ISSUE BRIEF

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IMPACTS OF THE OBBBA ON MEDICAID AND CHIP IN KANSAS

Introduction

On July 4, 2025, H.R. 1 or the One Big Beautiful Bill Act (OBBBA), was enacted using an expedited process known as budget reconciliation, ushering in significant changes to Medicaid. These changes will have major implications for KanCare, the program which combines Medicaid and the Children's Health Insurance Program (CHIP) in Kansas. KanCare currently provides coverage for approximately 440,000 low-income Kansans, including children, parents, pregnant women, individuals with disabilities, older adults and people with certain health conditions.

The OBBBA includes over $4 trillion in tax cuts and federal spending shifts that prioritize border security, defense and energy. Medicaid reform was a central feature of this legislation, signaling a significant shift in federal support for safety-net programs. These changes will affect how Kansas administers Medicaid, impacting beneficiaries, providers and the state's budget. As Kansas prepares to respond, close monitoring of implementation and its evolving impacts will be essential.

About KanCare:

- Medicaid is traditionally the third-largest domestic program in the federal budget, behind only Medicare and Social Security. In Kansas, Medicaid ranks second in spending (state and general funds) behind only K-12 education.
- Medicaid costs are shared between the states and the federal government. In fiscal year (FY) 2025, the Federal Medical Assistance Percentage (FMAP) in Kansas is **61.87 percent**, meaning that for every $1 that Kansas spends on Medicaid, the federal government contributes $1.62. The FY 2025 FMAP for the Children's Health Insurance Program (CHIP) is **73.31 percent** in Kansas.
- Medicaid in Kansas is administered by the Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services. Kansas contracts with managed care organizations that provide health coverage for most Medicaid beneficiaries in Kansas.

KEY POINTS

✓ **Limits on Medicaid Financing Tools:** New federal restrictions on provider taxes and state directed payments will reduce Kansas' long-term flexibility to fund Medicaid. While current rates may be grandfathered, eventual requirements may call for alternative funding sources or reduced payments to providers.

✓ **Enrollment and Administrative Changes:** Shortened retroactive coverage windows may result in coverage disruptions, particularly for individuals with fluctuating incomes. Additionally, stricter eligibility checks and new verification requirements may increase administrative workload for Kansas Medicaid agencies.

✓ **Reduced Incentives for Medicaid Expansion:** Kansas will no longer be eligible to receive a federal funding incentive — an additional 5 percent added to the Federal Medical Assistance Percentage (FMAP) for regular Medicaid over two years — if it chooses to expand Medicaid. According to recent analysis by the Kansas Health Institute (KHI), Kansas would have received $542 million over two years for choosing to expand Medicaid, which would have covered approximately nine years of net state expansion costs.

Unpacking Changes and Their Impacts to Kansas

The final provisions included in the OBBBA emerged after months of negotiation in the U.S. House of Representatives and Senate over their respective budget resolutions. Federal Medicaid funding will be reduced by approximately $930 billion over 10 years nationally. While many of the changes included in the OBBBA apply specifically to states that, unlike Kansas, have expanded Medicaid (many of which will phase in beginning in 2026), there are other changes that will affect budgets and Medicaid beneficiaries in all states. Over time, state policymakers will need to consider whether to compensate for federal losses, pay providers less, reduce covered services or limit eligibility. For a timeline and summary of additional key provisions included in the OBBBA, see *insert*.

Limits on How States Fund Their Share of Medicaid Costs

Provider Taxes

Most states use provider taxes to fund a portion of their share of Medicaid. A provider tax is a fee that health care providers, such as hospitals or nursing homes, pay to the state. The state uses this money to fund part of its share of Medicaid, and the federal government matches it based on its established federal match rate. This helps states bring in more funding to support care for low-income patients. In fiscal year (FY) 2025, 49 states, including Kansas, and the District of Columbia used at least one provider tax, making it one of the most widely used Medicaid financing tools. While provider taxes are a common financing tool, some critics argue they inflate the amount the federal government must pay.

