



WA Tribal Impacts under OBBBA: Medicaid

Last Updated 10-31-25

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Overview and Call to Action

Overview. On July 4, 2025, President Donald J. Trump signed into law the [One Big Beautiful Bill Act](#) (OBBBA). This bill will impact almost every household and industry across multiple areas including health care with almost \$1 trillion in cuts to Medicaid and an estimated 10 million individuals losing their health care coverage over the next decade.¹ While the legislation includes a small number of exemptions for American Indians and Alaska Natives (AI/AN), OBBBA's impacts on Tribes, Indian health care providers (IHCPs), and the communities they serve will be detrimental if left unmitigated. These potential impacts include:

1. *Reduced Health Care Coverage for AI/AN and IHCP Patients*
2. *Loss of Jobs and Increased Workforce Shortages in Indian Country*
3. *Reduction in Tribal and IHCP Funds*
4. *Reduced Access to Specialty Care Providers*
5. *Increased Administrative Burden to Tribal and IHCP Staff*

Call to Action. Washington State and Tribes can work together to mitigate the harmful impacts to Tribes and AI/AN communities. The American Indian Health Commission (AIHC) created this living document to provide a [detailed analysis](#) of OBBBA Medicaid provisions as well as possible [strategies](#) for Tribes and IHCPs to consider when collaborating with Washington State agencies on the implementation of this legislation. AIHC will update this document periodically on the [AIHC website](#). We invite Tribes, Urban Indian Health Organizations, and others to provide recommended edits and suggestions to this document at vicki.lowe@aihc-wa.com.

¹ Estimates are based on the Kaiser Family Foundation analysis of the Congressional Budget Office's cost estimate published on July 21, 2025 at <https://www.cbo.gov/publication/61570>. See Kaiser Family Foundation, "[Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline](#)," July 23, 2025.



Timeline and 8 Key Impacts Affecting Tribal Health Care and Medicaid Under OBBBA*

*One Big Beautiful Bill Act

Last Updated 10-31-25

July 4, 2025



Delay on CMS Rules on Eligibility for MSPs and Medicaid ([§ 71101](#) and [§ 71102](#))

WHAT IT DOES: Delays the implementation of regulations designed to simplify health care enrollment for low-income individuals.

IMPACT: Fewer individuals expected to enroll in or maintain Medicaid, CHIP, and the Medicare Savings Program as a result.

July 4, 2025



Limits on State-Directed Payment ([§ 71116](#))

WHAT IT DOES: Limits state-directed payments (SDPs) that require managed care organizations to make certain types of payments to health care providers as a way to increase provider payment rates to increase access to quality of care.

IMPACT: Long-term funding shortfalls for hospitals from state budgets and increased difficulty in state budget forecasting.

Oct. 1, 2025



Opportunity for Rural Transformation Funds ([§ 71401](#))

WHAT IT DOES: Establishes a rural health transformation program that will provide \$50 billion in grants to states to be used for payments to rural health care providers and other purposes.

IMPACT: Washington State can use funds under this program for payments to certain health care providers, including Tribal FQHCs.

Dec. 31, 2026



More Frequent Eligibility Determinations ([§ 71107](#))

WHAT IT DOES: Increases eligibility redeterminations to every 6 months for Medicaid expansion adults (currently 12 months)

IMPACT: AI/AN are exempt from new 6-month redeterminations. Could negatively impact mixed AI/AN status families.

Jan. 1, 2027



Work Requirements ([§ 71119](#))

WHAT IT DOES: Most of the Medicaid expansion population will be required to complete 80 hours of community engagement (aka "Work Requirements") to qualify for Medicaid initially or maintain eligibility.

IMPACT: American Indians/Alaska Natives (AI/AN) are exempt from this requirement. Could negatively impact mixed AI/AN status families.

Jan. 1, 2027



Shortening Retroactive Medicaid Coverage ([§ 71112](#))

WHAT IT DOES: Limits retroactive Medicaid coverage (or Medicaid coverage for qualified medical expenses incurred prior to the date of application for coverage) to one month prior to application for expansion enrollees and two months prior to application for traditional enrollees.

IMPACT: Increased care costs and potentially creating gaps for those facing new circumstances like childbirth.

