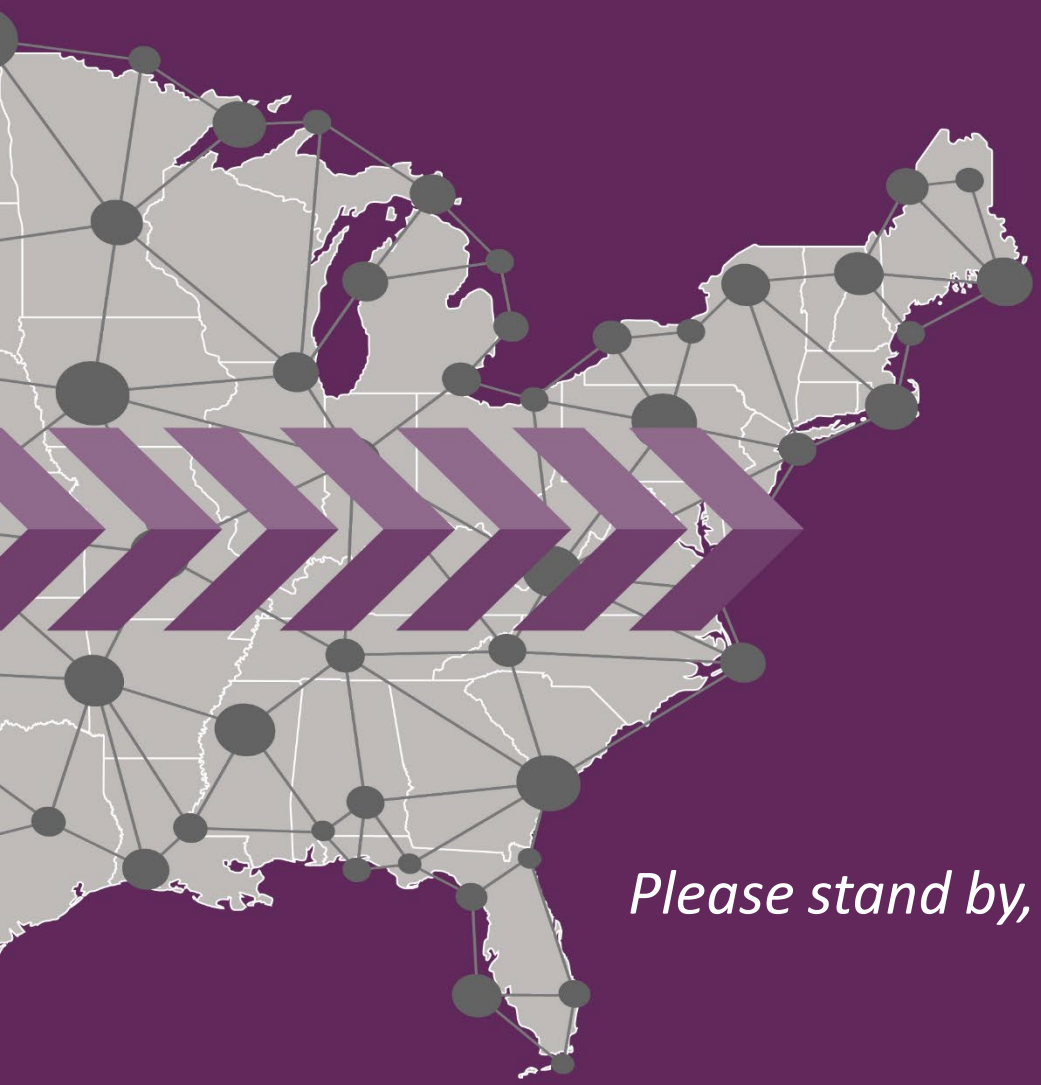


Medicaid Provisions in the House Budget Reconciliation Bill

May 22, 2025

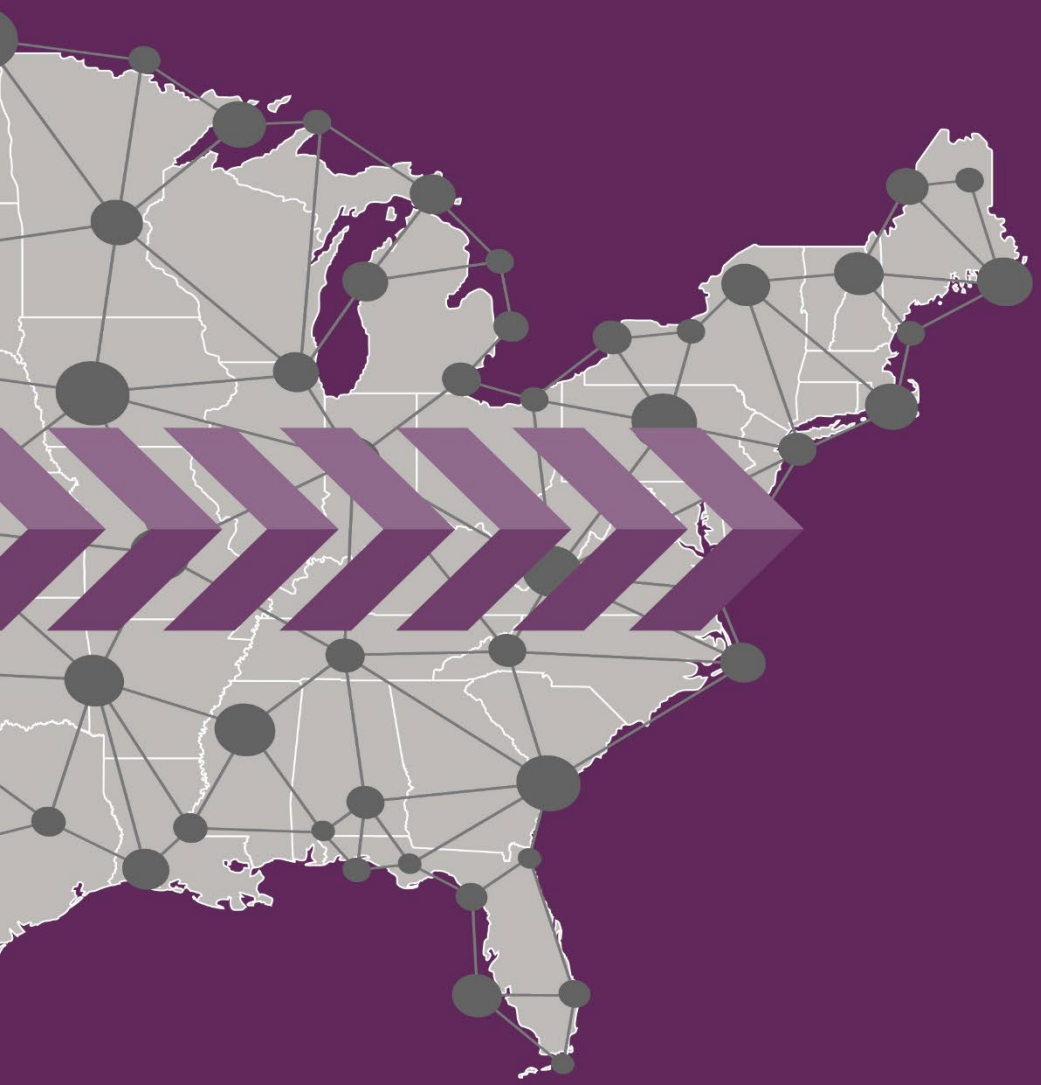
2:00 – 3:00 p.m. ET

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.
The views expressed here do not necessarily reflect the views of the Foundation.

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.
- After the webinar, the slide deck and a recording will be available at **www.shvs.org.**

Webinar Objectives

Today's Focus

Review key changes included in the House budget reconciliation bill ("House Budget Bill") to **Medicaid eligibility, payment and financing, and coverage**, and discuss implications for states.

Looking Ahead

On **Thursday, May 29 from 3:00 to 4:00 p.m. ET**, SHVS will host a second webinar to review key **Marketplace** changes proposed in the House Budget Bill.

Agenda

- **Level-Setting on Provisions in the House Budget Bill**
- **Key Medicaid Proposals and State Impacts**
- **Looking Ahead**
- **Discussion**

Level-Setting on Provisions in the House Budget Bill

Reminder of the Budget Reconciliation Process

Congress is advancing large reductions in Medicaid funding through the budget reconciliation process.

1. Congress passed budget resolution in April with reconciliation directives for committees.
2. House committees drafted reconciliation bills in April/May.
3. House committees held markups on reconciliation proposals [House Energy and Commerce (E&C) legislation advanced 5/14].
4. House Budget Committee packaged committee-passed bills on 5/18; sent bill to House Rules Committee.
5. House Rules Committee cleared bill for full House consideration on 5/21.
6. House passed the bill on 5/22; legislation now advances to Senate.

We Are Here

7. Senate committees prepare reconciliation legislation. Senate committees may bypass markups.
8. Once Senate Budget Committee weaves all individual bills together, Senate considers the budget reconciliation bill under the Congressional Budget Act guardrails (including the Byrd Rule).
9. Legislation returns to the House; House must approve Senate-passed legislation **verbatim** before it goes to the President's desk.

