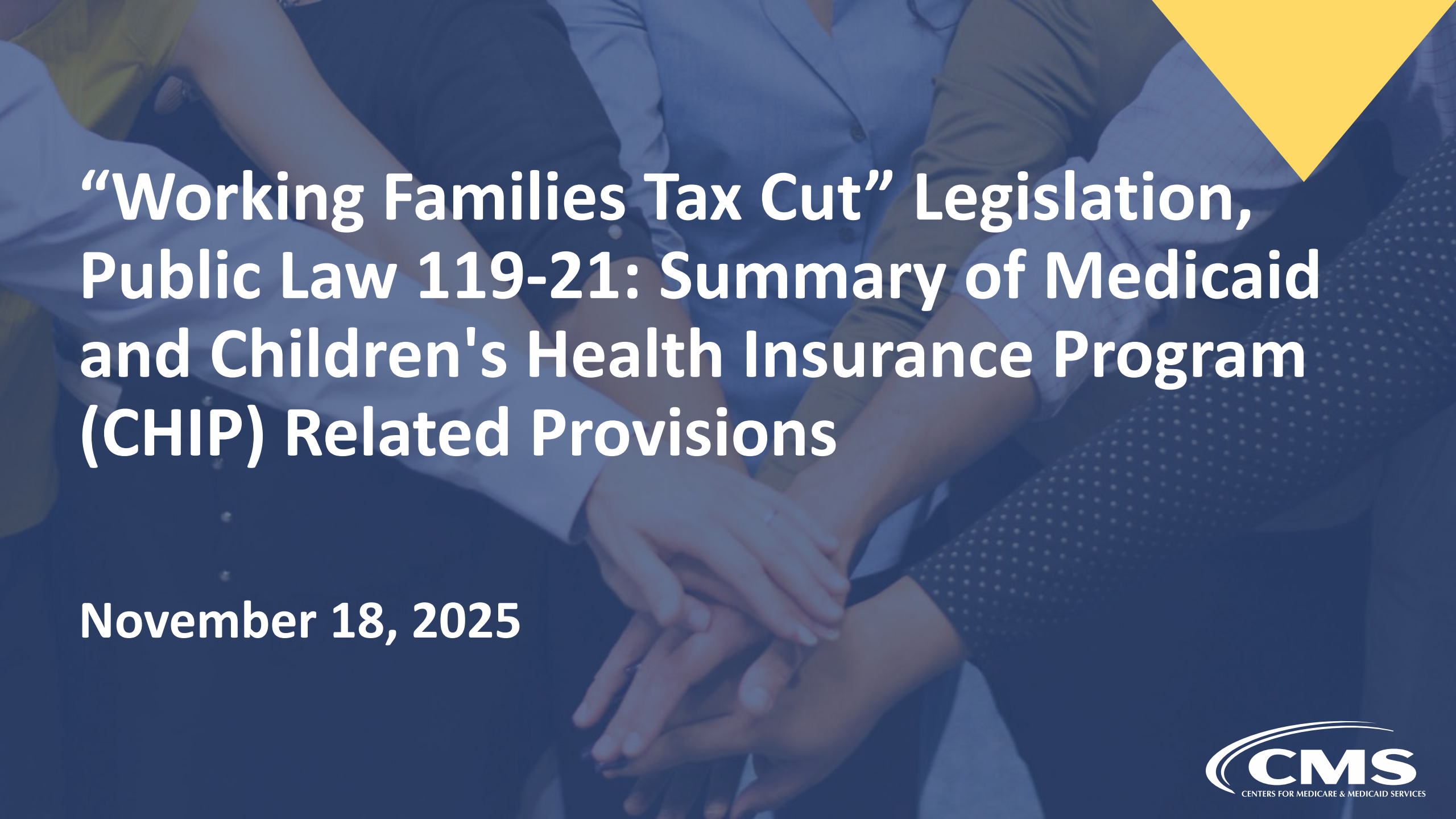

“Working Families Tax Cut” Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions

November 18, 2025

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Objectives

- This slide deck is a companion to the Center for Medicaid & CHIP Services (CMCS) Information Bulletin (CIB), *"Working Families Tax Cut" Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions.* This landmark legislation includes significant eligibility and financing reforms in Medicaid and CHIP and focuses on the connection of health to work through community engagement.

- This slide deck is intended to provide general information on the Medicaid and CHIP related provisions contained in Public Law 119-21, which the Centers for Medicare & Medicaid Services (CMS) refers to as the Working Families Tax Cut (WFTC) legislation. The deck provides an overview of each Medicaid and CHIP provisions in the legislation, as well as the effectives dates of those provisions, noted through a calendar icon on each relevant slide.

- This CIB and deck are part of a series of guidance documents that CMCS expects to issue to support WFTC legislation implementation.

Source: CMCS CIB, "Working Families Tax Cut" Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions. Hereinafter referred to as "the CIB."