The OBBBA made two major changes to provider tax policy:

1. **Freezes and Limits Provider Tax Rates:**

The OBBBA freezes current provider tax rates and prohibits states from implementing new taxes unless already enacted. For Medicaid expansion states, the maximum allowable provider tax rate will gradually decrease from 6 percent to 3.5 percent by FY 2032. Non-expansion states can maintain their current provider tax rates if they are within federal limits, preserving higher thresholds within federal limits. Kansas increased the provider tax rate up to 6 percent for inpatient and outpatient hospitals (tax waiver approved for 2025). Kansas later extended this rate to include Critical Access Hospitals (CAHs) and Rural Emergency Hospitals (REHs) above a certain threshold that will be determined by the Healthcare Access Improvement Panel (HCAIP). Because the state acted before a key federal deadline, either by making a good faith effort to obtain CMS approval before May 1, 2025, or by submitting a formal request by July 4, 2025, the additional waiver to include CAHs and REHs may be approved at the increased rate under the OBBBA's grandfathering provisions.

2. **Establishes Stricter Federal Criteria:**

To qualify for federal matching funds, provider taxes must meet several conditions, including being broad-based, uniform and generally redistributive, meaning the tax burden and benefits should be spread across providers. The OBBBA tightens the definition of "generally redistributive," limiting states' ability to design taxes that disproportionately benefit the providers paying them. These stricter rules apply to both new waivers and existing waivers when they come up for renewal, reducing state flexibility in financing Medicaid.

Provider Tax Rates in Kansas:

- **Hospitals:** Approved for up to 6 percent for 2025. The Healthcare Access Improvement Panel (HCAIP) determines the distribution of funds generated from this provider tax. In 2024, the 3 percent provider tax generated $193.8 million, resulting in $313.8 million in federal funds.
- **Other Facilities:** Under the Quality Care Assessment, nursing facilities with more than 45 beds are taxed at $4,908 per licensed bed. Other facilities, including continuing care retirement communities, facilities with 45 or fewer skilled nursing beds and high Medicaid volume providers offering multiple levels of care, are taxed at $818 per bed. In SFY 2024, this tax generated $27 million, resulting in $40.5 million in federal funds.

Potential Impacts

- The grandfathering provisions in the OBBBA allow Kansas to maintain existing provider tax rates.
- As existing provider tax waivers come up for renewal, Kansas may face constraints under the OBBBA's stricter rules due to the new definition of generally redistributive.

State-Directed Payments

State-directed payments (SDPs) help offset low base Medicaid provider rates and maintain access to care. The legislation caps SDPs at 100 percent of Medicare rates in expansion states and 110 percent in non-expansion

Figure 1. **State-Directed Payments in Kansas**

State-Directed Payments	Description	Status	Funding Source
Academic Medical Centers	For professional services delivered by licensed providers at an academic medical center (i.e., large public teaching hospital, such as the University of Kansas Hospital and the University of Kansas School of Medicine-Wichita Medical Practice Association) of up to $16 million.	Approved	Intergovernmental Transfer
Border City Children's Hospital and Academic Medical Center	For pay for performance incentives for the University of Kansas Hospital System and Children's Mercy Hospital, and inpatient and outpatient services of up to $30 million per year for a total of $60 million.	Approved	Intergovernmental Transfer and State General Fund
Border City Children's Hospital and Academic Medical Center	Uniform percentage increase for outpatient services at the University of Kansas Hospital System and Children's Mercy Hospital.	Pending Approval	Intergovernmental Transfer and State General Fund
Inpatient and Outpatient Hospitals	For inpatient and outpatient hospital services provided by general hospitals, not including state-owned hospitals incorporated outside the managed care capitation rates.	Pending Approval	Provider Tax

Note: State Directed Payments (SDPs) for the Border City Children's Hospital apply to Children's Mercy Hospital in Missouri. Children's Mercy Hospital located in Kansas receives SDPs through the Inpatient and Outpatient general hospital category.

Source: Kansas Health Institute analysis of the Centers for Medicare and Medicaid Services Approved State-Directed Payment Preprints and data provided by the Kansas Department of Health and Environment.

states, like Kansas. SDPs, when funded by provider taxes or other nonfederal funds, such as intergovernmental transfers, enable states to draw down federal matching funds when requiring managed care organizations (MCOs) to pay enhanced rates to certain providers, including hospitals, behavioral health centers and critical access hospitals (CAHs).

