OBBBA Impacts:

Medicaid Cuts & State Tax Implications

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Introductions



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Agenda and Learning Objectives

1. OBBBA's Impact on Medicaid
   - ✓ Details of spending cuts to programs
   - ✓ Potential impacts on providers
   - ✓ Summary of spending cuts by program and year
2. State Tax Implications
   - ✓ Tax funding strategies
   - ✓ Pros and cons of tax increases
   - ✓ Identify multi-state budgeting funding strategies
   - ✓ Case studies of wealth tax: California and New York

OBBBA Impacts on Medicaid

OBBBA Impacts on Medicaid

- Provider taxes
- State directed payments
- Community engagement requirements
  - Including potential effects on Medicare Disproportionate Share Hospital (DSH) payments and 340B Drug Pricing Program qualification
- Other Medicaid provisions
- Summary of spending cuts by program and year

Medicaid Background

- Medicaid is jointly funded by states and the federal government
  - State Medicaid expenditures are eligible for federal matching funds
- Federal Matching Assistance Percentage (FMAP) is the share of Medicaid costs in a given state that is paid by the federal government
  - The FMAP ranges from 50% to 83% depending on a state's per capita income level
    - The lower a state's per capita income level, the higher its FMAP
    - If a state's FMAP percentage is 60%, for every dollar it spends to finance Medicaid, it receives $1.50 from the federal government, resulting in $2.50 of total available funding

Provider Taxes

- Provider taxes are fees that states collect from hospitals, nursing homes, and managed care organizations to help states finance their share of Medicaid program costs
- Provider tax revenue may be used to finance increased Medicaid base payment rates and supplemental payments such as DSH payments, Upper Payment Limit (UPL) payments, and State-Directed Payments (SDPs)

Medicaid DSH Payments	UPL Payments	SDPs
• Support hospitals serving a high number of low-income, uninsured, or Medicaid patients	• Supplement Medicaid payments up to certain levels (e.g., Medicare-equivalent or ACR-equivalent)	• Medicaid managed care arrangements in which states direct plans to use specific provider payment methodologies or rates, often increasing reimbursement

Provider Taxes – OBBBA Impacts

- States cannot impose new or increased provider taxes that were not "enacted" or "imposed" as of July 4, 2025.
- Decrease in threshold for hold harmless ("safe harbor") provision for expansion states (currently 6% net patient revenue)
  - **Expansion states** (states that expanded Medicaid coverage under the Affordable Care Act) must reduce existing provider taxes to comply with decreasing thresholds
    - Threshold decreases by 0.5% each year beginning in FY 2028 until it reaches 3.5% in 2032
    - Applies to tax rate, not dollar amount
    - Existing provider taxes on nursing facilities and intermediate care facilities are not subject to required reduction
  - **Non-expansion states** may maintain those CMS-approved provider taxes enacted and imposed as of 7/4/2025 but cannot impose new taxes or expand existing taxes
- CBO: $226 billion reduction in federal spending over 10 years
  - Earlier estimates assumed an earlier implementation timeline, but delays in final legislative language (including phase-ins beginning around FY 2028) reduced near-term savings

Source: https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/

State-Directed Payments (SDPs)

- SDPs are payment arrangements through which state Medicaid agencies direct managed care organizations (MCOs) to use specific provider payment methodologies or rates to support state policy goals, such as improving quality of care, enhancing access to services, or addressing priority healthcare needs
  - Often used to support hospitals, academic medical centers, rural providers, and safety-net providers
  - Often result in healthcare providers receiving higher payments from MCOs than they otherwise would
    - Before OBBBA, CMS rules allowed states to require MCOs to pay up to average commercial rates (ACR)
      - Could be 250%+ of Medicare payment rates

Source: https://www.cbo.gov/system/files/2025-09/61699-Medicaid.pdf

SDPs – OBBBA Impacts

- No new SDPs exceeding 100% of Medicare rates for expansion states and 110% for non-expansion states
  - Prohibition does not extend to requests for new SDPs submitted to CMS by 5/1/2025 (or 7/4/2025 for SDPs targeting rural hospitals)
  - If no Medicare rate for a specific service exists, SDPs cannot exceed the Medicaid rate specified in the state plan
- For any existing SDPs exceeding the applicable limit, the state must reduce the rate by 10% each year beginning with rating periods on or after 1/1/2028 until the applicable rate limit is reached
  - This reduction applies equally to expansion and non-expansion states
  - Unlike for provider taxes, there is no exception for SDPs for nursing facilities or intermediate care facilities

