Changes to Medicaid in the Budget Reconciliation Law (H.R.1)

July 24, 2025

3:00 – 4:00 p.m. ET

Please stand by, this webinar will begin shortly

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

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About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this webinar was provided by the Robert Wood Johnson Foundation.
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About Manatt Health

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx.

Housekeeping Details

- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.**
- All participant lines are muted.
- A copy of the webinar transcript is available upon request. Please contact us to request a copy.
- After the webinar, the slide deck and a recording will be available at **www.shvs.org.**

Webinar Objectives

Today's Focus

Review selected **Medicaid provisions** included in the **budget reconciliation law (H.R.1)**, associated timelines for implementation, and considerations for states.*

Also Available

On July 10, SHVS hosted a webinar to review H.R.1's policies governing **Affordable Care Act (ACA) Marketplaces and private insurance.** The slides and a recording are available on www.shvs.org.

*See the Appendix for more detail on H.R.1's Medicaid provisions.

Agenda

- **Level-Setting: H.R.1 and the Law's Projected Impacts**
- **Select Medicaid Provisions and Considerations for States**
- **Discussion**

Level-Setting: H.R.1 and the Law's Projected Impacts

Overview of Health Policy Provisions in H.R.1

On July 4, the president signed the budget reconciliation legislation, H.R.1, making sweeping changes to Medicaid, the Children's Health Insurance Program (CHIP), and ACA Marketplaces.

TODAY'S FOCUS: Medicaid/CHIP

- Imposes new eligibility and access restrictions for the ACA's Medicaid expansion population (e.g., work requirements, copayments, more frequent redeterminations).
- Constrains the ways states can finance their share of Medicaid program costs and influence provider access through payment policy.
- Restricts noncitizen coverage and family planning access in Medicaid.

ACA Marketplace*

The law enacts policies that make it harder for individuals to enroll or reenroll in subsidized coverage through Marketplaces, with most provisions effective starting in plan year 2026.

On June 20, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that also restricts eligibility, reduces benefits, and imposes new paperwork burdens for enrollment, with most provisions taking effect in calendar year 2025 or 2026. Further, unless Congress acts, premium tax credits will expire on December 31, 2025.

*The law includes two private market provisions beyond the Marketplace: (1) allows high-deductible health plans to cover telehealth before the deductible; and (2) it makes certain direct primary care arrangements Health Savings Account-eligible.

H.R.1's Projected Impacts

The Congressional Budget Office estimates that the law would reduce federal spending by over a trillion dollars and cause coverage loss for 10 million people (reflects Medicaid and Marketplace provisions).

Select H.R.1 Medicaid Provisions	Change in Direct Federal Spending *($ Millions)*
Section 71119: Work Requirements Mandate	-$325,610
Section 71115 and 71117: Provider Taxes and Waiver of Uniform Tax Requirement	-$225,724
Section 71116: State-Directed Payments (SDPs)	-$149,424
Section 71101 and 71102: Delay of Select Biden-Era Eligibility and Enrollment (E&E) Final Rule Provisions	-$121,863
Section 71107: Eligibility Redeterminations	-$62,530
All Other Medicaid Provisions	-$104,516*
Section 71401: Rural Health Transformation Fund	$50,000**

This presentation highlights near-term action items for states' consideration to prepare for the law's implementation timelines and ensure individuals who are eligible maintain coverage.

*This figure reflects the sum of all other Medicaid provisions included in Subtitle B, Chapter 1.
**Reflects the budget authority. Estimated outlays are $47,152.

Effective Dates of H.R.1's Medicaid Provisions (1/2)

Medicaid Provisions		Section	Effective Date
Work Requirements	Requires issuance of an interim final rule on implementing work requirements	71119	June 1, 2026
	Requires states to conduct enrollee outreach about work requirements initially and "regularly" thereafter		June 30, 2026 – August 31, 2026
	Requires states to implement mandatory work requirements for expansion adults [states may implement earlier via a state plan amendment (SPA) or section 1115 waiver, or request a delay for up to two years until December 31, 2028, with Secretary approval]		January 1, 2027
Eligibility and Enrollment	Prohibits implementation or enforcement of select provisions in the E&E final rules	71101, 71102	July 4, 2025 – October 1, 2034
	Requires states to redetermine eligibility for expansion adults every six months	71107	December 31, 2026
	Requires states to limit retroactive coverage under Medicaid; state option under CHIP	71112	January 1, 2027
	Requires states to establish standardized processes to regularly update address information	71103	
	Requires states to verify eligibility against a Death Master file on a quarterly basis to ensure deceased individuals are not enrolled	71104	
	Codifies states' ceiling for the home equity limit allowable for individuals seeking long term care for homes zoned for agricultural use and homes not zoned for agricultural use	71108	January 1, 2028
	Creates a new section 1915(c) home and community-based services (HCBS) waiver option	71121	July 1, 2028
	Requires states to impose copayments on certain services for expansion adults with incomes above 100% of the federal poverty level (FPL)	71120	October 1, 2028
	Requires a new national federal database to be built that will identify individuals simultaneously enrolled in Medicaid in more than one state	71103	October 1, 2029
Noncitizen Coverage	Provides states with their regular federal medical assistance percentage (FMAP) for all emergency Medicaid services	71110	October 1, 2026
	Ends federal Medicaid/CHIP funding for refugees, asylees, and certain other noncitizens	71109	

Effective Dates for H.R.1's Medicaid Provisions (2/2)

