



AMERICA'S
ESSENTIAL
HOSPITALS



From Policy to Practice:

A Guide for Essential Hospitals Navigating the Compounding Effects of H.R. 1 and CMS Rulemaking

from Sellers Dorsey and America's Essential Hospitals

Executive Summary

Essential hospitals, which serve a disproportionate share of Medicaid and uninsured patients, are projected to be disproportionately affected by the 2025 reconciliation law, H.R. 1, which is projected to reduce federal Medicaid spending by roughly \$1 trillion over 10 years.ⁱ The Centers for Medicare & Medicaid Services' (CMS') rapid and complex implementation of the statute further complicates essential hospitals' efforts to understand how compounding changes to coverage, payments, and financing will affect access to essential care in their communities. To help essential hospital leaders better navigate the road ahead, this brief reviews the key policy changes that will have a cumulative impact on essential hospitals, including:

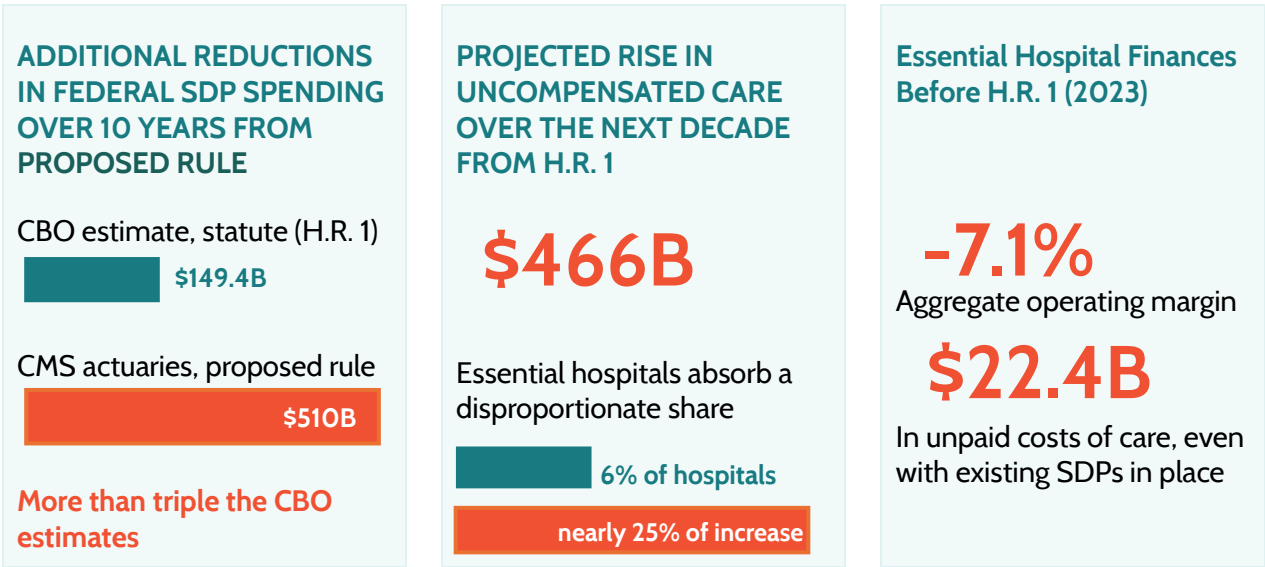
1. **Coverage losses** from more frequent eligibility redeterminations and new community engagement requirements.
2. **Reduced payments for Medicaid benefits** through state directed payments (SDPs), which help offset low payment rates in managed care and advance state quality and access goals.
3. **New constraints on states' ability to finance Medicaid payments with provider taxes**, a permissible funding source on which hospitals have historically relied.
4. **Changing budget neutrality rules** under Section 1115 waivers, a long-standing tool states have used to advance innovative proposals to target funding.
5. **New federal reporting and modeling requirements** that will make it more burdensome for states and essential hospitals to demonstrate compliance with federal rules.