CBO: $149 billion reduction in federal direct spending for Medicaid over 10 years

Community Engagement Requirements

- Effective 1/1/2027, states are required to condition Medicaid eligibility for the expansion population
  - This applies to patients enrolled in Medicaid through Affordable Care Act Medicaid expansion plans or equivalent coverage
  - Medicaid eligibility for non-disabled, non-excepted individuals ages 19-64 is conditioned on working or participating in qualifying activities for ≥ 80 hours/month
  - $200 million appropriated in FY2026 to assist states with implementation

What constitutes "community engagement"?

- ✓ Working at least 80 hours
- ✓ Performing at least 80 hours of community service
- ✓ Participating in a work program for at least 80 hours
- ✓ Being enrolled in an educational program (at least half-time)
- ✓ Some combination of the above totaling at least 80 hours
- ✓ **OR** a monthly income equal to at least the minimum wage times 80 hours

Community Engagement Requirements (*cont.*)

- State verification requirements
  - Must verify applicant met requirements for at least 1 month prior to application (state may require up to 3 months)
  - States must conduct renewals of eligibility every 6 months (previously every 12 months)
    - States may require more frequent verification of compliance
  - Individuals may initially self-attest to meeting community engagement requirements or exemptions, but verification is required afterwards
  - States may request up to 2 additional years to fully implement work requirements and verification processes (multiple extensions required)



Community Engagement Requirements (*cont.*)

- Exemptions exist for (but are not limited to) those who are:
  - Parents or guardians of a dependent child aged 13 or younger
  - Pregnant or those eligible for postpartum coverage in their state
  - Veterans with a total disability rating
  - Medically frail or otherwise have special medical needs that significantly impair their ability to comply with the requirement
  - Meet the TANF work requirements or are a member of a household receiving SNAP benefits and are not exempt from the SNAP work requirements
- States may allow short-term hardship exception for individuals:
  - Receiving inpatient hospital services or services of similar acuity
  - Residing in a county with a presidentially-declared emergency/disaster or high unemployment rate
  - Requiring extended travel to receive medical services for themselves or a dependent for a serious or complex medical condition
- CBO: $326 billion reduction in federal spending on Medicaid, and roughly 5 million people becoming uninsured over 10 years

Community Engagement Requirements – Potential Impact

Increased eligibility requirements for Medicaid coverage could result in:

- Procedural disenrollments
- Lower Medicaid patient volume
- An increase in self-pay and uninsured volume
- Lower Medicare DSH percentage
- Potential loss of qualification of Medicare DSH add-on payments for some hospitals
- Potential loss of qualification for 340B Drug Program discounts for some hospitals

Source: https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf

Community Engagement Requirements & Medicare DSH

- Lower Medicaid patient volume could affect the Medicare DSH percentage
- Medicare DSH
  - Medicare makes additional payments to hospitals that serve a disproportionate number of low-income patients.
    - The additional payments are intended to offset the higher costs associated with providing care to these patients
  - Different from Medicaid DSH, even though Medicare uses Medicaid-eligible days to determine eligibility
  - **Two types of Medicare DSH payments:**
    - "Empirically justified" or traditional DSH
      - Driven by a hospital's Medicaid-eligible days and Medicare Supplemental Security Income (SSI) percentage
    - Uncompensated Care (UCC) DSH
      - Driven by a hospital's cost of uncompensated care (charity care and bad debt)

Source: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate_share_hospital.pdf

How Does the Medicare DSH Percentage Impact Hospitals?

There are two main impacts of the Medicare DSH percentage:

1

DSH add-on payments on each Medicare Traditional inpatient claim for qualifying hospitals

The higher a hospital's DSH percentage, the higher its add-on payment on each inpatient claim.

2

Qualification for 340B Drug Program

Many hospitals are required to meet a certain DSH percentage threshold to qualify.

