

MEDICAID POLICY BRIEF

# HR1 and Michigan Medicaid: Budgetary and administrative impacts

May 22, 2026



# HR1 Impacts on the State of Michigan

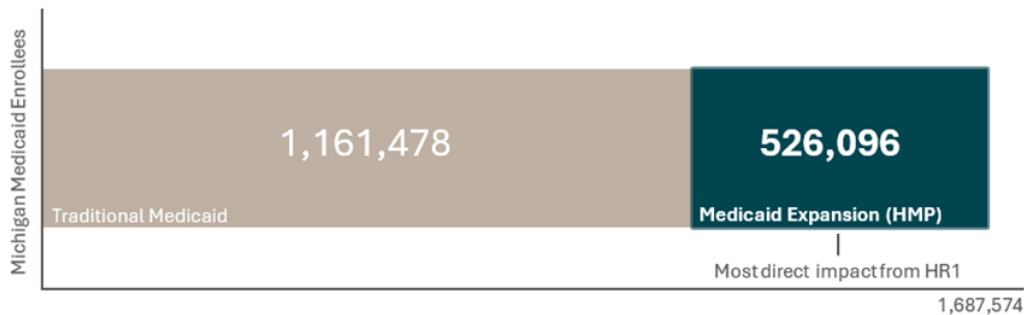
In March 2026, nearly 1.7 million Michigan residents were enrolled in the Medicaid program. Of these, over 526,000 are part of the Healthy Michigan Plan (HMP), Michigan’s Medicaid expansion program.

The 2025 budget reconciliation bill, also known as HR1 or the One Big Beautiful Bill Act (OBBBA), introduced sweeping changes to the way Medicaid is financed and administered by states through four core changes to the Medicaid program.

1. **Provider tax limits:** Michigan levies taxes on certain provider types to generate revenue for the Medicaid program. Reducing the maximum provider tax rate restricts a primary mechanism for funding the state’s share of the Medicaid program.
2. **State directed payment (SDP) caps:** Michigan uses SDPs to improve access to care for Medicaid beneficiaries. SDP caps limit the amount of supplemental payments that the state can make to hospitals and providers.
3. **Work requirements:** Healthy Michigan Plan (HMP) enrollees will be required to meet 80 hours of community engagement requirements per month to maintain their Medicaid coverage. These requirements are expected to reduce Medicaid enrollment through administrative barriers.
4. **Redeterminations and retroactive coverage:** HMP enrollees will be required to renew their eligibility every six months rather than 12 months. The period of retroactive coverage will decrease from three months to one month for Medicaid expansion enrollees and to two months for traditional Medicaid enrollees.

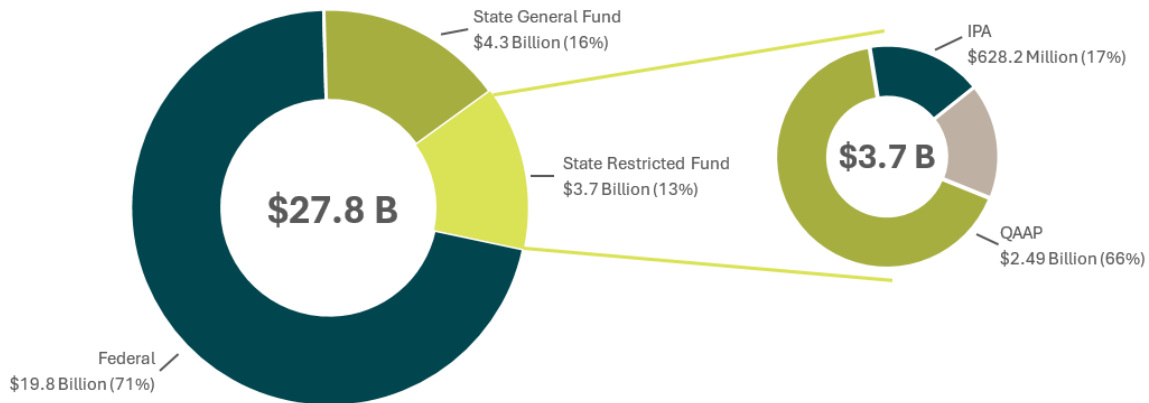
Figure 1

Michigan Medicaid enrollment (traditional Medicaid and healthy Michigan Plan) in March 2026



**Figure 2**

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



### Budgetary impacts

HR1 reduces federal funding by restricting the methods that states use to generate their “state share” of Medicaid costs. Because the federal government matches a percentage of what the state spends, a reduction in the state’s ability to raise revenue automatically triggers a reduction in federal matching funds. For example, \$1 billion lost in state Medicaid revenue results in an additional loss of \$1.88 billion federal Medicaid dollars for Michigan, resulting in a total loss of \$2.88 billion in Medicaid funding for the state.