SDPs in Kansas

Kansas uses SDPs to enhance Medicaid payments for providers. In 2025, the state directs payments to support services at inpatient and outpatient hospitals, academic medical centers and Children's Mercy Hospital. See *Figure 1* for details.

Potential Impacts

- Beginning Jan. 1, 2028, Kansas must reduce all state-directed payments (SDPs) that exceed 110 percent of Medicare rates by 10 percentage points annually, including grandfathered payments. With SDP rates in Kansas projected to exceed 200 percent of Medicare by 2028, hospitals are expected to see a decline in SDP-related revenue as phased reductions take effect. By 2038, these payments must be fully phased down which may require Kansas to find alternative funding sources or adjust Medicaid payment strategies.

Enrollment and Administrative Changes

Medicaid enrollees in Kansas may be affected by the following new eligibility and enrollment procedures required under the OBBBA:

- The period in which Medicaid enrollees can retroactively enroll in Medicaid after a qualifying event is shortened, reducing it from 90 days to 60 days for traditional Medicaid populations, and from 90 to 30 days for expansion enrollees.
- States now have to conduct quarterly deceased status checks and disenroll beneficiaries and providers found to be deceased.
- The Department of Health and Human Services (HHS) must create a system to detect and prevent people from being enrolled in Medicaid in more than one state. States must submit social security numbers, verify addresses and remedy the case if duplicate enrollment is found.

Potential Impacts

- The changes to retroactive coverage requirements could lead to barriers to enrollment, including coverage disruptions, particularly for individuals with unstable incomes, those in long term-care facilities or applications that are pending for a longer period of time.
- The state may face additional administrative burdens due to increased enrollment verification procedures and requirements.

Changes Related to Medicaid Expansion

The OBBBA resulted in major changes to the federal funding available to states for Medicaid expansion. In Kansas, adults age 19–64 without children are not eligible for Medicaid even if their income is $0, unless they qualify because of pregnancy, disabilities or specific health conditions. Because Kansas is one of 10 states that has not expanded Medicaid, the changes included in the OBBBA make expansion less financially viable.

Eliminates Enhanced FMAP for New Expansion States

After enactment of the American Rescue Plan Act (ARPA) in 2021, non-expansion states that chose to adopt Medicaid expansion received an additional 5-percentage-point increase in their regular federal Medicaid match rate (FMAP) for two years. However, the OBBBA eliminated this incentive, meaning states such as Kansas that have not yet expanded Medicaid will no longer be eligible to receive this boost. The incentive has played a key role in encouraging expansion in states such as North Carolina.

Potential Impacts:

- According to recent analysis by KHI, Kansas would have received $542 million for choosing to expand Medicaid, which would have covered approximately nine years of net state expansion costs.
- With the incentive no longer available to Kansas, expanding Medicaid is less financially viable and may lead to slower or stalled expansion decisions.

Establishes Work Requirements and Cost Sharing for Expansion Enrollees

Beginning Dec. 31, 2026, the OBBBA mandates work requirements for Medicaid expansion enrollees age 19–64 or another similar waiver group approved by CMS. To maintain coverage, individuals must complete at least 80 hours per month of work, job training, volunteering or other qualifying activities. Exemptions apply for pregnant and postpartum individuals, people with disabilities, Native Americans, caregivers, the medically frail and those experiencing hardship. Data show that nearly two-thirds of non-elderly adult Medicaid enrollees work full or part time. It also introduces cost-sharing for expansion adults earning 100–138 percent of the federal poverty level. Starting Oct. 1, 2028, states must charge up to $35 per medical visit (with a 5 percent household income cap). Cost-sharing exemptions include primary, prenatal, pediatric, emergency and mental health care in addition to substance use treatment, and visits to certain community health centers.

Potential Impacts:

- Because Kansas has not expanded Medicaid, enrollees will not be subject to work, reporting and cost-sharing requirements. If it does expand Medicaid in the future, enrollees in the expansion population would be subject to these requirements.
- Medicaid expansion states may face coverage losses from work requirements due to reporting challenges, straining state resources and increasing costs. Cost-sharing rules could also raise out-of-pocket expenses, affecting access to care. For more information, see KHI's analysis on other states' experiences with implementing work requirements under Medicaid.