Content Overview

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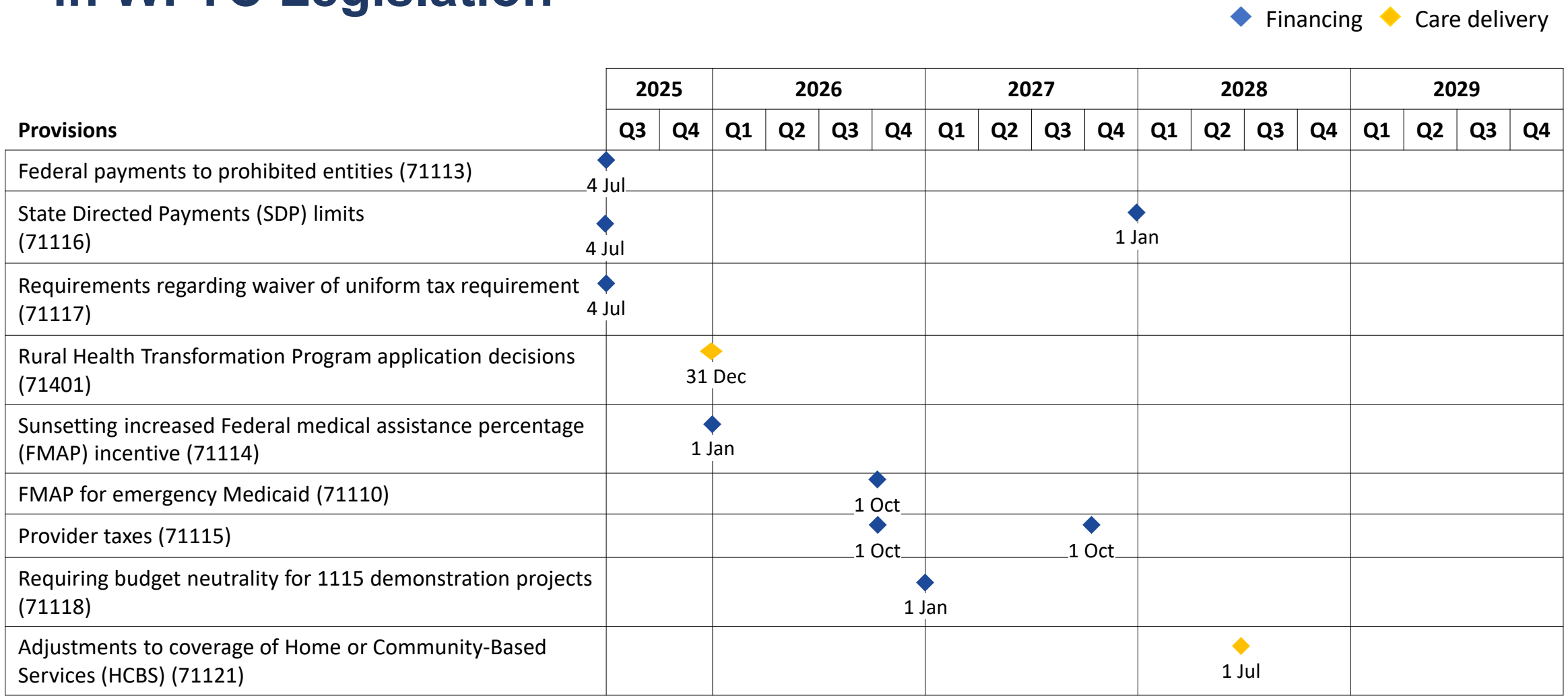
1. The references to “subchapters” are to subchapters of chapter 1 of subtitle B of title VII of Public Law 119-21.
2. Specifically, chapter 4 of subtitle B of title VII of Public Law 119-21.

Calendar of WFTC Legislation Effective Dates

Effective Dates for Eligibility and Enrollment Provisions in WFTC Legislation

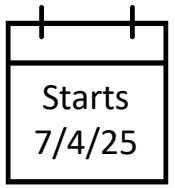
Provision	2025		2026				2027				2028				2029			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Moratorium on Rules (71101, 71102, 71111)	4 Jul																	
Alien Medicaid eligibility (71109)					1 Oct													
Reducing duplicate enrollment (71103)						1 Jan											1 Oct	
Ensuring deceased individuals do not remain enrolled (71104)						1 Jan												
Eligibility redeterminations every 6 months for expansion adult group (71107)						1 Jan												
Medicaid community engagement requirements (71119)						1 Jan												
Reducing state Medicaid costs (71112)						1 Jan												
Ensuring deceased providers do not remain enrolled (71105)										1 Jan								
Revising home equity limit for Long-term Care (LTC) (71108)										1 Jan								
Modifying cost sharing requirements (71120)														1 Oct				
Payment reduction for erroneous excess payments (71106)																		1 Oct

Effective Dates for Financing and Care Delivery Provisions in WFTC Legislation



Subchapter A – Reducing Fraud and Improving Enrollment Processes

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



Temporarily prohibits CMS from implementing, administering, or enforcing certain amendments made by the provisions of the MSP final rule[1] that had a compliance date after July 4, 2025:

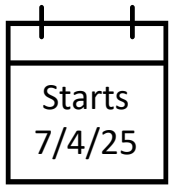
- While the moratorium is in effect, CMS will, in general, revert to regulations in place as of November 16, 2023.
- The moratorium on these amendments ends on September 30, 2034.
- See Appendix E of the CIB for the complete list of provisions in the MSP final rule and their status under the moratorium.