**Table 1**

**Estimated reduction to the state medicaid fund**

| Driver                   | Estimated Reduction |
|--------------------------|---------------------|
| Work requirements        | ~ \$615 million     |
| Provider taxes           | ~ \$1 billion       |
| 6-month redeterminations | ~ \$63 million      |

### Provider taxes

The Social Security Administration defines provider taxes as those for which at least 85% of the tax burden falls on health care items, services, or providers.<sup>i</sup> Every state except Alaska uses provider taxes to support its state share of Medicaid spending. Although the reliance on provider taxes varies by state, it

makes up a considerable share of the Medicaid budget.<sup>ii</sup> In Michigan, provider taxes account for approximately 20% (or \$3 billion) of the state's share of Medicaid spending.<sup>iii</sup>

Michigan levies provider taxes to support Medicaid on four categories of health care providers:

- Hospitals and nursing facilities: taxed between 5.01% and 5.5%.
- Ambulance providers and managed care organizations (including Medicaid health plans): taxed at or below 3.5%.<sup>iv</sup>

### Reductions in tax rates

Reductions in Michigan's State Medicaid Fund from changes to provider taxes are projected to be over \$1 billion in 2028.<sup>v</sup> HR1 prohibits states from assessing new provider taxes or increasing rates on existing provider taxes.<sup>vi</sup> Beginning in 2028, Michigan must gradually reduce its provider tax rates by 0.5% per year until they reach the new limit of 3.5% in 2032.<sup>vii</sup> These limits will decrease the total revenue Michigan can raise via provider taxes to draw down funding from the federal government to support the state's Medicaid program. Notably, taxes on nursing facilities are excluded from these changes, so the reduction in rates only applies to hospitals.

### Insurance Provider Assessment

Some provider taxes are levied on managed care organizations. In Michigan, these taxes are specifically applied to Medicaid health plans and known as the Insurance Provider Assessment (IPA). These taxes are now impermissible under HR1, and a February 2026 CMS Final Rule outlines the transition period guidance for states to implement required changes.<sup>viii</sup> This policy change eliminates the ability for states to apply variable tax rates to Medicaid health plans versus non-Medicaid plans. In Michigan, the IPA generates nearly \$500 million annually for the state budget to offset general fund costs.<sup>ix</sup>

### State directed payments

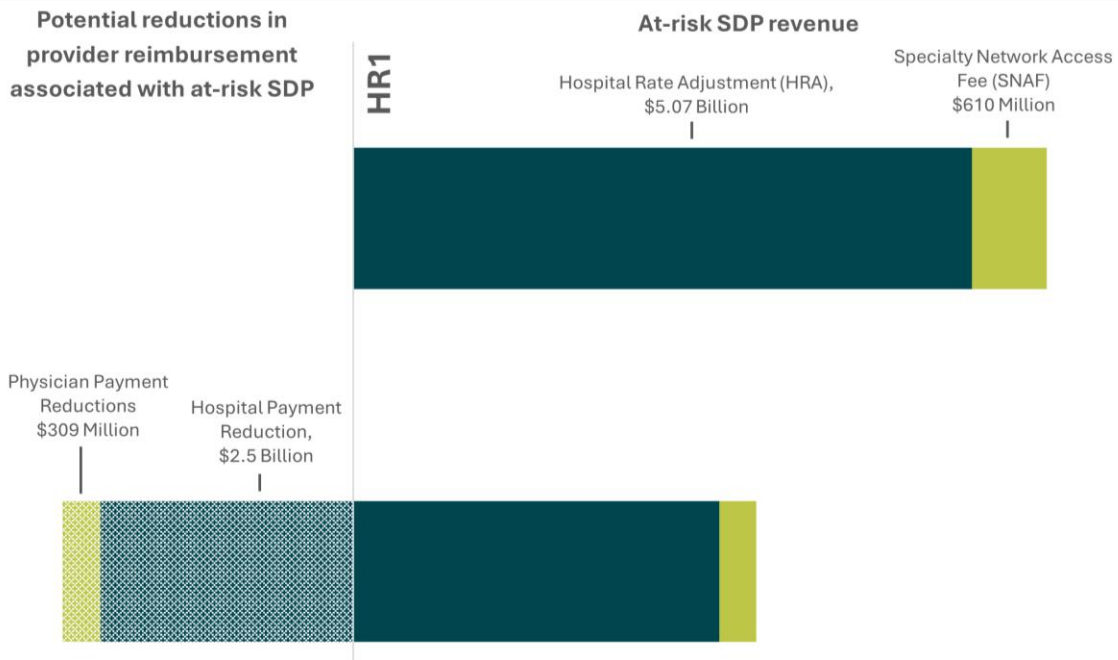
State directed payments (SDPs) allow states to supplement the base rates that providers receive for Medicaid services, which are often considerably lower than actual provider costs. SDPs are also used to require managed care organizations to pay specific rates to providers, often with the goal of improving access to care. HR1 restricts these payments by:

1. Capping new SDPs at Medicare rates (SDPs are currently capped based on average commercial rates, which are significantly higher), and
2. Gradually phasing down existing SDPs that exceed Medicare rates starting in 2028.

