Protecting Medicaid Reimbursement Through Data-Driven Advocacy

LeadingAge Michigan + Plante Moran

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Introduction

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OBBA Impact on Provider Tax

Section 71115

Enactment

- Signed into law July 4, 2025, as H.R. 1 of the 119th Congress
- Enacted as Public Law 119-21 (139 Stat. 72)
- Cleared the Senate 51-50 and the House 218-214 in the days before signing
- CMS refers to the health financing provisions as the Working Families Tax Cuts Legislation
- Medicaid financing changes phase in over the following decade rather than at enactment

Section 71115: provider taxes

- Effective Oct. 1, 2026, replaces the 6% indirect hold harmless threshold with state and provider-class specific percentages
- Blocks new or increased taxes: the threshold is 0% for any tax not enacted and imposed as of July 4, 2025
- Expansion states face a five-year phase down starting FY 2028, stepping the cap from 6% to 3.5% by FY 2032
- Nursing facilities and intermediate care facilities are exempt from the phase down at rates at or below 6%
- CMS guidance of Nov. 14, 2025 defines "enacted" and "imposed" and addresses pending tax waivers
- Scored at roughly $191 billion in federal savings over 10 years

Sources: P.L. 119-21; CMS Dear Colleague letter, Nov. 14, 2025; KFF; CBO

OBBA: Medicaid cuts are now a provider operating issue

$911B

estimated 10-year federal Medicaid spending reduction after interactions

10M

increase in uninsured people cited in CBO/KFF estimates

76%

of reductions occur in the final five years

14%

of projected federal Medicaid spending over 10 years

The central risk is not a single national spending cut, but the chain reaction across state Medicaid financing models.

Provider taxes, state-directed payments, redetermination frequency, and work/reporting requirements create both direct reimbursement risk and indirect payer-mix pressure.

For Michigan SNFs, the message should stay focused on scenario planning: what happens if state financing resources tighten, even where nursing facility provider taxes receive partial protection?

Savings drivers under enacted law

KFF's analysis of the enacted package shows where Medicaid savings come from and how late they land.

Provision	Provider relevance	Savings
Work and reporting requirements	ACA expansion adults	**$326B**
Provider tax limits	New or increased taxes plus expansion-state cap phase down	**$191B**
State-directed payment limits	Hospital, nursing facility, and other provider payments	**$149B**
Eligibility and renewal barriers	Including redetermination and enrollment rules	**$122B**
ACA expansion redeterminations	Semiannual reviews	**$63B**

These are enacted-law estimates; implementation detail and state responses remain variable.

Source: KFF analysis of the enacted reconciliation package

Cuts slow growth, but federal health spending still rises

Why this nuance matters

- The law creates substantial Medicaid reductions relative to prior law
- That does not mean all federal health spending falls in nominal terms
- CBO's July 2026 projections still show federal health subsidies growing across 2026 to 2036

$33.6 trillion

Federal subsidies for health insurance projected over 2026 to 2036

7.4% of GDP in 2026

8.4% of GDP in 2036

OBBBA is a Medicaid financing shock inside a healthcare system that is still growing overall.

Source: CBO and JCT, Federal Subsidies for Health Insurance, 2026 to 2036, July 23, 2026

Michigan and SNF focus: indirect risk, not certainty

Separating direct statutory protection from state-budget ripple effects.

Direct protection to note

Nursing home and intermediate care facility tax rates are generally frozen below the 6% threshold, which limits direct exposure to the new 3.5% cap.

Financing design still matters

KFF identifies Michigan among the states relevant to the provider tax uniformity provision, so state financing design belongs on the watch list.

Most important provider message

Even partial protection does not eliminate risk. If hospitals, MCOs, or state-directed payments lose resources, states may revisit Medicaid payment policy across the system.

MI SNF takeaway

Scenario planning is needed around tiering and the state financing response: direct statutory impact is limited, but indirect pressure remains possible.

Sources: P.L. 119-21 Section 71115; KFF provider tax analysis

What providers should do now

A practical close tailored to healthcare operators.

1

Model exposure

Quantify Medicaid revenue, provider tax exposure, supplemental payment add-ons, and payer-mix sensitivity.

2

Segment risk

Separate direct statutory impact from indirect state-budget and reimbursement risk.

3

Strengthen reporting

Align charity care, bad debt, and revenue-cycle workflows, and before uncompensated care volumes rise.

4

Prepare advocacy points

Frame requests around access, facility viability, quality, workforce, and state Medicaid financing tradeoffs.