CMS continues to analyze the impact of the moratorium on eligibility and enrollment processes and expects to provide future guidance.

Affects regulations applicable to all states and the District of Columbia (DC); regulations impacted by the MSP final rule do not impact the territories as they have not adopted the MSPs

1. CMS Final Rule, Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment, 88 Federal Register 65230 (September 21, 2023).

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



Temporarily prohibits CMS from implementing, administering, or enforcing certain amendments made by the provisions of the Eligibility and Enrollment final rule[1] that had a compliance date after July 4, 2025:

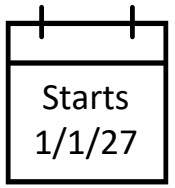
- While the moratorium is in effect, CMS will, in general, revert to the regulations in place as of June 2, 2024, for those regulations subject to the moratorium.
- The moratorium on these amendments ends on September 30, 2034.
- See Appendix F of the CIB for the complete list of provisions in the Eligibility and Enrollment final rule and their status under the moratorium.

CMS continues to analyze the impact of the moratorium on eligibility and enrollment processes and expects to provide future guidance.

Affects regulations applicable to all states, DC, and the territories

1. CMS Final Rule, Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, 89 Federal Register 22780 (April 2, 2024).

Section 71103. Reducing Duplicate Enrollment under the Medicaid and CHIP Programs: Address Verification Processes (1/2)



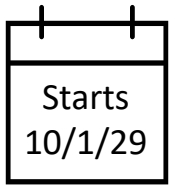
Creates new state plan requirements related to address verification:[1]

- States must regularly obtain address information from "reliable data sources"[2] and take actions as the Secretary specifies with respect to address changes based on this information.
- Each contract with MCOs, PIHPs, PAHPS and PCCMs must require that the entity or plan promptly transmit to the state any address information received directly from enrollees or verified by the plan directly with the enrollee.

Applicable to all states and DC; address verification provision does not apply to the territories

1. Adds 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.
2. Reliable data sources are: 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), and primary care case manager (PCCM)), and other data sources as identified by the state and approved by the Secretary.

Section 71103. Reducing Duplicate Enrollment under the Medicaid and CHIP Programs: Creation and Use of New System (2/2)



Requires CMS to establish a system that CMS and states will use to prevent an individual from being simultaneously enrolled in Medicaid or CHIP in multiple states.

States will be required to submit data to the system at least monthly and during each eligibility determination or redetermination.

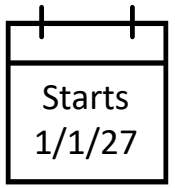
- Does not eliminate the existing PARIS[1] requirements,[2] however, it does allow the Secretary to determine a state is not required to operate an eligibility system that provides for data matching through PARIS

The system will transmit information monthly to states, identifying whether individuals enrolled or seeking to enroll in their respective state are identified as also being enrolled in another state. States will be required to identify whether these individuals are residents of the state and, if not, disenroll the individuals (unless individuals meet an exception the Secretary may specify).

Use of new system provision is applicable to all states, DC, and the territories.

1. PARIS is the Public Assistance Reporting Information System.
2. 1903(r)(3) of the Act.

Section 71104. Ensuring Deceased Individuals Do Not Remain Enrolled



States will be required to:

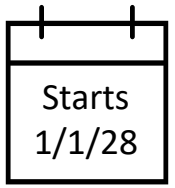
- Check the Social Security Administration's (SSA) Death Master File (DMF) on at least a quarterly basis to determine whether Medicaid enrollees are deceased.[1]
- Treat DMF information as factual and, following notice and fair hearing rights,[2] disenroll individuals from Medicaid without requesting additional information.
- Immediately reenroll an individual, retroactive to the date of disenrollment, if a state determines that the DMF misidentified the individual as deceased.

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.

Applicable to all states and DC; provision does not apply to the territories

1. Adds a new paragraph (89) to section 1902(a) of the Act.
2. Consistent with 42 CFR part 431, subpart E.

Section 71105. Ensuring Deceased Providers Do Not Remain Enrolled



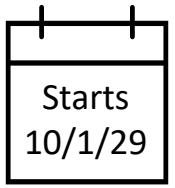
Adds a requirement that states check the DMF no less frequently than quarterly to determine whether a provider is deceased:[1]

- This provision is in addition to the current requirements that states check the DMF when enrolling, reenrolling, or revalidating enrollment of a provider in Medicaid or separate CHIP.

Applicable to all states, DC, and the territories

1. Amends section 1902(kk)(1) of the Act to add to existing provider screening requirements. Applicable to separate CHIPs through an existing cross reference at section 2107(e)(1)(G) of the Act.

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



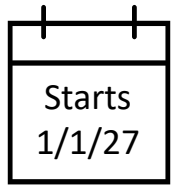
Requires the Secretary to issue eligibility-related disallowances and restricts good faith waiver authority for states with Medicaid eligibility-related error rates exceeding 3 percent.[1]

CMS expects to provide additional guidance to states on implementation of this provision.