Coverage losses and changing budget neutrality rules are expected to take effect within three months of this publication, and reductions in payments and Medicaid financing will begin by the end of 2027 (Figure 1). Because these policies will have cumulative and interactive effects, essential hospitals must start planning now. For example, lower Medicaid enrollment will increase uncompensated care costs for uninsured individuals while also reducing the Medicaid funding that hospitals receive through SDPs, threatening access to essential services in their communities.

Using data from the Congressional Budget Office (CBO), America’s Essential Hospitals projects that hospital uncompensated care costs will increase by \$466 billion over the next decade. Although essential hospitals are just 6% of acute-care hospitals nationwide, they will absorb nearly 25% of that increase because they serve a disproportionate share of Medicaid and uninsured patients.ⁱⁱ These added costs will compound the financial challenges predated H.R. 1 (Figure 1).

Recent CMS regulations and guidance create new challenges for essential hospitals by adding reductions in funding that are not required by the statute. The new requirements increase complexity and administrative burden, further straining hospitals’ finances.

FIGURE 1. COMPOUNDING FINANCIAL CHALLENGES FOR ESSENTIAL HOSPITALS



In this challenging financial environment, essential hospitals must adapt to new financial constraints while pursuing innovative strategies and policy changes to preserve access to essential care. The challenge extends beyond determining the financial impact of these changes to translating that analysis into operational and strategic priorities. Without an integrated view, leaders might struggle to identify which populations require attention, target limited staff resources, and evaluate whether interventions are improving performance.

Three Priorities for Navigating the Road Ahead

As financial and operational pressures converge, essential hospitals should focus on **three priorities**:

- 1) **Understand the Impact.** Quantify financial and operational exposure and identify where action is most urgent.
- 2) **Prioritize Strategically.** Use data and resources more effectively to protect performance and sustain access to essential care.
- 3) **Strengthen Partnerships.** Engage payers and state and federal stakeholders to navigate implementation and shape workable solutions.

Together, America's Essential Hospitals and Sellers Dorsey can help essential hospitals navigate these headwinds, bringing the resources, insights, and expertise needed to translate a changing policy environment into informed, actionable strategies.

The Cumulative Impact: Five Simultaneous Policy Headwinds

Essential hospitals are facing several overlapping pressures all at once. Each policy is significantly restrictive on its own; together, spread across interim final rules, proposed rules, and subregulatory guidance, they compound to far more consequential impacts.

1. LOST COVERAGE: GROWING NUMBER OF UNINSURED INDIVIDUALS

CBO estimates that H.R. 1 will increase the number of uninsured individuals by 10 million in 2034. Most coverage losses would come from new procedural barriers to enrollment for eligible beneficiaries. These include requirements to redetermine eligibility for Medicaid expansion beneficiaries every six months rather than annually, and to require Medicaid expansion beneficiaries to complete 80 hours of community engagement each month.ⁱⁱⁱ For hospitals, coverage losses projected from these requirements translate into greater uncompensated care, driving up costs. More frequent eligibility checks create additional operational challenges for systems that already devote significant resources to helping patients maintain coverage.

In June 2026, CMS published an interim final rule (IFR) providing additional guidance on implementing work requirements that further defined allowable exemptions. The rule sets a more detailed standard for the “medically frail” exemption from community engagement requirements: individuals must not only have a qualifying condition but also demonstrate that the condition “significantly impairs” their ability to comply. CMS estimates that implementation of the community engagement requirement could lead to disenrollment of 15% of affected beneficiaries.^{iv}

Four states opted to implement community engagement requirements early: Nebraska (May 1, 2026), Montana and Arkansas (July 1, 2026), and Iowa (Dec. 1, 2026). These states will provide critical early data about the extent of eligibility churn in the coming months. Although Nebraska has not released any official disenrollment data, early reporting indicates increased call volumes and wait times at the state’s Medicaid call centers, as well as anecdotal reports of general confusion among Medicaid enrollees.^v

The number of uninsured individuals is also increasing following the expiration of enhanced premium tax credits on Dec. 31, 2025. Early evidence suggests the effects on marketplace coverage alone are significant, especially in nonexpansion states. A KFF survey fielded in February and March 2026 found that 9% of 2025 marketplace enrollees had become uninsured, and nearly one in six returning enrollees were not confident they could afford their premiums for the full year.^{vi}

2. REDUCED PAYMENTS FOR MEDICAID BENEFITS: SDPS UNDER NEW CONSTRAINTS

H.R. 1 directly constrains the SDP payment mechanisms states have increasingly used to support Medicaid payment rates in managed care. The law adds Medicare-based limits on SDPs for inpatient and outpatient hospital services, nursing facilities, and qualified practitioner services at academic medical centers. Grandfathered programs must begin phasing down SDPs to the new limits in 2028.