Jan. 1, 2027



Verification of Address and Other Information ([§ 71103](#))

WHAT IT DOES: Requires states to regularly submit enrollees' social security number (SSN) to a national system created and maintained by Health and Human Services (HHS). Also requires states to verify enrollee addresses to prevent individuals from being enrolled in multiple states.

IMPACT: Increase in privacy concerns regarding the centralization and use of an individual's personal information.

Oct. 1, 2028



Cost Sharing ([§ 71120](#))

WHAT IT DOES: Will require state plans to impose cost-sharing of up to \$35 for most of the Medicaid expansion population whose income is between 100%-138% FPL. Additional services exempt from cost sharing include, but are not limited to, primary care and behavioral health services.

IMPACT: Items or services furnished to AI/AN through Indian Health Programs or through referral under contract health services are exempt from this cost sharing requirement.



9 Strategies to Reduce Loss of Health Care Coverage and IHCP Funds under OBBBA*

*One Big Beautiful Bill Act

Last Updated 10-31-25

Medicaid is a crucial component of the United States' social safety net. The One Big Beautiful Bill Act (OBBBA) will have devastating impacts on the future of Medicaid for Tribes, Indian health care providers (IHCPs), and American Indians and Alaska Natives (AI/AN). As Washington State begins its efforts to implement this legislation, the State and Tribes can use their longstanding history of working together to prevent and mitigate harm to Tribal and native communities. This document provides 9 possible strategies Tribes and Washington State can employ sooner than later in responding to OBBBA. We invite Tribes, Urban Indian Health Organizations (UIHOs), and others to provide additional strategies for inclusion in this document to vicki.lowe@aihc-wa.com.

1. Conduct Ongoing Consultation and Collaboration with Tribes and IHCPs on OBBBA's Impacts. Even with OBBBA's limited AI/AN exemptions, the legislation's massive restructuring of the Medicaid program will have severe impacts on state and Tribal health systems including the staffing that supports the Medicaid program. Tribes, IHCPs and Washington State can work together to ensure AI/AN access to Medicaid benefits and protect the federal trust responsibility to provide health care to Tribes and AI/AN. This partnership can be achieved by formal consultation and collaboration through the Health Care Authority's (HCA) Monthly Tribal Meetings and the Governor's Indian Health Advisory Council.

2. Enhance and Support Tribal Assisters. Tribal assisters will continue to play a significant role in maintaining AI/AN enrollees in Medicaid. Tribes employ over 150 Tribal assisters across Washington State, many with decades of experience enrolling thousands of state residents. Washington State agencies and the Governor's Office should work directly with Tribal Assisters to develop and implement strategies for maintaining Medicaid enrollees including, but not limited to, the following:

- **Provide Tribal Assisters Access to Income Verification in WA Healthplanfinder.** The current lack of income verification has created a backlog in Medicaid applications from being processed or renewed. Allowing Tribal Assisters to conduct income verification/redeterminations will reduce this backlog and prevent loss of Medicaid coverage.
- **Provide Tribal Assisters Eligibility Determination Services Training.** Ensuring Tribal assisters receive the same training as the HCA MEDS (Medical Eligibility Determination Services) staff will help expedite verification of income and other required information, reduce the administrative burden on HCA staff, and keep eligible people on coverage.

3. Advocate for Inclusion of IHCPs in the State Application for Rural Health Transformation Funds. HCA should hold a Tribal consultation regarding the inclusion of

Tribes and IHCPs when applying for funds under the Rural Health Transformation Program and any other available funds that support Tribal health care.