- The only statutory deadline for congressional action is the end of the federal fiscal year on **September 30**.
- The de facto deadline for legislative action is the debt ceiling "X date"—the point at which the U.S. Treasury is no longer able to meet its obligations without additional borrowing authority—expected **in August**.

Budget Reconciliation Legislation: *Impact on Healthcare Spending and Enrollment*

- The reconciliation budget adopted by Congress in April directed the House E&C Committee to find **at least $880 billion in federal savings**, of which most would need to come from Medicaid.
- On May 14, E&C adopted a legislative proposal that included **significant Medicaid policy changes** primarily targeting the Medicaid expansion group and state tools for financing the non-federal share of Medicaid, and proposed to **codify the Marketplace program integrity proposed rule**. The Congressional Budget Office (CBO) preliminarily estimated that the E&C bill would:

  - Cut healthcare spending by at least **$715 billion** over 10 years [federal fiscal year (FFY) 2025 to FFY 2034].
  - Result in **8.6 million** individuals losing health coverage if enacted as proposed.
  - In total, result in **nearly 14 million people** losing health coverage and becoming uninsured when the Medicaid and Marketplace provisions are considered with related rule changes and the scheduled expiration of the enhanced premium tax credits (PTCs).

- The House Ways and Means (W&M) Committee separately advanced reconciliation legislation to impose **additional conditions on financial assistance available through the health insurance Marketplaces and to eliminate automatic re-enrollment**.
- **CBO released preliminary estimates of the legislation** on May 20; and, on May 22, the House passed the "One Big Beautiful Bill Act" **with significant modifications**.

House Budget Reconciliation Legislation: *Medicaid and Marketplace Impact*

The House Budget Bill, if enacted, would have broad implications across the health coverage continuum—driving significant funding and coverage losses, while partially offsetting the federal deficit.

- **Compounded coverage loss** as individuals disenrolled from Medicaid because of new work requirements are unable to access subsidized Marketplace coverage; and other lower-income people will lose or be unable to get Marketplace coverage because of elimination of a special enrollment period, loss of eligibility for PTC during verification, and failure to extend enhanced PTCs.

- **Higher rates of churn within and between programs** driven by new Medicaid and Marketplace eligibility restrictions (e.g., more frequent eligibility determinations for expansion adults, new paper verification requirements and elimination of passive reenrollment in the Marketplace).

- **Barriers to getting, keeping, and using coverage**—such as copayments for expansion adults, removal of caps on the amount of money people who receive an APTC may need to repay at tax filing, lower PTC, higher cost sharing at each Marketplace metal level, and a shorter open enrollment period.

- **Deep cuts to federal funding**—such as restrictions on state financing tools including provider taxes and state directed payments (SDPs)—would shift fiscal pressure to states. While some states may experience modest reductions in their own expenditures, these savings will be outweighed by the scale of federal losses.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act.

House Budget Reconciliation Legislation: *Medicaid and Marketplace Impact (Continued)*

- **Increased administrative burden and implementation costs for states** that will need to hire/train additional staff, modify information technology (IT) systems, and conduct enrollee outreach/education to comply with the new requirements.
- **Higher uncompensated care costs and financial strain on providers**, particularly safety net institutions, due to rising uninsurance and disruptions in continuity of coverage, threatening access to care.
- **Sicker and more expensive risk pools** in both Medicaid and the Marketplace, as healthy individuals lose coverage due to procedural barriers (e.g., reporting requirements, cost sharing requirements)—exacerbating affordability challenges and reducing market stability.
- **Reduced coverage pathways for immigrant populations**, including a lower Medicaid expansion match for states supporting coverage of certain immigrants, elimination of Marketplace eligibility for Deferred Action for Childhood Arrivals (DACA) recipients, and tighter restrictions on which lawfully present individuals can receive PTCs.
- **Limits on access to certain healthcare services** [e.g., prohibiting federal Medicaid and Children's Health Insurance Program (CHIP) funding for gender-affirming medications/procedures, banning gender-affirming care as an Essential Health Benefit for youth and adults, barring federal payments to Planned Parenthood for abortion services].
- **Eliminates the need for section 1115 demonstration authority for work requirements**, though states would have to adhere to minimum federal requirements in designing/implementing their programs.