Medicaid Provisions		Section	Effective Date
Payment and Financing	Prohibits any tax that: imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes; or that taxes Medicaid units of service at a higher rate than non-Medicaid units of service (also prohibits taxes that have the "same effect")	71117	July 4, 2025
	Caps any future SDPs submitted after July 4, 2025, at 100% of Medicare payment levels for expansion states and 110% of Medicare for non-expansion states	71116	
	Establishes a $50 billion rural health transformation fund	71401	December 31, 2025
	Ends the temporary FMAP increase for states that newly adopt Medicaid expansion	71114	January 1, 2026
	Prohibits states from implementing any new provider taxes and increasing existing tax rates (tax must be in effect as of July 4, 2025)	71115	October 1, 2026
	Codifies CMS' requirement that section 1115 waivers not cost the government more than the state's Medicaid program would cost absent the demonstration	71118	January 1, 2027
	Modifies the provider tax cap for expansion states, with the current 6% tax threshold reduced by half a percentage point per year until the threshold hits 3.5%	71115	October 1, 2027
	Requires states with existing SDPs above Medicare rates to reduce payments by 10 percentage points per year until the SDPs are no greater than 100% of Medicare payment levels for expansion states or 110% of Medicare payment levels for non-expansion states	71116	January 1, 2028
	Eliminates the waiver authority permitting CMS to waive states' disallowance of its federal funds associated with "excess" improper payments	71106	October 1, 2029
Provider Participation and Oversight	Bars Medicaid participation by certain providers of abortion services (including Planned Parenthood) for one-year (federal district court issued preliminary injunction on July 21, 2025)	71113	July 4, 2025 – July 4, 2026
	Delays implementation and enforcement of the nursing home staffing final rule	71111	July 4, 2025 – October 1, 2034
	Codifies certain existing requirements for states to screen Medicaid providers	71105	January 1, 2028

Medicaid Provisions Removed From the Final Legislation

Several provisions in prior versions of the budget reconciliation bill language were struck, including through challenges under the Byrd Rule in the Senate.

Struck Through Byrd Bath Process

- FMAP penalty for states providing coverage to certain noncitizens.
- Prohibitions on gender-affirming care in Medicaid and CHIP.
- Special provisions for Alaska and Hawaii in Medicaid (and Medicare).
- A ban on Medicaid spread pricing and requirements that pharmacies participate in a nationwide survey to calculate the national average drug acquisition cost.
- A ban on federal Medicaid funding while individuals have citizenship or immigration status verified.
- Deferral of cuts to federal allotments for Medicaid disproportionate share hospital (DSH) payments.
- Expedited enrollment pathway for certain out-of-state providers seeking to treat Medicaid or CHIP enrollees under the age of 21.

Select Medicaid Provisions and Considerations for States

Overview of Select Medicaid Provisions in H.R.1*

This presentation will focus on:

- Work Requirement Mandate
- Six-Month Eligibility Redeterminations for Certain Adults
- Noncitizen Coverage Restrictions
- Provider Taxes Policy Limits
- State-Directed Payment Limits
- Rural Health Transformation Fund
- Barring Federal Payments to "Prohibited Entities" Providing Abortion Services

*See the Appendix for more information on H.R.1's Medicaid provisions not featured today, to include: (1) other E&E changes (e.g., limits to retroactive coverage, new cost-sharing, addressing duplicate enrollment); (2) moratorium on select E&E final rules; (3) the new HCBS option; (4) payment reduction related to improper eligibility payments; (5) sunset of enhanced match for expansion states; (6) budget neutrality policy; (6) delay of the nursing home staffing final rule minimum staffing standards; and (7) provider screening requirements.

Medicaid Work Requirement Mandate

States must condition Medicaid eligibility on compliance with work requirements for adults covered by Medicaid expansion or expansion-like coverage ages 19 to 64.

- **Implementation Date.** January 1, 2027 – though states can implement earlier via a SPA or section 1115 waiver or delay until December 31, 2028 with Secretary approval.
- **Qualifying Activities.** 80 hours per month of: work, a Supplemental Nutrition Assistance Program (SNAP)-defined work program, community service, part-time education, or a combination of these activities. Alternatively, individuals can qualify by earning at least $580/month—or averaging that over six months for seasonal workers.
- **Exemptions.** The law outlines mandatory and short-term hardship exemptions (see Appendix). States must use *ex parte* data "where possible."
- **Outreach.** States must begin enrollee outreach between June 30, 2026 and August 31, 2026, depending on how many months of compliance they require before application, and continue outreach regularly thereafter.[1]
- **Compliance Checks.** States must verify compliance at both application and renewal using *ex parte* data—meaning individuals need to demonstrate completion of 80 hours of qualifying activities for at least one month prior to application and again once enrolled for at least one month within every six-month period. States may impose more stringent approaches.

1. If a state chooses to implement work requirements earlier than January 1, 2027, this outreach must begin earlier—specifically, three months plus the length of the state's lookback period prior to application.

Medicaid Work Requirement Mandate *(Continued)*

- **Terminations.** If a person is denied or disenrolled due to work requirements, they need to file a new application to re-apply (triggering the compliance check for at least the month prior to application).

Individuals denied Medicaid due to work requirements are not permitted to receive Marketplace tax credits for as long as the individual meets Medicaid eligibility criteria other than work requirements.

- **Rulemaking.** The U.S. Department of Health and Human Services (HHS) must issue an interim final rule by June 1, 2026.

- **Funding.**
  - The law provides $200 million to CMS for fiscal year (FY) 2026 to support implementation efforts.
  - HHS will provide $200 million to support state systems in FY 2026—half based on each state's share of individuals subject to the work requirement as of March 31, 2025, and half distributed equally.
  - States can also receive federal Medicaid administrative matching funds to support implementation.

Immediate Action Items for State Consideration:

- Assess E&E system and operational readiness to implement, including data sharing and automation capacity.
- Assess existing infrastructure for state-level workforce program capacity and linkages.
- Based on assessments, determine need to request Secretary approval to delay implementation (e.g., impact assessment expansion enrollee demographics).
- Determine need for and pursue state legislation and implementation funding.
- Collaborate with SNAP, Marketplace, other state agencies and managed care plans to develop and deploy an immediate/ongoing public communication campaign.
- Establish implementation team and governance structure across policy, program, systems (cross division or agency as needed).

Six-Month Eligibility Redeterminations for Certain Adults

States must redetermine eligibility for adults enrolled through Medicaid expansion under a state plan or waiver once every six months.