- 4. Inform and Train Tribal and IHCP Staff Including Tribal Assistors on Key Changes to State Medicaid Redetermination Systems.** This includes making sure training modules are updated with WA Healthplanfinder for AI/AN and IHCP specific provisions in OBBBA.
- 5. Develop and Implement Social Media and Communications Outreach Regarding Medicaid Enrollment.** The State should collaborate with Tribes on the development of social media and Ad campaigns for Medicaid retention efforts including education regarding the AI/AN exemption from work requirements and cost sharing for services received at an IHCP or through referral from an IHCP.
- 6. Enhance State Monitoring and Enforcement of Managed Care Organization Compliance with Federal and State Protections for IHCPs and AI/AN.** This includes HCA adopting guidance similar to the OIC-AIHC "[Federal and State Legal Protections for American Indian/Alaska Native Enrollees and Indian Health Care Providers](#)" document. Such guidance will help mitigate the anticipated rise in unlawful reimbursement denials to IHCPs under OBBBA.
- 7. Increased Efforts to Expand the Use and Functionality of Electronic Health Record Systems for IHCPs.** Provide support to IHCPs to expand electronic health records' use and functionality to help alleviate anticipated increases in administrative burdens and reduction of health coverage and specialty care services to IHCP patients.
- 8. Enhance the Indian Health Delivery System to Increase Participation by AI/AN Enrolled in Medicaid.** The State should collaborate with Tribes and IHCPs to improve the State Medicaid systems of care for non-natives served by IHCPs and increase the number of AI/AN served by IHCPs. Strategies for this could include:
 - Leveraging telemedicine to serve AI/AN outside the Indian health care delivery area;
 - Increasing care coordination agreements to bring more specialty care providers into the Indian health care delivery system through the Medicaid program; and
 - Executing lease agreements between IHCP and inpatient facilities. These lease agreements can be used to leverage the federal Medicaid match for services provided to AI/AN.
- 9. Maintain Tribal and IHCP Workforce.** In response to the expected increased staff responsibilities and reduction in funds resulting from OBBBA, Tribes, and IHCPs may want to consider strategies to maintain current Tribal staff. In the AIHC COVID-19 After-Action interviews, several Tribes and IHCPs reported staff burnout as one of their biggest challenges in responding to the pandemic. Some Tribes and IHCPs reported that staff knowing they had support from Tribal council and administration as well as employee appreciation activities (e.g. food truck parked outside Tribal clinic) was critical for staff remaining with the Tribe through difficult times.



WA Tribal Impacts and Action Steps under OBBBA Medicaid Provisions: A Detailed Review

TOPIC	SUMMARY	EFFECTIVE DATE	TRIBAL IMPACTS/ACTION STEPS
MEDICAID EXPANSION			
<p>Cost-Sharing Requirements §71120</p>	<ul style="list-style-type: none"> • Eliminates enrollment fees or premiums for expansion adults. • Requires states to impose cost sharing of up to \$35 per service on expansion adults with incomes 100-138% FPL; explicitly exempts primary care, mental health, and substance use disorder services from cost sharing, maintains existing exemptions of certain services from cost sharing, and limits cost sharing for prescription drugs to nominal amounts. • Maintains the 5% of family income cap on out-of-pocket costs. • Exempts services provided by federally qualified health centers, behavioral health clinics, and rural health clinics* <p>*SOURCE: “Health Provisions in the 2025 Federal Budget Reconciliation Bill, ” Kaiser Family Foundation, July 8, 2025</p>	<p>Oct 1, 2028</p>	<p>AI/AN OR IHCP SPECIFIC PROVISIONS <u>Items or services furnished to AI/AN through Indian Health Programs or through referral under contract health services are exempt from cost sharing under § 71120.</u></p> <p>NOTE: The new language specifically provides that exemptions from cost sharing under 42 U.S.C. § 1396o(j) shall remain. 42 U.S.C. § 1396o(j) provides that no cost sharing “shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.”</p> <p>POTENTIAL ISSUES/QUESTIONS</p> <ul style="list-style-type: none"> • AI/AN status can be met through self-attestation https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Information-for-AIANs-Appling-for-Coverage2017.pdf • Many AI/AN individuals may not know about the exemption or have inaccurate Medicaid information and not enroll in Medicaid as a result. This may result in individuals delaying or forgoing care. Education will be critical