Bottom line: OBBBA is a Medicaid financing story, a coverage story, and a provider strategy story.

Recommendations synthesized from cited policy updates and Plante Moran provider materials

Thinking Strategically

LeadingAge Michigan has been strategically preparing for growing federal and state budget pressures, including increased CMS scrutiny around waste, fraud, and abuse and Michigan's efforts to maximize federal matching funds amid ongoing fiscal constraints. These challenges are unfolding during a major political cycle, with both legislative chambers and the Governor's race shaping budget and policy discussions.

To strengthen its advocacy efforts, LeadingAge Michigan engaged Plante Moran to provide data-driven analysis on **variable cost limits, potential provider tax revisions, and quality measures initiative** to help policymakers better understand the realities facing nonprofit aging services providers.

Michigan Reimbursement Landscape is Changing

Why this matters

Medicaid funding pressures

State support needs to remain defensible as provider finances tighten.

Federal scrutiny

Provider taxes and supplemental payment structures require clear documentation.

New political landscape

A new Governor and Legislature will reframe policy priorities.

Defensible advocacy

Data-supported recommendations outperform anecdotal advocacy.

Strategic implication

The story should move quickly from “what is changing” to “what the member data tells us” and “what LeadingAge Michigan can credibly ask policymakers to fix.”

Why LeadingAge Michigan Started This Initiative

Key Questions the data will help answer

Question 1

Why do reimbursement outcomes differ?

Question 2

Are nonprofit providers advantaged or disadvantaged?

Question 3

Which variables matter most?

Question 4

What policy changes should be pursued?

The Four Biggest Drivers

Michigan's Quality Assurance Assessment Program (QAAP),Quality Assurance Supplement (QAS), Quality Measure Initiative (QMI)

QAAP

Tax paid into the financing structure

QAS

Supplemental payments received

QMI

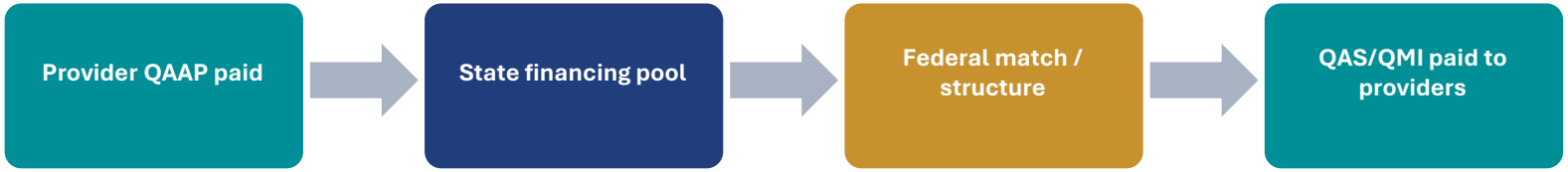
Quality-linked payment and rate implications

Variable Cost Limits

Ceiling position and cost settlement dynamics

Provider Tax: The Biggest Redistribution Mechanism in Michigan

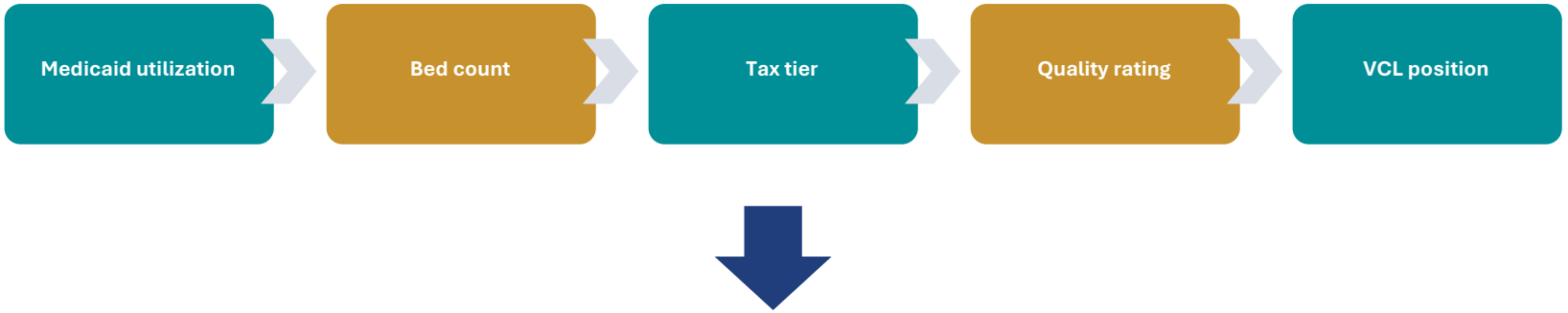
Conceptual financing flow



Advocacy question: does the financing structure redistribute resources in a way that aligns with membership priorities and long-term access?