Applicable to all states and DC; provision does not apply to the territories

1. Amends section 1903(u)(1) of the Act. 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 71107. Eligibility Redeterminations



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) and 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) to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act:

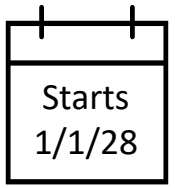
- Beginning with renewals scheduled on or after January 1, 2027, renewals must be conducted once every 6 months for these individuals.[1]
- New requirements do not apply to certain American Indians and Alaska Natives.[2]
- The new requirements of this section do not change renewal requirements for individuals enrolled in all other eligibility groups, whether modified adjusted gross income (MAGI) based or non-MAGI based.

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

Applicable to all states and DC that provide coverage to the affected populations; provision does not apply to the territories

1. Amends section 1902(e)(14) of the Act to add a new subparagraph (L).
2. Described in section 1902(xx)(9)(A)(ii)(II) of the Act.

Section 71108. Revising Home Equity Limit for Determining Eligibility for LTC Services under the Medicaid Program



Caps the maximum home equity limit for homes on land not zoned for agricultural use at $1,000,000;[1] states will continue to have the option to impose a limit between the applicable minimum and maximum amounts:

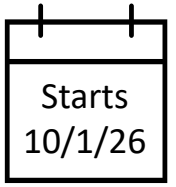
- Homes on land not zoned for agricultural use will continue to have a minimum home equity limit of $500,000, adjusted by increases in the CPI-U[2] dating back to 2011 (which, in 2025, is $730,000). However, effective 2028, the maximum limit will be $1,000,000, and the minimum will only continue to increase based on CPI-U increases until it reaches $1,000,000. Also beginning in 2028, the maximum will no longer increase annually.
- For homes on land zoned for agricultural use, the same minimum limit 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 these homes that is effectively the current maximum ($1,097,000 for 2025) and which will continue to increase based on the CPI-U.

Prohibits states from using a methodology to determine home equity value that effectively raises the limits above those described above.[3]

Applicable to all states, DC, and the territories

1. Amends section 1917(f)(1) of the Act.
2. CPI-U is the consumer price index for all urban consumers.
3. Amends sections 1902(e)(14)(D)(iv) and 1902(r)(2).

Section 71109. Alien Medicaid Eligibility



Restricts federal financial participation (FFP) for medical assistance (Medicaid) and child or pregnancy-related health assistance (CHIP) to the following groups:[1]

1) U.S. citizens and U.S. nationals 2) Lawful Permanent Residents (LPRs or "green card holders")
3) Cuban and Haitian entrants 4) Compacts of Free Association (COFA) migrants

FFP limitations in section 71109 do not apply to expenditures for:[2]

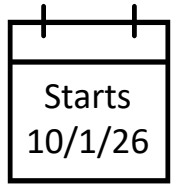
1) Emergency Medicaid authorized under section 1903(v)(2) of the Act[3]
2) Medicaid and CHIP coverage for lawfully residing children and pregnant women under "the CHIPRA 214 option" in states that have elected this option as authorized under section 1903(v)(4) of the Act[4]
3) State-designed Health Services Initiatives (HSIs) authorized under 2105(a)(1)(D)(ii) of the Act

Applicable to all states, DC, and the territories

CMS continues to assess the implications of section 71109 and expects to issue future guidance.

1. Adds new paragraph (5) to section 1903(v) of the Act and amends section 2107(e)(1) of the Act. Section 71109 does not amend the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Public Law 104-193). See "Section 71109. Alien Medicaid Eligibility" on pages 10-11 of the CIB for more information.
2. Section 1903(v)(5) of the Act excepts sections 1903(v)(2) and (4) of the Act from the payment limitations. Section 2107(e)(1)(R) of the Act excepts section 2105(a)(1)(D)(ii) of the Act from the payment limitations. See "Section 71109. Alien Medicaid Eligibility" on pages 10-11 of the CIB for more information.
3. Sections 1903(v)(2) and (3) of the Act; 8 U.S.C. § 1611(b)(2)(A).
4. Section 214 of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Public Law 111-3).

Section 71110. Expansion FMAP for Emergency Medicaid



Limits the Federal medical assistance percentage (FMAP) for emergency Medicaid services provided to noncitizens to the state's regular FMAP:[1]

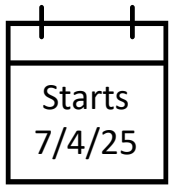
- FFP is authorized for care and services necessary to treat an emergency medical condition for certain noncitizens who do not have satisfactory immigration status for full Medicaid benefits but otherwise meet a state's eligibility criteria.
- Currently, if a noncitizen meets the criteria for the Medicaid adult group (under section 1902(a)(10)(A)(i)(VIII)) and the criteria in 1905(y) or 1905(z) are met, a state can claim the 90 percent FMAP for expenditures on services for an emergency medical condition.
- Beginning October 1, 2026, the 90 percent FMAP will no longer be available for emergency Medicaid services for noncitizens who meet the eligibility requirements under the Medicaid adult group except for not being eligible noncitizens.

