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CMCS Informational Bulletin

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SUBJECT: **"Working Families Tax Cut" Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions**

Introduction

On July 4, 2025, President Trump signed Public Law 119-21, also known as the "One Big Beautiful Bill Act," which the Centers for Medicare & Medicaid Services (CMS) refers to as the "Working Families Tax Cut" (WFTC) legislation, into law. This landmark legislation includes significant eligibility and financing reforms in Medicaid and the Children's Health Insurance Program (CHIP) and focuses on the connection of health to work through community engagement. Specific eligibility reforms aim to ensure lawful enrollment in Medicaid and CHIP. The financing reforms in the law focus on ensuring that states contribute their full commitments to finance Medicaid and reducing financing loopholes. Community engagement requirements have the potential to empower Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation, build confidence, and achieve prosperity.

These provisions reflect a commitment to safeguarding Medicaid and CHIP for the most vulnerable Americans now and in the future. These reforms also impact program operations, enhance oversight capabilities, and establish new accountability measures for Medicaid and CHIP. Taken together with other CMS priorities, the reforms lay the groundwork for a stronger state-federal partnership that improves health outcomes among beneficiaries.

This CMCS Informational Bulletin (CIB) provides general information to states, stakeholders, and others on the Medicaid and CHIP provisions contained in the WFTC legislation. This CIB represents part of a series of guidance documents that CMCS expects to issue to support the implementation of the WFTC legislation provisions. CMCS expects to provide additional detailed guidance in the coming months addressing specific provisions and implementation requirements. We also plan to undertake rulemaking as required under the law or as otherwise warranted. CMCS is committed to supporting successful implementation of these transformative

changes through detailed guidance, technical assistance, and ongoing partnership with state agencies.

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Summary of Working Families Tax Cut Legislation Provisions

Subchapter A[1] – Reducing Fraud and Improving Enrollment Processes

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

On September 21, 2023, CMS published a final rule entitled "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," (known as the MSP final rule), that instituted new requirements for states to expand eligibility and streamline enrollment processes for the Medicare Savings Programs (MSPs).[2] The MSP final rule went into effect on November 17, 2023, and CMS outlined a phased-in approach for states to come into compliance with each provision between 2024 and 2026.

Section 71101 temporarily prohibits CMS from implementing, administering, or enforcing certain amendments made by the provisions of the MSP final rule that had a compliance date after July 4, 2025, the date the WFTC legislation was enacted. The moratorium on these amendments ends on September 30, 2034.

While the moratorium is in effect, CMS will, in general, revert to the regulations in place as of November 16, 2023, for sections of the regulation subject to the moratorium.[3] CMS continues to analyze the impact of the moratorium on MSP eligibility and enrollment processes and expects to provide additional information to states in future guidance.

See ***Appendix E*** for the complete list of provisions in the MSP final rule and their status under the moratorium.

Section 71101 affects regulations applicable to all states and the District of Columbia; the regulations impacted by the MSP final rule do not impact the territories because they have not adopted the MSPs.[4]

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

On April 2, 2024, CMS published a final rule entitled "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," (known as the Eligibility and Enrollment final rule), that outlined changes to processes for eligible people to enroll in and

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[1] The references to "Subchapters" in the headings are to Subchapters of Chapter 1 of Subtitle B of Title VII of Public Law 119-21.

[2] https://www.federalregister.gov/documents/2023/09/21/2023-20382/streamlining-medicaid-medicare-savings-program-eligibility-determination-and-enrollment

[3] https://www.ecfr.gov/on/2023-11-16/title-42/chapter-IV

[4] The MSPs are mandatory Medicaid eligibility groups for the 50 states and the District of Columbia, but optional for territories per section 1905(p)(4)(A) of the Social Security Act.

retain Medicaid, CHIP, and Basic Health Program (BHP) coverage.[5] The Eligibility and Enrollment final rule went into effect on June 3, 2024, and CMS outlined a phased-in approach for states to come into compliance with each provision between 2024 and 2027.

Section 71102 temporarily prohibits CMS from implementing, administering, or enforcing certain amendments made by the provisions of the Eligibility and Enrollment final rule that had a compliance date after July 4, 2025, the date the WFTC legislation was enacted. The moratorium on these amendments ends on September 30, 2034.

While the moratorium is in effect, CMS will, in general, revert to the regulations in place as of June 2, 2024, for sections of the regulation subject to the moratorium.[6] CMS continues to analyze the impact of the moratorium on eligibility and enrollment processes and expects to provide additional information to states in future guidance.

See ***Appendix F*** for the complete list of provisions in the Eligibility and Enrollment final rule and their status under the moratorium.

Section 71102 affects regulations applicable to all states, the District of Columbia, and the territories.

Section 71103. Reducing Duplicate Enrollment under the Medicaid and CHIP Programs

Section 71103 creates two new state plan requirements related to address verification for states at new paragraph (88) under section 1902(a) of the Social Security Act (the Act) for Medicaid, with corresponding amendments to section 2107(e)(1) of the Act to apply these requirements to separate CHIPs. Beginning no later than January 1, 2027, each of the 50 states and the District of Columbia will need to have a process to regularly obtain address information from the following "reliable data sources": mail returned by the U.S. Postal Service with a forwarding address; the U.S. Postal Service National Change of Address Database; certain managed care entities (i.e., managed care organizations (MCOs); prepaid inpatient health plans (PIHPs); prepaid ambulatory health plans (PAHPs); primary care case manager (PCCM)); and other data sources as identified by the state and approved by the Secretary. Based on this information, states must take such actions as the Secretary specifies with respect to any address changes for individuals enrolled under the state plan (or a waiver of such plan).

Beginning January 1, 2027, this provision also requires that each contract under a state plan that a state has with certain entities or plans (MCOs, PIHPs, PAHPs and PCCMs) require that such entity or plan promptly transmit to the state any address information received directly from enrollees or verified by the entity or plan directly with the enrollee. This provision builds on processes many states established during the COVID-19 Public Health Emergency (PHE), since

[5] https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health
[6] https://www.ecfr.gov/on/2024-06-02/title-42/chapter-IV/subchapter-C

these contracted plans and entities often have the most up-to-date beneficiary address information.

Section 71103 also requires CMS to establish, by October 1, 2029, a system that CMS and states will use to prevent an individual from being simultaneously enrolled under the state plans (or waivers of such plans) of multiple states. States will be required to submit data to the system at least monthly and during each determination or redetermination of eligibility of an individual for medical assistance under a state plan (or waiver of such plan). Information that states will be required to submit to the system will include an individual's social security number (if an individual has a social security number and is required to provide such number to enroll under such plan or waiver), and other applicant and beneficiary information that the Secretary determines is necessary to prevent individuals from being inappropriately enrolled in Medicaid or CHIP in multiple states (unless such individual meets such an exception as the Secretary may specify).

In addition, section 71103 requires that, at least once each month, the system described above transmits information to the states identifying whether individuals enrolled or seeking to enroll in their respective state are identified as also being enrolled under another state's state plan (or waiver thereof). Should the system identify such an individual, the state will be required to take appropriate action as determined by the Secretary to determine whether that individual is a resident of the state and, if not, disenroll the individual (unless such individual meets such an exception as the Secretary may specify).

This new provision does not eliminate the existing requirement under section 1903(r)(3) of the Act that states must have in operation an eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS). However, it does provide that, beginning October 1, 2029, the Secretary may determine that a state is not required to have in operation such an eligibility determination system to comply with this requirement.

Except as noted above with respect to section 1902(a)(88)(A) of the Act, section 71103 is applicable to all states, the District of Columbia, and the territories.

Section 71104. Ensuring Deceased Individuals Do Not Remain Enrolled

Section 71104 adds a new paragraph (89) to section 1902(a) of the Act by which a state plan must provide that a state, beginning on January 1, 2027, check the Social Security Administration's (SSA) Death Master File (DMF) or a successor system on at least a quarterly basis to determine whether Medicaid enrollees are deceased. States will be required to treat such information as factual and, following the provision of notice and fair hearing rights consistent with 42 CFR part 431 subpart E, disenroll such individuals from Medicaid without requesting additional information from the household or authorized representative. If a state determines that the DMF misidentified an individual as deceased, such individual must be immediately reenrolled in Medicaid retroactive to the date of disenrollment. This section also provides that

states are permitted to use other electronic data sources in addition to the DMF, such as vital statistics data on deaths available through State Health Departments and State Vital Statistics Offices, to timely identify potentially deceased beneficiaries, as long as the state also complies with requirements of this section and other Medicaid eligibility determination and redetermination requirements.

Section 1902(a)(89) of the Act, as added by section 71104, is applicable to all states and the District of Columbia; it does not apply to the territories.

Section 71105. Ensuring Deceased Providers Do Not Remain Enrolled

Under current regulations, states are required to check the DMF when enrolling, reenrolling, or revalidating enrollment of a provider in their state Medicaid program or separate CHIP.[7] Section 71105 amends section 1902(kk)(1) of the Act to, in addition to current requirements, also require states, beginning January 1, 2028, to check the DMF no less frequently than quarterly to determine whether a provider is deceased. This requirement is applicable to separate CHIPs through an existing cross-reference at section 2107(e)(1)(G) of the Act.