			<ul style="list-style-type: none"> • Many IHCPs serve non-AI/AN who may be seeking services that are not exempt from cost-sharing requirements. This may result in individuals delaying or forgoing care • Tribes may want to consider having a Tribal FQHC affiliated agreement in place to ensure coverage for AI/AN specialty care
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ELIGIBILITY POLICIES			
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<p>“Community Engagement Requirements” (AKA Work Requirements) §71119</p>	<p>Requires states to establish community engagement requirements as a condition of eligibility for able-bodied adults between 19 and 64 years old. Requires 80 hours of work or equivalent qualifying activity in the month(s) preceding eligibility determinations and between redeterminations. Includes mandatory and optional exceptions, expectations for state communication and verification processes, and grants to states for creating needed systems.*</p> <p>Exemptions. Individuals who are exempt from community engagement requirements (§71119(a)(9)(ii)):</p> <ol style="list-style-type: none"> 1. <i>American Indian/Alaska Natives (AI/AN)</i> as defined in the Indian Health Care Improvement Act (IHCIA), §4(13) and (28), §809(a) or deemed eligible as an Indian for Indian Health Service (IHS) under Health and Human Services (HHS) regs. 2. <i>Parents/guardians/caretakers of dependent child under the age of 13 or a disabled individual</i> 3. <i>Disabled veteran</i> 4. <i>Medically frail</i> or otherwise has a special need including following individuals: <ul style="list-style-type: none"> ○ Blind/Disabled ○ Has a substance use disorder ○ Has disabling mental disorder ○ Has a physical, intellectual, or developmental disability that meets certain conditions 	<p>HHS must promulgate guidance by June 1, 2026. States must establish community engagement requirements beginning Jan 1, 2027. (With the exception of one year delay for hardship good faith effort if granted by the HHS Secretary)</p>	<p>AI/AN OR IHCP SPECIFIC PROVISIONS AI/AN exempt from work requirements (Indian as defined in IHCIA, §4(13) and (28), §809(a) or deemed eligible as an Indian for IHS under HHS regs) See §71119(a)(xx)(9)(A)(ii)(II).</p> <p>GENERAL WA STATE IMPACTS <u>According to HCA</u>, more than 620,000 adults would be at risk of losing or delaying coverage due to administrative red tape. Assuming similar experiences from other states, an estimated 187,000 Washington adults will lose Medicaid coverage.</p> <p>POTENTIAL ISSUES/QUESTIONS</p> <ul style="list-style-type: none"> • AI/AN status can be met through self-attestation https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Information-for-AIANs-Applying-for-Coverage2017.pdf • Many AI/AN individuals may not know about the exemption or have inaccurate Medicaid information and not enroll in Medicaid as a result. Education will be critical
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	<ul style="list-style-type: none"> ○ Has a serious or complex medical condition 5. <i>Entitled to Medicare Part A/Enrolled in Medicare Part B</i> 6. <i>Meeting SNAP/TANF requirements</i> 7. <i>Participating in SUD treatment program as defined in §3(h) of the Food and Nutrition Act</i> 8. <i>Inmate of a public institution</i> 9. <i>Pregnant or receiving postpartum coverage*</i> <p>OTHER NOTES Seasonal workers meet requirements if average monthly income meets specified standard §71119(a)(2)(G).</p> <p>*SOURCE: “Health Provisions in the 2025 Federal Budget Reconciliation Bill,” Kaiser Family Foundation, July 8, 2025</p>		<ul style="list-style-type: none"> ● Mixed AI/AN families may have non-AI/AN family members who are subject to work requirements ● Many Indian health care providers (IHCP) serve non-natives. This provision may impact those patients and IHCP funds <p>ACTION STEPS</p> <ul style="list-style-type: none"> ● Work with HCA and WHBE to ensure current self-reporting process for verifying AI/AN status will continue under OBBBA ● Conduct education and outreach to ensure AI/AN correctly indicate their AI/AN status in state databases ● Evaluate current WA Tribal assister access and ensure they have the ability to verify income for conducting eligibility determinations. Expanding Tribal assister capabilities will reduce administrative burden to the state
<p>Eligibility Determinations (AKA Redeterminations) §71107</p>	<ul style="list-style-type: none"> ● Requires states to conduct eligibility redeterminations at least every 6 months for Medicaid expansion adults (previously was every 12 months) 	<p>Not later than December 31, 2026, or earlier at state option</p>	<p>AI/AN OR IHCP SPECIFIC PROVISIONS AI/AN exempt from new 6-month redeterminations (Indian as defined in IHCIA, §4(13) and (28), §809(a) or deemed eligible as an Indian for IHS under HHS regs). See §71119(xx)(9)(A)(ii)(II)</p> <p>GENERAL WA STATE IMPACTS According to HCA, the new eligibility redeterminations:</p> <ul style="list-style-type: none"> ● Impacts 620,000 adults enrolled in Apple Health

