Tiffany Ford and Jamila Michener, "Medicaid Reimbursement Rates Are a Racial Justice Issue," Commonwealth Fund, June 16, 2022, https://doi.org/10.26099/h5np-x425.
31. "Directed Payments in Medicaid Managed Care," *MACPAC*, Oct. 29, 2024, https://www.macpac.gov/publication/directed-payments-in-medicaid-managed-care/.
32. Ibid.
33. "Value-Based Care: What It Is, and Why It's Needed," Commonwealth Fund, Feb. 7, 2023, https://doi.org/10.26099/fw31-3463.
34. "Directed Payments in Medicaid Managed Care."
35. "OH Fee IPH.OPH.Oth1 Renewal 2025–2025 ," Centers for Medicare and Medicaid Services, Jan. 22, 2026. https://www.medicaid.gov/medicaid/managed-care/downloads/OH_Fee_IPH.OPH.Oth1_Renewal_20250101-20251231.pdf
36. Lindgren, "LBO Analysis of Enacted Budget," *Ohio Department of Medicaid*.
37. "Care Innovation and Community Improvement Program," UToledo Health, 2024, https://health.utoledo.edu/depts/quality/cicip-team.html.
38. "Non-Federal Financing," *MACPAC*, Dec. 23, 2020, https://www.macpac.gov/subtopic/non-federal-financing/.
39. "OH_VBP.Fee_AMC.Oth_Renewal_20250101-20251231," Centers for Medicare and Medicaid Services, Nov. 14, 2025. https://www.medicaid.gov/medicaid/managed-care/downloads/OH_VBP.Fee_AMC.Oth_Renewal_20250101-20251231.pdf John F. Giles Jr., "OH_Fee_AMC.Oth1_Renewal_20250101-20251231," personal communication, Jan. 22, 2026.
40. OH_Fee_AMC.Oth1_Renewal_20250101-20251231," Centers for Medicare and Medicaid Services, Nov. 25, 2025. https://www.medicaid.gov/medicaid/managed-care/downloads/OH_Fee_AMC.Oth1_Renewal_20250101-20251231.pdf
41. Congressional Budget Office, "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline."
42. Anne Karl et al., "How Medicaid State-Directed Payments Support Critical Health Care Providers," Commonwealth Fund, July 3, 2025, https://doi.org/10.26099/f4na-qw54.
43. Partika, "H.R. 1 (OBBBA) Updates."
44. "CMS Issues Guidance to Strengthen Oversight of Medicaid State Directed Payments," Centers for Medicare and Medicaid Services, Sept. 9, 2025, https://www.cms.gov/newsroom/press-releases/cms-issues-guidance-strengthen-oversight-medicaid-state-directed-payments.
45. Partika, "H.R. 1 (OBBBA) Updates."
46. Rhiannon Euhus et al., "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package," *KFF*, July 23, 2025, https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/.
47. "Health Provisions in the 2025 Federal Budget Reconciliation Law," *KFF*, Aug. 22, 2025, https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/.
48. Celia Horstman and Akeiisa Coleman, "States Respond to Medicaid Cuts — Will Enrollees Lose Benefits?," Commonwealth Fund, Oct. 14, 2025, https://doi.org/10.26099/4bk8-jj06.
49. New Jersey Human Services, "Meeting of the Medical Assistance Advisory Council."
50. Lindgren, "LBO Analysis of Enacted Budget," *Ohio Department of Medicaid*.
51. Horstman and Coleman, "States Respond to Medicaid Cuts — Will Enrollees Lose Benefits?"
52. Mark V. Pauly and José A. Pagán, "Spillovers And Vulnerability: The Case Of Community Uninsurance," *Health Affairs* 26, no. 5 (2007): 1304–14, https://doi.org/10.1377/hlthaff.26.5.1304.
53. Horstman and Coleman, "States Respond to Medicaid Cuts — Will Enrollees Lose Benefits?"
54. "Important Information: Fee-for-Service Reimbursement Rate Increases," Public Consulting Group, Dec. 28, 2023, https://ohiohcbs.pcgus.com/news/important-information-fee-for-service-reimbursement-rate-increases.
55. Lindgren, "LBO Analysis of Enacted Budget," *Ohio Department of Medicaid*.
56. John R. Bowblis and Robert Applebaum, "How Does Medicaid Reimbursement Impact Nursing Home Quality? The Effects of Small Anticipatory Changes," *Health Services Research* 52, no. 5 (2017): 1729–48, https://doi.org/10.1111/1475-6773.12553.
57. Health Policy Institute of Ohio, "Ohio Medicaid Basics 2025."
58. Astha Singhal et al., "Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs," *Health Affairs* 45, no. 5 (2015), https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1358. "Eligibility," MACPAC, accessed Feb. 9, 2026, https://www.macpac.gov/medicaid-101/eligibility/.
59. "Eligibility," MACPAC, accessed Feb. 9, 2026, https://www.macpac.gov/medicaid-101/eligibility/.
60. "Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State," *MACPAC*, Feb. 4, 2026, https://www.macpac.gov/publication/medicaid-and-chip-income-eligibility-levels-as-a-percentage-of-the-federal-poverty-level-for-children-and-pregnant-women-by-state/.
61. "Medicaid Expansion," National Conference of State Legislatures, accessed Feb. 9, 2026, https://www.ncsl.org/health/medicaid-expansion.
62. Ohio Department of Medicaid, "Caseload Reports."
63. "2025 Ohio Medicaid Expansion Study," Health Policy Institute of Ohio, May 2025, https://www.healthpolicyohio.org/our-work/publications/2025-ohio-medicaid-expansion-study.
64. Health Policy Institute of Ohio, "2025 Ohio Medicaid Expansion Study."
65. Pauly and Pagán, "Spillovers And Vulnerability."
66. Health Policy Institute of Ohio, "2025 Ohio Medicaid Expansion Study."
67. Madeline Guth and Meghana Ammula, "Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021," *KFF*, May 6, 2021, https://www.kff.org/affordable-care-act/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/.
68. Schafer et al., "Association between Medicaid Expansion and 5-Year Survival among Individuals Diagnosed with Cancer."
69. Guth and Ammula, "Building on the Evidence Base."
70. Jennifer Tolbert et al., "Key Facts about the Uninsured Population," *KFF*, Dec. 18, 2024, https://www.kff.