Source: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate_share_hospital.pdf

Other Medicaid Provisions

Retroactive Coverage

- Effective 1/1/2027, retroactive Medicaid coverage for new enrollees will be reduced from 90 days prior to application to 1 month for expansion population and 2 months for non-expansion population

Cost Sharing

- Effective 10/1/2028, states must impose cost-sharing of up to $35 per service for certain expansion adults with incomes 100-138% of the FPL
  - Maintains exemptions for specific services and populations, and a cap of 5% of family income on out-of-pocket expenses
  - States may impose higher cost-sharing for non-emergency hospital services

Erroneous Medicaid Payments

- Beginning in FY 2030, states may face FMAP reductions if their Medicaid payment error rates exceed specified thresholds, including:
  - Errors related to payments to ineligible individuals
  - Insufficient eligibility verification
  - Overpayments to eligible individuals

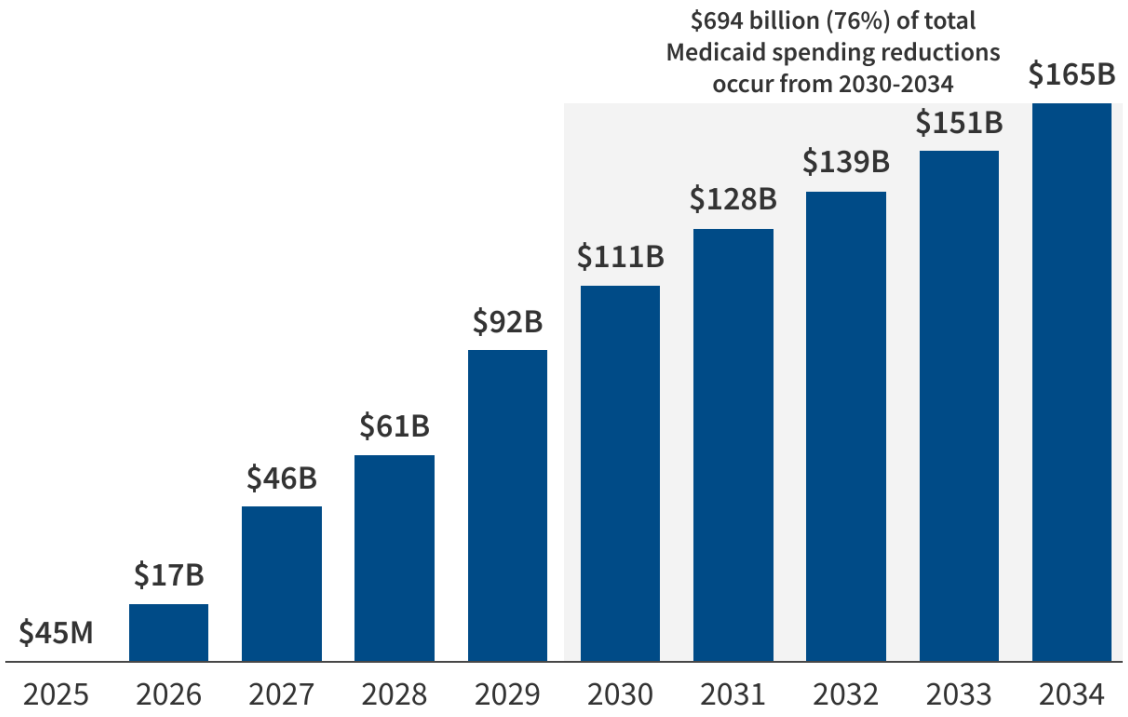
Other Medicaid Provisions (cont.)

- Moratorium on enforcement of nursing facility minimum staffing rule through 9/30/2034
  - Pauses 2024 rule requiring minimum staffing levels and 24/7 RN coverage
- Eliminates enhanced federal matching (FFP) for emergency Medicaid services for certain noncitizens beginning 10/1/2026
- Creates a new state option to expand access to home- and community-based services (HCBS) to individuals with a level of care need less than that required in an institutional, as defined by the state
  - HCBS: long-term care services provided in a person's home or community setting (rather than in institutions like nursing homes) to help people with disabilities or chronic conditions live independently
- Requires CMS to certify budget neutrality for Section 1115 waiver programs
  - Reinforces requirement that waivers must not increase federal Medicaid spending

CBO Estimate of Medicaid Cuts in OBBBA Over Time

Federal Medicaid cuts in the Enacted Reconciliation Package, by year

Source: https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/



Note: Estimated interaction effects are included each year. Over the 10-year period, the Medicaid spending reductions total $911B, including $79B in estimated Medicaid spending interactions. Without accounting for interactions, the total is $990B. See Methods in "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package" for more details.