- **Implementation Date.** December 31, 2026. Unlike work requirements, there is no option to delay. States that obtain approval to delay implementation of work requirements will have misaligned effective dates.
- **Policy Requirements.** Redeterminations for expansion adults must occur twice a year.

  This is a major departure from previous Medicaid eligibility rules, whereby states may redetermine eligibility for expansion enrollees no more frequently than annually or unless information received by a state indicates a change in circumstances.
- **Exemptions.** The law exempts American Indian/Alaska Natives (AI/AN) from this provision. Territories are also exempt from six-month redeterminations.
- **Timeline.** CMS must issue guidance by January 5, 2026 (within six months of July 4, 2025).

Immediate Actions for State Consideration:

- Assess time and investment needed to implement eligibility system changes, including de-linking of renewal periods for expansion adults relative to other populations.
- Integrate more frequent renewals into communication and governance strategies.

Noncitizen Coverage Restrictions

Effective October 1, 2026, the law imposes new restrictions on eligibility and a reduction in federal funding for emergency services for certain noncitizens.

Reduces Emergency Medicaid Services FMAP to regular match.

- **States will no longer receive the 90% enhanced match for emergency Medicaid services for individuals who would qualify for expansion but for their immigration status.** Instead, they'll receive the standard FMAP.
- The provision also applies to services provided to **refugees, asylees, and other lawfully present individuals.**

Ending Federal Medicaid Funding for Refugees, Asylees, and Certain Other Noncitizens

- Federal Medicaid/CHIP funding is no longer available for full coverage of most noncitizens, **except**: (1) lawfully residing children and pregnant women under the Children's Health Insurance Program Reauthorization Act (CHIPRA) 214 option; (2) lawful permanent residents after five years; (3) Cuban-Haitian entrants; and (4) Compacts of Free Association migrants.
- **States lose enhanced funding for most refugees, asylees, trafficking victims, and others unless covered under CHIPRA 214.**

Immediate Actions for State Consideration:

- Consider options for covering newly ineligible people using state funds.
- Take-up the CHIPRA 214 option (if not already) to maintain coverage for lawfully residing children and pregnant women.
- Develop a communications strategy (e.g., coordinating with providers and community-based organizations).

Provider Taxes Policy Limits (1/2)

All states except Alaska currently use provider taxes to help finance their share of Medicaid expenditures. The law imposes significant new limits on use of this mechanism.

Prohibits any new Medicaid provider tax or increases to existing rates for taxes enacted prior to July 4, 2025 (for both local- and state-imposed taxes.)

- **The law effectively "grandfathers" the existing tax rate applied to provider taxes**—not simply the dollar amount—even in states that currently use a fixed dollar amount when taxing providers. Specifically, **the law prohibits states from increasing existing taxes as a percentage of net patient revenues, regardless of how the actual tax is structured.**
- **In non-expansion states**, this means existing taxes can continue to increase with inflation.
- **In expansion states,** however, the law includes a separate provision that reduces the allowable tax rate, effectively undercutting the value to these states of being able to "grandfather" their existing provider taxes.

For expansion states, reduces the existing 6% cap on provider taxes by 0.5 percentage points per year beginning October 1, 2027, until the cap reaches 3.5% by October 1, 2032. (Skilled nursing facilities and intermediate care facilities are exempt.)

Immediate Actions for State Consideration:

- Track CMS rulemaking and guidance.
- Model the fiscal impact and identify mitigating steps (e.g., identify new revenue sources, convene providers to monitor financial needs).
- Assess and deploy options to render existing taxes compliant with the ramp-down.

Provider Taxes Policy Limits (2/2)

Provider taxes must generally be "broad-based" and "uniform," but states have traditionally obtained waivers by demonstrating to CMS—via a complex statistical test—that the tax is "generally redistributive" and does not shift the burden onto Medicaid providers.

In addition to the prohibition on new or increased provider taxes, the law newly prohibits any tax that:

1. Imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes.

2. Taxes Medicaid units of service at a higher rate than non-Medicaid units of service (e.g., discharges, bed days, revenue, or member months).

3. Has the "same effect" as in (1) or (2) above; this provision exposes states to significant uncertainty as to what is allowable.*

Immediate Actions for State Consideration:

- Engage with CMS to gauge the availability of a transition period.
- If a transition period is granted, assess and deploy options to render existing taxes compliant.

CMS may allow for a transition period, not to exceed three years from July 4, 2025.

*The law vests CMS with significant discretion to assess which taxes have the "same effect" as the prohibited taxes. While providing CMS with discretion means that the federal government will have more flexibility to deny taxes it determines fail to meet the spirit of the law, it also means less certainty for states.

State-Directed Payment Limits

States are currently permitted to establish SDPs up to the average commercial rate ("ACR"). The law caps future SDP payment levels and reduces existing SDPs.

New SDPs

- All new SDPs are capped at 100% of Medicare rates for expansion states. States that have not expanded Medicaid may create new SDPs at 110% of Medicare.

The law ties payment limits to the Medicare fee schedule, giving states less flexibility than under Medicaid fee for service, where multiple methodologies to calculate rates are allowed. This raises questions about whether payment levels will be appropriate for pediatric, obstetric, and other services infrequently covered by Medicare.

Existing, "Grandfathered" SDPs

- States with existing SDPs above Medicare rates will need to reduce payments by "10 percentage points" per year beginning January 1, 2028 until the SDPs are no greater than 100% of Medicare payment levels for expansion states, or 110% of Medicare payment levels for non-expansion states.
- Grandfathered payments are those approved by CMS prior to May 1, 2025 (or the Secretary determines the state made a good faith effort to secure approval); for rural hospitals, approved by CMS (or a good faith effort to secure approval) prior to the date of enactment of the bill; or submitted to CMS prior to the date of enactment.

Immediate Actions for State Consideration:

- Assess options to reduce existing SDP payment levels in compliance with the law.
- Model the fiscal impact and identify mitigating steps.
- Explore new revenue sources, including the Rural Health Transformation Fund.