In May 2026, CMS issued a proposed rule that substantially expanded the scope of these cuts. The proposed rule accelerates the phase-down of existing SDPs, extends Medicare-based caps to all non-grandfathered SDPs, establishes Medicare limits at the individual service and provider level, restricts uniform rate increases, and—perhaps most significantly—applies Medicare-based limits to certain targeted fee-for-service payments that are not required by statute.

Concerns related to these restrictions are widely shared. In public comment letters submitted to CMS, stakeholders argued that service- and provider-level Medicare limits are a poor proxy for Medicaid payment adequacy. They warned that mapping Medicaid payments to Medicare rates at the individual service code-level would require states and managed care organizations to reprocess every claim, with a risk of underpaying the services essential hospitals are most likely to provide.^{vii}

3. CONSTRAINED STATE FINANCING: NEW LIMITS ON PROVIDER TAXES

H.R. 1 prohibits new provider taxes and phases down the permissible tax threshold in expansion states beginning October 2027. Because provider taxes help states finance the nonfederal share of Medicaid spending, these limits will reduce states' ability to preserve Medicaid coverage and sustain Medicaid payments that help support essential hospitals, such as SDPs.

CMS' July 2026 provider tax proposal is more consistent with the statute than some of the agency's other rules implementing H.R. 1. However, it extends beyond the statute by creating new provider tax requirements for health insurers and imposing new one-time and quarterly reporting requirements for states that likely will add administrative burden for hospitals.^{viii}

4. CHANGING SECTION 1115 DEMONSTRATION WAIVER RULES: BUDGET NEUTRALITY UNDER TIGHTER SCRUTINY

Section 1115 waivers are a key tool for states to pursue innovative approaches to improve care for Medicaid beneficiaries without increasing federal spending, a requirement known as budget neutrality. Beginning Jan. 1, 2027, H.R. 1 requires the CMS chief actuary to certify the budget neutrality of Section 1115 demonstrations. The statute was intended to codify existing policies, but new CMS guidance fundamentally changes the agency's approach to calculating budget neutrality.

Specifically, CMS' State Medicaid Director Letter replaces the agency's historical "without waiver" approach to demonstrate savings, limits the treatment and rollover of savings, and

introduces a new “Medicaid Authorizable Populations and Services” framework to describe which activities could hypothetically be covered by Medicaid.^{ix,x} Under the new guidance, uncompensated care and provider pools and reentry infrastructure will be classified as Section 1115–only activities, requiring rigorous documented financial impact analysis. It eliminates expenditure limits and budget neutrality caps, because CMS will not approve waivers expected to increase federal spending. This change follows CMS’ 2025 decision to stop approving several initiatives previously leveraged under 1115 authority, including workforce programs, nonmedical health-related social needs programs, and expanded continuous eligibility.

5. COMPLIANCE AND MODELING COMPLEXITY: NEW OPERATIONAL BURDENS

Each policy change brings new administrative demands. Eligibility changes require states to develop new processes, hire additional staff, and make costly system changes. Provider tax changes add one-time and quarterly reporting obligations. SDP changes require modeling at the individual service and provider level. Changes to the Section 1115 waiver budget neutrality framework also will require states to redesign programs and conduct additional actuarial analysis to meet CMS’ approval standards.