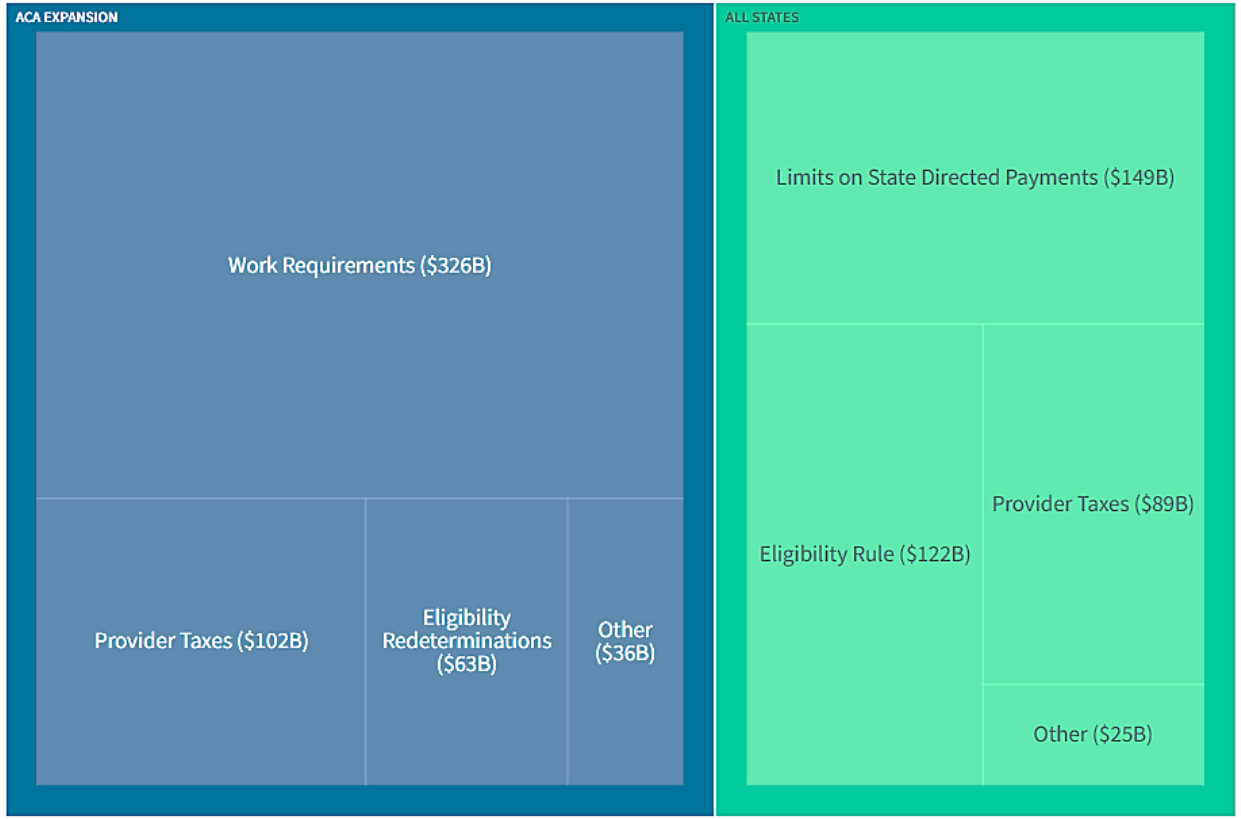
Source: KFF analysis of CBO estimates of the enacted reconciliation package

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CBO Estimate of Medicaid Cuts in OBBBA