Conclusion

Together, the policy changes in the OBBBA could impact access to care, administrative workload and the overall structure of Medicaid in Kansas in the years ahead. As federal Medicaid policy debates continue, Kansas must prepare for potential shifts that could impact Medicaid enrollees and their families. State policymakers may need to explore alternative funding mechanisms or state policies to address potential funding shortfalls to maintain health care access for Medicaid enrollees.

ABOUT THE ISSUE BRIEF

This brief is based on work by Sheena L. Schmidt, M.P.P. It is available online at khi.org/articles/Impacts-of-the-OBBBA-on-Medicaid-and CHIP-in-Kansas.

KANSAS HEALTH INSTITUTE

For 30 years, the Kansas Health Institute has believed evidence-based information, objective analysis and civil dialogue enable policy leaders to be champions for a healthier Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, KHI is a nonprofit, nonpartisan educational organization based in Topeka.

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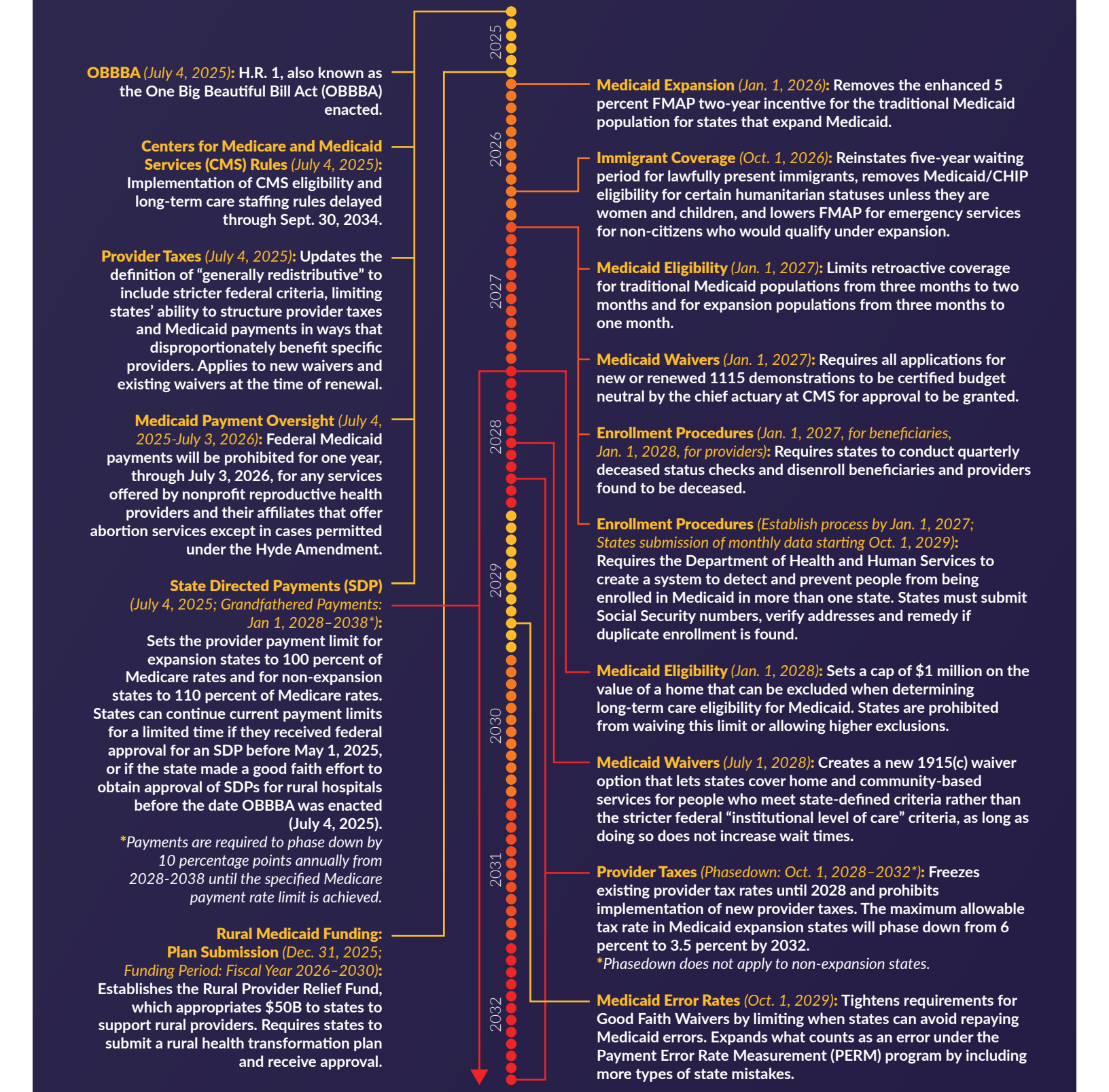
Timeline of OBBBA's Key Medicaid Provisions

