Budget Reconciliation
Summary of Medicaid Provisions

ANCOR

Budget Reconciliation: Overview of H.R. 1

On July 4, 2025, the budget reconciliation bill, H.R. 1, was signed into law, making cuts of almost $1T to Medicaid funding. Below is a summary of key provisions impacting the Medicaid program. Text of the final legislation can be found here.

State Financing Limits

Provider Taxes

States are permitted to finance the non-federal share of Medicaid spending through multiple sources, including state general funds, health care related taxes (provider taxes), and local government funds. Every state except for Alaska has at least one provider tax.

HR 1 freezes or reduces provider taxes based on whether a state has expanded Medicaid coverage through the ACA.

New federal rules imposed by HR 1:

- Non-expansion states:
  - Current provider taxes imposed by a state or local government must be frozen at current rates in effect as of the date of enactment of the legislation.

- Expansion states:
  - Current provider taxes imposed by a state or local government must be frozen at current rates in effect as of the date of enactment of the legislation.
  - Beginning in fiscal year 2028, the applicable tax rate percentage is decreased by 0.5% each year, down to a maximum of 3.5%. The maximum rates are:
    - For FY 28: 5.5%
    - For FY 29: 5%
    - For FY 30: 4.5%
    - For FY 31: 4%
    - For FY 32 (and subsequent years): 3.5%

- *Carve out for certain health care services*: Provider taxes imposed by a state or local government on nursing facility services and intermediate care facility services for individuals with intellectual disabilities are not subject to the rate reductions that begin in FY 28.

State Directed Payments

State directed payments (SDPs) allow states to provide additional funding to Managed Care Organizations (MCOs) for specific services, which can include HCBS.

HR 1 requires the Secretary of HHS to revise federal regulations to limit SDPs. Expansion states and non-expansion states will be treated differently under the new federal regulations.

New limits imposed by HR 1:

- Non-expansion states:
  - States must cap the total payment rate at 110% of the specified total published Medicare payment rate
- Expansion states:
  - States must cap the total payment rate at 100% of the specified total published Medicare payment rate

Phase out of current approvals: SDPs approved prior to the legislation's enactment are grandfathered in, but must be reduced by 10 percentage points each year (starting January 1, 2028) until they reach the allowable Medicare-related payment limit.

Administrative Requirements

Work Requirements

New federal rules imposed by HR 1 will require states to condition Medicaid eligibility on working or participating in qualifying activities and will apply to individuals ages 19-64 applying for coverage or enrolled through the ACA expansion group (or a waiver).

New work requirements imposed by HR 1:

- Individuals must demonstrate:
  - At least 80 hours per month of work, community service, or participation in a work program;

    - A monthly income equivalent to at least minimum wage for 80 hours; or
    - Part-time enrollment in an educational program.

- An individual could combine any of the work or community service activities to meet the 80-hour-per-month requirement. A seasonal worker could also meet the requirement by having an average monthly income over the past six months that is greater than minimum wage multiplied by 80 hours.

Exemptions: HR 1 mandates that states exempt certain adults from work requirements, including:

- Those who are medically frail (which includes individuals with I/DD);
- Parents or caretakers for a disabled individual or dependent; and
- Parents of dependent children under the age of 13.

Verification:

- For individuals applying for Medicaid coverage, states must verify their compliance with this requirement for one month, or more, but not more than 3 consecutive months, immediately preceding the month during which such individual applies for such medical assistance.
- For individuals to renew Medicaid coverage, states must verify their compliance with this requirement with their regularly scheduled redetermination; however, a state may choose to verify compliance more frequently.
- Requires states to use data matching "where possible" to verify whether an individual meets the requirement or qualifies for an exemption.

Effective Date:

- Not later than December 31, 2026, or earlier at state option.
- Allows the Secretary to exempt states from compliance with the new requirements until no later than December 31, 2028, if the state is demonstrating a good faith effort to comply and submits progress in compliance or other barriers to compliance.

Interim Final Rulemaking.—Not later than June 1, 2026, the HHS Secretary shall promulgate an interim final rule implementing these provisions.

Eligibility Redeterminations

States must renew eligibility every 12 months for Medicaid enrollees whose eligibility is based on modified adjusted gross income (MAGI), including children, pregnant individuals, parents, and expansion adults, and must renew eligibility at least every 12 months for enrollees whose eligibility is based on age 65+ or disability. **Many of the protections in place to prevent individuals from being disenrolled are removed due to the language in HR 1 to not implement the Eligibility and Enrollment rule. See Rule Moratoriums below.*

New eligibility requirements in HR 1:

- Requires states to conduct eligibility redeterminations at least every 6 months for all adults in the Medicaid expansion population.

Effective Date:

- For renewals scheduled on or after December 31, 2026,
- Requires the HHS Secretary to issue guidance within 180 days of enactment.

Regulation Moratoriums

Eligibility and Enrollment Rule

H.R. 1 delays implementation of certain provisions of HHS rules "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" and the "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" until September 30, 2034.