Applicable to all states, DC, and the territories

1. Adds new subsection (kk) to section 1905 of the Act.

Subchapter B – Preventing Wasteful Spending

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



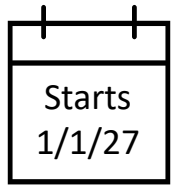
Temporarily prohibits CMS from implementing, administering, or enforcing certain provisions of the nursing home minimum staffing final rule:[1]

- Rules in effect before May 10, 2024, will continue to be enforced.
- The moratorium on these provisions[2] ends on September 30, 2034.
- This moratorium does not apply to the enhanced facility assessment requirements[3] or the Medicaid Institutional Payment Transparency Reporting provisions.[4]

Affects regulations implemented by all states, DC, and the territories

1. CMS Final Rule, Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 89 Federal Register 40876 (May 10, 2024).
2. The moratorium applies to revised provisions found at 42 CFR §§ 483.5 and 483.35.
3. Set out at new 42 CFR § 483.71.
4. Set out at new 42 CFR § 442.43.

Section 71112. Reducing State Medicaid Costs



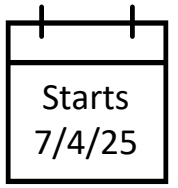
Shortens the retroactive eligibility period in Medicaid, for applications made on or after January 1, 2027:[1]

- The retroactive eligibility period for individuals enrolled in the Medicaid adult group[2] will be limited to one month prior to the month of application.
- For all other individuals, the retroactive eligibility period will be limited to two months prior to the month of application.
- States retain the option to provide retroactive CHIP eligibility, but cannot begin the coverage any earlier than two months prior to the month of application.[3]

Applicable to all states, DC, and the territories

1. Amends sections 1902(a)(34) and 1905(a) of the Act.
2. Under section 1902(a)(10)(A)(i)(VIII) of the Act.
3. Amends section 2102(b)(1)(B) of the Act by adding a new paragraph (vi).

Section 71113. Federal Payments to Prohibited Entities



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 four conditions as of October 1, 2025:[1]

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 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 Medicaid expenditures for medical assistance furnished in fiscal year 2023 made directly or by a "covered organization"[2] to the entity 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.

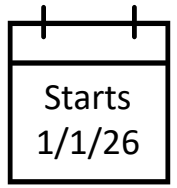
The federal funding prohibition applies to "any payments made directly to the prohibited entity or under a contract or other arrangement between a [s]tate and a covered organization."

States should expect to provide assurances in quarterly expenditure reporting that claims for FFP are only for Medicaid expenditures permitted by law.

1. Affiliates, subsidiaries, successors, and clinics of a prohibited entity are also prohibited entities.
2. A "covered organization" is a MCO, PCCM, PIHP, or PAHP as defined in 42 CFR § 438.2.

Subchapter C – Stopping Abusive Financing Practices

Section 71114. Sunsetting Increased FMAP Incentive



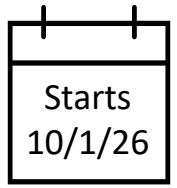
Ends the availability of the 5-percentage-point FMAP increase incentive[1] for states that adopt the Medicaid adult group[2] expansion:

- The American Rescue Plan Act of 2021 provided a temporary (8 calendar quarters) 5-percentage-point increase to a state's regular FMAP for states that newly expanded eligibility to the Medicaid adult group described in section 1902(a)(10)(A)(i)(VIII) under the state plan or waiver of such plan.

Applicable to all states and DC; provision does not apply to the territories[3]

1. Amends section 1905(ii)(3) of the Act, which was added by section 9814 of the American Rescue Plan Act of 2021 (Public Law 117-2).
2. Described in section 1902(a)(10)(A)(i)(VIII).
3. Territories were not eligible for the increase under section 9814 of American Rescue Plan Act. As such, this sunset provision does not apply to them.

Section 71115. Provider Taxes



Beginning October 1, 2026, section 71115 effectively 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 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:[1]

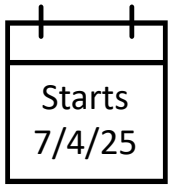
- Beginning October 1, 2027, the indirect hold harmless threshold for Medicaid expansion states[2] is reduced to the lower of July 4, 2025, levels or 5.5 percent. This limit then decreases annually by 0.5 percent until reaching 3.5 percent in FY 2032.
- This phase-down is not applicable to non-expansion 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 to states outlining preliminary guidance.[3]

Applicable to all states and DC; provisions do not apply to the territories

1. Amends section 1903(w)(4) of the Act, which describes the requirements for health care-related taxes, including that taxes must be imposed on a permissible class of providers, must be broad-based and uniform (unless a waiver is approved), and taxpayers are not held harmless.
2. Section 71115(a)(2) 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."
3. CMS Dear Colleague Letter, Section 71115 and 71117 of Working Families Tax Cuts Legislation on Provider Taxes.

Section 71116. State Directed Payments (SDPs)



Reduces[1] the total payment rate limit for SDPs[2] for inpatient and outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center to:

- 100 percent of the total published Medicare payment rates for expansion states;[3] and
- 110 percent of the total published Medicare payment rates for non-expansion states.
- In the absence of a total published Medicare payment rate, CMS will utilize the payment rate under the Medicaid state plan or waiver as the limit.

