

SUMMARY OF MEDICAID CHANGES

TOPIC (SECTION)	DESCRIPTION	IMPACT LEVEL
MSP Streamlining Rule (71101)	Delays implementation, administration and enforcement of CMS's September 21, 2023, rule designed to simplify Medicare Savings Program eligibility and enrollment processes until September 30, 2034.	Low
Medicaid/CHIP/BHP Streamlining Rule (71102)	Delays implementation, administration and enforcement of CMS's April 2, 2024, rule that streamlines renewals and enrollment for Medicaid, CHIP, and Basic Health Programs until September 30, 2034.	Low
Duplicate Enrollment Reduction (71103)	Requires states to integrate with an HHS-maintained data hub for monthly address matching starting January 1, 2027, and to submit full enrollment files by October 1, 2029, to avoid duplicate beneficiary records.	Low
Deceased Beneficiary Removal (71104)	Mandates that states establish procedures—using death records and data matches—to promptly identify and terminate eligibility for beneficiaries who have died.	Medium
Deceased and Expelled Provider (71105)	Requires states to terminate enrollment of providers who are deceased or have lost licensure/been expelled, stopping all payment to such providers immediately.	Medium
Erroneous Payment Recovery (71106)	Expands the definition of “erroneous excess payment,” gives the HHS Secretary the option to allow state-conducted audit findings to be considered in determining a state's error rate and puts new limits on the amounts of penalties the HHS Secretary may waive through good faith effort.	Medium
Eligibility Redeterminations (71107)	Semiannual Reviews: Requires states to redetermine eligibility every 6 months (instead of once per year) for adults covered under the ACA Medicaid expansion. Sets uniform timelines and documentation standards for periodic Medicaid renewals to reduce churn—requiring states to complete renewals within 30 days of receiving info.	Medium
Home Equity Limits (71108)	Caps the permissible home equity value at \$1M for individuals seeking eligibility for long-term care services; prohibits the use of asset disregards being applied to waive home equity limits.	Low
Alien Medicaid Eligibility (71109)	Aligns Medicaid eligibility rules for qualified aliens with those in other federal health programs, standardizing documentation and residency requirements.	High
Emergency Medicaid FMAP Cap (71110)	Caps the Federal Medical Assistance Percentage (FMAP) for emergency services provided to aliens at the standard Medicaid match rate rather than the higher state match.	Low
LTC Staffing Standards (71111)	Delays implementation of CMS's May 10, 2024, rule imposing minimum staffing ratios in nursing homes—pausing enforcement until September 30, 2034.	Low
Retroactive Eligibility (71112)	Retroactive coverage for traditional Medicaid and CHIP is two months and expansion is one month.	High
Disqualified Entity Payment Ban (71113)	Prohibits Medicaid payments for services provided by tax-exempt essential community providers that deliver family planning and abortion services, other than those allowable under the Hyde Amendment, and that received federal and state Medicaid reimbursements exceeding \$800,000 in 2023. *Note: TRO and appeal playing out in Federal Court.	Medium
Expansion FMAP Incentive Sunset (71114)	Eliminates the 5-percentage-point FMAP “bump” for ACA expansion populations unless the state has already begun spending the enhanced match on those enrollees. States must begin expending the enhanced FMAP by January 1, 2026, or	Low

	forfeit it entirely. This change sunsets any remaining incentive for expansions enacted after that date.	
Provider Tax Uniformity and Caps (71115)	Revises the “hold-harmless” provider-tax threshold under § 1903(w)(4) by (1) for FY 2027+, replacing the flat 6% cap with a dynamic “applicable percent” based on whether a state expanded in 2014: Expansion states: the lower of their existing hold-harmless rate or a sliding scale (5.5% in FY 2028; 5.0% in FY 2029; 4.5% in FY 2030; 4.0% in FY 2031; 3.5% in FY 2032+). Non-expansion states: their hold-harmless percent if within threshold, otherwise 0%. This ensures provider taxes remain budget-neutral and phase down over time.	High
State-Directed Payment Standards (71116)	Caps state-directed managed-care payments (SDPs) at a percent of Medicare rates: Expansion states (SDP ≤100% of the Medicare published total payment rate.) Non-expansion states (SDP ≤110% of that rate.) Grandfathers any SDP with written prior approval by May 1, 2025 (or rural hospital SDPs approved by enactment) through a phase-down: reduce those existing rates by 10 percentage points each year starting January 1, 2028 until they meet the new 100%/110% cap.	High
Provider Tax Waivers (71117)	Requirements regarding waiver of uniform tax requirements for Medicaid provider taxes. Modifies the criteria HHS must use when determining whether certain health-related taxes are generally redistributive.	Low
Demonstration Budget Neutrality (71118 §1115)	Requires states to obtain HHS actuarial sign-off confirming that §1115 waiver demonstrations will not raise federal outlays, effective January 1, 2027.	Low
Community Engagement Requirements (71119)	Directs HHS and the states to impose “community engagement” (a.k.a. work) requirements on non-elderly, non-pregnant, non-Medicare, non-medically-frail Medicaid enrollees in the ACA expansion population. Under the rule: At least 80 hours per month of one or more qualifying activities: (1) Employment (part- or full-time); (2) Unpaid community service or volunteering; (3) Participation in job skills training, education programs, or workfare; (4) Meeting a monthly earnings threshold (monthly income that is at least 80 times the federal hourly minimum wage; seasonal workers with average monthly income over previous 6 months that is at least 80 times the federal hourly minimum wage). Some exemptions. Interim final rule due by June 1, 2026.	High
Expansion Population Cost-Sharing (71120)	Exempts Medicaid expansion enrollees from premiums/lock-out periods after October 1, 2028, but authorizes sliding-scale cost-sharing based on income to encourage personal responsibility. Applies to adults who gained coverage under the ACA expansion with incomes over 100% of the federal poverty level (generally 100–138% FPL). Includes (1) per-service copays; (2) annual out-of-pocket cap; (3) limited state flexibilities.	High
HCBS Coverage and Eligibility (71121)	Effective July 1, 2028, the HHS Secretary may approve a new standalone waiver that does not require participants to require a nursing home or ICF/IDD level of care to receive HCBS services	Low
Access to Care (71203)	This section makes technical corrections to current law by permitting product sponsors to have one or more orphan drug indication to be exempt from the Drug Price Negotiation Program in statute. Current law limits exemptions from the Drug Price Negotiation Program to one rare disease indication. This section also revises the start of the timeline in which a manufacturer would be eligible for negotiation until an orphan drug receives its first non-orphan indication.	N/A
Rural Access to Care (71401)	Appropriates \$50 billion to states to support rural providers. As such, requires applicants establish a rural health transformation plan and is subject to approval of awards.	N/A

GALLERY WALK DISCUSSION GUIDE



KEY PROMPTS FOR ADVISORY GROUP AND PUBLIC COMMENT

- What should we consider for a potential safety net when this change takes effect?
- How could we leverage community assets or build capacity to navigate the change?
- What other creative budget savings or revenue generating ideas should we consider together?
- Which populations or communities must we prioritize for potential supports and outreach?
- What other system, technology, people, or process changes should we consider?

Please come prepared to add your considerations and feedback on Tuesday!