These rules contained provisions to prevent coverage loss through the enrollment and redetermination process, such as the prohibition of requiring in-person interviews for individuals who qualify for Medicaid coverage because of a disability, as well as more frequent eligibility checks for beneficiaries with disabilities.

Nursing Home Staffing Rule

H.R. 1 requires HHS to delay implementation, administration, or enforcement of certain provisions of its final rule "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional

Payment Transparency Reporting" until September 30, 2034.

The rule also contains payment transparency and reporting provisions which imposed new administrative burdens upon ICF/IIDs without addressing the root cause of the direct support workforce crisis. Those provisions were untouched by the bill and are still required to be implemented beginning May 10, 2028.

New Funding

Expanded Eligibility for HCBS

HR 1 established a new state optional pathway for HCBS eligibility. Beginning July 1, 2028, States can apply for a standalone 1915(c) waiver to provide HCBS services to people who do not meet an institutional level of care for an initial term of 3 years which can be extended for additional 5-year periods.

Limits:

- Cannot result in a material increase in the average amount of time that individuals currently eligible for HCBS will need to wait to receive services;
- Cannot exceed the average per capita expenditure for individuals receiving an institutional level of care; and
- Medicaid payments cannot be made to third parties for benefits on behalf of the provider.

Approved states must report at least annually:

- The cost of services and number of individuals served;
- The length of time individuals received services; and
- Comparison data on the cost of delivering HCBS against the cost of delivering institutional care.

Funding:

- FY 26 - $50M to CMS for implementation.
- FY 27 - $100M for payments to states to deliver 1915(c) or 1115 HCBS.
    - Payments to states shall be made based on the proportion receiving HCBS as compared to all states.

Rural Health Transformation Program

HR 1 established the Rural Health Transformation Program and appropriated $10 billion per year for five years ($50B total), beginning FY 26, to CMS to provide allotments to states for purposes of carrying out activities described below. Not later than December 31, 2025, the CMS Administrator shall approve or deny all applications submitted for an allotment. If approved, the state is eligible for an allotment each year from FY 2026-2030.

State applications must include a detailed plan to:

- Improve access to hospitals, other health care providers, and health care items and services furnished to rural residents;
- Improve health care outcomes of rural residents;
- Prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management;
- Initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other health care providers;
- Enhance economic opportunity for, and the supply of, health care clinicians through enhanced recruitment and training;
- Prioritize data and technology driven solutions that help rural hospitals and other rural health care providers furnish high-quality health care services;
- Outline strategies to manage long-term financial solvency and operating models of rural hospitals; and
- Identify specific causes driving the accelerated rate of stand-alone rural hospitals becoming at risk of closure, conversion, or service reductions.

Allotments:

- 50% distributed equally among all approved states; and
- 50% determined by the CMS Administrator under the following guidance:
    - Not less than ¼ of the approved states should be allotted funds with consideration for:
        - 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 in the state relative to the number of rural health facilities nationwide. Rural health facility is defined to include:
            - Hospital
            - Critical access hospital
            - A sole community hospital

        - A medicare-dependent, small rural hospital
        - A low-volume hospital
        - A rural emergency hospital
        - A rural health clinic
        - A federally qualified health center
        - A community mental health center
        - A health center that is receiving a grant under section 330 of the Public Health Service Act
        - An opioid treatment program
        - A certified community behavioral health clinic
    - The situation of hospitals in the state; and
    - Any other factors that the CMS Administrator determines appropriate.

Terms and conditions:

- Each state submits a plan to carry out 3 or more listed activities below and provide annual reporting:
    - Promoting evidence-based, measurable interventions to improve prevention and chronic disease management;
    - Provide payments to health care providers for the provision of health care items or services, as specified by the Administrator;
    - 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;
    - 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, 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, as appropriate;
    - Additional uses designed to promote sustainable access to high quality rural health care services, as determined by the Administrator.

Limits:

- Can't be used to supplant non-federal share of expenditures required under any provision of law.
- Not more than 10% of the amount allocated can go to administrative activities.
- Any funds not expended by October 1, 2032 will be returned to the Treasury. If CMS determines that a State is not using amounts allotted appropriately, it can withhold, reduce, or recover payments to return to the Treasury.

Inclusion of the Enable Act

HR 1 permanently extends provisions related to ABLE Accounts that were set to expire before January 1, 2026:

- ABLE to Work: An individual with a disability who is employed can contribute an additional amount—equal to either the prior year's federal poverty level for a one-person household or the beneficiary's yearly compensation—to his or her ABLE account.
- ABLE Saver's Credit: An individual with a disability who makes qualified contributions to their ABLE account can qualify for a nonrefundable saver's credit of up to $1,000.
- 529 to ABLE rollover: An individual with a disability may roll over from a 529 education savings account to an ABLE account that is less than or equal to the annual ABLE contribution limit are not subject to income taxation.