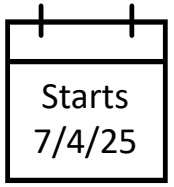
On September 9, 2025, CMS sent a letter to states outlining preliminary guidance to aid state planning until a final rule is promulgated.[4]

Includes a grandfathering period for certain SDPs until the rating period beginning on or after January 1, 2028, at which point such SDPs must comply with phase down requirements

Applicable to all states and DC; provision does not apply to the territories

1. By directing the Secretary to revise 42 CFR § 438.6(c)(2)(iii).
2. SDPs permit states to direct specific payments made by MCOs, PIHPs, and PAHPs to provides under certain circumstances (42 CFR 438.6(c)).
3. Section 71116(a)(1) of the WFTC legislation defines an expansion state as a State that provides coverage to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) that is equivalent to MEC under the State plan or waiver of such plan.
4. CMS Dear Colleague Letter, Section 71116 of One Big Beautiful Bill Act on State Directed Payments.

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



Codifies[1] proposed rule[2] provisions that a health care-related tax would not be considered generally redistributive and thus is unable to meet requirements for taxes to be broad-based and uniform if the tax rate imposed (within a permissible class):

- On a taxpayer/group explicitly defined by its relatively lower volume/percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer/group explicitly defined by its relatively higher volume/or percentage of Medicaid taxable units, or
- On any taxpayer/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.

- A tax is not considered generally redistributive if it accomplishes the same effect as the first two provisions by identifying a taxpayer/group based on or defined by any description, including without explicitly naming Medicaid.

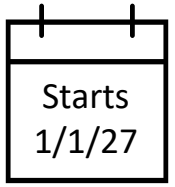
Provides authority to the Secretary to grant a transition period for states to come into compliance, not to exceed 3 years.

On November 14, 2025, CMS sent a letter to states outlining preliminary guidance, including the minimum transition periods that may be available.[3]

Applicable to all states and DC; does not apply to the territories

1. Amends section 1903(w) of the Act, which describes the requirements for health care-related taxes, including that taxes must be imposed on a permissible class of providers, taxes must be broad-based and uniform (unless a waiver is approved), and taxpayers are not held harmless. Currently, 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.
2. CMS Proposed Rule, Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule, 90 Federal Register 20578 (May 15, 2025).
3. CMS Dear Colleague Letter, Section 71115 and 71117 of Working Families Tax Cuts Legislation on Provider Taxes.

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



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.[1]

- 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.

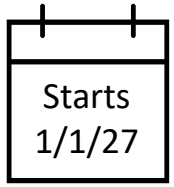
CMS expects to provide additional guidance to states on implementation of this provision.

Applicable to all states, DC, and the territories

1. Adds budget neutrality as a new statutory requirement in subsection (g) of section 1115 of the Act.

Subchapter D – Increasing Personal Accountability

Section 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals (1/6)



Requires states to condition Medicaid eligibility for applicable individuals on their demonstration of community engagement:[1]

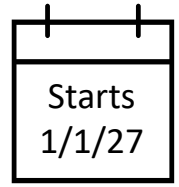
- Unless an exception or exclusion applies, applicable individuals are those eligible or enrolled in the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act or individuals who are eligible for or enrolled under a waiver of the state plan (including a section 1115 demonstration) that provides coverage that is equivalent to MEC and who are age of 19 – 64 years of age, are not pregnant, are not entitled to, or enrolled for, Medicare, and are not otherwise eligible to enroll under the state plan.[2]

States may elect an early implementation date and should contact CMS for more details about that option.

Applicable individuals can demonstrate community engagement in a month 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 other options.

1. Amends section 1902 of the Act by adding a new subsection (xx).
2. MEC is 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.

Section 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals (2/6)

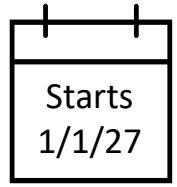


Certain individuals ("specified excluded individuals") are excluded from the definition of "applicable individuals" and are therefore not subject to community engagement requirements. These individuals are:

- former foster care children;
- certain American Indians and Alaska Natives;
- parents, guardians, caretaker relatives, or family caregivers[1] of a dependent under age 14 or a disabled individual;
- veterans with a total disability rating;
- medically frail or who otherwise have special medical needs;[2]
- compliant with Temporary Assistance for Needy Families (TANF) work requirements;
- members of a household that receives Supplemental Nutrition Assistance Program (SNAP) benefits who are not exempt from SNAP work requirements;
- participants in certain substance use disorder programs;
- inmates of a public institution; and
- pregnant women or individuals entitled to postpartum medical assistance.[3]

1. As defined in section 2 of the RAISE Family Caregivers Act (Public Law 115-119).
2. 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.
3. Postpartum medical assistance is available under section 1902(e)(5) or (16) of the Act.

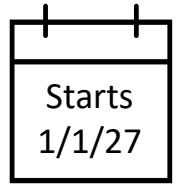
Section 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals (3/6)



In addition to specifically excluded individuals, other individuals are excepted from demonstrating community engagement and are similarly not subject to the requirements for that month. These are individuals who, for part or all of a month, are:

- under the age of 19;
- entitled to, or enrolled for, benefits under Medicare Part A or enrolled for benefits under Medicare Part B;
- described in any of the mandatory eligibility groups listed in subclauses (I) through (VII) of section 1902(a)(10)(A)(i) of the Act; or
- an inmate of a public institution at any point during the three-month period ending on the first day of a month in which they are otherwise required to demonstrate community engagement.