Rural Health Transformation Fund

The law establishes a $50 billion fund for rural healthcare providers. To qualify for funding, states will need to apply to CMS for approval. CMS is required to approve or deny applications by December 31, 2025.

Distribution Approach	▪ The funding will be distributed in **$10 billion annual allotments from FYs 2026 to 2030:** ○ **50% of the funding will be allocated equally across all states** with an approved transformation plan. ○ **50% will be distributed at CMS Administrator discretion**, considering a number of factors, including the state's percentage of rural residents, and the share of rural healthcare facilities in the state compared to such facilities nationwide. ▪ **Only states may apply.** Each state will submit one application for funding for a five-year period. **One quarter or more of states with an approved application must be allocated funding from this 50%.**
Allowable Uses of Funds	▪ **States have significant discretion** around how to use their funds, including which providers receive funds and how much to dedicate to providers.* ▪ **States must fund at least three "allowable activities" in the law** (see Next Slide). ▪ **No more than 10% of a state's allotment can be used on administrative expenses.**
Limitations	▪ **States will not be allowed to use the funding as the non-federal share of Medicaid payments.**

*See the Appendix for more detail on provider eligibility.

Rural Health Transformation Plan

To access funding, states must submit a detailed transformation plan to CMS. The deadline to submit a plan has yet to be established by CMS but will fall before December 31, 2025.

Required Plan Components	Activities Eligible for Funding *(States Must Select At Least 3)*
States must specify how they will: • Improve access to hospitals and other healthcare providers • Improve health outcomes for rural residents • Prioritize the use of new and emerging technologies, including artificial intelligence (AI), emphasizing prevention and chronic disease management • Foster local and regional strategic partnerships between rural hospitals and other providers • Enhance supply of clinicians via recruitment and training • Prioritize data and other technology-driven solutions for rural hospitals and other rural providers • Outline strategies to manage long-term solvency of rural hospitals • Identify specific causes of stand-alone rural hospital closures or conversions	• Promoting chronic disease management interventions • Providing payments to healthcare providers • Promoting consumer-facing, technology-driven solutions for prevention and managing chronic disease • Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals • Recruiting and retaining clinical workforce to rural areas, with commitments to serve rural communities for at least five years • Technical assistance, software and hardware for information technology • Assisting rural communities to right-size their delivery systems • Supporting access to behavioral health treatment • Supporting innovative models of care that include value-based care arrangements and alternative payment models

Immediate Actions for State Consideration: Begin developing a rural health transformation plan, including determining eligible providers, funding distribution strategy, allowable uses of funding. Identify and convene state partners in developing the transformation plan.

Barring Federal Payments to "Prohibited Entities" Providing Abortion Services

The law prohibits certain providers of abortion services, including Planned Parenthood, from receiving federal Medicaid funding for one year (until July 4, 2026).

- The Hyde amendment has long banned use of Medicaid funds for abortion services except in narrow circumstances.
- The law defines a "prohibited entity" as an entity – "including its affiliates, subsidiaries, and clinics" – that:
  - Is a nonprofit organization that meets the federal definition of an "essential community provider" under 45 C.F.R. § 156.235;
  - Is "primarily engaged in family planning services, reproductive health, and related medical care;"
  - Offers abortion services in circumstances beyond those that qualify for federal funding under the Hyde Amendment (i.e., abortions in circumstances other than rape, incest, or medical emergency); and
  - Received at least $800,000 in Medicaid payments in FY 2023, aggregated across any "affiliates" or "nationwide healthcare provider networks."

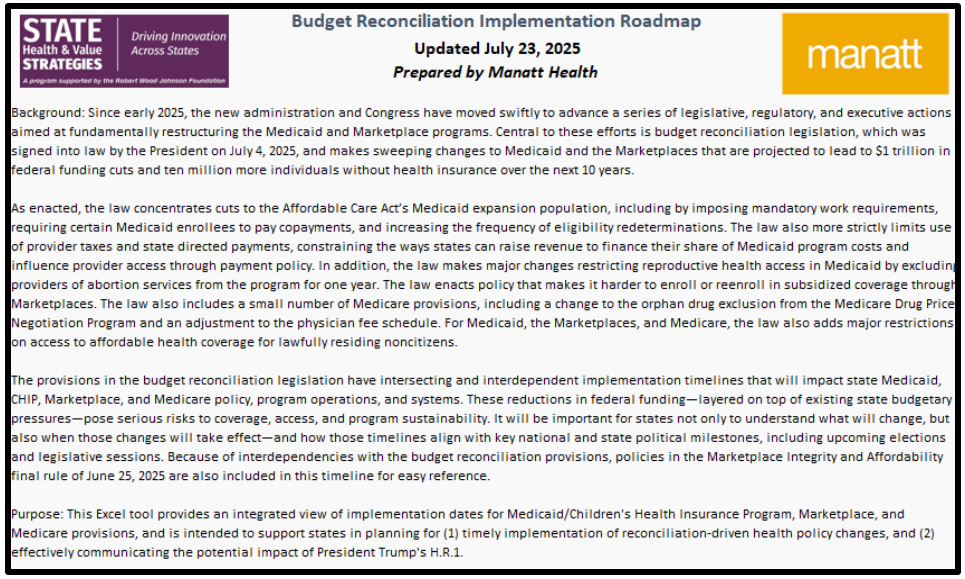
On July 21, a federal district court issued a preliminary injunction granting relief to Planned Parenthood members who do not independently meet the "defund" provision's definition of a "prohibited entity," that is, who cannot provide abortions because of state abortion bans, or who received less than $800,000 in Medicaid reimbursements in 2023.

Near-Term Action Items for State Consideration: States may replace federal funding for Planned Parenthood and other abortion providers using state funds (e.g., WA).