CBO's estimated 10-year federal spending cuts, by policy

Source: https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/



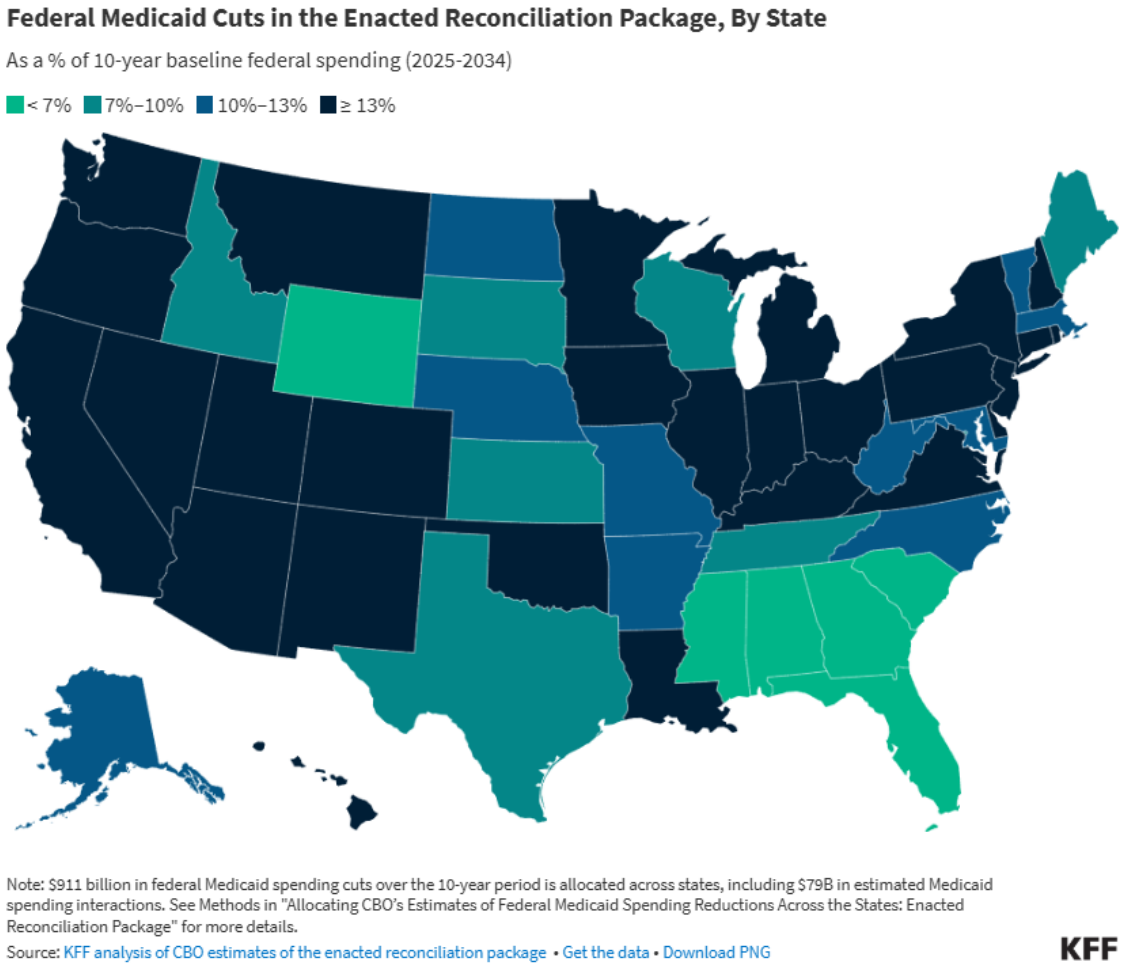
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Source: KFF analysis of CBO estimates of the enacted reconciliation package

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CBO Estimate of Medicaid Cuts Impact by State

Federal Medicaid cuts in the Enacted Reconciliation Package, by state

Source: https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/



State Tax Implications

The Fiscal Shock – What States Are up Against

$900B+

Federal Medicaid cuts over 10 years (OBBBA)