Effective Dates for Changes

H.R. 1, also known as the One Big Beautiful Bill Act (OBBBA), outlines a phased timeline for numerous policy shifts that will impact Medicaid in Kansas. While some provisions take effect immediately, others are delayed allowing states time to adjust to new requirements. For more details about other provisions in the OBBBA see back of this insert. Understanding the changes and timing for implementation is critical for stakeholders as Kansas evaluates its Medicaid strategy, ranging from 2025 to 2030 and beyond.



Note: The timeline may not include all provisions that could impact Medicaid included in the OBBBA.

Source: Kansas Health Institute analysis of H.R. 1 The Omnibus Budget and Benefits Balance Act, also known as the One Big Beautiful Bill Act (OBBBA), 2025.

Other Medicaid Provisions in OBBBA

In addition to changes to how states finance their share of Medicaid, enrollment procedures and funding available for Medicaid expansion, the OBBBA includes several other provisions that will affect how Kansas administers its Medicaid program. These include delays to new federal rules, changes to waivers and restrictions on certain Medicaid payments, among others. Please see below for details.

Waivers and Spending Rules

- Requires the CMS Chief Actuary to certify that 1115 waivers are budget neutral, meaning they will not increase federal spending. It also includes requirements for how savings from these waivers can be used if a state wants to renew the program.

Delayed Medicaid Rules

- Delays implementation of two CMS rules until Jan. 1, 2035, that would:
  - Require higher staffing levels in nursing homes and more reporting.
  - Simplify Medicaid enrollment by reducing paperwork and automating eligibility checks.

Home and Community Based Services (HCBS)

- Creates a new 1915(c) waiver option beginning in 2028 that lets states cover HCBS for people who meet state-defined criteria rather than the stricter federal "institutional level of care" criteria, if doing so does not increase wait times. Federal funds will support implementation, but many states, including Kansas, may face barriers due to existing waitlists.

Medicaid Payment Oversight

- Beginning in 2030, if states make too many incorrect payments (such as covering ineligible individuals), their federal Medicaid funding may be reduced.
- Federal Medicaid payments will be prohibited for one year, through July 3, 2026, for any services offered by nonprofit reproductive health providers and their affiliates that offer abortion services except in cases permitted under the Hyde Amendment (rape, incest or life endangerment of the pregnant person).

Immigrant Coverage

- Effective Oct. 1, 2026, the OBBBA reinstates a five-year waiting period for lawfully present immigrants, including children and pregnant women, before they can enroll in Medicaid or CHIP. Under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, states had the option to eliminate the five-year waiting period for lawfully present immigrants, including children and pregnant women, before they could enroll in Medicaid or CHIP. The OBBBA reinstates the five-year waiting period for these individuals, which aligns with existing Kansas policy.
- Effective Oct. 1, 2026, refugees, asylees, humanitarian parolees and individuals with temporary protected status are no longer eligible for Medicaid or CHIP (unless they are pregnant women or children).
- Effective Oct. 1, 2026, the federal match (FMAP) for emergency Medicaid services provided to non-citizens who would otherwise qualify for Medicaid expansion will be reduced from the 90 percent expansion rate to the state's regular Medicaid match rate. This provision does not currently apply to Kansas, as the state has not expanded Medicaid.

Medicaid Funding for Rural Providers

- The OBBBA established the Rural Health Transformation Program, which appropriates $50 billion over five years to states to support rural providers. It requires states to submit a rural health transformation plan by Dec. 31, 2025, and receive approval for the funding period (federal FY 2026–2030).