= Today's Focus

Reconciliation Proposals Impacting Medicaid

Key Provisions in Title IV		Section	Effective Date
Medicaid Work Requirements	Sub-regulatory guidance promulgated by the United States (U.S.) Department of Health and Human Services (HHS)	44141	December 31, 2025
	Begin conducting outreach to enrollees on work requirements		September 30, 2026
	Implement mandatory work requirements		December 31, 2026
Medicaid Expansion	Redetermine eligibility for certain adults every six months	44108	December 31, 2026
	Sunset eligibility for American Rescue Plan Act (ARPA) increased FMAP for expansion states	44131	January 1, 2026
	Require cost sharing for certain Medicaid expansion enrollees	44142	October 1, 2028
Medicaid Eligibility	Stop implementation of Biden-era eligibility and enrollment (E&E) final rule	44101, 44102	Date of enactment
	Reduce retroactive coverage under Medicaid and CHIP	44122	December 31, 2026
	Establish a standardized process to regularly update address information	44103	January 1, 2027
	New national federal database for address verification established by HHS		October 1, 2029
	New administrative requirements to ensure deceased individuals are not enrolled	44104	January 1, 2028
	Revise home equity limit for determining eligibility for long-term care services	44109	
	Remove good faith waiver for payment reduction related to eligibility-related improper payments	44107	October 1, 2029

= Today's Focus

Reconciliation Proposals Impacting Medicaid *(Continued)*

Key Provisions in Title IV		Section	Effective Date
Medicaid Payment and Financing	Ban on any new or increased provider taxes	44132	Date of enactment
	Prohibit certain existing provider taxes	44134	
	Payment limit for SDPs capped at 100% of Medicare for expansion states and 110% of Medicare for non-expansion states	44133	
	Require budget neutrality for section 1115 Medicaid demonstration projects	44135	Date of enactment
	Delay of disproportionate share hospital (DSH) reductions	44303	October 1, 2028
Gender-Affirming Care	Prohibit federal Medicaid and CHIP funding for gender-affirming medications and procedures	44125	Not specified (we assume date of enactment)
Provider Participation and Oversight	Bar Medicaid participation by Planned Parenthood for providing abortion services	44126	Not specified (we assume date of enactment)
	Stop implementation of Biden-era nursing home staffing final rule	44121	Date of enactment
	Additional Medicaid provider screening requirements (including new administrative requirements to ensure providers are not deceased)	44105, 44106	January 1, 2028
	Streamlined enrollment process for eligible out-of-state providers under Medicaid and CHIP	44302	Four years after enactment
Non-Citizen Coverage	Prohibition on federal financial participation (FFP) for applicants whose self-attested U.S. citizenship or qualifying immigration status cannot be verified	44110	October 1, 2026
	Reduce expansion FMAP for states that support coverage for certain immigrants	44111	October 1, 2027

Key Medicaid Proposals and State Impacts

Key House Reconciliation Proposals Impacting Medicaid

The House Budget Bill proposals would reduce federal Medicaid funding and establish new restrictions on eligibility, benefits, enrollment, and financing as part of the budget reconciliation process.

- Manatt has produced 10-year (FFY 2025 to FFY 2034) expenditure and enrollment estimates for the following key provisions for which sufficient public data are available:
  - *Standalone Impact:* Mandatory work requirements for Medicaid expansion adults (sec. 44141).
  - *Combined Impact*:
    - Mandatory work requirements for certain Medicaid enrollees (sec. 44141).
    - Redetermining eligibility for certain adults every six months (sec. 44108).
    - Establishing a ban on future new or increased provider taxes (sec. 44132).
    - Limiting SDPs (sec. 44133).
    - Reducing expansion FMAP for states voluntarily supporting coverage for certain immigrants (sec. 44111).
- Modeling will be updated to account for changes included in the final version of the House Bill.

- If the current legislative proposals are enacted, **every state—expansion and non-expansion—would see large reductions in federal funds.**
- Work requirements alone would result in **5.1 million fewer people** enrolled in Medicaid each year and **$487 billion in reduced federal funds** for the 41 expansion states and Wisconsin.
- When combined with the other key provisions listed above, the size of the **federal cuts increases to $807 billion**.

Other Medicaid House Reconciliation Proposals

Due to data limitations, Manatt's estimates do not account for several policy changes that would have major implications for states and Medicaid enrollees outside of the expansion group.

Repeal of the two Medicaid/CHIP E&E rules is expected to cause some 2.3 million fewer seniors, people with disabilities, children, and others to receive Medicaid coverage.

New mandatory cost sharing on certain adults in Medicaid of up to $35 can be expected to significantly affect their access to care.

Revoking already-approved "uniform" provider taxes will cost states such as California, Illinois, Michigan, New York, Ohio, and West Virginia billions of dollars.