$664B

Projected state Medicaid budget reductions, 2025–2034

$7.6M

Estimated Americans losing Medicaid by 2034

- 20 states are expected to see Medicaid budget reductions of 5% or more
  - Arizona, Iowa, and Nevada face reductions exceeding 15% of their total Medicaid budgets
  - California and New York would see the largest overall reductions at about $112 billion and $63 billion
- Medicaid expansion states with extensive use of state-directed payments (SDPs) and provider taxes will face the largest budget impacts
- Nearly all states operate under balanced budget requirements: only three options — cut spending, raise taxes, or tap reserves

Source: RAND Corporation analysis, Feb. 2026; CBO estimates

How States Are Fighting Back

Wealth & High-Earner Taxes

- Taxes on millionaires and billionaires
- One-time wealth levies
- Income surtaxes on top brackets
- Capital gains surcharges

Budget & Spending Measures

- Draw down state reserve funds
- Cut non-Medicaid programs
- Narrow eligibility criteria

Structural & Legislative

- Decouple from OBBBA tax provisions
- Pass emergency budget legislation
- State constitutional amendments

Case Study – California

The 2026 Billionaire Tax Initiative: Key Facts

Tax Rate	5% one-time levy
Threshold	Net worth > $1 billion
Eligible Date	CA resident as of Jan. 1, 2026
Taxpayers Affected	~200 individuals (*world's 500 wealthiest*)
Revenue Target	$100B total (≈ *$20B/yr over 5 years, 2027–2031*)
Medi-Cal Shortfall	~$110B over 5 years

- **Ballot and political status**
  - Backed by SEIU-UHW; qualified for the Nov. 3, 2026 ballot after collecting 1.6M signatures, nearly double the 875K required
  - Applies to 5% tax on worldwide net worth (excluding real estate directly held) valued as of Dec. 31, 2026
  - Funds earmarked for Medi-Cal, K–14 education, and SNAP/food assistance programs
  - Bipartisan opposition from Gov. Newsom and other CA groups; prominent business leaders warn of outmigration
  - Individuals may pay in 5 equal installments beginning 2027, with 7.5% annual deferral charge on unpaid balance

Case Study – California

Billionaire Tax: Legal Risks and Economic Debate

- **Legal and constitutional risks**
  - Due process consideration raises retroactivity challenges
    - The tax would apply to residents as of Dec. 31, 2025, but would not be enacted until Nov. 3, 2026, and valuation date is Dec. 31, 2026
    - Legal scholars say this could violate the due process clause assessing a tax on retroactive residence and valuing the assets a year after residency is established
  - Taxing worldwide net worth including out-of-state assets is constitutionally vulnerable to Dormant Commerce Clause challenges
    - CA residents could argue states cannot enact laws that unduly burden, discriminate against, or interfere with interstate commerce since residents could claim wealth was earned outside of CA
  - Primary-residence cutoff (Jan. 1, 2026) means billionaires who left in late 2025, but before end of year may argue against CA's claim
    - If enacted, expected wave of residency challenges, valuation disputes before first payment is due in 2027

Case Study – California

Billionaire Tax: Legal Risks and Economic Debate (*cont.*)

- **Revenue and economic debate**
  - ITEP analysis projects $100B over 5 years from ~200 taxpayers, but Tax Foundation warns actual yield could be far lower
  - CA's 2012 Prop. 30 rate hike:
    - Top earners reduced taxable income by ~10% through behavioral changes, and combined with outmigration, ~61% of projected revenue was eroded within 2 years, mostly from those who remained CA residents
  - 72% of wealth of CA billionaires is in the form of publicly traded stocks.
  - Private business valuation formula will be book value (the sum of all assets in the business) plus 7.5 times annual book profits (averaged over the most recent 3 years)
  - Illiquid individuals would have to sell stock or borrow against the value of their wealth creating assets to pay for tax, causing secondary economic burdens

Case Study – New York

NYC Pied-à-Terre Tax: What Just Passed



- **ENACTED**
  - Passed NY State Legislature May 27, 2026
  - Effective July 1, 2026; Expires June 30, 2031

Tax Type	Annual surcharge on non-primary NYC residences
Threshold	Market value > $1M up to $5M depending on property category
Properties Affected	~10,000–11,200 NYC condos, co-ops, and 1-3 family homes
Rate Structure	Variable based on class; highest percentage is 6.5%
Revenue Estimate	$500M/year (*NYC Comptroller range: $340–510M*)
Key Exemption	Primary NYC residents, renters, family members
Sunset Clause	Expires June 30, 2031, unless renewed by legislature