Section 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals (4/6)



States also have the option to except persons who experience the following short-term hardship events:

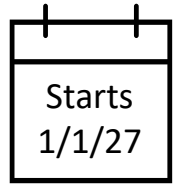
- receiving inpatient hospital services or certain other types of medical care;
- residing where there is a Presidential declaration of a disaster or emergency;
- residing in a locality with an unemployment rate over certain thresholds; or
- needing to traveling outside of their community, for themselves or their dependents, for an extended period of time to receive treatment of a serious or complex medical condition where such treatment is not available within the individual's community of residence.

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 of application.
- 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 verification of compliance with community engagement requirements.

Section 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals (5/6)



Generally, to verify compliance with or exception 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.

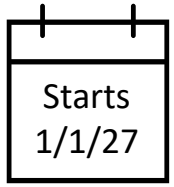
- If a state cannot verify compliance, it must provide notice and 30 calendar days for the individual to demonstrate compliance or exemption.
- If no satisfactory showing of compliance or inapplicability of the requirement is made, the state must determine whether the individual has any other basis for eligibility for Medicaid or another insurance affordability program. The state must then provide written notice and fair hearing rights[1] (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 are prohibited from using MCOs, PIHPs, or PAHPs or other contractors with financial relationships to these entities to determine beneficiary compliance with community engagement requirements.

States must provide outreach to enrolled applicable individuals several months prior to implementation (either December 31, 2026, or earlier if the state selected an earlier implementation).

- States are also required to provide outreach on a periodic basis thereafter.

1. In accordance with 42 C.F.R. part 431 subpart E

Section 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals (6/6)



The Secretary may exempt a state from implementing community engagement requirements if the state demonstrates good faith efforts to comply.

- Any such exemptions will expire no later than December 31, 2028.

The community engagement requirements cannot be waived under section 1115 demonstration authority.

CMS will award $200 million to states 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 or redeterminations.

CMS must issue an interim final rule implementing section 71119 by June 1, 2026. Additional guidance from CMS on this provision is forthcoming.

Applicable to all states and DC that provide coverage to applicable individuals; provisions do not apply to the territories

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

Starts 10/1/28

Requires[1] 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,[2] or in certain waivers of the state plan (including through a section 1115 demonstration) that provides coverage equivalent to MEC in states that provide such coverage to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act.

Cost sharing imposed under this section cannot exceed $35 for any care, item, or service.[3]

- States are prohibited from imposing premiums or enrollment fees on this population.
- Exempts primary care, behavioral health, federally qualified heath center (FQHC), rural health clinic, and certified community behavioral health clinic services (CCBHC) from cost sharing.

Aggregate out-of-pocket costs for all individuals in the family cannot exceed 5 percent of the income of the family.

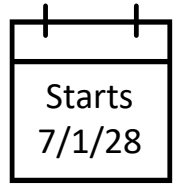
Applicable to all states and DC that provide coverage to the individuals noted above; does not apply to the territories.

Existing cost sharing exemptions for American Indians and Alaska Natives are not changed by this section and still apply.

1. Amends section 1916 of the Act by adding subsection (k).
2. Under section 1902(a)(10)(A)(i)(VIII) of the Act.
3. Cost sharing amounts for prescription drugs remain subject to the rules and limitations established by section 1916A of the Act.

Subchapter E – Expanding Access to Care

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



Creates a new waiver option for states to cover HCBS for individuals without requiring an institutional level of care (ILOC) determination, under several conditions:[1]

1. use needs-based criteria[2] 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.[3]

Appropriates $100 million in FY 2027 to support state systems to deliver HCBS under section 1915(c) waivers or section 1115 demonstrations

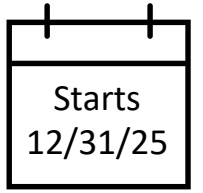
- Funds will be allotted based on the proportion of the state's population receiving HCBS under section 1915(c) or section 1115 of the Act, as compared to all states.

Applicable to all states, DC, and the territories

1. Amends section 1915(c) of the Act.
2. Subject to Secretary approval.
3. As specified under section 1915(c)(11)(B)(vii) of the Act.

Chapter 4 – Protecting Rural Hospitals and Providers

Section 71401. Rural Health Transformation Program



Establishes a Rural Health Transformation (RHT) Program[1] and appropriates $10 billion annually for allotments to states for fiscal years 2026 through 2030:[2]

- The program is administered by the CMS Administrator and provides funding to states with approved applications to improve rural health care access and outcomes.
- Half the funds will be distributed equally across the approved states, and the other half will be allocated 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 quality of the state's rural health transformation plan.

The Administrator must approve or deny a state's application by December 31, 2025.

- States have two years to expend funds provided for each fiscal year (e.g., FY 2027 funds are available through FY 2028).