Closing off states' ability to adopt new provider taxes or increase current taxes, or limitations on provider taxes other than hospital taxes, will have broad implications for states—beyond those reflected in Manatt's modeling.

Medicaid Work Requirement Mandate

By December 31, 2026, states would be required to condition Medicaid eligibility on compliance with work requirements for adults ages 19 to 64 enrolled through Medicaid expansion or a section 1115 demonstration providing minimum essential coverage (MEC).

How the Work Requirement Would be Structured

- **Compliance Checks.** States would need to verify compliance at both application and renewal using *ex parte* data "where possible"—meaning individuals would need to demonstrate completion of 80 hours of qualifying activities in the month prior to application and again once enrolled for at least one month within every six-month period.
  - States could alternatively adopt a more stringent approach by:
    - Requiring people to meet the requirements for multiple months before they can enroll;
    - Requiring individuals to comply for multiple months within any six-month period; and/or
    - Imposing more frequent verifications of compliance.

- **Qualifying Activities.** Defined as 80 hours in a given month of: work, a work program, community service, part-time education, a combination of these activities, or having a monthly income of at least $580 (the federal minimum wage multiplied by 80 hours).

- **Exemptions.** The bill lays out required exemptions and optional temporary exemptions (see appendix) but does not specify the way in which states would define and determine exemptions.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44141.

Medicaid Work Requirement Mandate *(Continued)*

- **Terminations.** Before denying or terminating coverage, states must provide 30 calendar days for the individual to demonstrate compliance or an exemption. If a person is denied or disenrolled due to work requirements, they would:
  - Need to file a new application to re-apply (triggering the compliance check for at least the month prior to application); and
  - Be barred from receiving subsidized Marketplace coverage for as long as the individual meets Medicaid eligibility criteria other than work requirements.

Implementation Details

- **Rulemaking.** HHS must promulgate guidance by December 31, 2025, with states expected to begin outreach to enrollees regarding the work requirement three months prior to implementation (i.e., by September 30, 2026, or earlier).
- **Funding.**
  - HHS will distribute $100 million across states to support state systems development for FY 2026 (allocated based on the number of people in the state subject to work requirements).
  - States should be able to receive federal Medicaid administrative matching funds but would need to contribute state funds to cover their share of the administrative costs.
- **Restrictions on Waiver Authority.** States may not waive the work requirement through section 1115 demonstration authority.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44141.

Standalone Impact of Mandatory Work Requirements

Implementing work requirements by December 31, 2026, for Medicaid expansion and expansion-like adults ages 19 to 64 would:

Cut federal funding for state Medicaid programs by:

$292 billion – $682 billion with a midpoint estimate of $487 billion
over 10 years

(5% to 12% of Medicaid spending overall and 14% to 32% of spending on the expansion group)

Terminate coverage for millions of people:

3.0 million – 7.1 million with a midpoint estimate of 5.1 million
fewer people will have Medicaid coverage, on average, each year

(4% to 10% of total Medicaid enrollment and 14% to 34% of expansion adults)

Funding cuts range from **1% - 3% in Wisconsin** to **7% - 17% in Montana**. States where Medicaid expansion spending represents a larger share of total Medicaid spending would be hit particularly hard (e.g., reductions of **7% - 16% in Louisiana and Nevada**).

Enrollment declines range from **2% - 5% in Wisconsin** to **7% - 17% in Oregon**. **Louisiana** and **Nevada** would also see large enrollment declines (**6% - 14%** and **6% - 13%,** respectively).

Notes: Manatt's estimate is based on the policy parameters of the House Budget Bill and a review of experience in states that previously implemented or began to implement work requirements. We estimate the impact on expenditures and enrollment as a range; specifically, we estimate the impact of the provisions using the midpoint estimate of work requirements on enrollment and expenditures, but the impacts will look substantially different across states and nationally.

Redetermine Eligibility for Certain Adults Every Six Months

If enacted, legislation would introduce a new requirement expected to increase churn for adults enrolled through Medicaid expansion or a section 1115 demonstration providing MEC.

- Beginning December 31, 2026, **states would be required to redetermine eligibility for expansion and expansion-like adults once every six months.**

This is a major departure from current 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.

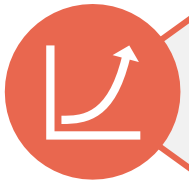
- This requirement would result in:
  - Individuals cycling in and out of the Medicaid program with greater frequency, creating a risk of disruptions to care.
  - Earlier terminations for some individuals who experience an increase in income (including a seasonal or temporary increase).
  - Procedural terminations for individuals who remained eligible but failed to complete all necessary paperwork.
  - Increased state administrative workload and associated costs.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44108.

Provider Taxes Policy Changes

All states except Alaska currently use provider taxes to help finance their share of Medicaid expenditures. The proposed legislation would prohibit states from establishing new or revised provider taxes.

Establishes a ban on new or revised provider taxes, allowing states with existing taxes to maintain them but prohibiting states from implementing any new, increased, or restructured Medicaid provider taxes after the date of enactment.



Leaves ambiguity regarding permissible adjustments to existing taxes, including whether states can maintain existing growth rate factors or recurring changes to their tax base data that are included in their provider tax policies.

Prohibits certain existing provider taxes that CMS deems not to be "broad based" and "uniform," including if they impose a lower tax rate on providers with low Medicaid volume or tax Medicaid services at a higher rate than equivalent non-Medicaid services.

States that have not passed legislation or issued regulations to impose Medicaid provider taxes prior to the proposed legislation's enactment would be unable to create new taxes or restructure existing taxes, permanently limiting their ability to finance their Medicaid programs moving forward.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44132, 44134.

State-Directed Payment (SDP) Policy Changes

States are currently permitted to establish SDPs up to the average commercial rate ("ACR"). The proposed legislation would cap future SDPs at 100% and 110% of Medicare payment levels.

New SDPs

- Under the proposed legislation, all new SDPs would be capped at 100% of Medicare rates for expansion states, as established in the Medicare fee schedule.
- States that have not expanded Medicaid may create new SDPs at 110% of Medicare.

Existing, "Grandfathered" SDPs

- SDPs that have already been approved or that are submitted to CMS for approval prior to the proposed legislation's enactment can be set up to the average commercial rate.
- States can continue to use these SDPs in subsequent rating periods but are limited to the amount in effect upon the legislation's enactment; application of growth rates (e.g., inflation) is not permitted.

This policy raises questions about whether the Medicare-based limit is adequate for pediatric, obstetric, and other services infrequently covered by Medicare. It is also unclear whether lower SDPs will be sufficient to sustain providers with low commercial payor mix, including many hospitals and nursing facilities.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44133.

Policy Changes Impacting Coverage for Non-Citizens

The legislation seeks to discourage Medicaid coverage of certain immigrant populations by cutting federal funding to states that support such coverage, even with state only dollars.

Prohibition on FFP for Applicants Whose Self-Attested U.S. Citizenship or Qualifying Immigration Status Cannot be Verified

- If enacted, the legislation would prohibit federal reimbursement for services during the "reasonable opportunity period" for individuals whose citizenship or immigration status is not immediately verified.
- States may choose to continue providing coverage during this period, but they will be financially at risk for any individuals who fail to submit appropriate documentation.

Reduce Expansion FMAP for States that Support Coverage for Certain Immigrants

- States that provide certain types of health coverage for undocumented immigrants (i.e., state-operated programs providing "comprehensive health benefits coverage" to undocumented individuals or financial assistance to help undocumented immigrants purchase "health insurance coverage") would face a reduced federal match rate (from 90% to 80%) for their Medicaid expansion population.
- The May May 21 amendment: (1) clarifies that the penalty does not apply to CHIPRA 214; (2) does not protect coverage for lawfully-residing people other than under CHIPRA 214 (some states fund coverage for lawfully-residing immigrants who do not qualify for federally-funded coverage); and (3) applies the penalty to humanitarian parolees.
- Federal funding cuts would vary by state, with California and New York being hit particularly hard: $41 billion and $17 billion over ten years, respectively.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44110, 44111. CHIPRA = Children's Health Insurance Program Reauthorization Act.

Sec. 44141, 44108, 44132, 44133, 44111

Combined Impact of Select Proposals

Implementing proposals to (1) mandate work requirements for certain Medicaid enrollees; (2) redetermine eligibility for certain adults every six months; (3) establish a ban on future new or increased provider taxes; (4) limit SDPs; and (5) reduce the expansion FMAP for states voluntarily supporting coverage for certain immigrants would:

Cut federal funding for state Medicaid programs by:

↓ $807 billion

over 10 years

(11% overall)

Losses range from **1% in WY** to **22% in MT. MT, NV, VA, and WA** would see declines in total funding of **15% or more**. Non-expansion states also face reductions (**7%** in **TN, 8%** in MS, and **10%** in **SC**).

Terminate coverage for millions of people:

↓ 5.4 million

fewer people will have Medicaid coverage, on average, each year

(8% overall and 25% among expansion adults)

All expansion states and **WI** would see coverage losses ranging from **3% - 13%** of total enrollment. **LA**, **NV**, and **OR** would lose **10%** or more of their total Medicaid program enrollment.

Notes: (1) Provider Taxes: The model includes hospital taxes only. We assume that hospital taxes would be frozen at FFY 2025 levels and would not be permitted to increase over time to account for inflation. No state would be able to levy any new or increased provider tax after enactment. We do not estimate the forgone federal funding states would have received from increasing their provider taxes absent the moratorium. We also assume that states would not replace the lost provider tax revenue resulting from the tax moratorium with state funds.
(2) SDPs: No state would be able to submit a new SDP after the date of enactment that allows for payment to hospitals and other providers at commercial rates; rates could be no higher than Medicare levels. States with existing SDPs that exceed Medicare levels could continue them at the same dollar level. States would not have flexibility to adjust existing SDPs for inflation – which is accounted for in the model. The model does not estimate the loss of funding that would have occurred if states were allowed to implement new SDPs to bring rates up to commercial levels.
(3) Reducing the Expansion FMAP for States Providing Coverage for Undocumented Immigrants: Estimates assume that impacted states will voluntarily eliminate associated coverage for immigrants so as to not incur the penalty on the 90% FMAP..

Looking Ahead

Next Steps on Budget Reconciliation

- With House passage of the reconciliation bill, **it will now go before the Senate for consideration.**
- Like the House, the **Senate committees will prepare reconciliation legislation** (but will likely bypass committee markups).
- Once the Senate Budget Committee combines the various bills, **the Senate will consider the budget reconciliation bill under the Congressional Budget Act guardrails (including the Byrd Rule).**
- Based on reconciliation instructions, the Senate does not necessarily need to incorporate the same level of Medicaid cuts as the House. However, there **remains pressure to agree to large spending cuts** to counterbalance the federal deficit increase from extending the tax cuts.
- **The House and Senate must pass identical legislation** before it goes to the President's desk.

Looking Ahead

- Remember to register for the second webinar in our two-part series on budget reconciliation, scheduled for **Thursday, May 29 from 3:00 to 4:00 p.m. ET**.

- Experts will review changes proposed as part of the House Budget Bill to policies governing the **Affordable Care Act (ACA) Marketplace** and discuss implications for state officials.

- Register at the following link: **https://princeton.zoom.us/webinar/register/WN_QSmDn51aRbGCJJmM9wPlSg**

For more information, see this new SHVS/Manatt analysis describing 10-year expenditure and enrollment estimates for select Medicaid provisions in the House Budget Bill (to be updated to account for changes included in the final version of the House Bill).

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

Other Medicaid Expansion Policy Changes

If enacted, legislation would introduce requirements disincentivizing additional state adoption of Medicaid expansion and increasing risk of churn among the Medicaid expansion population.

Sunset of Eligibility for ARPA Increased FMAP For Expansion States

- If enacted, states that elect to expand Medicaid after January 1, 2026, would no longer be eligible to receive the two-year five-percentage-point ARPA increase to their standard FMAP for most non-expansion Medicaid population.
- This is separate from the 90% FMAP for the expansion population.

Require Cost Sharing for Certain Medicaid Expansion Enrollees

- States would be required to impose copayments on all services except those exempted under existing law (e.g., prenatal, family planning, certain emergency services) for adults with incomes above 100 percent of the FPL.
- The May 18 amendment adds language exempting primary care services, mental healthcare services, or substance-use disorder services from these copayment requirements.
- States would decide the amount, not to exceed $35 per service and subject to a limit of 5% of family income. At state option, providers could deny services for failure to pay.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44131, 44142.

Other Medicaid Eligibility Policy Changes

The legislation would effectively repeal the Medicaid and CHIP E&E final rule (the second largest source of spending reductions in Title IV) while reducing retroactive coverage.

Repeal of the Medicaid and CHIP E&E Final Rule

- The legislation would delay implementation of the Medicaid E&E final rule (parts 1 and 2) until 2035.
- CBO estimates that this will cause **2.3 million** people (including seniors, people with disabilities, children, and others) to lose Medicaid coverage.
- The rule aimed to reduce barriers to enrollment in Medicare Savings Programs, and streamline Medicaid/CHIP application and renewal processes.
- The delay would: allow continued use of CHIP premium lock-outs, waiting periods, and annual/lifetime limits on benefits for children; and maintain enrollment and renewal barriers for older adults and people with disabilities.

Reduce Retroactive Coverage Under Medicaid and CHIP

- Medicaid retroactive coverage would be shortened from three months to one month.
  - Shortening Medicaid retroactive coverage would limit access to Medicaid coverage in the months preceding the individual's Medicaid application, increasing the risk of unpaid medical bills and higher uncompensated care costs.
- States would be permitted to provide one-month of CHIP retroactive coverage. (Currently CHIP does not have retroactive coverage and services may only be paid in the month of the application.)

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44101, 44102, 44122.

Other Medicaid Eligibility Policy Changes *(Continued)*

The legislation includes several provisions aimed at tightening Medicaid eligibility and oversight.

States would need to 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 federal data matching service to identify dual-state enrollment by October 2029.

States would be required to check the Social Security Administration Death Master File quarterly, treat the information as factual, and disenroll deceased individuals from Medicaid. (States would need to retroactively reenroll anyone incorrectly removed.)

The home equity limit used to determine financial eligibility for Medicaid LTSS would 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 CPI); (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.

Except in limited cases involving the Medicaid "spend down" group, **the legislation would eliminate CMS' ability to waive federal disallowances for states that exceed the 3% error rate** for eligibility-related improper payments, even when states make good faith efforts to comply. The error rate would be calculated based on Payment Error Rate Measurement findings, Medicaid Eligibility Quality Control findings, and HHS Inspector General and CMS audits.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44103, 44104, 44109, 44107.

Other Medicaid Payment and Financing Policies

The proposed legislation would reinforce certain existing financing practices in the Medicaid program.

Require Budget Neutrality for Medicaid Demonstration Projects Under Section 1115

- CMS has imposed a longstanding requirement that section 1115 demonstrations must cost no more to the government than the state's Medicaid program would cost absent the demonstration (i.e., be "budget neutral"). The proposed legislation would codify this requirement into law.
- This provision does not appear to make any changes to how budget neutrality policy works today.
- CBO estimates that this provision will have no impact on federal spending in the next ten years.

Delay DSH Reductions

- Reductions in the federal allotments for DSH payments—a significant source of supplemental funding for hospitals—have been slated to take effect since 2014. However, these cuts have been delayed more than a dozen times in the intervening years.
- The proposed legislation further delays these cuts until Fiscal Year (FY) 2029.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44135, 44303.

Gender-Affirming Care (GAC) and Abortion

The proposed legislation would eliminate federal Medicaid match for gender-affirming medications and procedures, as well as for certain reproductive health providers (i.e., Planned Parenthood).

Prohibits states from claiming federal Medicaid/CHIP match for medications and procedures to treat transgender Medicaid enrollees of all ages, while maintaining these services for people with other diagnoses. To continue covering medical gender-affirming services, states would be required to use state-only dollars.

Marketplace Intersection: ACA Marketplace plans would also be prohibited from covering GAC as an essential health benefit.

Bars federal payments to "prohibited entities" that provide abortion services. This provision appears to target Planned Parenthood and would prohibit all federal Medicaid funding to qualifying providers, regardless of the services being rendered. Notably, CBO estimates this would *increase* federal spending by $261 million over ten years.

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44125, 44126.

Provider Participation and Oversight Provisions

The proposed legislation includes several provisions that would impact how providers interact with state Medicaid agencies, including delaying the Biden-era Nursing Home Staffing Rule.

Prohibits implementation of the Biden-era nursing home staffing rule until 2035, delaying enforcement of new minimum staffing requirements and reporting of the percentage of Medicaid reimbursement that goes to direct care workers' compensation.

Codifies existing provider screening requirements that states confirm whether a provider has been terminated from Medicare or another state Medicaid agency on at least a monthly basis and cross-reference the Death Master File when enrolling and revalidating providers to ensure the provider is not deceased.

Requires states to implement an expedited enrollment process for out-of-state providers that seek to treat Medicaid members under the age of 21. If in good standing with Medicare and/or another state Medicaid agency, these providers must be allowed to enroll with the state without additional screening and must be permitted to remain enrolled for 5 years (unless terminated for cause).

Source: House Committee on Rules, H.R. ____ - One Big Beautiful Bill Act, Title IV, Sec. 44121, 44105, 44106, 44302.

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/caregivers of a dependent child or disabled individual
- Pregnant or receiving Medicaid postpartum coverage
- Foster youth and former foster youth under the age of 26
- American Indians and Alaska Natives
- Disabled veterans
- Incarcerated or recently released from incarceration within the past 90 days
- Entitled to Medicare Part A or enrolled in Medicare Part B
- Meeting TANF or SNAP work 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* exempt individuals for a given month if, at any point during that month, they experience and request a "short-term hardship" exemption during that month, 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 Secreyary
- 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 4.2% as of April 2025)