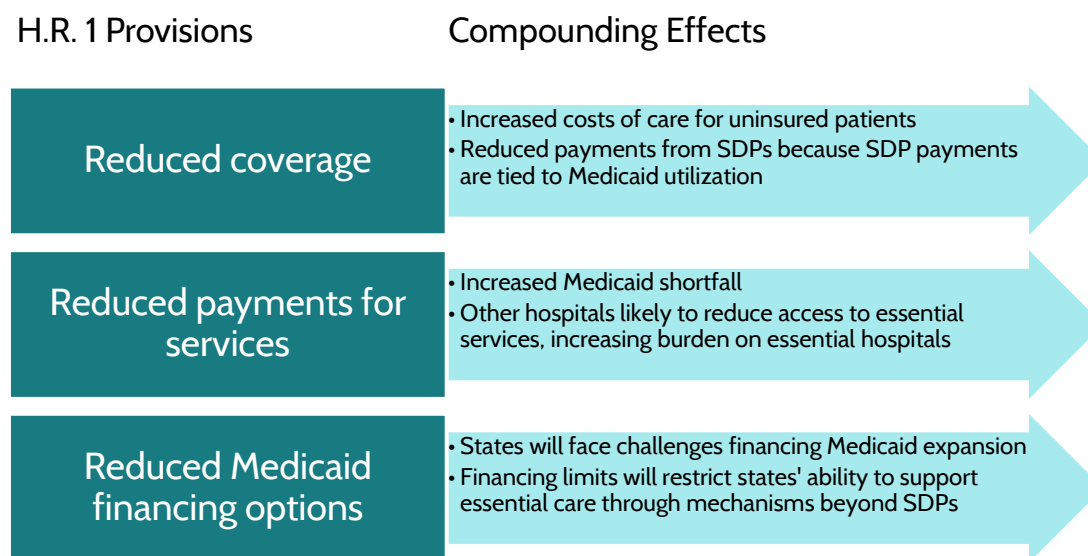
Individually, these are compliance tasks. Collectively, they represent a significant expansion in the analytic and modeling capacity finance and operations teams need—often on overlapping timelines and without adequate system support. Managed care organizations and state agencies face immediate operational challenges, as rate-setting ambiguity threatens plan participation in already-fragile markets and risks disrupting beneficiary access.^{xi}

Pressures extend beyond finance and compliance teams. Quality, population health, and care management teams must work across multiple payer requirements, reporting cycles, and sources of clinical and claims data. Common challenges include delayed payer reports, manual chart review, incomplete documentation of care already delivered, and limited visibility across programs and patient populations. As resources tighten, these administrative demands can divert staff time from patient outreach and care coordination and make it harder for leaders to target interventions effectively.

Why This Matters for Essential Hospitals

The new coverage, payment, and financing changes will compound hospital uncompensated care costs, disproportionately harming essential hospitals and the patients they serve (Figure 2). Although essential hospitals are only 6% of hospitals nationally, they are expected to bear 25% of the added uncompensated care costs. In 2023, essential hospitals already reported \$22.4 billion in uncompensated and under-reimbursed care and provided 29% of the nation's charity care.^{xii}

FIGURE 2. COVERAGE, PAYMENT, AND FINANCING CHANGES HAVE COMPOUNDING EFFECTS ON HOSPITAL UNCOMPENSATED CARE



Reduced funding could undermine access to critical services essential hospitals provide in their communities. Essential hospitals often are the only hospitals in their community that provide intensive inpatient care, such as trauma, burn care, emergency psychiatric services, and neonatal intensive care units. They also have invested in expansive ambulatory care networks and other services to prevent avoidable hospitalizations. As other hospitals close similar service lines, demand for these services is likely to grow, putting more pressure on essential hospitals to preserve access to needed care for their communities.

States that want to help preserve access to essential care will face new financing constraints. Analysis of enacted state fiscal year (SFY) 2027 state budgets shows that many states are making targeted cuts to Medicaid spending or dipping into emergency funding this year to address early H.R. 1 effects and prepare for the fiscal cliff ahead.^{xiii} However, reducing benefits, lowering reimbursement levels, and adjusting beneficiary eligibility can only do so much to fill the gap.

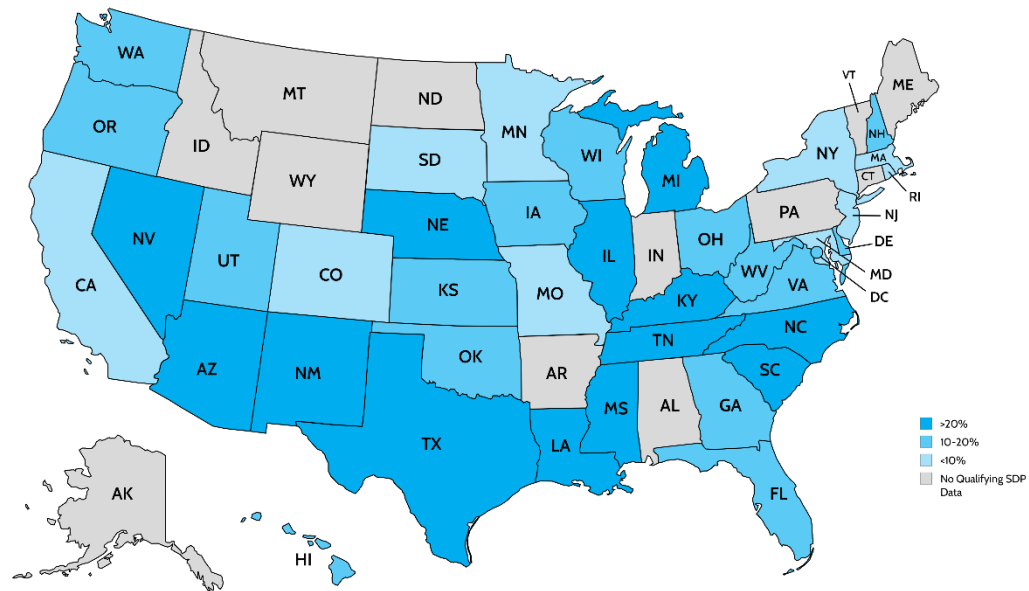
State-by-State Vulnerability Mapping

A single national estimate understates the range of exposure because these policies affect states differently depending their Medicaid financing structures and coverage landscape. The impact of the new SDP limits will vary widely by state, but the magnitude of exposure is substantial. As Figure 3 illustrates, SDPs above the new payment limits represent a meaningful share of Medicaid spending across many states, but the degree of reliance on these arrangements varies considerably. Across the 39 jurisdictions analyzed, these payments average 12.5% of total Medicaid spending and exceed 30% of Medicaid spending in some states. Nearly three-quarters of states tie at least 10% of Medicaid spending to these arrangements, including 13 states with SDPs above 20% of total Medicaid spending.

Medicaid expansion status adds another dimension to that exposure. Expansion states are projected to have larger declines in Medicaid enrollment, while nonexpansion states have experienced greater increases in uninsured individuals following the expiration of enhanced premium tax credits (Figure 4). Expansion states also face reductions in the share of provider revenue that can be taxed, while nonexpansion states can continue provider taxes at current levels.

States that rely heavily on Section 1115 waivers face additional challenges. The new budget neutrality requirements will limit their ability to pursue innovative financing and delivery system reforms to mitigate the negative effects on essential hospitals. States with waivers expiring at the end of 2026 already have scaled back proposals involving health-related social needs and other innovative services. Hospitals in states with waivers expiring after the January 2027 effective date of the new budget neutrality standards, including Massachusetts, New York, and Arizona, might need to reassess waiver structures and make additional changes in anticipation of CMS Chief Actuary review.