			<ul style="list-style-type: none"> • Will likely lead to thousands of individuals losing coverage. 80-85% of population automatically renews, but 15% of population who needs active management will drive significant staffing <p>POTENTIAL ISSUES/QUESTIONS</p> <ul style="list-style-type: none"> • AI/AN status can be met through self-attestation. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Information-for-AIANs-Appling-for-Coverage2017.pdf • Many Indian health care providers (IHCP) serve non-natives. This provision may impact those patients and IHCP funds. • Will the WA State AI/AN verification process including self-attestation remain the same? • Will verification of AI/AN status continue to be processed through Washington Healthplanfinder? <p>ACTION STEPS</p> <ul style="list-style-type: none"> • Work with HCA and WHBE to preserve current process for verification of AI/AN status
<p>Retroactive Coverage §71112</p>	<ul style="list-style-type: none"> • Limits retroactive coverage to one month prior to application for coverage for expansion enrollees and two months prior to application for coverage for traditional enrollees.* 	<p>January 1, 2027</p>	<p>AI/AN OR IHCP SPECIFIC PROVISIONS No AI/AN exemption</p> <p>GENERAL WA STATE IMPACTS None yet specified by HCA. However, according to Congress.Gov, this provision will result in several billion dollars in cuts to Medicaid over the</p>

	<p>*SOURCE: “Health Provisions in the 2025 Federal Budget Reconciliation Bill,” Kaiser Family Foundation, July 8, 2025</p>		<p>next ten years. https://www.congress.gov/crs-product/R48569</p> <p>POTENTIAL ISSUES/QUESTIONS</p> <ul style="list-style-type: none"> • Reduced AI/AN enrollment and reduction of funds for IHCPs • Could increase reliance on already limited IHS funds and decrease Medicaid compensated care for IHCPs and patients, as services rendered in earlier months may no longer be covered <p>ACTION STEPS</p> <ul style="list-style-type: none"> • Conduct education and outreach to encourage AI/AN communicate regularly with their Tribal assisters to ensure no lapses in coverage
<p>Verifying Enrollee Address and Other Information §71103, §71104</p>	<ul style="list-style-type: none"> • Requires states to obtain enrollee address information using reliable data sources, including the National Change of Address Database and managed care entities. <i>Provides discretion to Secretary to determine if a State is not required to have in operation an eligibility determination system which provides for data matching.</i> §71103 • Requires the Secretary to establish a system to share information with states for purposes of preventing individuals from being simultaneously enrolled in two states and requires states to submit monthly enrollee SSNs and other information to the system. §71103 • Requires states to review the Death Master File at least quarterly to determine if any enrolled individuals are deceased. §71104* 	<p><u>January 1, 2027</u> for states to obtain contact information;</p> <p><u>October 1, 2029</u> to establish system to prevent enrollment in two states simultaneously;</p> <p><u>January 1, 2027</u> to review Master Death File</p>	<p>AI/AN OR IHCP SPECIFIC PROVISIONS No AI/AN exemption</p> <p>GENERAL WA STATE IMPACTS None yet specified by HCA. However, CBO estimates this provision will reduce federal Medicaid spending by \$17 billion over 10 years. According to the Kaiser Foundation, “This provision is not expected to impact the number of people who are uninsured.”</p> <p>POTENTIAL ISSUES/QUESTIONS</p> <ul style="list-style-type: none"> • Increase in sensitive Tribal data possibly being accessed by federal agencies using the data for non-health purposes (See Washington State Sues Trump Administration)