New SHVS Tool: Budget Reconciliation Implementation Roadmap

The provisions in the budget reconciliation law have intersecting and interdependent implementation timelines that will impact state Medicaid, CHIP, Marketplace, and Medicare policy, program operations, and systems.

SHVS' new tool provides an integrated view of the implementation dates for Medicaid/CHIP, Marketplace, and Medicare provisions in H.R.1 and the Marketplace Integrity and Affordability final rule. The tool is **intended to support states in planning for (1) timely implementation of reconciliation-driven health policy changes, and (2) effectively communicating potential impacts.**



STATE Health & Value STRATEGIES — Driving Innovation Across States
A program supported by the Robert Wood Johnson Foundation

Budget Reconciliation Implementation Roadmap

Updated July 23, 2025

Prepared by Manatt Health

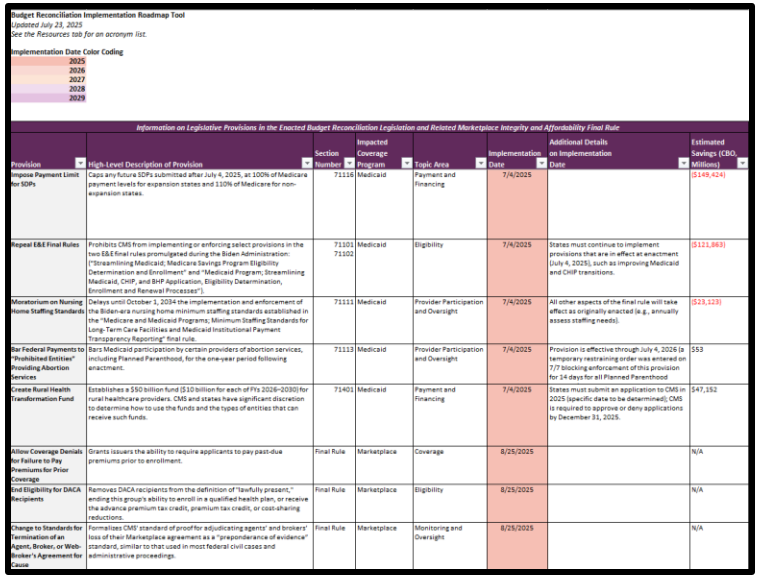
manatt

Background: Since early 2025, the new administration and Congress have moved swiftly to advance a series of legislative, regulatory, and executive actions aimed at fundamentally restructuring the Medicaid and Marketplace programs. Central to these efforts is budget reconciliation legislation, which was signed into law by the President on July 4, 2025, and makes sweeping changes to Medicaid and the Marketplaces that are projected to lead to $1 trillion in federal funding cuts and ten million more individuals without health insurance over the next 10 years.

As enacted, the law concentrates cuts to the Affordable Care Act's Medicaid expansion population, including by imposing mandatory work requirements, requiring certain Medicaid enrollees to pay copayments, and increasing the frequency of eligibility redeterminations. The law also more strictly limits use of provider taxes and state directed payments, constraining the ways states can raise revenue to finance their share of Medicaid program costs and influence provider access through payment policy. In addition, the law makes major changes restricting reproductive health access in Medicaid by excluding providers of abortion services from the program for one year. The law enacts policy that makes it harder to enroll or reenroll in subsidized coverage through Marketplaces. The law also includes a small number of Medicare provisions, including a change to the orphan drug exclusion from the Medicare Drug Price Negotiation Program and an adjustment to the physician fee schedule. For Medicaid, the Marketplaces, and Medicare, the law also adds major restrictions on access to affordable health coverage for lawfully residing noncitizens.

The provisions in the budget reconciliation legislation have intersecting and interdependent implementation timelines that will impact state Medicaid, CHIP, Marketplace, and Medicare policy, program operations, and systems. These reductions in federal funding—layered on top of existing state budgetary pressures—pose serious risks to coverage, access, and program sustainability. It will be important for states not only to understand what will change, but also when those changes will take effect—and how those timelines align with key national and state political milestones, including upcoming elections and legislative sessions. Because of interdependencies with the budget reconciliation provisions, policies in the Marketplace Integrity and Affordability final rule of June 25, 2025 are also included in this timeline for easy reference.

Purpose: This Excel tool provides an integrated view of implementation dates for Medicaid/Children's Health Insurance Program, Marketplace, and Medicare provisions, and is intended to support states in planning for (1) timely implementation of reconciliation-driven health policy changes, and (2) effectively communicating the potential impact of President Trump's H.R.1.



Budget Reconciliation Implementation Roadmap Tool

Updated July 23, 2025

See the Resources tab for an acronym list.

Implementation Date Color Coding

2025
2026
2027
2028
2029

Information on Legislative Provisions in the Enacted Budget Reconciliation Legislation and Related Marketplace Integrity and Affordability Final Rule