FIGURE 3. MEDICAID SPENDING EXPOSURE TO NEW STATE DIRECTED PAYMENT LIMITS, BY STATE

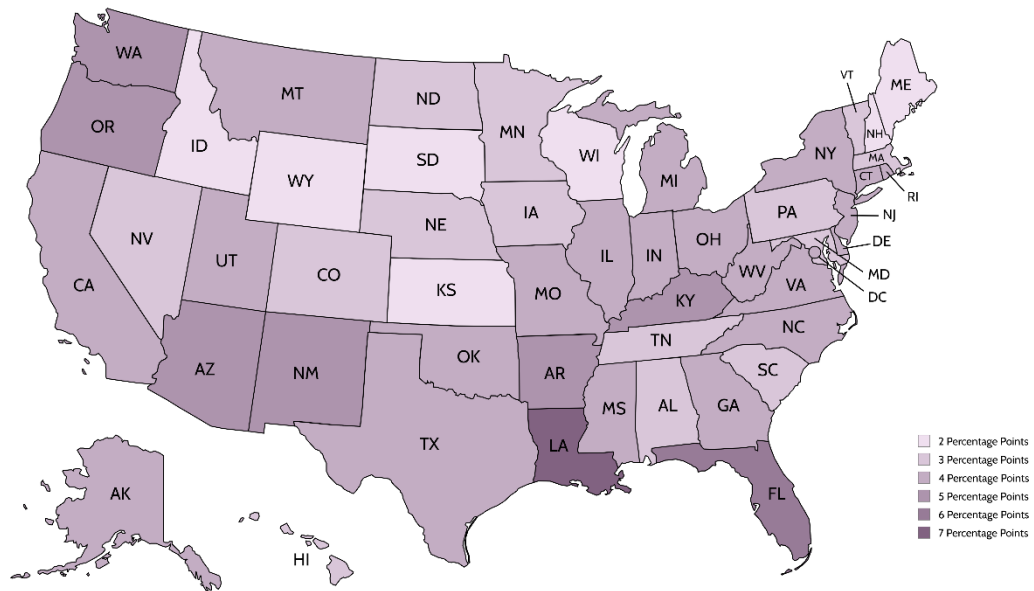


Created with mapchart.net

Note: Values reflect average 2024–2025 SDP spending as a share of fiscal year 2024 Medicaid spending. The analysis excludes states without Medicaid managed care, those without applicable SDPs during the study period, and those whose applicable SDPs did not pay above Medicare rates.

Source: Lipson DJ. New Medicaid State-Directed Payment Limits Are Likely To Decrease Medicaid Spending By 10–25 Percent In 17 States. Health Affairs. 2026;45(9):986–993. <https://doi.org/10.1377/hlthaff.2026.00116>. Accessed Oct. 16, 2026.

FIGURE 4. INCREASE IN UNINSURED RATES DUE TO H.R. 1 AND EXPIRATION OF PREMIUM TAX CREDITS, BY STATE



Created with mapchart.net

Source: Burns A, Ortaliza J, Lo J, et al. *How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State? Allocating CBO's Estimate's of Additional Uninsured People Across the States*. KFF. 2025. <https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/>. Accessed Oct. 22, 2026.

The impact of H.R. 1 will vary across states, underscoring the need for state-specific analysis to understand how it will affect access to essential services. In Tennessee, where Medicaid rates cover only 41% of the cost of care without SDPs, one hospital warned that CMS' accelerated phase-down of funding would "destabilize the program as a whole."^{xiv} In Louisiana, where SDPs total roughly \$4.3 billion and cover nearly 30% of the state's population, hospital advocates also noted the disruptive impact of CMS' proposal for an expedited phase-down.^{xv} Meanwhile, SFY 2027 state budget analysis shows states struggling to replace lost federal funding. For example, in Colorado, rates were cut by 2% following a \$750 million mid-2025 deficit.

What Essential Hospitals Should Do Now: Three Integrated Workstreams

Responding effectively requires more than a point-in-time financial assessment. Hospitals need to understand their financing environment, operating model, payer relationships, and patient populations and connect that expertise with the data and technology needed to support action.

WORKSTREAM 1: UNDERSTAND THE CUMULATIVE IMPACT (ANALYTICS AND MODELING)

Hospital-level exposure will depend not only on an institution's finances and operations but also on its state's Medicaid environment and response to federal changes. Understanding that exposure requires connecting the hospital's financial and operating profile to the state's Medicaid financing structure, available flexibility, and policy choices. This integrated view helps hospitals move beyond broad policy estimates, identify what areas will be affected, and plan accordingly.

Institution-specific impact models can help hospitals quantify this exposure across:

- Coverage-loss scenarios, by payer and service line, considering 340B savings implications
- Supplemental payment reduction modeling including SDPs, DSH, and provider taxes
- State policy landscape tracking
- Waiver redesign implications

Unifying clinical, quality, and payer data into a more connected view can further enhance impact models. This analysis can help hospitals examine performance across patient populations, providers, payers, and programs to identify where policy and financing changes could create the greatest pressure.