Why Similar Providers Can Have Very Different Results

Small differences in variables can produce large differences in net outcome



Net reimbursement outcome

Same market. Similar mission. Different results.

Provider Tax Tiers Defined

Four Separate “Tiers”

10/1/2024 - 9/30/2025

Nursing Facility Rates FY2025				
Tier	0	1	2	3
# of Facilities	4	56	314	50
QAAP	$0.00	$2.00	$36.30	$18.20
QMI	$0.00	$0.00	$3.90	$2.50

10/1/2025 - 9/30/2026

Nursing Facility Rates FY2026				
Tier	0	1	2	3
# of Facilities	4	56	312	50
QAAP	$0.00	$2.00	$36.45	$18.35
QMI	$0.00	$0.00	$3.90	$2.50

Tier definitions

- **0** Qualifying CCRCs
- **1** Less than 40 dual-certified beds
- **2** “Everyone Else”
- **3** Top 50 in Medicaid Days

Tier 3 Medicaid days threshold

FY2025: 33,238 **FY2026: 32,961**

Threshold decreased by 277 days

What changed year over year

Tier 2 facilities decreased from 314 to 312; QAAP increased $0.15 in Tiers 2 and 3. QMI rates remained unchanged.

LAMI Member Provider Tax Results (Actual)

Overall Provider Tax Margin for LeadingAge MI member SNFs

Total QAAP paid	Total QAS received	Aggregate net position
$20.3 million	$ 32.8 million	$ 12.5 million

$20 million in total QAAP expense results in $32 million of payments to LAMI members

LAMI Member Provider Tax Results (Flat Tax Rate)

Overall Provider Tax Margin for LeadingAge MI member SNFs

Total QAAP paid	Total QAS received	Aggregate net position
$24 million	$ 32.8 million	$ 8.8 million

w/ flat tax rate providers pay $24 million in total QAAP expense results in $32.8 million of payments to LAMI members, reducing the overall margin to $8.8 million

LAMI Member Provider Tax Results (39 Bed SNFs Actual)

<40 Bed SNF Provider Tax Margin for LeadingAge MI member SNFs

Total QAAP paid

$244,000

Total QAS received

$ 5 million

Aggregate net position

$ 4.76 million

16 LAMI SNFs w/ 39 or fewer beds, currently pay $2/non-Medicare day resulting in a $4.76 million aggregate net position

LAMI Member Provider Tax Results (39 Bed SNFs w/ Flat Tax Rate)

<40 Bed SNF Provider Tax Margin for LeadingAge MI member SNFs

Total QAAP paid

$3.7 million

Total QAS received

$ 5 million

Aggregate net position

$ 1.3 million

w/ flat tax rate, 16 LAMI SNFs w/ 39 or fewer beds, currently pay $2/non-Medicare day resulting in a $1.3 million aggregate net position

QMI Impact on LAMI Members

Quality dollars today and rate implications tomorrow

Revenue received

$ 4.7 million

Tax expense paid

$ 1.9 million

Long-term rate impact

$ 2 million retained after net QMI adjustment

42% of QMI revenue received by LAMI members is retained, after the net QMI adjustment's impact on future rate setting

Unexpected Findings

Where analysis becomes valuable

Smaller CCRCs

Are smaller campuses disproportionately exposed?

Medicare-heavy providers

Do lower Medicaid utilization profiles alter the net tax result?

High quality, weak outcome

Do quality scores fail to translate into adequate reimbursement?

VCL impacts

Are cost limit positions masking reimbursement inequity?

