September 18, 2025

Summary of P.L. 119-21, An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14

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Medicaid and CHIP Payment and Access Commission

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Overview

- Medicaid and the State Children's Health Insurance Program (CHIP) provisions
  - Eligibility and enrollment
  - Financing
  - Services and payment
  - Other provisions
- Questions

Eligibility and Enrollment

Moratorium on Eligibility Rules

- 10-year moratorium (July 4, 2025 to September 30, 2034) on implementing certain provisions of:
  - Medicare Savings Program Eligibility Determination and Enrollment final rule published September 21, 2023
  - Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes final rule published April 2, 2024
- $1 million appropriated to the Centers for Medicare & Medicaid Services (CMS) Administrator for fiscal year (FY) 2026

Eligibility Redeterminations

- Beginning January 1, 2027, states are required to make redeterminations every six months for the Medicaid expansion new adult group
  - Exempts individuals who are Indian, Urban Indians, California Indians, or other Indians eligible for the Indian Health Service
- Applies to 50 states and the District of Columbia
- The Secretary of Health and Human Services (the Secretary) will issue guidance no later than 180 days after the date of enactment
- $75 million appropriated to CMS Administrator for FY 2026

Alien Medicaid Eligibility

- Beginning October 1, 2026, federal funding for coverage of qualified aliens through Medicaid and CHIP is only available in the following categories:
  - Lawful permanent residents
  - Certain Cuban and Haitian immigrants
  - Individuals lawfully residing in the U.S. under the Compact of Free Association
- Other qualified aliens are only eligible for Medicaid through the emergency Medicaid pathway
- Does not apply to those eligible through the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option

Work and Community Engagement Requirements

- Beginning January 1, 2027, states are required to impose work and community engagement requirements for certain individuals in the Medicaid expansion new adult group
  - Individuals have to engage in work or a work program, an educational program, community service, or a combination for at least 80 hours in a month or have a monthly income that is equal to or above the applicable minimum wage multiplied by 80 hours
  - Individuals must demonstrate compliance for up to three consecutive months immediately preceding application month, and one or more months before their biannual redetermination
- Certain populations are exempted and states can choose to provide certain short-term hardship exceptions
- States must implement requirements by January 1, 2027, but can receive up to an additional two years through a good faith effort waiver given by the Secretary
- $200 million in state grants in FY 2026
- $200 million appropriated to CMS Administrator for FY 2026

Retroactive Coverage

- Reduces the number of months of Medicaid and CHIP retroactive coverage that may be provided
- Beginning January 1, 2027, retroactive coverage for the Medicaid expansion new adult group can only be provided for one month prior to the application month
- For those not enrolled in the new adult group, retroactive coverage can be provided for two months prior to the application month
  - Same limit is applied to states that choose to provide retroactive coverage in CHIP
- $10 million appropriated to CMS Administrator for FY 2026

Reducing Duplicate Enrollment

- Beginning January 1, 2027, states are required to obtain address information for Medicaid and CHIP enrollees using reliable data sources
  - Managed care plans must transmit address information to state
- Beginning October 1, 2029, states are required to collect and report information into a system established by the Secretary to prevent individuals from being simultaneously enrolled in multiple states
- Applies to 50 states and the District of Columbia
- $10 million appropriated to the CMS Administrator for FY 2026 to establish system and $20 million for FY 2029 to maintain system

Disenrolling Deceased Individuals and Providers

- Beginning January 1, 2027, states are required to review Death Master File at least quarterly and disenroll Medicaid enrollees who are deceased
- Beginning January 1, 2028, states are required to review Death Master File at least quarterly and disenroll Medicaid providers who are deceased
- Applies to 50 states and the District of Columbia