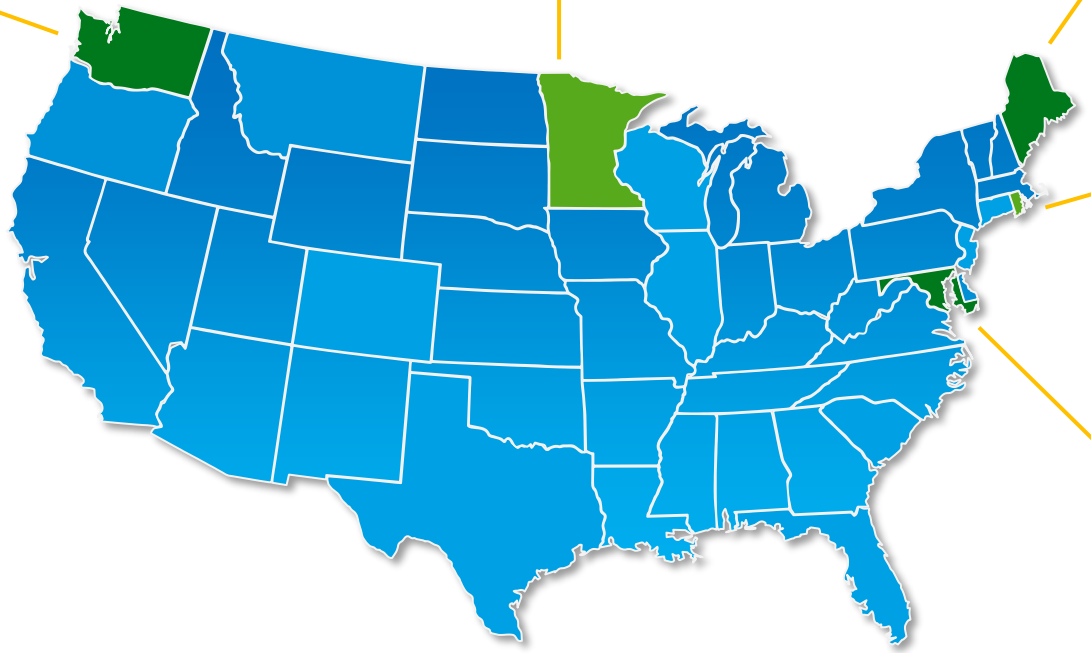
What Other States Are Doing

Minnesota (Proposed)

HF 4616: proposed 1% annual levy on taxable wealth >$10M for individuals/trusts (~5,600 taxpayers). **Would generate ~$290M/yr.**

Washington (In Effect)

9.9% income tax on household income >$1M, signed March 30, 2026 (eff. 2028). State's first broad income tax. **Projected $3.5B/yr by 2029.**



Maine (In Effect)

Proposed millionaire's tax would raise state's top income tax rate to 9.15%, raising competitiveness concerns.

Rhode Island (Proposed)

'Fair Share' package: 1% annual wealth tax on financial assets >$25M. **Projected $650M/yr.**

Maryland (In Effect)

Nation's most aggressive 2025 tax package: 2% capital gains surtax, new 3% digital services tax. Top marginal rate rose to 6.5%. **Raised ~$580M/yr.**

Pros & Cons – Arguments **FOR** Higher State Taxes

Preserves Healthcare Access

Replaces lost federal funding to keep Medicaid enrollees covered, hospitals open, and provider networks intact — particularly for rural and safety-net facilities

Progressivity & Equity

Wealth and high-earner taxes place the burden on those with the greatest capacity to pay, targeting a narrow population while leaving the broader tax base unaffected

Revenue Stability

Income taxes on high earners can generate substantial, recurring revenue — Washington projects $4B annually once its millionaires' tax is fully in effect by 2029

Addresses Balanced Budget Mandate

Revenue increases give states a legal, direct path to close gaps without cutting spending on Medicaid, education, or other safety-net programs

Broader Economic Benefit

Maintaining Medicaid and healthcare infrastructure supports healthcare employment, reduces uncompensated care costs, and sustains rural economies