What the Data Suggests Needs Attention

Advocacy implications that emerge from member-level analysis

Equity concerns

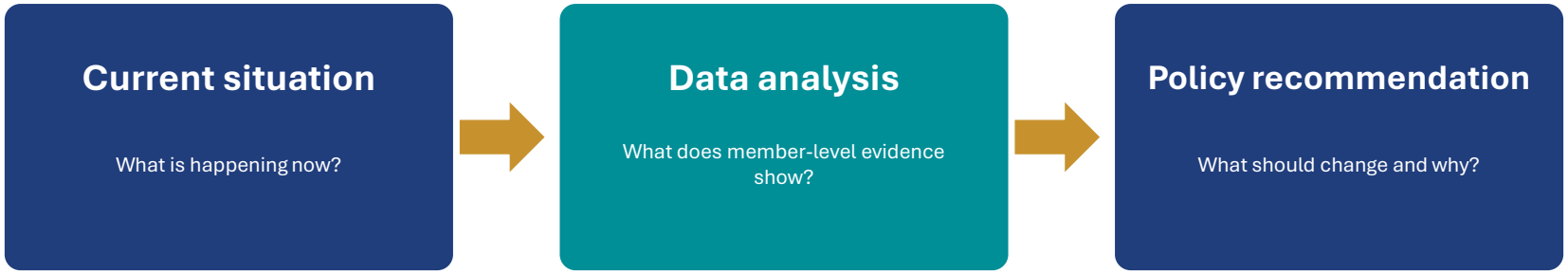
Unintended winners / losers

Sustainability concerns

Nonprofit provider impacts

Using Data to Educate Policymakers

From current situation to policy recommendation



Data closes the gap between member anecdotes and policy action.

Occupancy, Bed Management, and Non-Available Bed Plans

Michigan's Non-Available Bed Plan rules are moving from temporary flexibilities toward a proposed permanent policy. The next slides outline the policy history, current requirements, proposed qualifying criteria, and the extension and ineligibility framework.

Non-Available Bed Plan Policy History

How temporary flexibilities evolved toward a proposed permanent policy

26 Oct. 2021

MSA Bulletin 21-43

- Temporary policy effective through September 30, 2024
- No contiguous requirement
- 6-month plans
- No square-footage reduction

6 Feb. 2024

Temporary flexibilities extended

- MDHHS extended current NABP flexibilities to September 30, 2025

29 Aug. 2025

Temporary update for FY 2026

- One additional plan up to 12 months while permanent policy is developed
- Plant square footage shifted to non-reimbursable cost centers

26 May proposal

Proposed permanent policy outline

- 12-month approved plans
- Up to two 12-month extensions
- 24-month ineligibility period after expiration
- Non-reimbursable costs for non-available area

Non-Available Bed Plan Policy Rules

Prior temporary rules compared with the current temporary rules

Prior temporary rules	Current temporary rules
Requested within 60 days of effective date	No change
Effective date must be the first day of a month	No change
No contiguous requirement	No change
Beds locked into 6-month plans	**Beds locked into no more than one 12-month plan (10/1/2025 - 9/30/2026)***
No square footage moved to non-reimbursable cost center	**Plant square footage moved to non-reimbursable cost center**

***The 12-month plan must end on 9/30/2026.**

Proposed NABP Qualifying Criteria

Non-contiguous arrangements remain available, with new room- and wing-level guardrails

Room-level rule

An NABP must include all licensed beds in a patient care room. Creating private rooms through bed management remains available outside the NABP process and will be clarified in existing policy.

Non-contiguous allowed

NABPs do not have to be in a discrete area or contiguous physical arrangement if the proposed floor plan meets the qualifying criteria and is approved by RARSS.

Wing / unit / area limit

For any non-contiguous arrangement, rooms designated non-available cannot exceed 50% of the rooms in any wing, unit, or area.

Additional floor plan constraints

- NABPs cannot create isolated available rooms separated by non-available rooms.
- Proposed NABP floor plans are subject to approval at RARSS' discretion.
- Plans must continue to avoid “mixed usage rooms” when modified during extensions.

Planning implication: identify rooms by licensed-bed room, not just individual beds

Extensions, Modifications and Ineligibility Period

The proposal permits limited extensions and reductions, but no other amendments

Proposed rule element	Policy treatment
Initial approved plan	12 months from approved bed-removal date
Extension opportunity	Facility may request up to two 12-month extensions
Extension modification	At extension request, facility may remove any number of non-available rooms from the NABP and return those beds to service
Not permitted	Cannot change the location of NABs / rooms; cannot add beds; other amendments will not be approved
After expiration	Facility is not eligible to submit a new NABP for 24 months following expiration of the previously approved plan

Source: MDHHS NABP Outline Proposal for Stakeholders, 5.26

2027 Advocacy Agenda

Areas for discussion with state leaders

Governor

Frame reimbursement as access, quality, and mission preservation.

Legislature

Provide district-level examples and member-driven policy choices.

MDHHS

Use the data to support technical revisions and rate-setting refinements.

Key Takeaways & Discussion

1. Reimbursement variation is significant.
2. Data identifies specific policy drivers.
3. Evidence-based advocacy creates stronger outcomes.