Section 1902(kk)(1), as amended by section 71105, is applicable to all states, the District of Columbia, and the territories.

Section 71106. Payment Reduction Related to Certain Erroneous Excess Payments under Medicaid

Currently, the Secretary is required to disallow federal monies if a state Medicaid program has an eligibility-related error rate greater than 3 percent. However, the Secretary may waive, in certain limited cases, all or part of such a disallowance with respect to any state if such state is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such state (described in regulation as a "good faith waiver").

Section 71106 amends section 1903(u)(1) of the Act to specify, beginning in Fiscal Year 2030, when the Secretary must issue eligibility-related disallowances and establishes new restrictions on the Secretary's authority to issue good faith waivers for states with Medicaid eligibility-related error rates exceeding 3 percent. CMS expects to provide additional guidance to states on implementation of this provision.

Section 1903(u)(1) of the Act, as amended by section 71106, is applicable to all states and the District of Columbia; it does not apply to the territories.

Section 71107. Eligibility Redeterminations

Federal regulations currently in effect require states to redetermine eligibility once every 12 months, and no more frequently than once every 12 months, for Medicaid beneficiaries whose

[7] See 42 CFR § 455.436; 42 CFR § 457.990(b).

financial eligibility is determined using modified adjusted gross income (MAGI), including beneficiaries in the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.[8]

Section 71107 amends section 1902(e)(14) of the Act to add a new subparagraph (L) that requires more frequent eligibility redeterminations for the population enrolled in the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. Additionally, these requirements apply to individuals who are described in section 1902(a)(10)(A)(i)(VIII) who are otherwise enrolled in coverage under a waiver of the state plan (including through a section 1115 demonstration) that provides coverage that is equivalent to minimum essential coverage (MEC)[9] to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act.

Beginning with renewals scheduled on or after January 1, 2027, states and the District of Columbia will be required to conduct renewals once every 6 months for these individuals, rather than once every 12 months.

The new requirements of this section do not apply to certain American Indians and Alaska Natives described in section 1902(xx)(9)(A)(ii)(II)[10] of the Act who otherwise would be subject to the new 6-month renewal requirement. The new requirements of this section do not change renewal requirements for individuals enrolled in all other eligibility groups, whether MAGI-based or non-MAGI based.

CMS is required to issue guidance related to section 71107 by December 31, 2025.

Section 1902(e)(14)(L) of the Act, as added by section 71107, is applicable to all states and the District of Columbia that provide coverage to the affected populations as noted above; it does not apply to the territories.

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

Section 1917(f)(1) of the Act prohibits states, subject to certain exceptions, from providing Medicaid coverage of nursing facility services and other long-term services and supports to individuals whose home equity exceeds certain dollar limits.[11] This rule applies to both MAGI-

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[8] CMS refers to the renewal requirements at 42 CFR § 435.916 in effect as of 2023. Amendments to renewal requirements were made by the 2024 Eligibility & Enrollment Final Rule. Although states were originally required to comply with these amendments by June 2027, the moratorium at Section 71102 temporarily prohibits CMS from implementing, administering, or enforcing these amendments until September 30, 2034.

[9] MEC is defined in the statute as follows: "as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and determined in accordance with standards prescribed by the Secretary in regulations."

[10] This exemption specifically applies to: an Indian or Urban Indian (as such terms are defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act); a California Indian described in section 809(a) of such Act; or those who have otherwise been determined eligible as an Indian for the Indian Health Service under regulations promulgated by the Secretary.

[11] CMS has instructed states that they should follow the basic policies of the supplemental security income (SSI) program in determining home equity value. CMS State Medicaid Director Letter #06-018, Enclosure, "Section 6011 and 6016," page 23, available at https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/toaenclosure.pdf.

based and non-MAGI-based Medicaid beneficiaries.[12] Section 1917(f)(1) of the Act currently sets the minimum and maximum home equity limits at $500,000 and $750,000, respectively, and, per section 1917(f)(1)(C) of the Act, these figures have increased since 2011, from year to year, based on the percentage increase in the consumer price index for all urban consumers (CPI-U).[13] In 2025, the minimum and maximum home equity limits are, respectively, $730,000 and $1,097,000.[14] A state may elect to set its home equity limit between these minimum and maximum thresholds.[15]

Section 71108 amends section 1917(f)(1) of the Act, beginning January 1, 2028, to cap the maximum home equity limit at $1,000,000, except that this limit will not apply to homes on land zoned for agricultural use.[16] States will continue to have the option to impose a limit between the applicable minimum and maximum amounts, and this option will apply to both homes that are on land zoned for agricultural use and homes that are not.

For non-agricultural homes, the minimum and maximum limits will be, respectively, the amount described in section 1917(f)(1)(A) of the Act, adjusted by CPI-U increases per section 1917(f)(1)(C) of the Act (which, as described above, equals $730,000 in 2025) and $1,000,000. The minimum home equity limit will continue to increase based on CPI-U increases until it reaches $1,000,000.

For homes on land zoned for agricultural use, the same minimum limit imposed for non-agricultural homes and described in section 1917(f)(1)(A) of the Act will apply and will continue to increase based on CPI-U increases until it reaches $1,000,000. However, states will be permitted to elect a maximum limit for homes on land zoned for agricultural use that is effectively the current maximum limit ($1,097,000 for 2025, as described above, and subject to CPI-U increases year to year), and this maximum limit will continue to increase based on CPI-U increases in lieu of the $1,000,000 cap that will apply to non-agricultural homes.

Section 71108 also amends sections 1902(e)(14)(D)(iv) and 1902(r)(2) of the Act to prohibit states from using a methodology to determine home equity value that effectively raises the limits above those mandated by section 1917(f)(1).

Section 1917(f)(1) of the Act, as amended by section 71108, is applicable to all states, the District of Columbia, and the territories.

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[12] CMS State Medicaid Director Letter #14-001, "Application of Liens, Adjustments and Recoveries, Transfer of Asset Rules and Post-Eligibility Income Rules to MAGI Individuals," page 5, available at https://www.medicaid.gov/federal-policy-guidance/downloads/SMD-14-001.pdf

[13] See U.S. Bureau of Labor Statistics, available at https://www.bls.gov/cpi/

[14] CMCS Informational Bulletin, November 15, 2024, "2025 SSI, Spousal Impoverishment, and Medicare Savings Program Resource Standards," available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11152024.pdf

[15] Section 1917(f)(1)(B) of the Act.

[16] Note that Section 71108 creates new and different home equity-related treatment for homes on land zoned for agricultural use and homes that are not.

Section 71109. Alien Medicaid Eligibility

Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Public Law 104-193), certain "qualified aliens," also referred to as "qualified noncitizens,"[17] (e.g., lawful permanent residents (LPRs)/"green card holders," refugees, and asylees) are eligible for federal public benefits, including full Medicaid and CHIP coverage, if they meet all other eligibility requirements in the state (e.g., residency, income). Other federal statutes require other categories of individuals – including certain victims of human trafficking[18] and certain Afghan[19] and Ukrainian[20] parolees – to be treated as "refugees" and therefore they are considered eligible for full Medicaid or CHIP coverage, if they meet all other eligibility requirements in the state.

In accordance with PRWORA, many qualified noncitizens are subject to a five-year waiting period before becoming eligible for full Medicaid benefits or CHIP coverage, but some noncitizens are exempted from the five-year waiting period in Medicaid and CHIP (e.g., refugees and asylees).[21] The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Public Law 111-3) authorized an option for states to provide full Medicaid and CHIP coverage to children up to age 21 (up to age 19 for CHIP) and pregnant women who are lawfully residing in the U.S., without having to meet the five-year waiting period if otherwise applicable (often referred to as the "CHIPRA 214 option").

Section 71109 amends sections 1903(v) and 2107(e)(1) of the Act to restrict, with limited exceptions, federal financial participation (FFP) for medical assistance (Medicaid) and child or pregnancy-related health assistance (CHIP) to the following groups beginning October 1, 2026:

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[17] "Qualified noncitizen" is defined at 42 CFR § 435.4 for Medicaid and cross referenced at 42 CFR § 457.320(c) for CHIP, and includes: 1) noncitizens who are considered "qualified aliens" under 8 U.S.C. § 1641(b) and (c); and 2) noncitizens who are treated as refugees under other Federal statutes.

[18] 22 U.S.C. § 7105(b)(1)(C), or who are classified as nonimmigrants under § 101(a)(15)(T)(ii) of the Immigration and Nationality Act (8 U.S.C. § 1101(a)(15)(T)(ii)), pursuant to 22 U.S.C. § 7105(b)(1)(A). See also 8 U.S.C. § 1641(c)(4).