	<p>*SOURCE: “Health Provisions in the 2025 Federal Budget Reconciliation Bill,” Kaiser Family Foundation, July 8, 2025</p>		<p><i>for Illegally Sharing Personal Health Data with ICE</i></p> <ul style="list-style-type: none"> Concern that Washington Healthplanfinder might not be the system to collect this data and instead WA will have to submit data into federally created database. See §77103 <p>ACTION STEPS</p> <ul style="list-style-type: none"> Work with the HCA and WHBE to ensure that Tribal data is protected from wrongful use by federal agencies
<p>Delays CMS Rules on Eligibility and Enrollment for Medicaid and Medicare §71101 §71102</p>	<p>§71101. Delays the implementation of a CMS rule that reduces barriers to enrollment in Medicare Savings Programs (MSPs), which provides Medicaid coverage of Medicare premiums and cost sharing for low-income Medicare beneficiaries. The HHS Secretary is prohibited from implementing, administering, or enforcing this rule until October 1, 2034.*</p> <p>§71102. Delays the implementation of a CMS rule that streamlines application and enrollment processes in Medicaid, aligns renewal policies for all Medicaid enrollees, facilitates transitions between Medicaid, CHIP, and subsidized Marketplace coverage, and eliminates certain barriers in CHIP. Implementation deadlines for states vary across provisions but many provisions are already in effect, and for others, states are already in compliance. Implementation deadlines for states vary across provisions but many provisions are already in effect, and for others, states are already in compliance. The HHS Secretary is prohibited from implementing, administering, or enforcing this rule until October 1, 2034.*</p> <p>*SOURCE: “Health Provisions in the 2025 Federal Budget Reconciliation Bill,” Kaiser Family Foundation, July 8, 2025</p>	<p>July 4, 2025</p>	<p>AI/AN OR IHCP SPECIFIC PROVISIONS No specific language re AI/AN or IHCPs</p> <p>GENERAL WA STATE IMPACTS None yet specified by HCA.</p> <p>POTENTIAL ISSUES/QUESTIONS</p> <ul style="list-style-type: none"> Possibly a role back and negative impact on people currently on coverage, causing them to lose coverage Delaying the CMS rule to 2034 will significantly impact individuals who have treaty income. The MSPs benefit AI/AN who do not pay federal income, social security or Medicare taxes on treaty rights income. The OBBBA prohibition on the CMS Eligibility and Enrollment Final Rule means these AI/AN will not be eligible for Medicare Part A for free if they don't qualify for MSP. As a result, the Tribal PRC program (or the person if they are not eligible for PRC) will need to pay their Part

			<p>A premium (\$585/mo) or pay the cost of their care.</p> <ul style="list-style-type: none"> • Lost opportunity provided by the now prohibited Medicaid eligibility rule to increase enrollment of dual-eligible individuals <p>ACTION STEPS</p> <ul style="list-style-type: none"> • Work with HCA to determine how many AI/AN in Washington might be impacted by this provision
FINANCING			
<p>Provider Taxes §71115, §71117</p>	<p>Freezes the current provider tax thresholds for all states for two years and reduces the allowable level of provider taxes for expansion states by 0.5% each year until it reaches 3.5% in FY 2032. New limit applies to taxes on all providers except nursing facilities and intermediate care facilities.*</p> <p>*SOURCE: “Health Provisions in the 2025 Federal Budget Reconciliation Bill,” Kaiser Family Foundation, July 8, 2025</p>	<p>July 4, 2025</p>	<p>WA is not among the 22 states that may be affected by this since WA’s tax threshold is below 3.5%. See KFF, Which States Might have to Reduce Provider Taxes Under the Senate Reconciliation Bill?</p>
<p>State-Directed Payments §71116</p>	<p>Sets the payment limit for state-directed payments to 110% of Medicare rates for non-expansion states and 100% of Medicare rates for expansion states. For states that newly expand Medicaid, all state-directed payments will be subject to this provision, even if previously approved. Existing state-directed payment limits would be reduced by 10% annually to reach the Medicaid allowable rate.*</p> <p>*SOURCE: “Health Provisions in the 2025 Federal Budget Reconciliation Bill,” Kaiser Family Foundation, July 8, 2025</p>	<p>July 4, 2025</p>	<p>AI/AN OR IHCP SPECIFIC PROVISIONS No specific language re AI/AN or IHCPs</p> <p>GENERAL WA STATE IMPACTS According to HCA, existing SDPs supporting hospital services, which include the Hospital Safety Net Assessment and payments to the University of Washington will be reduced by over \$1.5 billion annually, once fully reduced.</p> <p>POTENTIAL ISSUES/QUESTIONS</p> <ul style="list-style-type: none"> • Washington does not have an IHS run hospital and must rely on the state hospital system for the most expensive care. Any reduction to WA state hospitals will have