Provision	High-Level Description of Provision	Section Number	Impacted Coverage Program	Topic Area	Implementation Date	Additional Details on Implementation Date	Estimated Savings (CBO, Millions)
Impose Payment Limit for SDPs	Caps any future SDPs submitted after July 4, 2025, at 100% of Medicare payment levels for expansion states and 110% of Medicare for non-expansion states.	71116	Medicaid	Payment and Financing	7/4/2025		($149,424)
Repeal E&E Final Rules	Prohibits CMS from implementing or enforcing select provisions in the two E&E final rules promulgated during the Biden Administration: ("Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" and "Medicaid Program; Streamlining Medicaid, CHIP, and BHP Application, Eligibility Determination, Enrollment and Renewal Processes").	71101 71102	Medicaid	Eligibility	7/4/2025	States must continue to implement provisions that are in effect at enactment (July 4, 2025), such as improving Medicaid and CHIP transitions.	($121,863)
Moratorium on Nursing Home Staffing Standards	Delays until October 1, 2034 the implementation and enforcement of the Biden-era nursing home minimum staffing standards established in the "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" final rule.	71111	Medicaid	Provider Participation and Oversight	7/4/2025	All other aspects of the final rule will take effect as originally enacted (e.g., annually assess staffing needs).	($23,123)
Bar Federal Payments to "Prohibited Entities" Providing Abortion Services	Bars Medicaid participation by certain providers of abortion services, including Planned Parenthood, for the one-year period following enactment.	71113	Medicaid	Provider Participation and Oversight	7/4/2025	Provision is effective through July 4, 2026 (a temporary restraining order was entered on 7/7 blocking enforcement of this provision for 14 days for all Planned Parenthood	$53
Create Rural Health Transformation Fund	Establishes a $50 billion fund ($10 billion for each of FYs 2026–2030) for rural healthcare providers. CMS and states have significant discretion to determine how to use the funds and the types of entities that can receive such funds.	71401	Medicaid	Payment and Financing	7/4/2025	States must submit an application to CMS in 2025 (specific date to be determined); CMS is required to approve or deny applications by December 31, 2025.	$47,152
Allow Coverage Denials for Failure to Pay Premiums for Prior Coverage	Grants issuers the ability to require applicants to pay past-due premiums prior to enrollment.	Final Rule	Marketplace	Coverage	8/25/2025		N/A
End Eligibility for DACA Recipients	Removes DACA recipients from the definition of "lawfully present," ending this group's ability to enroll in a qualified health plan, or receive the advance premium tax credit, premium tax credit, or cost-sharing reductions.	Final Rule	Marketplace	Eligibility	8/25/2025		N/A
Change to Standards for Termination of an Agent, Broker, or Web-Broker's Agreement for Cause	Formalizes CMS' standard of proof for adjudicating agents' and brokers' loss of their Marketplace agreement as a "preponderance of evidence" standard, similar to that used in most federal civil cases and administrative proceedings.	Final Rule	Marketplace	Monitoring and Oversight	8/25/2025		N/A

Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You

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Appendix

Medicaid Work Requirements Exemptions

Required Exemptions. States *must* exempt the following individuals from work requirements for a given month if, at any point during that month, they are:

- Parents/guardians/caretaker relatives, or family caregivers of a dependent child age 13 and under or a disabled individual
- Pregnant or receiving Medicaid postpartum coverage
- Foster youth and former foster youth under the age of 26
- AI/ANs
- Veterans with a disability rated as total
- Incarcerated or recently released from incarceration within the past 90 days
- Entitled to Medicare Part A or enrolled in Medicare Part B
- Meeting Temporary Assistance for Needy Families or SNAP work compliance requirements
- Participating in a drug addiction or alcohol treatment program
- Medically frail:
  - Blind or disabled
  - Have a substance use disorder
  - Have a disabling mental disorder
  - Have a significant physical, intellectual, or developmental disability
  - Have a serious or complex medical condition

Optional Temporary Exemptions. States *may* (under procedures established by the state in accordance with the Secretary's standards) exempt individuals for a given month if, at any point during that month, they experience a "short-term hardship" exemption, including:

- Receiving inpatient hospital care, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric care, or other services of similar acuity (including related outpatient care) determined by the Secretary*
- Living in a county impacted by a federally declared emergency or disaster
- Living in a county with a high unemployment rate (at or above the lesser of 8% or 150% of the national unemployment rate, which was 4.1% as of June 2025)
- Traveling for an extended period to access medically necessary care for a serious or complex medical condition that is not available in the individual/their dependent(s)' community*

*Exemption only available if specifically requested by the individual.

Other Medicaid Eligibility Policy Changes (1/2)

Limiting Medicaid Retroactive Coverage

- **Effective January 1, 2027, Medicaid retroactive coverage will be shortened from three months to one month for expansion adults and two months for all other Medicaid applicants.**
- **This provision also allows states to provide two months of CHIP retroactive coverage** (Currently, CHIP does not have retroactive coverage, and services may only be paid in the month of the application).

Require Cost Sharing for Certain Medicaid Expansion Enrollees

- **Beginning October 1, 2028, requires states to impose cost sharing for services provided to Medicaid expansion adults with incomes above 100% of the FPL** ($15,560 per year). (Territories are exempted.)
- **States decide copayment amounts**, not to exceed $35 per service and subject to an aggregate limit of 5% of family income (see next slide).
- **Cost sharing must not apply to** exemptions under current law (e.g., prenatal, family planning, and certain emergency services) or to primary care services, behavioral health services, federally qualified health center services, rural health clinic services, and certified community behavioral health clinic services.

Requiring Cost Sharing for Certain Medicaid Expansion Enrollees, Detail

States have the flexibility to decide the copayment amounts, subject to the following limitations:

- **For drugs,** the law retains the existing requirement that copayments be "nominal," defined in CMS regulations as a maximum of $4 for preferred drugs and $8 non-preferred drugs as of 2015, and adjusted for inflation over time (42 C.F.R. § 447.53).
- **For services received in a hospital emergency department that are deemed non-emergency services**, states may provide for a "nominal" charge of no more than $8 as of 2015 and adjusted for inflation over time (42 C.F.R. § 447.54).
- **For other services**, cost sharing may not exceed $35 per item or service.
- **Cost sharing is subject to an aggregate limit of 5% of family income**, which states may calculate on a monthly or quarterly basis.

States are prohibited from imposing an enrollment fee or monthly premiums on this group of enrollees. At state option, providers may deny services if an individual does not pay the required cost sharing.

Other Medicaid Eligibility Policy Changes (2/2)

Effective January 1, 2027, states must use data sources from managed care plans, the National Change of Address Database, returned mail, and other data sources identified by the Secretary to regularly update enrollee addresses. HHS also intends to establish a new national federal database by October 1, 2029, that will identify individuals simultaneously enrolled in Medicaid in more than one state.

Effective January 1, 2027, states must check the Social Security Administration Death Master File, or another database, quarterly, treat the information as factual, and disenroll deceased individuals from Medicaid. (States must retroactively reenroll anyone incorrectly removed.)