[19] Section 2502 of the Extending Government Funding and Delivering Emergency Assistance Act (Public Law 117-43 as amended, enacted September 30, 2021) and Section 1501 of the Consolidated Appropriations Act, 2023, Public Law 117-328.

[20] Section 401 of the Additional Ukraine Supplemental Appropriations Act (Public Law 117-128 as amended, enacted May 21, 2022; Title III, Section 301 of Public Law 118-50, which amends Section 401(a)(1)(A) of the Additional Ukraine Supplemental Appropriations Act, 2022.

[21] 8 U.S.C. § 1613(b).

1) U.S. citizens and nationals, 2) LPRs,[22] 3) Cuban and Haitian entrants,[23] and 4) Compacts of Free Association (COFA) migrants.[24] We note that section 71109 does not amend PRWORA.

The FFP limitations described in section 71109 do not apply to expenditures for: 1) care and services necessary for the treatment of an emergency medical condition as described in section 1903(v)(3) of the Act, authorized under section 1903(v)(2) of the Act (often referred to as "emergency Medicaid");[25] 2) medical assistance to lawfully residing children and pregnant women under the CHIPRA 214 option authorized by section 1903(v)(4) of the Act;[26] and 3) any state-designed Health Services Initiatives (HSIs) to improve the health of low-income children authorized under section 2105(a)(1)(D)(ii) of the Act.[27]

CMS is continuing to assess the implications of section 71109 on Medicaid and CHIP and expects to address any additional information in forthcoming guidance.

Sections 1903(v)(5) and 2107(e)(1)(R) of the Act, as added by section 71109, are applicable to all states, the District of Columbia, and the territories.

Section 71110. Expansion FMAP for Emergency Medicaid

FFP is authorized for care and services necessary to treat an emergency medical condition (as described in section 1903(v)(3) of the Act) for certain noncitizens who do not have satisfactory immigration status for full Medicaid benefits, provided they otherwise meet a state's Medicaid eligibility criteria (e.g., income, state residence),[28] generally at the state's regular Federal medical assistance percentage (FMAP) under section 1905(b) of the Act. Currently, if such a noncitizen meets the criteria in section 1902(a)(10)(A)(i)(VIII) of the Act for the Medicaid adult group, and the criteria in section 1905(y) or 1905(z) are met, a state can claim the associated 90 percent FMAP for its expenditures on services for an emergency medical condition for that noncitizen.

Section 71110 adds a new subsection (kk) to section 1905 of the Act. Beginning October 1, 2026, new subsection 1905(kk) limits the FMAP for emergency Medicaid services provided to noncitizens to no greater than the FMAP determined under section 1905(b) of the Act for such

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[22] Section 1903(v)(5)(B)(ii) as added by section 71109(a) of the WFTC legislation, section 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act (INA); an individual who is lawfully admitted for permanent residence under the INA (8 U.S.C. § 1101 et seq.); 8 U.S.C. § 1641(b)(1)).

[23] Section 1903(v)(5)(B)(iii) as added by section 71109(a) of the WFTC legislation, section 501(e) of Refugee Education Assistance Act of 1980. See 8 U.S.C. §§ 1612(b)(2)(A)(iv), 1613(b)(1)(D), and 1641(b)(7).

[24] Section 1903(v)(5)(B)(iv) as added by section 71109(a) of the WFTC legislation; see also Section 2107(e)(1)(R) (applying the same limitation to CHIP). See 8 U.S.C. §§ 1612(b)(2)(G), 1613(b)(3), and 1641(b)(8)). Coverage of COFA migrants under Medicaid is optional for territories.

[25] Section 1903(v)(5) of the Act, added by section 71109(a) of the WFTC legislation; 8 U.S.C. 1611(b)(1)(A).

[26] Section 1903(v)(5) of the Act, added by section 71109(a) of the WFTC legislation. The CHIPRA 214 option is applicable to CHIP through a cross-reference at section 2107(e)(1)(Q) of the Act to section 1903(v)(4) of the Act.

[27] Section 2107(e)(1)(R) of the Act, added by section 71109(b) of the WFTC legislation.

[28] 8 U.S.C. § 1611(b)(1)(A) and sections 1903(v)(2) and (3) of the Act. See also section 1903(v)(5) of the Act, added by section 71109(a) of the WFTC legislation, which will apply beginning October 1, 2026, as discussed above.

state, notwithstanding subsections 1905(y) and (z) of the Act.[29] That means that the 90 percent FMAP described above will no longer be available for emergency Medicaid services for individuals who meet the eligibility requirements under the Medicaid adult group.

Section 1905(kk) of the Act, as added by section 71110, is applicable to all states, the District of Columbia, and the territories.

Subchapter B – Preventing Wasteful Spending

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

On May 10, 2024, CMS published a final rule, "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," which establishes certain minimum nurse staffing and enhanced facility assessment requirements for nursing homes, and requires states to report on the percentage of Medicaid payments that are spent on compensation for direct care workers and support staff in nursing facilities and intermediate care facilities for individuals with intellectual disabilities.[30]

Section 71111 temporarily prohibits CMS from implementing, administering, or enforcing certain nursing home staffing provisions of the nursing home minimum staffing final rule through September 30, 2034. Specifically, the moratorium applies to revised provisions found at 42 CFR §§ 483.5 and 483.35. The rules in effect before May 10, 2024 will continue to be enforced.

This moratorium does not apply to the enhanced facility assessment requirements set out at new 42 CFR § 483.71 or the Medicaid Institutional Payment Transparency Reporting provisions set out at new 42 CFR § 442.43.

Section 71111 affects regulations implemented by all states, the District of Columbia, and the territories.

Section 71112. Reducing State Medicaid Costs

Currently, states are required to provide applicants retroactive eligibility in Medicaid for up to three months prior to the month of application if the individual has received Medicaid services covered under the state plan during that period and such individual would have been eligible at

[29] To the extent a state was able to claim the increased FMAP for emergency services to noncitizens (including for services through a section 1115 demonstration), the FMAP will now be no greater than the FMAP determined under section 1905(b) of the Act for such state.

[30] https://www.federalregister.gov/documents/2024/05/10/2024-08273/medicare-and-medicaid-programs-minimum-staffing-standards-for-long-term-care-facilities-and-medicaid

the time services were received had they applied. For separate CHIPs, any period of retroactive eligibility is optional.

Section 71112 amends sections 1902(a)(34) and 1905(a) of the Act to shorten the retroactive eligibility period in Medicaid. Effective for applications made on or after January 1, 2027, the retroactive eligibility period for individuals enrolled in the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act will be limited to one month prior to the month of application. For all other individuals, that is, those not enrolled in the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, the retroactive eligibility period will be limited to two months prior to the month of application.

This provision also makes similar amendments to CHIP at section 2102(b)(1)(B) of the Act by adding a new paragraph (vi), where states retain the option to provide retroactive eligibility, but cannot begin the coverage any earlier than two months prior to the month of application. The CHIP amendments will also be effective for applications made on or after January 1, 2027.

Sections 1902(a)(34), 1905(a), and 2102(b)(1)(B) of the Act, as amended by section 71112, are applicable to all states, the District of Columbia, and the territories.

Section 71113. Federal Payments to Prohibited Entities

Section 71113 prohibits federal Medicaid funding for items and services furnished during the 1-year period beginning July 4, 2025, by a "prohibited entity," defined as an entity that meets the below four conditions as of October 1, 2025, along with such an entity's affiliates, subsidiaries, successors, and clinics. The four conditions are as follows:

1) The entity is a nonprofit organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of that Code.
2) The entity is an essential community provider[31] primarily engaged in family planning services, reproductive health, and related medical care.
3) The entity provides for abortions other than an abortion if the pregnancy is the result of an act of rape or incest, or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
4) The total amount of federal and state[32] Medicaid expenditures for medical assistance furnished in fiscal year 2023 made directly or by a "covered organization"[33] to the entity

[31] As described in regulations at 45 CFR § 156.235, as in effect on July 4, 2025, the date of enactment of the WFTC legislation.
[32] "State" includes the states, the District of Columbia, and the territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands). See section 71113(b)(4) of the WFTC legislation (referencing section 1101 of the Act).
[33] A "covered organization" is a managed care organization, primary care case manager, prepaid inpatient health plan or a prepaid ambulatory health plan as defined in 42 CFR § 438.2.

> or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000.

The federal funding prohibition applies to "any payments made directly to the prohibited entity or under a contract or other arrangement between a [s]tate and a covered organization." Consistent with existing processes on quarterly expenditure reporting, states should expect to provide assurances that claims for FFP are only for Medicaid expenditures permitted by law.

Subchapter C – Stopping Abusive Financing Practices

Section 71114. Sunsetting Increased FMAP Incentive

Section 1905(ii) of Act as added by section 9814 of the American Rescue Plan Act of 2021 (Public Law 117-2) provided a temporary (8 calendar quarters) 5-percentage-point FMAP increase to a state's regular FMAP determined under section 1905(b) of the Act for states that newly expand eligibility to all individuals in the Medicaid adult group described in section 1902(a)(10)(A)(i)(VIII) under the state plan or waiver of such plan. As of November 2025, 4 states received this increase.

Section 71114 amends section 1905(ii)(3) of the Act to end the availability of the 5-percentage-point FMAP increase incentive for states that adopt the Medicaid adult group expansion on or after January 1, 2026.

Section 1905(ii)(3) of the Act, as amended by section 71114, is applicable to all states and the District of Columbia; it does not apply to the territories.[34]

Section 71115. Provider Taxes

Under current law, states may use revenue generated through certain health care-related taxes to fund the non-federal share of Medicaid expenditures. Health care-related taxes must meet requirements in section 1903(w) of the Act and implementing regulations at 42 CFR Part 433. These requirements include that taxes must be imposed on a permissible class of providers and must be broad-based and uniform (unless a waiver is approved). The statute also prohibits multiple types of hold harmless arrangements, including those that guarantee taxpayers receive their tax cost back through Medicaid or other payments. Regulations at 42 CFR § 433.68(f) specify two specific types of hold harmless arrangements that involve guarantees: direct and indirect. An indirect hold harmless arrangement generally occurs when the state taxes health care providers at a high rate relative to their revenue, historically set to 6 percent of net patient

[34] Territories are eligible for the expansion state enhanced FMAP for adults without dependent children, which states were eligible to receive for expansions prior to the Affordable Care Act under section 1905(z) of the Act (although we note neither American Samoa nor the Commonwealth of the Northern Mariana Islands have claimed any expenditures under this FMAP). As such, territories were not eligible for the increase under section 9814 of American Rescue Plan Act, and this sunset provision does not apply to them.

revenue, resulting in a presumption that the tax costs will be repaid to the taxpayer through increased Medicaid payments, after the state draws down federal financial participation. Generally, the 6 percent indirect hold harmless threshold limits the amount each state can collect in provider taxes on a per-class basis.[35]

Section 71115 amends section 1903(w)(4) of the Act by modifying the indirect hold harmless threshold, beginning on October 1, 2026. Effectively, this provision prohibits states from increasing the revenue a health care-related tax can generate in almost all instances and generally prohibits states from establishing new provider taxes. This effect is achieved by setting the indirect hold harmless threshold equal to the percent of net patient revenue attributable to such permissible class as of July 4, 2025. Beginning October 1, 2027, the indirect hold harmless threshold for Medicaid expansion states[36] is reduced to the lower of July 4, 2025, levels or 5.5 percent, which decreases annually by 0.5 percentage points until reaching 3.5 percent in FY 2032. This phase-down is not applicable to non-expansion states or to health care-related taxes imposed on the nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) permissible classes. On November 14, 2025, CMS sent a letter[37] to states outlining preliminary guidance on section 71115 (and section 71117).

Under section 71115(b), the amendments made to section 1903(w)(4) of the Act are applicable to all states and the District of Columbia; they do not apply to the territories.

Section 71116. State Directed Payments

Generally, states may not direct MCO, PIHP, or PAHP expenditures, except in limited circumstances. One such circumstance is when states obtain approval for a state directed payment (SDP), which permits states to direct specific payments made by MCOs, PIHPs, or PAHPs to providers under certain circumstances. The regulation finalized in 2024 at 42 CFR § 438.6(c)(2)(iii) requires that the total payment rate for SDPs for inpatient and outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center not exceed the average commercial rate (ACR).

Section 71116 directs the Secretary to revise 42 CFR § 438.6(c)(2)(iii) to reduce the total payment rate limit for SDPs for these services to 100 percent of the total published Medicare payment rates for expansion states[38] and 110 percent of the total published Medicare payment

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[35] A tax that generates revenue more than 6 percent of net patient revenue for the class may be permissible where 75 percent or more of providers do not receive at least 75 percent of their tax cost back, but in practice, this secondary test is virtually never satisfied.

[36] Section 71115(a)(2) of the WFTC legislation defines an expansion state as "a State that, beginning on January 1, 2014, or on any date thereafter, elects to provide medical assistance to all individuals described in section 1902(a)(10)(A)(i)(VIII) under the State plan under this title or under a waiver of such plan."

[37] https://www.medicaid.gov/medicaid/downloads/providertax_dcl_11142025.pdf

[38] Section 71116(a)(1) defines an expansion states as "a State that provides coverage to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396(a)(10)(A)(i)(VIII)) that is equivalent to minimum essential coverage (as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and

rates for non-expansion states for rating periods beginning on or after July 4, 2025. In the absence of a total published Medicare payment rate, section 71116 directs CMS to utilize the payment rate under the Medicaid state plan (or under a waiver of such plan) as the limit. Section 71116(b) also includes a temporary grandfathering period for certain SDPs until the rating period beginning on or after January 1, 2028, at which point such SDPs must comply with specified phase down requirements.

On September 9, 2025,[39] CMS sent a letter to states outlining preliminary guidance on section 71116 to aid state planning until a final rule is promulgated. CMS acknowledges that this letter is preliminary in nature, and final policies will depend on the contents of a final rule.

Under section 71116(d)(3), this provision is applicable to all states and the District of Columbia; it does not apply to the territories.

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

As discussed earlier in this CIB, states are currently allowed to fund the non-federal share of Medicaid through certain health care-related taxes. Health care-related taxes must meet requirements in section 1903(w) of the Act and implementing regulations at 42 CFR Part 433.

These requirements include that taxes must be imposed on a permissible class of providers, the taxes must be broad-based and uniform (unless a waiver is approved), and that taxpayers are not held harmless. Broad-based and uniform requirements may be waived as long as the tax is generally redistributive in nature and the amount of the tax is not directly correlated to Medicaid payments for items or services with respect to which the tax is imposed. The regulations establish two statistical tests for determining whether a proposed tax would be generally redistributive in nature, with the applicable test depending on whether a waiver of the uniformity requirement is requested. An unintended loophole in the statistical test used to determine if a health care-related tax is generally redistributive where a waiver of the uniformity requirement is requested has enabled some states to shift the financial burden of financing the Medicaid program to the federal government without the state bearing the requisite non-federal share. CMS issued a proposed rule on May 15, 2025, to close this loophole.[40]

Section 71117 amends section 1903(w) of the Act to codify the proposed rule's provisions that a health care-related tax would not be considered generally redistributive if, within a permissible class, the tax rate imposed on the taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any

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determined in accordance with standards prescribed by the Secretary in regulations) under the State plan (or waiver of such plan) of such State under title XIX of such Act.

[39] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-09092025.pdf

[40] Federal Register: Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule

other taxpayer or tax rate group explicitly defined by its relatively higher volume or percentage of Medicaid taxable units.

The tax would also not be considered generally redistributive if, within a permissible class, the tax rate imposed on any taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable units. Finally, a tax is not considered generally redistributive if it accomplishes the same effect as the first two provisions by identifying a taxpayer or tax rate group based on or defined by any description, including without explicitly naming Medicaid.

Section 71117(c) provides authority to the Secretary to grant a transition period for states to come into compliance with section 71117, not to exceed 3 years. On November 14, 2025, CMS sent a letter[41] to states outlining preliminary guidance on section 71117 (and section 71115, discussed previously), specifically the transition periods CMS is providing in accordance with section 71117(c). In the letter, we note these are the minimum transition periods that may be available; final policies will depend on the contents of notice and comment rulemaking.

Under section 71117(b), the amendments made by this section are applicable to all states and the District of Columbia; they do not apply to the territories.

Section 71118. Requiring Budget Neutrality for Medicaid Demonstration Projects under Section 1115

Under long-standing practice, CMS will not approve a demonstration project under section 1115 of the Act unless the project is expected to be budget neutral to the federal government. Currently, the CMS Office of the Actuary (OACT) does not play a role in determining whether a project is expected to be budget neutral; CMS determines budget neutrality for each project.

Section 71118 adds budget neutrality as a new statutory requirement in subsection (g) of section 1115 of the Act. New subsection 1115(g) states that, beginning January 1, 2027, the Secretary may not approve an application for (or an amendment or renewal of) a Medicaid section 1115 demonstration project unless the CMS Chief Actuary certifies that such project is not expected to result in an increase in the amount of federal expenditures compared to the amount that such expenditures would otherwise be in the absence of such project. CMS expects to provide additional guidance to states on implementation of this provision.

Section 1115(g) of the Act, as added by section 71118, is applicable to all states, the District of Columbia, and the territories.

[41] https://www.medicaid.gov/medicaid/downloads/providertax_dcl_11142025.pdf

Subchapter D – Increasing Personal Accountability

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

Section 71119 amends section 1902 of the Act by adding a new subsection (xx) under which, beginning January 1, 2027, states must condition Medicaid eligibility for "applicable individuals" on their demonstration of community engagement. Unless an exception or exclusion applies (see below), applicable individuals are 1) individuals eligible for or enrolled under the state plan in the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act; or 2) individuals who are eligible for or enrolled under a waiver of the state plan (including a section 1115 demonstration) that provides coverage that is equivalent to MEC[42] and who have attained the age of 19 and are under 65 years of age, are not pregnant, are not entitled to, or enrolled for, benefits under Medicare Part A or Part B, and are not otherwise eligible to enroll under the state plan.[43] States may elect an earlier implementation date and should contact CMS for more details.

Certain individuals ("specified excluded individuals") are excluded from the definition of "applicable individuals" and are therefore not subject to community engagement requirements. These individuals are: former foster care children;[44] certain American Indians and Alaska Natives;[45] parents, guardians, caretaker relatives, or family caregivers (as defined in section 2 of the RAISE Family Caregivers Act (Public Law 115-119)) of a dependent child under the age of 14 or a disabled individual; veterans with a total disability rating; individuals who are medically frail or who otherwise have special medical needs (as defined by the Secretary); [46] individuals who are already compliant with Temporary Assistance for Needy Families (TANF) work requirements; members of households that receive Supplemental Nutrition Assistance Program (SNAP) benefits who are not exempt from a SNAP work requirement; individuals who are participants in certain substance use disorder treatment and rehabilitation programs; inmates of a public institution; and pregnant women or individuals entitled to postpartum medical assistance.[47]

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[42] MEC is defined in the statute as follows: "as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and determined in accordance with standards prescribed by the Secretary in regulations."

[43] Notably, this definition for purposes of section 1902(xx) of the Act will capture states that provide coverage through a section 1115 demonstration to all individuals, or only to *some individuals*, who are described in section 1902(a)(10)(A)(i)(VIII) of the Act.

[44] Described in section 1902(a)(10)(A)(i)(IX) of the Act.

[45] Specifically, the exclusion applies to an Indian or Urban Indian (as such terms are defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act); a California Indian described in section 809(a) of such Act; or those who have otherwise been determined eligible as an Indian for the Indian Health Service under regulations promulgated by the Secretary.

[46] Including an individual: who is blind or disabled (as defined in section 1614 of the Act); with a substance use disorder; with a disabling mental disorder; with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition.

[47] Postpartum medical assistance is available under section 1902(e)(5) or (16) of the Act.

In addition to an individual who is a specified excluded individual for part or all of a month in which they would otherwise be required to demonstrate community engagement, other individuals are excepted from demonstrating community engagement and are similarly not subject to community engagement requirements for that month. These individuals include those who for part or all of a month in which they would otherwise be required to demonstrate community engagement are: under the age of 19; entitled to, or enrolled for, benefits under Medicare Part A, or enrolled for benefits under Medicare Part B; or described in any of the mandatory eligibility groups listed in subclauses (I) through (VII) of section 1902(a)(10)(A)(i) of the Act. Additionally, individuals are excepted for a month in which they are otherwise required to demonstrate community engagement, if, at any point during the three-month period ending on the first day of that month, they were an inmate of a public institution. States also have the option to implement an exception for persons who experience one of the following short-term hardship events: receiving inpatient hospital services or certain other types of medical care; residing in a locality where there is a Presidential declaration of a disaster or emergency; residing in a locality with an unemployment rate over certain thresholds; or needing to travel outside of their community for an extended period of time, for themselves or their dependents, to receive treatment of a serious or complex medical condition where such treatment is not available within the individual's community of residence.

There are several ways an applicable individual can demonstrate community engagement for a month, including through a combined minimum of 80 hours of work, community service, and/or participation in a work program, or enrollment in an educational program at least half-time, among others. States must require that applicable individuals seeking Medicaid coverage meet community engagement requirements for at least one month but not more than three consecutive months immediately preceding the month during which the individual applies. States must require current beneficiaries to meet the requirements for one or more months (consecutive or not) during the period between the individual's most recent eligibility determination and their next regularly scheduled redetermination. A state may opt to conduct more frequent verifications of compliance with community engagement requirements.

Generally, to verify compliance with, or an exception to, or exclusion from community engagement requirements, states must establish processes and use reliable information available to the state, without requiring individuals to submit additional information, where possible. If a state cannot verify an applicable individual's compliance with the community engagement requirements, it must provide notice of noncompliance and allow the applicant or beneficiary (as applicable) 30 calendar days to demonstrate compliance or show that the requirement does not apply to them. If no satisfactory showing of compliance or inapplicability of the requirement is made, the state must determine whether the individual has any other basis for eligibility for Medicaid or another insurance affordability program. The state must then provide written notice and fair hearing rights in accordance with 42 C.F.R. part 431 subpart E (including advance notice in the case of an eligibility termination or other adverse action) and, if there is no other basis for

Medicaid eligibility, deny the application or terminate eligibility by the end of the month following the end of the 30-day period.

States must provide outreach about the requirements to enrolled applicable individuals several months prior to December 31, 2026, or, if the state selected an earlier implementation date, several months prior to that date. The specific deadline for the required outreach will be based on the specific number of months for which a state opts to require applicants to have demonstrated community engagement before they apply for Medicaid plus three months. States are also required to provide outreach on a periodic basis thereafter. States are prohibited from using MCOs, PIHPs, or PAHPs, or other contractors with direct or indirect financial relationships to MCOs, PIHPs, or PAHPs to determine beneficiary compliance with community engagement requirements.

The Secretary may exempt a state from implementing community engagement requirements if it submits an exemption request and demonstrates good faith efforts to comply. Any such exemptions will expire no later than December 31, 2028. CMS will award $200 million to states in Government Efficiency Grants for fiscal year 2026 for states to establish systems necessary to carry out the community engagement requirement and other sections of the same chapter of the WFTC legislation that relate to conducting eligibility determinations and redeterminations. States are also reminded that enhanced federal matching funds for certain eligible administrative expenditures also continue to be available.[48]

The community engagement requirements cannot be waived under section 1115 demonstration authority. CMS must issue an interim final rule implementing section 71119 by June 1, 2026. Additional guidance from CMS on this provision is forthcoming.

Section 1902(xx) of the Act, as added by section 71119, is applicable to all states and the District of Columbia that provide coverage to "applicable individuals" as described above; it does not apply to the territories.

Section 71120. Modifying Cost Sharing Requirements for Certain Expansion Individuals under the Medicaid Program

Currently, states have the option to charge premiums and cost sharing for certain Medicaid enrollees and certain services. Cost sharing is generally limited to nominal amounts but may be higher for those with income above 100 percent of the federal poverty level (FPL). Aggregate out-of-pocket costs cannot exceed 5 percent of family income.

Section 71120 amends section 1916 of the Act to require states to impose cost sharing on certain care, items, or services as determined by the state, provided to individuals whose family income exceeds 100 percent of the FPL and are enrolled in the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. Additionally, these requirements apply to individuals whose

[48] See 42 CFR § 433.15

family income exceeds 100 percent of the FPL, who are described in section 1902(a)(10)(A)(i)(VIII) of the Act, and who are enrolled in coverage under a waiver of the state plan (including a section 1115 demonstration) that provides coverage that is equivalent to MEC[49] to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act.

Under new section 1916(k) of the Act, states must impose such cost sharing beginning October 1, 2028. Cost sharing imposed under this section cannot exceed $35 for any care, item, or service. Cost sharing amounts for prescription drugs remain subject to cost sharing rules and limitations established by section 1916A of the Act. The provision also prohibits states from imposing premiums or enrollment fees on this population.

The new section 1916(k) exempts primary care, behavioral health, federally qualified heath center (FQHC), rural health clinic, and certified community behavioral health clinic (CCBHC) services from cost sharing for this population, in addition to the previously existing exemptions.[50] Existing cost sharing exemptions for American Indians and Alaska Natives are not changed by this section and still apply.[51] Aggregate out-of-pocket costs for all individuals in the family cannot exceed 5 percent of the income of the family.

Section 1916(k) of the Act, as added by section 71120, is applicable to all states and the District of Columbia that provide coverage to the individuals noted above; it does not apply to the territories.

Subchapter E – Expanding Access to Care

Section 71121. Making Certain Adjustments to Coverage of Home or Community-Based Services under Medicaid

Section 1915(c) of the Act authorizes home and community-based services (HCBS) waivers. These waivers permit states to waive certain Medicaid state plan requirements, such as statewideness and comparability requirements, and to limit the number of individuals who may receive HCBS under the waiver. Under Section 1915(c)(1) of the Act, eligible individuals must meet an institutional level of care (ILOC) requirement (e.g., in the absence of HCBS, they would require hospital, nursing facility, or intermediate care facility care). States with approved 1915(c) waivers must meet numerous requirements, including cost neutrality and health and welfare protections.[52]

Section 71121 amends section 1915(c) of the Act to create a new waiver option for states that will be available beginning on July 1, 2028. Under this new waiver option, states may cover

[49] MEC is defined in the statute as follows: "as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and determined in accordance with standards prescribed by the Secretary in regulations."
[50] Sections 1916(a)(2), (b)(2) and Section 1916A(b)(3)(B) of the Act.
[51] Section 1916(j) of the Act.
[52] Section 1915(c)(2)(A) and Section 1915(c)(2)(D) & (E) of the Act.

HCBS for individuals without requiring an ILOC determination. Section 71121 establishes several conditions for approval, such as that states must:

1) use needs-based criteria, subject to Secretary approval, to determine eligibility for HCBS under the new waiver option;
2) demonstrate that approval of the waiver will not result in a material increase in the average time individuals who meet ILOC criteria will need to wait to receive HCBS under any other approved 1915(c) waiver;
3) attest that the state's average per capita Medicaid expenditures for individuals covered by the waiver will not exceed the state's average per capita Medicaid expenditures for individuals receiving institutional care under the state plan (or waiver of such plan); and
4) agree to provide to the Secretary at least annually certain cost and utilization data, as specified under section 1915(c)(11)(B)(vii) of the Act.

Under new section 1915(c)(11)(C) of the Act, states are prohibited from using Medicaid payments under this new waiver authority to pay third parties on behalf of an individual practitioner for benefits such as health insurance or skills training, if the practitioner belongs to a practitioner class for which Medicaid is the primary source of revenue.

Section 71121 also appropriates $100 million in FY 2027 for payments to states to support state systems to deliver HCBS under section 1915(c) waivers or section 1115 demonstrations. The FY 2027 funds will be allotted based on the proportion of the state's population receiving HCBS under section 1915(c) or section 1115 of the Act, as compared to all states.

Section 1915(c)(11) of the Act, as added by section 71121, is applicable to all states, the District of Columbia, and the territories.

Chapter 4[53] – Protecting Rural Hospitals and Providers

Section 71401. Rural Health Transformation Program

Section 71401 establishes a Rural Health Transformation (RHT) Program within Title XXI of the Act and appropriates $10 billion annually for allotments to states for fiscal years 2026 through 2030.[54] The program, added as new subsection (h) in section 2105 of the Act, is administered by the CMS Administrator and provides funding to states (excluding DC and territories) with approved applications to improve rural health care access and outcomes.

The total annual appropriation of $10 billion will be distributed in two ways. Half of the funds ($5 billion) will be distributed equally across all approved states. The remaining half ($5 billion) is allocated to at least 25 percent of approved states based on factors specified in the Act and by the Administrator, such as the percentage of the state's population living in rural areas and the

[53] Specifically, Chapter 4 of Subtitle B of Title VII of Public Law 119-21.
[54] For more information of the RHT Program, visit https://www.cms.gov/priorities/rural-health-transformation-rht-program/rural-health-transformation-rht-program.

proportion of rural health care facilities compared to the number of such providers nationwide, and the quality of the state's rural health transformation plan.

The Administrator must approve or deny a state's application by December 31, 2025, as described in statute. This is a one-time application and cannot be amended. Applications must include a detailed rural health transformation plan addressing multiple objectives, such as:

1) improved health care access and outcomes for rural residents;
2) new and strengthened local and regional strategic partnerships between rural hospitals and other health care providers;
3) prioritization of data and technology-driven solutions for rural health care delivery; and
4) long-term financial solvency and operating models of rural hospitals.

States have two years to expend funds provided for each fiscal year (e.g., FY 2027 funds are available through FY 2028). If a state does not spend all funds CMS awarded to it by the end of the subsequent fiscal year with respect to each budget period start date, these funds will be redistributed by the Administrator in the nearest following fiscal year possible. Funds cannot be used to finance the non-federal share of any expenditures or to pay for services reimbursable through other funding streams. All unexpended and unobligated funds as of October 1, 2032, return to the United States Treasury.

States must submit annual reports on the use of their allotments. The Administrator has authority to withhold, reduce, or recover payments if states have not expended funds consistent with their approved applications. States are required to demonstrate compliance with their approved rural health transformation plans through these reporting mechanisms.

Section 2105(h) of the Act, as added by section 71401, is applicable to the 50 states. It does not apply to the District of Columbia or the territories.

Tax-Related Provisions

The WFTC legislation contains several provisions related to federal tax law, which may impact the household income of some individuals, thereby affecting their financial eligibility for Medicaid or CHIP.

Under MAGI-based methodologies, the MAGI of a tax dependent or child is generally counted in determining household income only if the dependent's or child's gross income exceeds certain tax-filing thresholds.[55] CMS described filing thresholds and income counting in State Health

[55] The exception is that a child's income is always counted when the child is the only person in his/her MAGI-based household (or is living with his/her sibling(s)), regardless of whether the child's income exceeds the filing threshold. See 42 CFR § 435.603(d)(1).

Official Letter #19-003.[56] Under section 70102, the single filing threshold (under age 65 and not blind) is $15,750 for tax year 2025, increased from $14,600 in 2024.[57] This may result in an increase to the filing threshold of a dependent, which could affect whether the dependent's MAGI is included in household income. Starting with tax year 2026, the Internal Revenue Service (IRS) will resume adjusting the filing thresholds for inflation.

Certain changes in the law make earlier time-limited tax law changes permanent, with minor modifications. In particular, section 70113 makes permanent the elimination of the qualified moving expenses deduction. Active-duty members of the U.S. Armed Forces are already excepted from the elimination of the qualified moving expense deduction, and section 70113 adds, starting in 2026, members of the intelligence community to those who are excepted from the elimination. Additionally, section 70119 permanently extends the income exclusion for student debt discharged on account of the death or total disability of the student. (The moving expense and student debt-related changes, when first made temporary, were described by CMS in State Health Official Letter #19-003.)

The WFTC legislation also makes significant changes to federal tax law for individual taxpayers that do not affect MAGI-based methodologies for Medicaid and CHIP. In particular, section 70201, related to a deduction for qualified tips; section 70202, related to deduction for overtime premium pay; and section 70203, related to a deduction for loan interest on certain passenger vehicles each are deductions that occur after the calculation of adjusted gross income. As a result, these deductions are not part of the MAGI calculation and do not impact an individual's household MAGI. CMS continues to analyze other changes made to the federal tax law in WFTC legislation and is available to provide technical assistance to states.

These changes to federal tax law as they affect MAGI-based methodologies are applicable to all states, the District of Columbia, and the territories.

Closing

Medicaid and CHIP are critical components of our nation's health care safety net, serving as essential state-federal partnerships that provide coverage to millions of Americans. The successful implementation of the WFTC legislation will require coordinated efforts between CMS, state Medicaid and CHIP agencies, and other key stakeholders to ensure these programs continue to effectively serve our most vulnerable populations while implementing necessary reforms to eliminate waste, fraud, and abuse.

CMS recognizes that the provisions of this law represent significant programmatic changes that will require substantial planning, coordination, and resources at both the federal and state levels. CMS is fully committed to providing comprehensive support to states throughout the

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[56] CMS State Health Official Letter #19-003, "Changes to Modified Adjusted Gross Income (MAGI)-based Income Methodologies," pages 2-3, available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho19003.pdf.
[57] IRS Publication 501 discusses tax filing requirements in more detail. https://www.irs.gov/pub/irs-pdf/p501.pdf.

implementation process and will serve as a dedicated partner in navigating these changes. States will have access to ongoing technical assistance, detailed implementation guidance, and practical tools, including State Plan Amendment templates and systems change assistance.

CMS intends to issue additional detailed guidance in the coming months addressing specific provisions of the WFTC legislation. The agency stands ready to provide the technical assistance and support that states need during this implementation period. States requiring technical assistance or having questions regarding implementation should send an email to MedicaidReforms@cms.hhs.gov.

Appendix A. Key Dates

Section	Provision	Key Date(s)
Subchapter A – Reducing Fraud and Improving Enrollment Processes		
Section 71101	Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs	Effective July 4, 2025 Ends: September 30, 2034
Section 71102	Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program	Effective: July 4, 2025 Ends: September 30, 2034
Section 71103	Reducing Duplicate Enrollment under the Medicaid and CHIP Programs	January 1, 2027: Process established by states to obtain address information. January 1, 2027: State managed care contracts to include the requirement that covered entities and plans transmit enrollee address information. October 1, 2029: CMS to establish system to send applicant and enrollee data submissions. States to provide and utilize national enrollment data to prevent simultaneous enrollment in multiple states.
Section 71104	Ensuring Deceased Individuals Do Not Remain Enrolled	Applies beginning January 1, 2027
Section 71105	Ensuring Deceased Providers Do Not Remain Enrolled	Applies beginning January 1, 2028
Section 71106	Payment Reduction Related to Certain Erroneous Excess Payments under Medicaid	Applies beginning October 1, 2029
Section 71107	Eligibility Redeterminations	Applies beginning January 1, 2027
Section 71108	Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services under the Medicaid Program	Applies beginning January 1, 2028
Section 71109	Alien Medicaid Eligibility	Applies beginning October 1, 2026
Section 71110	Expansion FMAP for Emergency Medicaid	Applies beginning October 1, 2026
Subchapter B – Preventing Wasteful Spending		
Section 71111	Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities under the Medicare and Medicaid Programs	Effective: July 4, 2025 Ends: September 30, 2034
Section 71112	Reducing State Medicaid Costs	Applies to applications made on or after January 1, 2027.
Section 71113	Federal Payments to Prohibited Entities	Effective July 4, 2025 Ends: July 3, 2026

Section	Provision	Key Date(s)
Subchapter C – Stopping Abusive Financing Practices		
Section 71114	Sunsetting Increased FMAP Incentive	Applies to states adopting the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act on or after January 1, 2026.
Section 71115	Provider Taxes	October 1, 2026: Restriction on new or increased provider taxes. October 1, 2027: Expansion state hold harmless reduction begins.
Section 71116	State Directed Payments	Applies to rating periods beginning on or after July 4, 2025. For grandfathered SDPs, applies to rating periods beginning on or after January 1, 2028.
Section 71117	Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax	Effective July 4, 2025, subject to any transition period determined by the Secretary (not to exceed 3 fiscal years).
Section 71118	Requiring Budget Neutrality for Medicaid Demonstration Projects under Section 1115	Applies beginning January 1, 2027
Subchapter D – Increasing Personal Accountability		
Section 71119	Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals	Applies beginning January 1, 2027, or earlier at state option; outreach requirements will apply several months before implementation; state good-faith temporary exemption expires no later than December 31, 2028
Section 71120	Modifying Cost Sharing Requirements for Certain Expansion Individuals under The Medicaid Program	Applies beginning October 1, 2028
Subchapter E – Expanding Access to Care		
Section 71121	Making Certain Adjustments to Coverage of Home or Community-Based Services under Medicaid (new section 1915(c) option)	New waiver option available beginning July 1, 2028
Chapter 4 – Protecting Rural Hospitals and Providers		
Section 71401	Rural Health Transformation Program	Effective July 4, 2025 Administrator must approve or deny applications by December 31, 2025

Appendix B. Opportunities for Additional Financial Support for States

Section	Provision	Description of Financial Support
Section 71119	Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals	**What is Available?** • Government Efficiency Grants to states • Grant funding is to be used for state implementation of this provision and others in same chapter of the WFTC legislation related to eligibility determinations or redeterminations. **How Much is Available?** • $200 million **When Are Grants Available?** • Beginning Fiscal Year 2026 and available until expended. **How Will Grants be Disbursed?** • $100 million to be distributed equally across states. • $100 million in an amount for each state reflecting the ratio of individuals subject to the community engagement requirement to the total number of such individuals residing in all states as of March 31, 2025.
Section 71121	Making Certain Adjustments to Coverage of Home or Community-Based Services under Medicaid	**What is Available?** • Payments to states to support state systems to deliver HCBS under section 1915(c) waivers or section 1115 demonstrations. **How Much is Available?** • $100 million **When Are Payments Available?** • Beginning Fiscal Year 2027, and available until expended. **How Will Payments be Disbursed?** • Payments will be made to a state based on the proportion of the state's population that is receiving section 1915(c) or section 1115 HCBS, as compared to all states.
Section 71401	Rural Health Transformation Program	**What is Available?** • Allotments to states to be used for specified rural health-related activities, subject to approval and terms of state applications. **How Much is Available?** • $10 billion for each fiscal year 2026 through 2030. **When Will Allotments be Available?** • Fiscal Years 2026 through 2030. • States have two years to expend funds provided for a fiscal year (e.g., FY 2027 funds are available for FY 2027 and FY 2028). • Unexpended or unobligated funds may be redistributed. • The Administrator has the authority to withhold, reduce, or recover payments if a state has not expended funds consistent with its approved application. • Unexpended or unobligated funds as of October 1, 2032 return to the Treasury. **How Will Allotments be Disbursed?** • States except DC and territories can apply. • The Administrator must approve applications by December 31, 2025.

		• Half of the funds ($5 billion) are to be distributed equally across all approved states. • The other half of the funds ($5 billion) are to be distributed to at least a quarter of approved states based on factors established by Section 71401 and the Administrator.

Appendix C. Applicability to the Territories

Section	Provision	Applicable to Territories?
Subchapter A – Reducing Fraud and Improving Enrollment Processes		
Section 71101	Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs	Does not impact regulations that apply to the territories
Section 71102	Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program	Affects regulations that apply to the territories
Section 71103	Reducing Duplicate Enrollment under the Medicaid and CHIP Programs	Requirement to establish process to obtain address information by January 1, 2027 does not apply to territories; otherwise applies
Section 71104	Ensuring Deceased Individuals Do Not Remain Enrolled	Does not apply
Section 71105	Ensuring Deceased Providers Do Not Remain Enrolled	Applies
Section 71106	Payment Reduction Related to Certain Erroneous Excess Payments under Medicaid	Does not apply
Section 71107	Eligibility Redeterminations	Does not apply
Section 71108	Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services under the Medicaid Program	Applies
Section 71109	Alien Medicaid Eligibility	Applies
Section 71110	Expansion FMAP for Emergency Medicaid	Applies
Subchapter B – Preventing Wasteful Spending		
Section 71111	Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities under the Medicare and Medicaid Programs	Affects regulations that apply to the territories
Section 71112	Reducing State Medicaid Costs	Applies

Section 71113	Federal Payments to Prohibited Entities	Applies
Subchapter C – Stopping Abusive Financing Practices		
Section 71114	Sunsetting Increased FMAP Incentive	Does not apply
Section 71115	Provider Taxes	Does not apply
Section 71116	State Directed Payments	Does not apply
Section 71117	Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax	Does not apply
Section 71118	Requiring Budget Neutrality for Medicaid Demonstration Projects under Section 1115	Applies
Subchapter D – Increasing Personal Accountability		
Section 71119	Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals	Does not apply
Section 71120	Modifying Cost Sharing Requirements for Certain Expansion Individuals under The Medicaid Program	Does not apply
Subchapter E – Expanding Access to Care		
Section 71121	Making Certain Adjustments to Coverage of Home or Community-Based Services under Medicaid	Applies
Chapter 4 – Protecting Rural Hospitals and Providers		
Section 71401	Rural Health Transformation Program	Does not apply

Appendix D. Applicability to American Indians and Alaska Natives

This is a summary of the Tribal exceptions in the WFTC legislation. CMS is still analyzing the impacts of the provisions on American Indian and Alaska Native (AI/AN) Medicaid beneficiaries and is committed to continuing to work with Tribes on future guidance.

Section	Provision	Applicable to American Indians and Alaska Natives?
Section 71107	Eligibility Redeterminations	Does not apply to AI/ANs described in subsection (xx)(9)(A)(ii)(II)[58]
Section 71119	Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals	Does not apply to AI/ANs described in subsection (xx)(9)(A)(ii)(II)[59]
Section 71120	Modifying Cost Sharing Requirements for Certain Expansion Individuals under The Medicaid Program	Does not apply because existing cost sharing exemptions for certain American Indians and Alaska Natives are not changed by this section and still apply[60]

[58] Specifically, the exemption applies to: an Indian or Urban Indian (as such terms are defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act); a California Indian described in section 809(a) of such Act; or those who have otherwise been determined eligible as an Indian for the Indian Health Service under regulations promulgated by the Secretary.
[59] See footnote 45.
[60] See section 1916(j) of the Act.

Appendix E. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs

MSP Final Rule Provisions Subject to Moratorium (Do Not Apply During Moratorium) CMS is prohibited from implementing, administering, or enforcing the policies described below until the moratorium ends on September 30, 2034. States should refer to the Code of Federal Regulations in effect as of November 16, 2023, for requirements under the below-listed rules while the moratorium is in effect.	
Regulation	**Description of Provision as Amended by the Medicare Savings Programs (MSP) Final Rule**
42 CFR § 406.21(c)(5)	Requires group payer states to start Qualified Medicare Beneficiary (QMB) eligibility group coverage for certain individuals as early as the month of Medicare Part A entitlement.
42 CFR § 435.4	Defines Medicare Part D Low Income Subsidy (LIS) Application data ("leads data") as data the Social Security Administration (SSA) electronically transmits to state Medicaid agencies in accordance with section 1144(c) of the Act. **NOTE:** The statutory requirements described in section 1144(c) of the Act remain in effect.
42 CFR § 435.601(e)	Requires states to include at the least the individuals described in the Medicare Part D LIS definition of family size at 42 CFR 423.772 when determining the "family of the size involved" for MSP income eligibility.
42 CFR § 435.911(e)	Codifies in regulation statutory requirements described in section 1935(a)(4) of the Act for states to receive LIS leads data from SSA and to treat such receipt as an application for the MSP eligibility groups and establishes new requirements for states to make MSP eligibility determinations without re-verification when possible. **NOTE:** The statutory requirements described in section 1935(a)(4) of the Act remain in effect for states.
42 CFR § 435.952(e)	Requires states to reduce documentation individuals must provide to verify the value of certain income and resources (i.e., dividend and interest income, non-liquid resources, burial funds and life insurance) when making MSP eligibility determinations.

MSP Final Rule Provisions Excluded from Moratorium (Current Rules Apply) CMS is *not prohibited* from implementing, administering, or enforcing the policies described below. States should refer to the current Code of Federal Regulations for requirements, including while the moratorium is in effect.	
Regulation	**Description of Provision as Amended by the Medicare Savings Programs (MSP) Final Rule**
42 CFR § 435.909(a)	Moves pre-existing requirements for auto enrollment of certain individuals into Medicaid in states that have agreements with the Social Security Administration under 1634 of the Act from paragraph (b) of 435.909 to paragraph (a).
42 CFR § 435.909(b)(1)	Requires states to automatically enroll most Medicare-eligible supplemental security income (SSI) recipients into the QMB eligibility group, effective October 1, 2024.
42 CFR § 435.909(b)(2)	Created an option for group payer states to automatically enroll SSI recipients who lack premium-free Medicare Part A into the QMB eligibility group, effective November 17, 2023.

42 CFR § 435.909(b)(3)	Specifies the effective date of QMB coverage for SSI recipients automatically enrolled into the QMB eligibility group.

Appendix F. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program

Eligibility and Enrollment Final Rule Provisions Subject to Moratorium (Do Not Apply During Moratorium) CMS is prohibited from implementing, administering or enforcing the policies described below until the moratorium ends on September 30, 2034. States should refer to the Code of Federal Regulations in effect as of June 2, 2024, for requirements under the below listed rules while the moratorium is in effect.	
Regulation	**Description of Provision as Amended by 2024 Eligibility and Enrollment Final Rule**
42 CFR § 435.407	Allows verification of citizenship with a state vital statistics agency or the Systematic Alien Verification for Entitlements (SAVE) Program without separate identity verification.
42 CFR § 435.907	Requires states to provide beneficiaries with a minimum of 15 days to respond to a request for information, allow applicants to provide requested information through all modalities, accept non-MAGI applications and supplemental forms through all modalities, and provide a minimum 90-day reconsideration period after the date of denial due to failure to return information needed to determine eligibility.
42 CFR § 435.912	Establishes requirements, standards, and timeframes for states to complete redeterminations at renewal and when acting on changes in circumstances.
42 CFR § 435.916	Aligns renewal requirements for MAGI and non-MAGI beneficiaries.
42 CFR § 435.919 (see 42 CFR § 435.916 for requirements as of June 2, 2024)	Establishes a new 42 CFR § 435.919 that codifies steps for states to act on changes in circumstances and outlines processes to update address information and process returned mail in Medicaid. Technical edits were made to regulations at 42 CFR § 431.213(d) (notices when a beneficiary's whereabouts become unknown) and § 435.911(c) (eligibility determinations) to cross reference the new § 435.919. Please note that, because the only amendments to these provisions are technical in nature, there are no substantive changes to the policies described in 42 CFR §§ 431.213(d) and 435.911(c).
42 CFR §§ 435.1200(b)(3)(i)-(v), 435.1200(e)(1)(ii) and 435.1200(h)(1)	Requires Medicaid and CHIP agencies to issue combined notices and transfer accounts to the Marketplace when a beneficiary is procedurally disenrolled from Medicaid or CHIP.
42 CFR § 447.56(a)(1)(v)	Permits states to exempt from premiums and cost sharing individuals eligible for Medicaid under the newly codified optional eligibility group at 42 CFR § 435.223. **NOTE:** The statutory requirements described in sections 1916 and 1916(a) of the Act remain in effect for states.
42 CFR § 457.344 (see 42 CFR § 457.343 and 457.960 for requirements as of June 2, 2024)	Codifies steps for states to act on changes in circumstances and outlines processes to update address information and process returned mail in CHIP.
42 CFR § 457.960 (removal)	Removes this section of the regulation regarding changes in circumstances and relocated to updated § 457.344 (see above).

Eligibility and Enrollment Final Rule Provisions Subject to Moratorium (Do Not Apply During Moratorium) CMS is prohibited from implementing, administering or enforcing the policies described below until the moratorium ends on September 30, 2034. States should refer to the Code of Federal Regulations in effect as of June 2, 2024, for requirements under the below listed rules while the moratorium is in effect.	
Regulation	**Description of Provision as Amended by 2024 Eligibility and Enrollment Final Rule**
42 CFR §§ 457.1140(d)(4), 457.1170	Specifies that states must also provide beneficiaries with the opportunity to continue CHIP benefits when the state fails to make a timely eligibility determination. Technical edits were also made to regulations at 42 CFR § 457.1140(d)(4) to cross reference changes made to § 457.1170, and this technical change is also subject to the moratorium.
42 CFR § 457.1180	Clarifies that notice of an action that is subject to review must also include an explanation of the circumstances under which benefits may continue pending the review.

Eligibility and Enrollment Final Rule Provisions Excluded from Moratorium (Current Rules Apply) CMS is *not* prohibited from implementing, administering or enforcing the policies described below. States should refer to the current Code of Federal Regulations for requirements, including while the moratorium is in effect.	
Regulation	**Description of Provision as Amended by 2024 Eligibility and Enrollment Final Rule**
42 CFR § 431.10	Includes separate CHIPs and Basic Health Programs (BHPs) on list of entities to which Medicaid agencies may delegate authority to make eligibility determinations.
42 CFR § 431.17	Specifies the type of information and length of time states must maintain eligibility determination records.
42 CFR § 431.231(d) (removal)	Removes 42 CFR § 431.231(d) and relocates requirements regarding reinstatement of coverage when a beneficiary's whereabouts become known to new 42 CFR § 435.919.
42 CFR § 435.223	Creates an optional eligibility group for all or a reasonable classification of individuals under age 21 whose eligibility is excepted from use of the MAGI-based methodology (e.g., those living with a disability). A technical edit was also made to the regulation at 42 CFR § 435.222 to rename the eligibility group that the provision (42 CFR § 435.222) describes and distinguish it from this newly codified group under 42 CFR § 435.223.
42 CFR § 435.601	Updates income counting methodology to account for new optional eligibility group described at 42 CFR § 435.223.
42 CFR § 435.608 and 436.608 (removal)	Removes the requirement for applicants and beneficiaries in states and territories to apply for other cash benefits as a condition of Medicaid eligibility.
42 CFR § 435.831 and 436.831	Provides states and territories the option to determine non-institutionalized applicants meet their required "spenddown" for medically needy coverage by adding up their projected predictable expenses instead of requiring individuals to first incur such expenses.
42 CFR § 435.914	Clarifies recordkeeping requirements for Medicaid.
42 CFR § 435.940	Clarifies to which provisions the "Basis and scope" paragraph applies.
42 CFR § 435.952	Clarifies that verification regulations regarding use of electronic data and reasonable compatibility apply to asset verification as well as income.

Eligibility and Enrollment Final Rule Provisions Excluded from Moratorium (Current Rules Apply) CMS is *not* prohibited from implementing, administering or enforcing the policies described below. States should refer to the current Code of Federal Regulations for requirements, including while the moratorium is in effect.	
Regulation	**Description of Provision as Amended by 2024 Eligibility and Enrollment Final Rule**
42 CFR § 435.956	Removes state option to limit the number of reasonable opportunity periods (ROPs) during which otherwise eligible applicants receive Medicaid while they complete verification of their U.S. citizenship or satisfactory immigration status.
42 CFR § 435.1200 *except* for §§ 435.1200(b)(3)(i)-(v), 435.1200(e)(1)(ii), and 435.1200(h)(1).	Requires Medicaid agency to make eligibility determinations on behalf of, and accept MAGI determinations from, the CHIP agency and transition beneficiaries between Medicaid and CHIP.
42 CFR § 457.65	Prohibits waiting periods in CHIP.
42 CFR § 457.340	Establishes requirements for making timely eligibility determinations and requires that Medicaid and CHIP send combined notices. Note that this provision cross-references 42 CFR § 435.912 (timely determination of eligibility). Because the amendments made to 42 CFR § 435.912 are subject to the moratorium, states should refer to the timeliness requirements in effect as of June 2, 2024.
42 CFR § 457.348	Requires CHIP agencies accept eligibility determinations made by Medicaid and establish procedures to transition children between programs as appropriate.
42 CFR § 457.350	Requires CHIP agencies to make MAGI-based eligibility determinations on behalf of Medicaid and establish procedures to transition children between programs as appropriate.
42 CFR § 457.480	Prohibits annual and/or lifetime limits on benefits in CHIP.
42 CFR § 457.570	Prohibits states from disenrolling or locking-out CHIP beneficiaries for failure to pay premiums.
42 CFR § 457.805	Requires states to establish a substitution monitoring strategy to use in place of a waiting period.
42 CFR § 457.810	Prohibits waiting periods prior to CHIP enrollment.
42 CFR § 457.965	Clarifies CHIP recordkeeping requirements.
42 CFR § 600.330	Clarifies requirements related to coordination between BHPs with other insurance affordability programs (Marketplace, Medicaid and CHIP).
42 CFR § 600.525	Prohibits premium lock-out periods in BHPs.