Financing

Payment Reduction Related to Certain Erroneous Excess Payments

- Currently, states are penalized the amount of federal share for erroneous excess payments over three percent of total payments
  - Secretary can waive these fiscal penalties if a state has made a “good faith effort” to meet all requirements
- Added new category of erroneous excess payment that includes payment for items and services to an individual not eligible to receive those items or services, or payments where insufficient information is available to confirm eligibility
- Beginning with FY 2030 (October 1, 2029–September 30, 2030), the amount that the Secretary can waive under the good faith effort waiver is limited to the amount over three percent in one category of erroneous excess payment
  - Essentially means financial penalties over the three percent error rate for payments made for ineligible individuals or ineligible items and services cannot be waived

Expansion FMAP for Emergency Medicaid

- Beginning October 1, 2026, federal matching funds for emergency Medicaid for individuals who would otherwise be eligible for expansion coverage except for their immigration status will be determined at the state's regular federal medical assistance percentage (FMAP) rather than the expansion FMAP
- $1 million appropriated to CMS Administrator for FY 2026

Sunsetting Increased FMAP Incentive

- Under the American Rescue Plan Act (ARPA; P.L. 117-2), states that expand Medicaid coverage to the new adult group after March 11, 2021 receive a five percentage point increase to their regular FMAP rate for eight quarters
- This FMAP incentive is eliminated for states that expand Medicaid after December 31, 2025

Federal Payments to Prohibited Entities

- For a one-year period beginning July 4, 2025, no federal funds can be used for Medicaid payments to a prohibited entity
  - an entity, including its affiliates, subsidiaries, successors, and clinics, that (as of October 1, 2025) is a tax-exempt, essential community provider primarily engaged in family planning services, reproductive health, and related medical care that provides for abortion services
  - Must have received total federal and state Medicaid payments exceeding $800,000 in FY 2023
  - Exceptions are made for providers that only perform abortions in cases of rape, incest, or when the pregnancy endangers the life of the mother
- $1 million appropriated to CMS Administrator for FY 2026

Provider Taxes

- Beginning on October 1, 2026, the hold harmless safe harbor threshold is 0 percent for any provider tax arrangement not in effect as of July 4, 2025
- Grandfathers in existing provider tax arrangements, setting safe harbor threshold at rate of existing tax arrangement
- Expansion states are subject to an upper limit starting October 1, 2027
  - Hold harmless threshold is the lower of the existing provider tax rate or 5.5 percent in FY 2028, phasing down to 3.5 percent in FY 2032
  - Taxes on nursing facilities and intermediate care facilities are exempt from upper limit
- Applies to 50 states and the District of Columbia
- $20 million appropriated to CMS Administrator for FY 2026

Waiver of Uniform Provider Tax Requirements

- Beginning July 4, 2025, CMS will apply new standards for waivers of the uniform tax requirement for provider taxes
- A provider tax will not be considered generally redistributive if the arrangement taxes Medicaid units (e.g., hospital days) or high-volume Medicaid providers more than non-Medicaid units or low-volume Medicaid providers
- Secretary has discretion to apply a transition period not to exceed three fiscal years
- Applies to 50 states and the District of Columbia

Requiring Budget Neutrality for Section 1115 Demonstration Waivers

- Beginning January 1, 2027, the Chief Actuary for CMS must certify that a Section 1115 demonstration waiver is budget neutral
  - Waiver is not expected to result in an increase in the amount of federal expenditures compared to the amount of federal expenditures that would have occurred without the waiver
- The Secretary will specify a methodology for how any savings accrued during the approval period may be used during any subsequent waiver period
- $5 million appropriated to CMS Administrator for FYs 2026 and 2027

Services and Payment

Moratorium on Nursing Facility Staffing Rule

- 10-year moratorium (July 4, 2025 to September 30, 2034) on implementing certain staffing standards from the Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting final rule published May 10, 2024
  - Definition of hours per resident day (HPRD)
  - Minimum nursing staffing standards, including a registered nurse on site 24/7 and 3.48 HPRD

Revising Home Equity Limit for Determining Eligibility for Long-term Services and Supports