Effective January 1, 2028, the home equity limit used to determine financial eligibility for Medicaid long-term services and supports will be adjusted by: (1) allowing states to set a cap ($750,000) for homes on agricultural land (with a max of $1 million based on the Consumer Price Index); (2) permitting states to adopt a cap of up to $1 million for non-agricultural homes; and (3) prohibiting use of asset disregards to modify these limits.

Summary: Moratorium on the E&E Final Rules

Effective on enactment (July 4, 2025), the law delayed the implementation and enforcement of select provisions of two CMS E&E final rules until October 1, 2034.*

H.R.1 maintains E&E rule provisions in effect at enactment, for example:

- Remove access barriers for CHIP-eligible children (e.g., prohibit premium lockouts/ waiting periods and annual/lifetime limits).
- Improve Medicaid/CHIP transitions.
- Eliminate limitations on the number of reasonable opportunity periods.
- Apply electronic verification and reasonable compatibility standards for verifying resources.
- Remove requirement to apply for other benefits.
- Deem certain Medicare Part A and Supplemental Security Income enrollees eligible for Qualified Medicare Beneficiary (QMB) coverage, without requiring an application.

Examples of delayed E&E rule provisions:

- Requirements to align Modified Adjusted Gross Income (MAGI) and non-MAGI enrollment and renewal policies (e.g., pre-populate renewal form,* accept applications/renewals through all modalities,* 90-day reconsideration period*).
- Requirements to establish processing timeframes at renewal and upon changes in circumstances.*

** = Provisions that may be implemented at state option.*

*"Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" and "Medicaid Program; Streamlining Medicaid, CHIP, and Basic Health Program (BHP) Application, Eligibility Determination, Enrollment and Renewal Processes."

**Separately, the law does not delay the requirement that states maintain extensive electronic eligibility records for each Medicaid/CHIP enrollee.

Medicaid Program; Streamlining Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes Final Rule, Effective Provisions

Provision and 42 CFR §	Effective Date
• Improve Transitions Between Medicaid and CHIP at renewal (§§ 431.10, 435.1200, 457.340, 457.348, 457.350, 600.330) • Apply Electronic Verification and Reasonable Compatibility Standards for Resources (§§ 435.952, 435.940) • Remove Requirement to Apply for Other Benefits (435.608, 436.608) • Remove Option to Limit the Number of Reasonable Opportunity Periods (§§ 435.956, 457.380) • Option to Allow Medically Needy Individuals to Deduct Prospective Medical Expenses (§§ 435.831, 436.831)	June 3, 2024 (Final Rule Effective Date)

• Remove Access Barriers for Children:
  ○ Prohibit Premium Lock Out Periods (§§ 457.570, 600.525)
  ○ Prohibit Waiting Periods (§§ 457.65, 457.340, 457.350, 457.805, 457.810)
  ○ Prohibit Annual or Lifetime Limits (§ 457.480)
• States with these existing policies in place had 12 months to remove them and establish a substitution monitoring strategy following removal of a waiting period (June 2025).
• States with biennial legislatures that require legislative action to implement these requirements can request an extension of up to 24 months following the effective date of the final rule.	

• Recordkeeping requirements (431.17; 435.914, 457.965)	June 3, 2026

Medicaid Program; Streamlining Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes Final Rule, Delayed Provisions

Provision and 42 CFR §	Effective Date
Agency action on returned mail (§§ 435.919, 457.344) Per H.R.1, by January 1, 2027, states must establish standardized processes to regularly update address information for Medicaid and CHIP enrollees using data received from managed care plans, the National Change of Address Database, returned mail, and other data sources identified by the U.S. Department of Health and Human Services Secretary.	December 3, 2025
Verification of citizenship and identity data sources (§ 457.407) (e.g., using Vital Statistics information for verifying citizenship)	June 3, 2026
Align non-MAGI enrollment and renewal processes with MAGI policies (e.g., pre-populated renewal form*, accept applications and renewal forms through all modalities*, and implement a 90-day reconsideration period) (§ 435.907)	June 3, 2027
Establish specific requirements for acting on changes in circumstances* (§§ 435.916, 435.919, 457.344, 457.960)	
Establish timelines requirements for determining and redetermining eligibility* (§§ 435.907, 435.912, 457.340, 457.1170)	

**Provisions that may be implemented at state option.*

Effective and Delayed Provisions in the Streamlining Medicaid; MSP Eligibility Determination and Enrollment Final Rule

In Effect

The Final Rule...	Federal Citation	Compliance Date
Requires states to enroll certain Supplemental Security Income recipients into the QMB group.	42 CFR § 435.909	October 1, 2024
Requires states to enroll individuals into an MSP using Medicare Part D low-income subsidy (LIS) data.	42 CFR §§ 435.4 and 435.911	April 1, 2026
Requires states to accept attestation without requiring further information for certain MSP eligibility criteria. (Requirement applies to dividend and interest income earned on resources, non-liquid resources, burial funds, and life insurance policies).	42 CFR § 435.952	
Defines family size for MSP to align with LIS program (i.e., defined to include at least the individual included in the definition of family size of the LIS program).	42 CFR § 435.601	
Clarifies the QMB effective date for certain individuals. [Beginning on or after January 1, 2023, the effective date of Medicare coverage for individuals who enroll in Medicare during the general enrollment period is the month following the month of enrollment; QMB coverage starts the month premium Part A entitlement begins (if the state determines the individual has met the eligibility requirements for QMB coverage in the same month that Part A enrollment occurs) or a month later than the month of Part A entitlement (if the individual is determined eligible for QMB the month Part A entitlement begins or later).]	42 CFR 406.21	

New HCBS Option

The law creates, beginning July 1, 2028, a new section 1915(c) waiver option covering HCBS for individuals meeting state-established, needs-based eligibility criteria.

