MISSOURI MEDICAID: KEY CHANGES FOR PROVIDERS

Reconciliation Bill Changes – Healthcare Provider Summary

Published August 2025 | Changes effective January 1, 2027 except where noted

CLAY COUNTY PUBLIC HEALTH CENTER

Provider Tax Reduction & Funding Changes

- *Phased in 2027-2031*
- Missouri provider tax cap reduced from 6% to 3.5%—may reduce Medicaid funding to hospitals, especially rural and safety-net providers.
- Limits on supplemental and directed payments could cut DSH and uncompensated care funding.

- **Provider action:**
  - Reassess Medicaid payer mix and long-term financial planning.
  - Engage in state-level advocacy to maintain supplemental funding.

Home and Community-Based Services Impact

- Increased administrative requirements and reduced funding may expand HCBS waitlists.

- **Provider action:**
  - Notify HCBS patients about possible delays.
  - Partner with community agencies to maintain service continuity.

Anticipated Coverage Loss in MO

- Estimated 130,000–170,000 Missourians could lose coverage in first year of implementation.
- Disproportionate impact on rural areas, children, and patients with disabilities.

- **Provider action:**
  - Develop continuity-of-care plans for high-need populations.
  - Educate patients proactively about changes starting in 2026.

Resource Links

- **Missouri MO HealthNet Provider Info**: dss.mo.gov/mhd/providers
- **Provider Billing Manuals & Bulletins**: dss.mo.gov/mhd/providers/bulletins
- **Missouri Hospital Association**: web.mhanet.com
- **Cover Missouri (patient enrollment help)**: 1-800-318-2596

Key Dates for Providers

- **Now – 2026**: Update patient intake processes; train staff on upcoming changes.
- **July 1, 2026:** 6-month eligibility redeterminations begin.
- **Jan 1, 2027:** Work requirements, co-pays, and reduced retroactive coverage take effect; HCBS waitlists may grow.
- **2031:** Full provider tax cut in effect —possible financial strain on rural and safety-net hospitals.

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Work & Activity Requirements

- Medicaid expansion adults (ages 19–64, income ≤138% FPL) must complete 80 hours/month of work or qualifying activities.
- Monthly reporting required; missed reporting will trigger coverage termination.
- Likely to cause churn and coverage gaps, even for eligible patients, due to paperwork and verification delays.

- **Provider action:**
  - Implement coverage status checks at every appointment starting in late 2026.
  - Train front-line staff to ask about work reporting and exemptions.
  - Create quick referral pathways to community organizations for patients at risk of losing coverage.

Increased Eligibility Redeterminations

- *Effective July 1, 2026*
- Medicaid eligibility verification required every 6 months (previously annual).
- Many patients will lose coverage due to procedural denials (missed mail, incomplete forms).

- **Provider action:**
  - Encourage patients to update their contact information with FSD.
  - Add reminder prompts in EHR for follow-up visits during redetermination months.
  - Prepare for higher self-pay volume and assist patients with re-enrollment.

Retroactive Coverage Reduction

- Retroactive coverage window reduced to 1 month for most adults, 2 months for some groups (previously 3 months).

- **Provider action:**
  - Verify coverage before delivering non-emergency care.
  - Accelerate Medicaid applications for uninsured patients—especially those admitted to inpatient care.

New Co-Pays for Certain Adults

- Adults with income between 100–138% FPL may be charged up to $35 per service.

- **Provider action:**
  - Adjust billing systems for new co-pay collection and patient notification.
  - Prepare scripts for staff to explain co-pays to patients without discouraging care.