- Beginning January 1, 2028, the home equity limit used for determining the eligibility of an individual for long-term services and supports (LTSS) is capped at $1 million for homes that are not located on a lot that is zoned for agricultural use, with no further adjustments for inflation over time
  - Home equity limit for homes located on a lot that is zoned for agricultural use continues to be indexed for inflation
- Home equity limit must be applied for the purposes of determining eligibility for LTSS for individuals who are not subject to modified adjusted gross income (MAGI) financial eligibility rules
- Home equity limit is no longer included among the types of incomes and assets states may exclude when determining an individual's eligibility for LTSS

Certain Adjustments to Coverage of Home and Community-based Services (HCBS)

- Beginning July 1, 2028, states have a new standalone 1915(c) waiver option to provide HCBS to individuals who need less than an institutional level of care
- States must demonstrate that the new waiver does not increase wait times for individuals who do need an institutional level of care under other 1915(c) waivers
- $50 million appropriated to CMS Administrator for FY 2026
- $100 million appropriated to CMS Administrator for FY 2027 to support state systems to deliver HCBS under 1915(c) waivers

Modifying Cost Sharing Requirements

- Beginning October 1, 2028, states are required to impose cost sharing on specified Medicaid expansion enrollees with incomes above 100 percent of the federal poverty level (FPL) for certain services
  - Cost sharing has to be greater than $0 but cannot exceed $35 per item or service
  - Total aggregate amount of cost sharing for the family is capped at 5 percent of family income
  - States can permit providers to deny service for non-payment, but provider can reduce or waive cost sharing on case-by-case basis
- Certain services are excluded from cost sharing requirement:
  - Services statutorily exempt from cost sharing
  - Primary care services
  - Mental health services
  - Substance use disorder services
  - Services provided by federally qualified health centers, certified behavioral health clinics, rural health clinics, or through the Indian Health Service
- Applies to 50 states and the District of Columbia
- $15 million appropriated to CMS Administrator for FY 2026

State Directed Payments

- For rating periods beginning on or after July 4, 2025, the upper limit for state directed payment (SDP) arrangements is reduced
  - 100 percent of published Medicare rate for expansion states
  - 110 percent of published Medicare rate for non-expansion states
- Grandfathers in the average commercial rate upper limit for certain SDP arrangements applying to rating periods within 180 days of July 4, 2025
  - SDPs with prior written approval made before May 1, 2025 (or a good faith effort to receive approval)
  - SDPs for rural hospitals with prior written approval before July 4, 2025 (or a good faith effort to receive approval)
  - SDPs with a completed preprint submitted prior to July 4, 2025
- For rating periods beginning on or after January 1, 2028, the total payment amount for grandfathered SDPs must phase down 10 percentage points each year until the payment level reaches 100 percent (expansion state) or 110 percent (non-expansion state) of Medicare
- Applies to 50 states and the District of Columbia
- $7 million appropriated to CMS Administrator annually for FYs 2026–2033

Other Provisions

Disallowing Premium Tax Credit During Periods of Medicaid Ineligibility due to Alien Status

- For taxable years beginning on or after January 1, 2026, lawfully present individuals with incomes below 100 percent FPL who are ineligible for Medicaid during the first five years after grant of status are not eligible for a premium tax credit

Rural Health Transformation Program

- $50 billion appropriated to CMS Administrator to provide state allotments to support rural health
  - $10 billion per year from FY 2026 to FY 2030
  - Any unexpended or unobligated amount remaining on October 1, 2032 will be returned
  - Only 50 states are eligible for an allotment
- States must submit application with rural transformation plan to CMS by December 31, 2025
- Must use allotment to carry out three or more of the specified activities
- Allotment distribution:
  - Half goes to all states with an approved application equally
  - Half distributed at the discretion of CMS based on certain metrics
- Additional $200 million appropriated to CMS Administrator for FY 2025 to carry out provisions

Questions

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SEPTEMBER MEETING

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