Because federal guidance and state decisions are still evolving, these models are only as reliable as their assumptions. Ongoing tracking of federal rulemaking, CMS approvals, and state budget and policy actions keeps model inputs current, allowing leaders to identify threats to financial projections before they see budget impacts.

WORKSTREAM 2: TIGHTEN OPERATION (EFFICIENCY AND CONTRACT OPTIMIZATION)

Hospitals need to negotiate Medicaid contract rates that maximize state payments under the new SDP framework and pinpoint where Medicaid margins are most constrained to optimize care delivery. Reanalyzing service-line profitability identifies which Medicaid programs remain sustainable under the new limits, while DSH and SDP application optimization helps ensure hospitals capture the full payment available to them under the revised rules. When 340B program eligibility, compliance, and savings are at stake, hospitals also need targeted support to protect that value.

Hospitals also evaluate managed care contract performance and support improvement in financial performance, quality incentive metrics, and operating terms. Standardized payer performance scorecards track trends in financial performance, denials, payment timeliness, quality incentives, and administrative burden. They help leaders identify early signs of payer underperformance or emerging risk and run root-cause analysis across operational, contractual, and clinical dimensions. When a payer, service line, or contract is underperforming, hospital leaders need to understand why and define corrective action plans with accountable owners. Hospitals should head into payer renewal cycles by summarizing performance history, open issues, and leverage points.

Data must translate into focused work for quality and care management teams. Hospitals should identify patients with open care gaps, prioritize outreach, coordinate follow-up, and monitor performance without relying on repeated manual chart review or disconnected worklists. This can help constrained teams direct their time toward higher-priority interventions while improving the capture of care already delivered.

WORKSTREAM 3: STRENGTHEN PAYER, STATE, AND FEDERAL PARTNERSHIPS (STRATEGIC POSITIONING)

Essential hospitals can benefit from working with states to manage CMS regulatory compliance in ways that preserve the hospital support mechanisms on which they rely. In states that pursue Section 1115 waivers, hospitals should help design demonstrations that remain sustainable under the new budget neutrality framework. Hospitals also should build health plan partnerships focused on joint savings opportunities and care management data sharing.

Additionally, hospitals should support provider-to-payer data exchange, using technology to improve timely claim adjudication, prior authorization efficiency, and risk program eligibility. Essential hospital leaders also should share their stories with federal policymakers to advocate for changes that mitigate the effects of funding cuts on essential hospitals and remove barriers to states' ability to preserve access to essential care through innovation.

Sellers Dorsey and America's Essential Hospitals are Here to Help

Successfully implementing all three workstreams takes partnership and collaboration across various systems and stakeholders. Sellers Dorsey and America's Essential Hospitals are committed to helping essential hospitals preserve access and sustainability for member populations and communities.

Contact Sellers Dorsey for an Impact Assessment to quantify your vulnerability, identify opportunities, and prioritize strategic initiatives.

America's Essential Hospitals' public analyses of the effects of H.R. 1 are available at [ProtectMedicaid.org](https://www.protectmedicaid.org), and comment letters are also available on [the association's website](#). Members of America's Essential Hospitals can access additional analyses of H.R. 1 through its [members-only resource center](#) and [Medicaid Financing interest group](#).

About Sellers Dorsey

At Sellers Dorsey, we believe everyone deserves access to quality, compassionate care. We partner with health care leaders to improve outcomes for vulnerable populations. Our team combines real-world expertise — from Medicaid directors to health care executives — with cutting-edge data analytics and visualization, delivering tailored strategies and proven solutions that drive impact.

About America's Essential Hospitals

America's Essential Hospitals is the leading advocate for hospitals dedicated to high-quality care for people who face social and financial barriers to health care access. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health and access to health care. We champion our more than [400 members and their mission](#) to care for low-income and uninsured patients, teach the next generation of health care professionals, and provide lifesaving services for all.

Endnotes

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