- **Waiver criteria must be less restrictive than a person needing an institutional level of care** (i.e., level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities).
- **Like traditional 1915(c) waivers, states under the new waiver:**
  - Will be able to cap enrollment.
  - May not implement the waiver in such a way that individuals who meet an institutional level of care are averaging a "material[ly]" longer wait for HCBS offered through a traditional 1915(c) waiver.
  - Cannot use the waiver to pay for room and board.
  - Must attest that average per capita Medicaid costs for individuals obtaining services are less than average per capita Medicaid costs for individuals receiving institutional care.
- **The provision appropriates $100 million to support state implementation of HCBS under 1915(c) waivers and section 1115 demonstrations**. Distribution of state funding will be proportionate to the relative number of individuals in a state receiving HCBS under a 1915(c) waiver or section 1115 demonstration as compared to other states.
- The provision codifies the Trump administration's 2019 "**anti-assignment rule**" prohibiting payments to certain types of third-party entities on behalf of individual practitioners (e.g., home care workers) for whom Medicaid is their primary source of income.
- **The Secretary will approve waivers for an initial three-year term, with five-year renewals thereafter.**

Rural Health Transformation Fund Provider Eligibility

While H.R.1 requires CMS to consider the number of rural health facilities in a state when determining funding allocations, the law doesn't explicitly define which providers are eligible for funding.

Providers Included in Definition of "Rural Health Facility" in H.R.1
▪ Hospitals located outside of metropolitan statistical areas (MSA)
▪ Hospitals that have reclassified as rural (this includes some hospitals in urban areas)
▪ Hospitals located in a rural census tract of an MSA
▪ Critical Access Hospitals
▪ Sole Community Hospitals
▪ Medicare-Dependent Small Rural Hospitals
▪ Low Volume Hospitals
▪ Rural Emergency Hospitals
▪ Rural Health Clinics
▪ Federally Qualified Health Centers
▪ Community Mental Health Centers
▪ Health Centers receiving section 330 grants
▪ Opioid Treatment Programs (OTPs) located in a rural census tract of an MSA
▪ Certified Community Behavioral Health Clinics located in a rural census tract of an MSA

Background on the Payment Error Rate Measurement Program (PERM)

Under the PERM program, CMS audits state Medicaid and CHIP programs for eligibility-related improper payments, such as covering ineligible individuals, services not allowed for an eligibility group, or missing documentation.*

- Each state is reviewed under the PERM program once every three years and works in conjunction with Medicaid Eligibility Quality Control programs during each PERM year to reduce erroneous spending by monitoring eligibility determinations.
- If more than 3% of a state's total payments in a given year were improper for reasons relating to enrollee eligibility, CMS must disallow federal funds for the "excess" improper payments above that threshold, as applied to the state's total federal payments for that year (not just the specific payments identified in the sample).**
- Prior to passage of H.R.1, CMS could waive this disallowance, in whole or in part, if a state was unable to achieve the 3% target despite good faith efforts. CMS regulations allowed states to qualify for this waiver by implementing a Corrective Action Plan and certain other program integrity activities.

In 2024, the nationwide improper payment rate for eligibility issues was 3.31%

*PERM does not identify fraudulent payments. Rather, it captures any payments that do not comply with federal requirements, including in cases of inadvertent error or missing documentation.

**The improper payment rate is calculated based on the dollar amount of the improper payments relative to total spending, not based on the number of improper claims relative to the total number of claims.

Payment Reduction Related to Eligibility-Related Improper Payments Under Medicaid

The law eliminates, starting October 1, 2030, the waiver authority under the PERM program permitting CMS to waive states' disallowance of its federal funds associated with "excess" improper payments.

- **CMS will only be able to waive the disallowance for two types of errors:**
  - Insufficient documentation to confirm eligibility; and
  - Certain types of errors in assessing eligibility for a so-called "spend down" group (optional eligibility categories for individuals or families whose incomes are above the threshold for Medicaid eligibility, but who may qualify for coverage after spending a certain amount on out-of-pocket medical expenses).
- **CMS will no longer have authority to waive disallowances** for any other types of eligibility-related improper payments, even when the state is operating in good faith to address the errors.
- **CMS is required** to issue disallowances upon identifying improper payments under federal audits beyond PERM, as well as, at the option of the Secretary, state audits.

Other Medicaid Financing and Payment Policy Changes

Sunset of Eligibility for American Rescue Plan Act (ARPA) Increased FMAP For Expansion States

- **Under ARPA, Congress enacted a temporary boost in federal funding** for states that newly adopted the ACA Medicaid expansion after March 11, 2021. Specifically, a five-percentage-point increase in the FMAP for most non-expansion Medicaid populations for two years (separate from the 90% FMAP that applies to the expansion population itself).
- **The law repeals this increased FMAP effective January 1, 2026.** The change does not affect the FMAP for the three states that expanded under ARPA (i.e., MO, OK, NC) or others that previously expanded Medicaid.

Budget Neutrality for Medicaid Demonstration Projects Under Section 1115

- **The law codifies CMS' longstanding requirement** that total spending under Medicaid demonstrations authorized under section 1115 of the Social Security Act are no higher than what the state would have spent absent the demonstration.
- **The law newly requires the Chief Actuary to certify budget neutrality for a waiver and, for renewals, for the duration of a preceding waiver.** This change places the Chief Actuary in a more central role in section 1115 demonstration approval than in previous practice.

Provider Participation and Oversight Provisions

The law includes provisions that impact how providers interact with state Medicaid agencies.

Delays until October 1, 2034 the implementation and enforcement of the Biden-era nursing home final rule minimum staffing standards. All other aspects of the final rule will take effect as originally enacted (e.g., annually assess staffing needs).

These minimum staffing requirements, which were set to phase in based on facility type between May 2026 and May 2029, would have required nursing facilities to meet the same baseline level of nursing coverage as all Medicare- and Medicaid-participating long-term care facilities, and have a registered nurse onsite 24 hours a day, seven days a week.

Effective January 1, 2028, this provision codifies an existing requirement for states to screen providers that participate in the Medicaid program by cross-referencing the Death Master File upon a provider's enrollment and revalidation. States must conduct quarterly checks between provider enrollment and revalidation.