			impacts for AI/AN especially those located in rural areas
Reduction of Good Faith Waiver Related to Certain Erroneous Medicaid Payments §71106	<p>Requires HHS to reduce federal financial participation to states for identified improper payment errors related to payments made for ineligible individuals and overpayments made for eligible individuals.</p> <p>Expands the definition of improper payments to include payments where insufficient information is available to confirm eligibility.*</p> <p>*SOURCE: “Health Provisions in the 2025 Federal Budget Reconciliation Bill,” Kaiser Family Foundation, July 8, 2025</p>	Beginning FY 2030	<p>AI/AN OR IHCP SPECIFIC PROVISIONS No specific language re AI/AN or IHCPs</p> <p>GENERAL WA STATE IMPACTS HCA has yet to specify impacts. However, the Congressional Budget Office (CBO) estimates this provision will reduce federal investment in Medicaid programs by over \$7.7 billion over 10 years. https://www.congress.gov/crs-product/R48569</p>

RURAL HEALTH FUNDING (INCLUDES FQHCS)

Rural Health Transformation Program §71401	<p>Establishes a rural health transformation program that will provide \$50 billion in grants to states between fiscal years 2026 and 2030, to be used for payments to rural health care providers and other purposes.</p> <p>USE OF FUNDS. —Amounts allotted to a State under this subsection shall be used for 3 or more of the following health-related activities:</p> <p>(A) Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.</p> <p>(B) Providing payments to health care providers for the provision of health care items or services, as specified by the Administrator.</p>	<p>October 1, 2025</p> <p>Date funds become available; CMS to determine state application deadline, which will be no later than December 31, 2025.</p>	<p>AI/AN OR IHCP SPECIFIC PROVISIONS Washington State can use funds under this program for payments to certain health care providers, including FQHCs. Tribes are considered FQHCs. See §71401(a)(h)(3)(D)(viii).</p> <p>See also definitions of FQHCs under SSA, §1896(aa)(4).</p> <p>ACTION STEPS</p> <ul style="list-style-type: none"> State needs to include Tribes/IHCPs when applying for funds under the Rural Health Transformation Program under §71401
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(C) Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.

(D) Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.

(E) Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.

(F) Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.

(G) Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.

(H) Supporting access to opioid use disorder treatment services (as defined in section 1861(jjj) (1)), other substance use disorder treatment services, and mental health services.

(I) Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.

(J) Additional uses designed to promote sustainable access to high quality rural health care services, as determined by the Administrator.*

*SOURCE: “[Health Provisions in the 2025 Federal Budget Reconciliation Bill](#),” Kaiser Family Foundation, July 8, 2025

IMMIGRANT COVERAGE

- **Emergency Medicaid FMAP** (§ 71110). Reduces the FMAP for emergency Medicaid services provided to “unlawfully present aliens” that would otherwise qualify for Medicaid expansion to the standard FMAP, rather than the expansion FMAP of 90%.
- **Medicaid Eligible Populations** (§ 71109). Limits Medicaid eligibility to US citizens, lawful permanent residents, certain Cuban or Haitian immigrants, and individuals living in the US through a compact of free association.
- **Marketplace Eligible Populations** (§ 71301). Limits premium tax credit eligibility for lawfully present immigrants to only a category of “eligible alien,” which is defined as: an individual who is an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act; an alien granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association.
- **Medicare Eligible Populations** (§ 71201). Limits Medicare eligibility to only citizens or individuals lawfully admitted for permanent residence under the Immigration and Nationality Act; an alien granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association.
- **Tax Credit Eligibility for Individuals Subject to the 5-year bar** (§ 71302). Prohibits premium tax credits for individuals under 100% FPL subject to the 5-year bar under Medicaid.*

*SOURCE: “[Health Provisions in the 2025 Federal Budget Reconciliation Bill](#), ” Kaiser Family Foundation, July 8, 2025

Oct 1, 2026

Oct 1, 2026

Jan 1, 2027

Jan 1, 2027

Jan 1, 2026

POTENTIAL ISSUES/QUESTIONS

Creates severe impacts on hospitals which AI/AN need access to. Immigrants will likely only receive care in the ER when they are sicker and will have poorer outcomes. This will be a strain on hospitals who will experience increases in uncompensated care.