Pros & Cons – Arguments **AGAINST** Higher State Taxes

Outmigration of High-Earners and Capital

California's 2012 Prop. 30 rate hike eroded ~61% of projected revenue as top earners reduced taxable income and relocated. Jeff Bezos moved from WA to FL after WA's 2021 capital gains tax

Constitutional and Legal Risk

California's billionaire tax faces challenges for retroactive application and taxing worldwide wealth accrued outside the state; NY's pied-à-terre tax faces valuation battles

Revenue Volatility

High-earner taxes are heavily concentrated — a small number of taxpayers drive most revenue. Economic downturns or market declines can cause sharp, unpredictable revenue drops

Business Competitiveness and Investment

Higher tax burdens may discourage business location and investment, reducing long-run economic growth and the broader tax base — especially for states already at top marginal rates

Temporary vs. Structural Fix

A one-time tax (like CA's proposal) provides only temporary relief from a permanent, decade-long federal funding reduction — creating a future fiscal cliff when revenue runs out

Provider Perspective – Multi-Jurisdictional Impacts

Payroll and Tax Exposure

Multi-State Employee & Physician Exposure

- Healthcare providers with staff or operations in multiple states are directly in the crosshairs
- As states like Washington (9.9% on income >$1M) and Maryland (top rate 6.5%) layer new income surtaxes on top of existing SALT caps, business owners, not only in healthcare, must strategize where they want to set up operations and hire employees

High-Earner Surtaxes on Physician Compensation

- Physician practices and medical groups with partners or W-2 employees earning above state thresholds need to model the after-tax compensation impact now
- A $1.2M-earning physician partner in Washington state, for example, faces a 9.9% state levy on $200K of their income beginning 2028, before FICA, federal, or local taxes

Capital Gains & Liquidity Event Exposure

- PE-backed provider groups, health systems pursuing M&A, and physician groups contemplating buyouts face a patchwork of state capital gains surtaxes
- Maryland's 2% capital gains surtax on high earners adds meaningful friction to transactions. Sellers in multiple states must model blended state effective rates across all jurisdictions where value was created

Wrap-Up

Key Takeaways

What providers and tax advisors need to know now

1

OBBBA's $664B in state Medicaid budget reductions is a decade-long structural shift…**not a one-year budget adjustment**

2

States have only 3 options:

Cut spending;

Raise taxes; or

Draw reserves

Most are pursuing all 3 simultaneously

3

California's Billionaire Tax *(Nov. 2026 ballot)*
Targets ~200 individuals for $100B

NYC's Pied-à-Terre Tax *(enacted May 2026)*
Generates ~$500M/yr from luxury second homes

4

Both strategies carry real risks: outmigration, legal challenges, revenue volatility, and market disruption; results will vary widely from projections



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PYA by the Numbers

56% FEMALE OWNERSHIP

Over 2x the average of similarly sized firms

- Inside Public Accounting

CLIENT LOCATIONS



INSIDE public accounting TOP 100 FIRMS 2025

accountingTODAY 2025 Top 100 Firms

1500
Healthcare valuation opinions requested annually

OVER **450**
Commercial Reasonableness Arrangements in the last 5 years

USA TODAY
AMERICA'S MOST RECOMMENDED TAX FIRMS
2025 IN COOPERATION WITH statista

TOP **15** LARGEST AUDITOR
of AHA's Top U.S. Multi-Hospital Systems
- Ames Research Group

Modern Healthcare 2025
Largest Healthcare Management Consulting Firms

MORE THAN **2700** HEALTHCARE CLIENTS

Academic Medical Centers | Accountable Care Organizations Ambulatory Surgery Centers | Blood Centers | Clinically Integrated Networks | County Owned Hospitals | Critical Access Hospitals Diagnostic Centers | Dialysis Centers | Health Plans | Health Systems | Home Health Agencies | Hospices | Hospitals Independent Practice Associations | Maternity Centers | Medical Groups | Mental Health Centers | Nursing Homes Physician-Hospital Organizations | Physician Practices | Physical Therapy Centers | Psychiatric Hospitals | Rural Health Centers Safety Net Hospitals | Surgery Centers | Urgent Care Centers

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