

# H.R.1: Impacts on Minnesota's Hospitals and Health Systems

**July 4, 2025:** Congress enacted H.R.1, a sweeping tax law with significant consequences for health care in Minnesota. The policy changes are estimated to reduce federal funding to the state by **\$1.4 billion over the next four years<sup>1</sup>** and cause up to **140,000 Minnesotans to lose health coverage<sup>2</sup>**. As a result, this loss of coverage will have a substantial negative impact on Minnesota's hospitals and health systems who are already struggling with significant financial challenges.



**Hospital charity care is estimated to increase by \$269 million annually<sup>3</sup>.**



**Hospitals may see a loss in revenue associated with Medicaid enrollment reductions of \$354 million annually<sup>3</sup>.**

## KEY DATES

- Nov. 5, 2025**  
State applications due
- Dec. 31, 2025**  
CMS decisions
- Jan. 1, 2026**  
Funding begins
- Oct. 1, 2026**

## PROVISION

**Rural Health Transformation Program**  
Creates a \$50 billion program (*\$10B annually from 2026–2030*) for transformation of rural health care delivery. Strategic goals include workforce development and technology innovation. Half of the funds will be split equally among Center for Medicare and Medicaid Services (CMS)-approved states; half will be allocated based on CMS assessment of factors including rural population, number of rural facilities, and certain state policy actions.

**Immigrant Health Care Coverage**  
Limits Medicaid, Medicare, and premium tax credit eligibility to legal residents and certain immigrant groups. Reduces federal matching funds from 90% to 51.16% (Minnesota's regular Federal Medical Assistance Percentage (FMAP)) for Emergency Medical Assistance provided to undocumented immigrants in the Medicaid expansion population.

## HOSPITAL IMPACT

While Minnesota hospitals may receive some of the one-time funding, the amount is uncertain and will fall far short of offsetting the significant losses caused by other provisions of the bill. The state of Minnesota's application outlines several goals including rural workforce development and increased telehealth utilization.

Hospitals may provide more uncompensated emergency care as some lawfully present immigrant populations lose health care coverage. Emergency departments will become the default safety net for these vulnerable patients. The reduction in federal matching funds to the state for Emergency Medical Assistance may impact payment for services provided under Emergency Medical Treatment and Labor Act (EMTALA) requirements<sup>2</sup>.

	PROVISION	HOSPITAL IMPACT
● Oct. 1, 2026	<b>Provider Taxes</b> Freezes state and local Medicaid provider taxes at July 2025 levels ( <i>excluding nursing homes and intermediate care facilities</i> ). Sets a 0% “hold harmless” threshold on new taxes, meaning states cannot impose new or increased taxes. Provider taxes will be phased down by 0.5% annually in expansion states from FY2028 to 2032, to a 3.5% cap.	Given our existing provider taxes are close to the new federal cap, without policy changes, any future directed payment programs could be jeopardized <sup>2</sup> . Minnesota currently has a 1.8% provider tax and a 1.56% Medicaid surcharge specifically on hospitals. This provision creates severe financial pressures for the state that threaten hospital stability and access to care for Minnesotans.
● Jan. 1, 2027	<b>Medicaid Retroactive Coverage</b> Limits the timeframe for retroactive Medicaid eligibility to 30 days prior to the application date for Medicaid expansion enrollees, and 60 days prior to the application date for all other enrollees, including pregnant women. Additionally, retroactive Children’s Health Insurance Program (CHIP) eligibility is limited to 60 days prior to the application date.	Currently patients are eligible for 90 days of Medicaid retroactive coverage. The shortened timeframe will result in higher levels of uncompensated care, especially in emergency rooms, due to a <b>\$40 million</b> reduction in funding for Medicaid coverage. This includes a loss of <b>\$31 million</b> from the federal government and <b>\$9 million</b> in state support, eliminating an important financial protection for patients and hospitals <sup>2</sup> .
● Jan. 1, 2027	<b>Work Reporting Requirements</b> Requires certain Medicaid expansion adults to document at least 80 hours per month of work or community engagement, verified quarterly. Exemptions include parents of children under 14 and caregivers of disabled individuals. CMS guidance to states is due June 1, 2026.	This mandate will cut hospital Medicaid revenue by <b>8.8%</b> and increase uncompensated care by <b>21.5%</b> , while also imposing significant new administrative costs on the state <sup>4</sup> .
● Jan. 1, 2027	<b>Medicaid Administrative Requirements</b> Expands oversight of Medicaid and CHIP by requiring states to conduct eligibility redeterminations for Medicaid expansion every six months. States must also perform quarterly checks to remove deceased individuals and providers, regularly update enrollee address information, and submit new enrollee data to the federal government each month. CMS guidance to states is due on Dec. 31, 2025.	Minnesota is <b>one of 10 states</b> where eligibility is determined at the county level. These new requirements will add complexity and likely delay determinations, as the state’s <b>36-year-old MAXIS IT system</b> is outdated, resulting in coverage losses, higher administrative costs and increased uncompensated care <sup>5</sup> .
● Jan. 1, 2028	<b>State Directed Payments</b> Caps state-directed Medicaid payments in expansion states at 100% of Medicare rates, with limited exceptions. Certain payments are grandfathered until Jan 1, 2028, then cut by 10% annually until they match Medicare rates.	Reducing state-directed payments to Medicare levels will reduce critical resources desperately needed by Minnesota hospitals and health systems, especially rural and safety-net providers. Minnesota’s State Directed Payment Program preprint, submitted to CMS before H.R. 1’s enactment, is still awaiting approval, leaving hospitals uncertain about future funding.
● Oct. 1, 2028	<b>Cost-sharing in Medicaid expansion population</b> Medicaid expansion enrollees with incomes above 100% FPL must pay up to \$35 per service in cost sharing, capped at 5% of family income. Exemptions apply for primary care, pregnancy-related, mental health, and certain safety-net clinic services.	Hospitals will face added administrative burdens collecting cost-sharing from low-income patients, with a projected <b>\$4 million</b> increase in enrollee out-of-pocket costs likely driving up bad debt <sup>2</sup> . Minnesota hospitals are estimated to absorb <b>\$3 million</b> annually in the form of charity care <sup>3</sup> . Higher copays for non-emergency ER visits may also discourage timely care, resulting in delayed treatment and more severe, costly hospital admissions.

**SOURCES:**

1. Minnesota Department of Human Services: [https://content.govdelivery.com/attachments/MNGOV/2025/07/30/file\\_attachments/3338441/Impact%20of%20Federal%20Reconciliation%20on%20Minnesota%20v3.pdf](https://content.govdelivery.com/attachments/MNGOV/2025/07/30/file_attachments/3338441/Impact%20of%20Federal%20Reconciliation%20on%20Minnesota%20v3.pdf)
2. Minnesota Department of Human Services: [https://mn.gov/dhs/assets/historic-cuts-to-health-care-will-impact-every-minnesotan\\_tcm1053-699475.pdf](https://mn.gov/dhs/assets/historic-cuts-to-health-care-will-impact-every-minnesotan_tcm1053-699475.pdf)
3. MHA Analysis
4. Commonwealth Fund: <https://www.commonwealthfund.org/publications/issue-briefs/2025/sep/impact-medicaid-work-requirements-hospital-revenues-margins>
5. Star Tribune: <https://www.startribune.com/burcum-tears-workarounds-and-1990s-screens-push-county-staff-to-the-limit/601480904>