In Michigan, two SDPs that will be impacted are the Hospital Rate Adjustment (HRA) at \$5.07 billion, which is used to support hospital access for Medicaid patients; and the Specialty Network Access Fee (SNAF) at \$610 million, which is used to support physician access for Medicaid patients.<sup>x</sup> Capping these SDPs at Medicare rates will limit the state's ability to supplement payments to providers that are serving Medicaid enrollees, reducing their ability to sustainably serve Medicaid patients. One model estimates this will result in a 45 percent reduction in Medicaid payments to Michigan hospitals.<sup>xi</sup>

Figure 3

Current at-risk SDP revenue and HR1’s potential impacts on provider reimbursement



### Administrative impacts

HR1 imposes significant new administrative and operational costs for states. Michigan must overhaul its Medicaid eligibility systems to accommodate increased frequency of beneficiary reviews and the implementation of verification processes and data matching for work requirements.

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

To support this administrative work, the state will incur costs to upgrade IT systems, increase staffing, and monitor compliance. In preparation for the implementation of work requirements in 2020, the Michigan Department of Health and Human Services (MDHHS) made significant investments in the state’s reporting and communication platforms.<sup>xii</sup> As of April 2026, MDHHS has not decided on plans to increase eligibility staff capacity.<sup>xiii</sup>

## Work requirements

By January 1, 2027, Michigan must implement work requirements for the Medicaid expansion population. The details of the work requirements policy are described elsewhere, including assumptions regarding how Michigan will implement [work requirements](#).

## Verification

States are required to verify compliance during each regularly scheduled redetermination. This means the state of Michigan will determine if a beneficiary has met their work requirements when they apply for Medicaid and renew their Medicaid coverage as part of their regular eligibility review.

In addition, HR1 encourages states to use existing data to verify compliance with work requirements and/or exemption criteria when possible. This type of ex parte verification reduces the administrative burden on individuals by requiring states to use existing data sources (e.g., payroll data). Although some of this can be automated with state-level data sources, the Congressional Budget Office (CBO) expects that this type of ex parte verification may be exceedingly difficult for certain populations, types of work, and types of exclusion criteria.<sup>xiv</sup>

## Mandatory outreach

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

## Summary

For Michigan policymakers, HR1 represents a contraction of available revenue and a simultaneous increase in operational costs. The budgetary impacts to the state's Medicaid program will create significant financial pressure, requiring policymakers to choose between identifying new revenue sources, reducing provider reimbursement rates, or cutting Medicaid services. While budgetary caps present a long-term challenge, the immediate administrative mandates of HR1 will require an unprecedented investment in staffing and technology to ensure the state remains in federal compliance while keeping as many beneficiaries enrolled as possible.

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<sup>i</sup> Social Security Act, Title XIX, Section 1903. [https://www.ssa.gov/OP\\_Home/ssact/title19/1903.htm](https://www.ssa.gov/OP_Home/ssact/title19/1903.htm)

<sup>ii</sup> KFF, "5 Key Facts About Medicaid and Provider Taxes". <https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/>

<sup>iii</sup> MDHHS, Executive Directive ED-2025-3 (PDF). <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Newsroom/ED-2025-3-FINAL.pdf>

<sup>iv</sup> MDHHS, Executive Directive ED-2025-3 (PDF). <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Newsroom/ED-2025-3-FINAL.pdf>

<sup>v</sup> RAND Corporation, RRA4098-1. [https://www.rand.org/pubs/research\\_reports/RRA4098-1.html](https://www.rand.org/pubs/research_reports/RRA4098-1.html)

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- vi Commonwealth Fund, “How New Limits on State Provider Taxes Will Affect Medicaid Funding”. <https://www.commonwealthfund.org/publications/explainer/2025/dec/how-new-limits-state-provider-taxes-will-affect-medicaid-funding>
- vii Commonwealth Fund, “How New Limits on State Provider Taxes Will Affect Medicaid Funding”. <https://www.commonwealthfund.org/publications/explainer/2025/dec/how-new-limits-state-provider-taxes-will-affect-medicaid-funding>
- viii Federal Register, 2026-02040 (Feb. 2, 2026 CMS Final Rule). <https://www.federalregister.gov/documents/2026/02/02/2026-02040/medicaid-program-preserving-medicaid-funding-for-vulnerable-populations-closing-a-health>
- ix MDHHS, SNAPMA HR1 presentation (PDF). <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid/MDHHS-Presentation---SNAPMA---HR1.pdf>
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- xi Commonwealth Fund, “How Medicaid State Directed Payments Support Critical Health Care Providers”. <https://www.commonwealthfund.org/blog/2025/how-medicaid-state-directed-payments-support-critical-health-care-providers>
- xii JAMA Health Forum, article 2793284. <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2793284>
- xiii KFF, Medicaid Work Requirements Tracker. <https://www.kff.org/medicaid/medicaid-work-requirements-tracker-state-national-data-and-policies/>
- xiv Congressional Budget Office, PL-119-21 Medicaid (PDF). [https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20\\_0.pdf](https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf)