National Alliance for Care at Home

July 7, 2025

HR1: The One Big Beautiful Bill Act
Provisions Relevant to Medicaid HCBS Providers

This summary provides information for providers that deliver Medicaid-funded home and community-based services (HCBS) about provisions in the House Resolution 1, the One Big Beautiful Bill Act, also known as the "Reconciliation" bill. President Trump signed the legislation on July 4, 2025, and therefore the provisions below will now become law.

Overall, the legislation represents a large reduction in Federal Medicaid expenditures, with CMS projecting a reduction in Federal Medicaid spending of over a trillion dollars between 2025 and 2034. Over the next few years, states will be forced to make challenging decisions about how to respond to these changes, including whether to "backfill" with additional state money and prevent reductions or whether to reduce state Medicaid spending commensurate with the loss of Federal matching funds. In the latter scenario, overall reductions at the service-level will be multiplied due to the loss of both state and Federal funds.

Importantly, the legislation draws distinctions between states that elected to adopt the Affordable Care Act Medicaid expansion (known as the ACA expansion or expansion states in many areas). At this time, all but ten states are expansion states.[1] For reference, the ten states that are not "expansion states" are:

1. Alabama
2. Florida
3. Georgia
4. Kansas
5. Mississippi
6. Tennessee
7. South Carolina
8. Texas
9. Wisconsin
10. Wyoming

Key provisions that are likely to impact home care providers, direct care workers, and/or the individuals we serve include:

- SEC. 71101: Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs.

[1] https://www.kff.org/status-of-state-medicaid-expansion-decisions/

- SEC. 71102. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and The Basic Health Program.
- SEC. 71107. Eligibility Redeterminations.
- SEC. 71108. Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services Under the Medicaid Program
- 71112. Reducing State Medicaid Costs
- 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals
- Sec. 71120. Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program.
- 71121. Making Certain Adjustments to Coverage of Home or Community-Based Services Under Medicaid
- SEC. 71401. Rural Health Transformation Program

Below, we also provide a section-by-section summary of Medicaid-specific provisions and their potential impact on HCBS, including the key provisions listed above. Please note that any references to the expected fiscal impact of a provision is drawn from the Congressional Budget Office's June 29th estimates[2] and may change as CBO issues updated analysis.

Notably, the legislation did not contain a moratorium on the Medicaid Access rule and the 80-20 provision. Though the Alliance advocated for inclusion, discussions with Committee staff indicated that such a moratorium did not meet the strict rules for Reconciliation and therefore could not be implemented as part of the law.

SEC. 71101: Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs.

This portion of the bill would prevent the Centers for Medicare & Medicaid Services (CMS) from implementing parts of the Medicare Savings (MSP) rule that focused on making it easier for individuals with disabilities and older adults to enroll in Medicaid programs that reduce their out-of-pocket Medicare expenses. Although initial versions of the legislation placed the entire rule under moratorium, our understanding is that the Senate parliamentarian told Congressional Republicans that provisions already implemented could not be frozen. Therefore, the moratorium is limited to portions of the rule that have not yet become effective. The moratorium is effective beginning on the date of the legislation's enactment and ending September 30, 2034. For reference, the full MSP rule is available here.

[2] https://www.cbo.gov/publication/61534

Portions of the rule subject to this moratorium include:

- Qualified Medicare Beneficiary Effective Date for Certain Individuals (§ 406.21): this is an extremely technical change that effectively expedited the enrollment of certain individuals into the Qualified Medicare Beneficiary (QMB) program. Specifically, it applies to individuals who reside in what is called a "Group Payer State" for Medicare Part A and who enroll in Part A at a time other than their initial enrollment period when they first become eligible for Medicare. (In Group Payer States, this enrollment occurs during the General Enrollment Period beginning on January 1 and ending on March 31 of each year). The states in question are: Alabama, Arizona, Colorado, Illinois, Kansas, Kentucky, Missouri, Nebraska, New Jersey, New Mexico, South Carolina, Utah, and Virginia.[3]
- Facilitate Enrollment Through Medicare Part D Low-Income Subsidy "Leads" Data (42 CFR 435.4, 435.601, 435.911, and 435.952): this provision requires states to streamline the eligibility and enrollment process for individuals who apply for Medicare Part D's Low-Income Subsidy (LIS) (also known as "extra help") by using information transmitted to Medicaid agencies from the LIS application to create an application for the MSP program(s). The provisions also require states to accept LIS application information and use self-attestation approaches for certain income/assets, provided the information is reasonably compatible with the State's data.

CMS has a PowerPoint available online that explains these provisions in more detail: https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall09262023.pdf

The smaller enrollment in MSPs due to the moratorium is expected to reduce Federal expenditures by $85 billion dollars over the 10-year period.

SEC. 71102. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and The Basic Health Program.

Similar to the MSP regulations discussed in the previous section, the Senate bill places a moratorium on specific items within the Medicaid eligibility and enrollment rule. Overall, the moratorium on this rule is expected to result in fewer older adults and people with disabilities who are able to access Medicaid assistance for their out-of-pocket costs and, for some individuals, fewer Medicaid enrollments. The resulting enrollment decline is

[3] https://medicareadvocacy.org/general-enrollment-period-and-part-a-buy-in

expected to reduce Federal expenditures by over $81 billion during the 2025-2034 budget window. For reference, the full rule is available online.

The portions of the rule subject to this moratorium cannot be implemented sooner than 2034. The provisions within the regulation that would be frozen include 42 CFR:

- 431.213(d): created an exception to advance notice procedures when "the beneficiary's whereabouts are unknown, and the post office returns mail directed to him indicating no forwarding address."
- 435.222: The changes to this section by the regulation re-named the section heading in order to draw a distinction between section 222 and the regulation's newly-created 223, which clarified the option for states to create an eligibility group for children who meet eligibility criteria for disability-based or other related groups. Notably, the legislation does not appear to place a moratorium on section 223, so the new eligibility would remain a state option.
- 435.407: this section would require states to verify U.S. citizenship directly through an electronic interface with a State vital statistics agency or through the Department of Homeland Security (DHS) SAVE system.
- 435.907 & 435.916: This provision would align eligibility procedures for older adults and people with disabilities (commonly referred to as non-MAGI individuals) with other Medicaid provisions, to apply and renew through all modalities, renewing eligibility no more frequently than every 12 months, providing a pre-populated renewal form, giving enrollees 30 days to respond, and allowing a 90-day reconsideration period. This is the most significant part of the moratorium for coverage of older adults and people with disabilities and will allow the burdensome and disparate Medicaid eligibility process used for older adults and people with disabilities to continue.
- 435.911 & 435.912: Established maximum timeframes for redetermination of eligibility at renewal and based on changes in circumstances as well as performance measures monitoring state compliance with those timelines.
- 435.919: Established required steps for states when redetermining Medicaid and CHIP eligibility based on changes in circumstances.
- 435.1200(b)(3)(i)-(v): streamlining, coordinating, and minimizing beneficiary burden for applications transitioning between Medicaid and the health insurance exchange.
- 435.1200(e)(1)(ii): streamlining coverage between CHIP and the exchange (or Basic Health Plan, if applicable) for individuals not eligible for Medicaid.
- 435.1200(h)(1): Requirements for a combined eligibility notice across various health programs.

- There are also references to moratorium of policies contained in parts 457 of 42 CFR, which apply to CHIP and not Medicaid and therefore are not discussed in this summary.

SEC. 71103. Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs

This section requires states to ensure that they have a process to regularly obtain updated address information for Medicaid beneficiaries, beginning January 1, 2027. Beginning October 1, 2029, CMS must establish a national data system to collect information on Medicaid enrollees and states must submit information to that system to ensure that participants are not enrolled in multiple state Medicaid programs simultaneously. This provision is expected to result in $17.4 billion of Federal savings during the 10-year budget score.

SEC. 71104. Ensuring Deceased Individuals do not Remain Enrolled

Beginning January 1, 2027, each state must match beneficiaries with the Social Security Administration's Master Death File and ensure that deceased individuals are disenrolled from the program. This must occur on at least a quarterly basis. CBO did not determine that this provision would result in any substantial Federal savings.

SEC. 71105. Ensuring Deceased Providers do not Remain Enrolled

Beginning January 1, 2028, each state must match providers, as part of initial provider enrollment and then quarterly while the provider remains a Medicaid-enrolled provider, with the Social Security Administration's Master Death File and ensure that deceased individuals are disenrolled from the program. This must occur on at least a quarterly basis. CBO did not determine that this provision would result in any substantial Federal savings.

SEC. 71106. Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid.

For states with erroneous excess Medicaid payments over the allowable error rate (3 percent), CMS is instructed to reduce Federal Medicaid payments but has the option to waive the reduction. The bill reduces the amount of reduction that could be waived and expands "erroneous payments" to include payments for services to individuals where there may be eligibility errors or other issues that preclude Federal funding for the participants. Overall, the expectation is that this will reduce payments to states which could further squeeze budgets. CBO projects that this will reduce Federal expenditures by $7.5 billion over the next ten years.

SEC. 71107. Eligibility Redeterminations.

Beginning January 1, 2027, States must perform eligibility redeterminations every 6 months—instead of the currently required annual redeterminations—for individuals enrolled in the Affordable Care Act (ACA) Medicaid expansion. Native Americans/American Indians are exempt from this requirement. While this provision is intended to focus on the ACA expansion population, complex eligibility criteria results in people with disabilities who receive home care services being enrolled in the expansion group. Further, we anticipate that many direct care workers will be impacted by this provision given that nearly a third are enrolled in Medicaid.[4] Overall, the reduced enrollment due to more frequent verifications is projected to reduce Federal expenditures by $62.6 billion over ten years.

SEC. 71108. Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services Under the Medicaid Program

The Deficit Reduction Act of 2005 placed limits on the amount of home equity that individuals could have and still qualify for long-term care services, including both institutional and HCBS. States are required to count home equity towards the Medicaid asset limits above a certain exempted threshold. For the exempted threshold, there is a minimum amount that states must exclude and a maximum amount that they can elect to exclude (i.e. States can increase the amount of equity "not counted" for eligibility if they would like). In 2025, the minimum amount that states must exclude is $730,000 and the maximum is $1,097,000. Previously, these limits increased with inflation each year. The legislation makes several key changes to this provision, effective on January 1, 2028:

1) It lowers the maximum amount that can be excluded to $1,000,000;
2) It removes the inflationary update on the maximum amount that can be excluded – in other words, the $1 million exclusion will remain static forever, whereas the $730,000 will continue to increase until it hits $1 million – at which point all states will be required to exclude $1 million and cannot go higher.
3) It prevents states from using "asset disregards" to increase the exclusion higher than $1 million (note: this provision appears to become effective immediately upon enactment of the legislation—an area we will work to clarify);
4) It creates a new exemption for homes on agricultural lots to avoid counting the agricultural assets towards Medicaid eligibility.

Though the initial reduction in the maximum amount of home equity that can be excluded is rather minor (from $1,097,000 to $1,000,000), the bigger impact of this policy will come from the removal of inflationary updates to that maximum. Essentially, the maximum home

[4] https://www.missioncare.com/workforce-report-2025

equity will be permanently capped at $1,000,000 regardless of cost-of-living increases. While $1 million seems like a lot of equity, it is important to remember that this policy will primarily impact older adults who purchased their homes many decades ago and experienced significant home value increases. In effect, this will force older adults to sell their homes and will likely result in them moving to assisted living or nursing facilities. CBO projects that this provision will save the Federal government $195 million over ten years,

SEC. 71109. Alien Medicaid Eligibility

This section clarifies and narrows the noncitizens that may be eligible for Medicaid, beginning October 1, 2026, resulting in a projected $6.2 billion of reduced Federal expenditures. Specifically, the provision prohibits any Federal payments under Medicaid for individuals unless they are a resident of one of the 50 states, the District of Columbia, or the territories; and are also one of the following:

1) A citizen or national of the United States;
2) An alien lawfully admitted for permanent residence as an immigrant, but not visitors, tourists, diplomats, and students who enter the United States temporarily with no intention of abandoning their residence in a foreign country;
3) An alien who has been granted the status of Cuban and Haitian; or
4) An individual who lawfully resides in the United States in accordance with a Compact of Free Association (refers to individuals legally living in the USA as part of agreements with the Freely Associated States of Micronesia, Marshall Islands, and Palau).

SEC. 71110. Expansion FMAP for Emergency Medicaid

Under longstanding Medicaid law, emergency services are the only payments that can be made for undocumented immigrants or individuals otherwise in the country illegally. These payments can only be made if the individual requires immediate emergency care and would otherwise qualify for Medicaid, except for their immigration status. This provision clarifies that the higher ACA Federal Matching rate of 90% is not available for individuals who would otherwise be eligible for the ACA expansion. Instead, emergency services that are provided to undocumented immigrants will be matched at the usual state rate.

As with other provisions in the legislation, this does not directly impact HCBS or long-term care services; however, reduced Federal payments to states will generally place strain on overall budgets. Overall, CBO projects that this will reduce Federal expenditures by $28 billion over 10 years.

SEC. 71111. Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities Under the Medicare and Medicaid Programs

The legislation places a moratorium on implementation of the Biden-era nursing home staffing rule, effective beginning on the date of the enactment and ending September 30, 2034. The moratorium is expected to reduce Federal expenditures by $23 billion over the 10-year CBO budget window.

The legislation places a moratorium on two key parts of the regulation:

- Section 483.5, which added the definitions of "Hours per resident day" and "Representative of direct care employees"
- Section 483.35, which set minimum standards for hours per resident day as well as a wide range of reporting and enforcement criteria. As a reminder, the minimum standards were:
    - No less than 3.48 hours per day of total nurse staffing for each resident, including:
        - 0.55 hours per resident day for registered nurses; and
        - 2.45 hours per resident day for nurse aides.

The full rule is available online for reference.

While the nursing home staffing rule did not directly impact HCBS or home care providers, it did have two important ancillary impacts. First, the rule would require nursing homes to increase staffing ratios and thus create greater competition with home health and HCBS agencies for nursing staff. The rule would also place pressure on state budgets as rate increases would be required to cover the increased personnel costs associated with the regulation. The moratorium on the rule is generally an indirectly positive provision for Alliance members.

SEC. 71112. Reducing State Medicaid Costs

This section, though the name is somewhat confusing, refers to retroactive Medicaid coverage for beneficiaries. Previous Medicaid policy provided for 3 months of retroactive coverage – i.e., Medicaid would pay for services rendered to an individual up to 3 months prior to their application for the program, if the individual met eligibility requirements at the time the service was delivered. This provision is often used to finance hospital services for individuals who are eligible but unenrolled at the time of admission but is also often available for a wide range of other services.

The legislation shortens retroactive coverage beginning January 1, 2027, creating two separate policies depending on the eligibility group of the individual:

- One month of retroactive coverage for those who are eligible for the ACA Expansion;
- Two months of retroactive coverage for everyone else.

HCBS is generally not provided on a retroactive basis, due to requirements around assessment and plan of care prior to delivery of HCBS; however, it is possible that home care providers could be impacted by limits on retroactive coverage for post-acute care. Additionally, direct care workers could also be impacted. The provision is expected to reduce Federal Medicaid expenditures by $4.2 billion over 10 years.

SEC. 71113. Federal Payments to Prohibited Entities

This section creates a prohibition on Medicaid payments to certain nonprofit entities that provide abortion services. The criteria is specifically targeted to remove Planned Parenthood as an allowable Medicaid provider. This provision is projected to result in $52 million of Federal savings over 10 years.

SEC. 71114. Sunsetting Increased FMAP Incentive

The American Rescue Plan Act, the Democratic Party reconciliation bill, included a provision that provided a time-limited 5% increase - to 95% for two years - to the ACA Medicaid expansion FMAP for states that adopt the expansion in the future. Beginning January 1, 2026, this provision rescinds that incentive, resulting in a projected $13.6 billion of Federal savings over the ten-year period.

SEC. 71115. Provider Taxes

Alongside the Community Engagement Requirements (discussed in Section 7119), changes to Provider Taxes are one of the most consequential parts of the legislation for Medicaid agencies. Though provider taxes are not generally utilized in the home health and HCBS space, the broader implications of provider tax restrictions will place serious pressure on overall state budgets, likely leading to challenging fiscal environments moving forward with the possibility of restrictions to eligibility for participants, including HCBS waiting lists; amount and scope of services covered; and rate restrictions.

The Provider Tax provision does several things and treats ACA expansion states differently from nonexpansion states. For nonexpansion states, the provider tax threshold is frozen at whatever was in place on the date of enactment of the legislation (including, if no tax was in place, 0%). States would not be permitted to expand taxes to new types of providers or services, nor would they be allowed to increase any existing tax rates.

For expansion states, the provider tax threshold is also frozen at whatever was in place on the date of enactment with prohibitions on new or increased taxes. Additionally, for these

states the maximum allowable provider tax rate slowly decreases from the current 6% to 3.5%. This occurs on the following schedule:

- 5.5% for Federal fiscal year (FFY) 2028
- 5% for FFY 2029,
- 4.5% for FFY 2030
- 4% for FFY 2031
- 3.5% for FFY 2032 and beyond.

In other words, nonexpansion states will be frozen at their current rates whereas expansion states will be capped at the lesser of their current rates or the percentages listed above in each year.

In expansion states, nursing facilities and intermediate care facilities for individuals with intellectual disabilities will not be subject to the lower threshold; taxes for these providers will be frozen at current rates, similar to non-expansion state policy. Thus, in states with existing institutional provider taxes, there may be further entrenchment of institutional bias due to this new favorable funding policy for such providers.

Overall, the provision is expected to reduce Federal expenditures by $191 billion over ten years.

SEC. 71116. State Directed Payments

State-directed payments (SDPs) are managed care policies often coupled with provider taxes at the state level, and Congress makes changes to SDPs as well. SDPs are a provision that allows states to direct managed care organizations to pay a certain amount to various types of providers. Under the recent Managed Care Rule, promulgated by the Biden Administration in 2024, state SDPs cannot exceed the average commercial rate for services. This legislation treats ACA expansion and nonexpansion states separately.

- Expansion state SDPs are limited to 100 percent of the Medicare rate or, if there is no Medicare rate, then the Medicaid State plan rate;
- Nonexpansion state SDPs are limited to 110 percent of the Medicare rate or, if there is no Medicare rate, then the Medicaid State plan rate. Notably, the language in this section is somewhat confusing so there will need to be confirmation regarding whether the limit is 100% or 110% of the Medicaid state plan rate in absence of a Medicare rate.

Starting January 1, 2028, if states currently have SDPs that exceed these limits, the payment amounts must decrease by 10% each year until it meets these new limits. Overall, CBO projects this provision to reduce Federal expenditures by $149 billion over ten years.

SEC. 71117. Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax.

This is a very technical provision that attempts to rectify a purported loophole in the way that some states impose provider taxes, resulting in $34.6 billion of reduced Federal expenditures. In a very oversimplified summary, some states have carefully constructed taxes—most often in the Managed Care space—in a manner that leverages a higher percentage of funding from Medicaid programs compared to other Medicare or Commercially-financed programs. Though Medicaid generally prohibits this type of practice, there are ways that states can meet statutory and regulatory requirements while still leveraging additional taxes on Medicaid-funded entities. Our understanding is that this provision will directly impact the managed care taxes in New York, California, Illinois, Ohio, West Virginia, Michigan, and Massachusetts. Those states will likely need to reconstruct taxes in a manner that meets the requirements (and doesn't violate the new restrictions on provider tax policy discussed above) or will lose potentially a substantial amount of Federal funding.

The provision is effective immediately but allows CMS to grant states up to three (3) years to phase-out the noncompliant taxes.

Of note, CMS has signaled previously—including under the Biden Administration—that they intended to close this loophole. For examples, see the 2024 letters sent to New York and to California.[5] The Trump administration issued regulations[6] that would have addressed this loophole; however, the legislation will preclude those regulations (and allow Congress to count the savings towards this bill).

SEC. 71118. Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115

Although 1115s are already required to be budget neutral, concerns have arisen among some members of Congress regarding whether this is actually occurring in practice. This legislation places additional requirements on budget neutrality, including assessment and oversight of such neutrality by the CMS Actuary Office, as well as directing CMS to issue new guidance around how savings generated by waivers can be reinvested in the program. CBO projects that this will result in $3.2 billion of reduced Federal spending over 10 years.

[5] NY: https://www.health.ny.gov/health_care/medicaid/rates/dfrs/docs/2024-12-20_cms_letter.pdf; CA: https://www.dhcs.ca.gov/services/Documents/1903w3B-and-C-MCO-Tax-2023-2026-Amendment.pdf

[6] https://www.cms.gov/newsroom/press-releases/cms-moves-shut-down-medicaid-loophole-protects-vulnerable-americans-saves-billions

SEC. 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals

This legislation requires states to implement Community Engagement Requirements no later than January 1, 2027, with a state option to implement them at an earlier date. The Community Engagement Requirements, also known as Work Requirements, are the most significant policy within the legislation and comprise the largest single portion of projected Federal savings at $325.7 billion over the ten-year CBO scoring period. The savings are primarily due to individuals no longer receiving Medicaid – and being barred from ACA exchange tax credits – if they do not meet the requirements.

The policy is extremely detailed, nuanced, and wide-reaching. Though many of the other provisions only apply to the ACA expansion population and/or states that adopted this expansion, this provision applies to all states. Given the significance of the provisions, we provide more detailed information on the underlying provisions.

Basic Requirement

In order to qualify for Medicaid, people subject to the requirements must perform at least 80 hours of Community Engagement during a covered month. The 80 hours can be met several ways, including:

1) Work
2) Education
3) Volunteering

For example, an individual can work for 40 hours, go to school for 20, and volunteer for 20 in order to fulfill these requirements. An individual can also meet these requirements if they have a monthly income that is at least the Federal minimum hourly wage (currently $7.25) times 80 hours ($580). There is also a provision to allow seasonal workers who have average wages equal to the minimum wage multiplied by 80 over the prior six months.

Populations Subject to the Community Engagement Requirements

The requirements apply to Medicaid enrollees between ages 19-64, with a number of exclusions, including:

- Individuals entitled to or enrolled in Medicare Part A or B;
- Individuals eligible for a Mandatory Medicaid enrollment group (note: optional groups are not included in the exemption);
- Individuals under age 26 who aged out of state Foster care;

- Indians, Urban Indians, California Indian, and those otherwise determined eligible as an Indian for the Indian Health Service;
- A parent, guardian, caretaker relative, or family caregiver of a dependent child 13 years of age and under, or of a disabled individual;
- A veteran with a total disability;
- A medically frail individual, or someone who otherwise has special medical needs, such as a person:
    - Who is blind or disabled;
    - With a substance use disorder;
    - With a disabling mental disorder;
    - With a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or
    - With a serious or complex medical condition.
- People already in compliance with TANF or SNAP work requirements;
- Those participating in a drug addiction or alcoholism treatment and rehabilitation program;
- Inmates of a public institution; or
- Women who are pregnant or entitled to postpartum medical assistance.

Verification

States must verify that each such individual has met the requirements during their initial eligibility determination as well as the regularly required redetermination; however, states can require more frequent verification.

When an individual is a new applicant, the state must verify that they met the requirements for at least one, but up to 3 (at state option) months PRIOR to Medicaid application. In other words, individuals must already have met these requirements before they can apply for Medicaid. When an individual is enrolled in Medicaid, at the time of their redetermination, the state must verify that they met the requirements for at least one month during their enrollment in the program (or, at state option, more than one month – potentially including every single month).

States must use reliable information available to the State (such as payroll data or payments or encounter data under this title for individuals and data on payments to such individuals for the provision of services covered under this title) without requiring, where possible, the applicable individual to submit additional information. Notably, this language was added after a request from the Alliance and our partners to expedite verification of workers who may provide Medicaid-funded services but also be enrolled in Medicaid.

Hardship Exemption

States may provide individuals a hardship exemption from the requirements if they meet one of the following circumstances:

- Receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or other services of similar acuity;
- Resides in a county (or equivalent unit of local government):
    - In which there exists an emergency or disaster declared by the President;
    - Has an unemployment rate that is at or above the lesser of:
        - 8 percent; or
        - 1.5 times the national unemployment rate; or
- The individual or their dependent must travel outside of their community for an extended period of time to receive medical services necessary to treat a serious or complex medical condition.

Good Faith Effort Exemption

Similar to what we saw with the Medicaid Electronic Visit Verification requirements, this legislation allows CMS to provide states with a time-limited exemption of the requirements if they demonstrate a good faith effort to comply with the requirements but do not meet the January 1, 2027 deadline. The good faith effort cannot be extended beyond December 31, 2028.

SEC. 71120. Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program.

Beginning October 1, 2028, this section requires states to impose cost-sharing on services delivered to individuals enrolled in the ACA expansion population with incomes above 100% of the Federal poverty level. The cost-sharing amounts must be greater than $0 but no more than $35 and also may not exceed 5% of the individual's gross family income.

Excluded services are:

- Services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over);
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;

- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required to pay a share of costs;
- Emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C);
- Services provided to an individual who is receiving hospice care;
- COVID-19 diagnostic and treatment services;
- Primary care services;
- Mental health care services;
- Substance use disorder services; or
- Services provided by a:
    - Federally qualified health center;
    - Certified community behavioral health clinic; or
    - Rural health clinic.

Notably, the cost sharing provisions do not exclude home health, private duty nursing services, personal care, or other HCBS. Though the number of individuals who receive these services and will be subject to cost-sharing requirements is small, it is greater than zero. Consistent with prior cost-sharing provisions, we anticipate that states will reduce the provider payments by an amount equal to the copayment and will expect the provider to collect the remainder of their payments from the recipient. In many cases, copayments cannot be collected and the cost-sharing policy results in a de facto rate reduction.

We also anticipate that providers who do attempt to collect cost-sharing will have administrative and operational expenses to establish and operate the required infrastructure. We further expect that some states will expand the copayment requirements beyond this Federal minimum into optional populations as part of future budget balancing exercises. Overall, we believe that this provision will be quite challenging both to participants and to providers. CBO projects that this provision will reduce Federal expenditures by $7.4 billion over ten years.

SEC. 71121. Making Certain Adjustments to Coverage of Home or Community-Based Services Under Medicaid

This section allows states to create a new 1915(c) waiver, beginning July 1, 2028, that serves individuals who do not meet the institutional level of care typically required for these waivers. The clinical eligibility for these waivers uses a needs-based criteria that is similar to the eligibility requirements for 1915(i) state plan HCBS. The state must demonstrate that the per-capita cost will be lower than the cost of institutional care for

serving these individuals, and that the waiver will not result in increased waiting times for those who meet the institutional level of care criteria.

Overall, this appears to be a positive provision that provides states with enhanced flexibility to serve individuals at lower levels of care prior to meeting institutional level of care requirements. It has some distinct differences from Section 1915(i) – including that it will allow states to cap enrollment and impose waiting lists and will require cost-neutrality compared to institutional care. The cost neutrality requirements may limit its applicability to behavioral health services.

CBO projects that this provision will increase Federal spending by $6.5 billion over the 10-year scoring window.

SEC. 71401. Rural Health Transformation Program

This section provides a total of $50 billion - $10 billion a year for the 5 years beginning FFY2026 and ending FFY2030 – to help offset the loss of Federal Medicaid funding for certain rural providers. The 50 states (but not DC) are eligible to apply for funding under this new program. In order to access the funding, states will need to submit a rural health transformation plan that addresses a variety of factors, including:

- Improving rural access hospitals, other health care providers, and health care items and services;
- Improving rural health care outcomes;
- Prioritizing technology to address prevention and chronic disease management;
- Initiating, fostering, and strengthening local and regional strategic partnerships between rural hospitals and other health care providers to:
    - promote measurable quality improvement;
    - increase financial stability;
    - maximize economies of scale; and
    - share best practices in care delivery.
- Enhancing economic opportunity for, and the supply of, health care clinicians through enhanced recruitment and training;
- Prioritizing data and technology driven solutions that help rural hospitals and other rural health care providers furnish high-quality health care services as close to a patient's home as is possible;
- Strategies to manage long-term financial solvency and operating models of rural hospitals in the State; and
- Identifying specific causes driving the accelerating rate of stand-alone rural hospitals becoming at risk of closure, conversion, or service reduction.

States must submit the plan to CMS no later than December 31, 2025 (or, potentially sooner depending on the CMS process and requirements). Notably, CMS must issue approvals and awards by December 31, 2025 so it is likely that applications will be submitted before this date. Based on the applications, half of the funding will be distributed to all approved states equally, whereas the other half will be distributed by CMS using a methodology that must take into account:

- the percentage of the State population that is located in a rural census tract of a metropolitan statistical area;
- the proportion of rural health facilities relative to the number of rural health facilities nationwide;
- the situation of hospitals which serve a disproportionate number of low-income patients with special needs; and
- any other factors that CMS determines appropriate.

Funding must be used for three or more of the following activities:

- Promoting evidence-based, measurable interventions to improve prevention and chronic disease management;
- Providing payments to health care providers for the provision of health care items or services, as specified by CMS;
- Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases;
- Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies;
- Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years;
- Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes;
- Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines;
- Supporting access to opioid use disorder treatment services, other substance use disorder treatment services, and mental health services;
- Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models; or

- Potential additional uses designed to promote sustainable access to high quality rural health care services, as determined by CMS.

Notably, the "facilities" described in this subsection are different types of rural hospitals and clinics, including FQHCs, and would only apply to home health or HCBS if it is operated by one of those entities. However, it is important to remember that the funding allocations for half of the appropriations are determined based on a formula that includes those facilities, but the use of funding could potentially include post-acute and HCBS services. The "health care providers" referenced in the allowable use of funding include those enrolled in Medicare, Medicaid, or CHIP.

Given that the states will be responsible for developing a state-specific rural health plan and for determining how to use the funding they receive, we anticipate that providers will need to proactively engage with their Administrations to ensure that home health, HCBS, pediatric, palliative care, hospice, and other relevant services are included within the initiatives. The timelines are extremely tight – with a December 31 deadline for CMS to provide funding awards – so it will be important to begin such engagement as soon as possible.