Applicable to the 50 states; does not apply to DC or the territories

1. Added as new subsection (h) in section 2105 within Title XXI of the Act.
2. For more information of the RHT Program, visit https://www.cms.gov/priorities/rural-health-transformation-rht-program/rural-health-transformation-rht-program.

Tax-Related Provisions

Tax Provisions Related to Medicaid or CHIP

WFTC legislation contains 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.

- Section 70102 sets the single filing threshold (under age 65 and not blind) as $15,750 for tax year 2025, increased from $14,600 in 2024.[1]
  - 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.
- Section 70113 permanently eliminates the qualified moving expenses deduction, which is now applicable for active-duty members of the U.S. Armed Forces and, starting in 2026, members of the intelligence community.[2]
- Section 70119 permanently extends the income exclusion for student debt discharged on account of the death or total disability of the student.[2]

Changes to federal tax law as they affect MAGI-based methodologies are applicable to all states, DC, and the territories.

1. Internal Revenue Service (IRS) Publication 501 discusses tax filing requirements in more detail. https://www.irs.gov/pub/irs-pdf/p501.pdf. Starting with tax year 2026, the IRS will resume adjusting the filing threshold for inflation.
2. The moving expense and student debt-related changes, when first made temporary, were described by 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.

Tax Provisions Not Affecting Medicaid or CHIP

The WFTC legislation also makes significant changes to federal tax law for individual taxpayers that do <u>not</u> affect MAGI-based methodologies for Medicaid and CHIP.

- Deductions in sections 70201 (related to a deduction for qualified tips), 70202 (related to deduction for overtime premium pay), and 70203 (related to a deduction for loan interest on certain passenger vehicles) all 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 the WFTC legislation and is available to provide technical assistance to states.

Closing

Next Steps

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 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**.

Appendices

Overview of CIB Appendices

The CIB includes seven appendices that contain further detail about the WFTC legislation. More information on the appendices bolded below is contained on the following slides.

- Appendix A. Key Dates:
  - Calendar of WFTC Legislation Effective Dates summarizes key statutory dates on slides 5 and 6 in this deck. See CIB Appendix A for full details.
- **Appendix B. Opportunities for Additional Financial Support for States**
- **Appendix C. Applicability to the Territories**
- **Appendix D. Applicability to American Indians and Alaska Natives**
- Appendix E. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs
  - Section 71101 is summarized on slide 8 in this deck. See CIB Appendix E for full details.
- Appendix F. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program
  - Section 71102 is summarized on slide 9 in this deck. See CIB Appendix F for full details.

Appendix B – Opportunities for Additional Financial Support for States

Provision	Description	Amount	Timing	Distribution
Medicaid Community Engagement Requirements (71119)	Government Efficiency Grants to states to be used for state implementation of this provision and others in same chapter of the WFTC legislation related to eligibility determinations or redeterminations	$200 million	Available beginning Fiscal Year (FY) 2026, and available until expended	$100 million to be distributed equally across states $100 million reflecting the ratio of individuals in a state subject to the requirement to the total number of such individuals in all states as of March 31, 2025
Adjustments to Coverage of Home or Community-Based Services under Medicaid (71121)	Payments to states to support state systems to deliver HCBS under section 1915(c) waivers or section 1115 demonstrations	$100 million	Available beginning FY 2027, and available until expended	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.
Rural Health Transformation Program (71401)	Allotments to states to be used for specified rural health-related activities, subject to approval and terms of state applications	$10 billion for each fiscal year	Available FY 2026-2030. States have two years to expend funds provided for a FY. Unexpended or unobligated funds from a FY will be redistributed and as of October 1, 2032, will return to the Treasury.	States can apply. DC and territories excluded The Administrator must approve applications by December 31, 2025.

Appendix C – Applicability to the Territories

Subchapter A Provision	Applicable to Territories?
71101	Does not affect regulations that impact the territories
71102	Affects regulations that apply to the territories
71103	Requirement to establish process to obtain address information by January 1, 2027, does not apply to territories; otherwise applies
71104	Does not apply
71105	Applies
71106	Does not apply
71107	Does not apply
71108	Applies
71109	Applies
71110	Applies

Subchapter B Provision	Applicable to Territories?
71111	Affects regulations that apply to the territories
71112	Applies
71113	Applies

Subchapter C Provision	Applicable to Territories?
71114	Does not apply
71115	Does not apply
71116	Does not apply
71117	Does not apply
71118	Applies

Subchapter D Provision	Applicable to Territories?
71119	Does not apply
71120	Does not apply

Subchapter E Provision	Applicable to Territories?
71121	Applies

Chapter 4 Provision	Applicable to Territories?
71401	Does not apply

Appendix D – Applicability to American Indians and Alaska Natives

Appendix D summarizes 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.

Provision	Applicable to American Indians and Alaska Natives?
Eligibility Redeterminations (71107)	Does not apply to AI/ANs described in subsection (xx)(9)(A)(ii)(II)[1]
Community Engagement Requirements (71119)	Does not apply to AI/ANs described in subsection (xx)(9)(A)(ii)(II)[2]
Modifying Cost Sharing Reductions (71120)	Does not apply because existing cost sharing exemptions for certain American Indians and Alaska Natives are not changed by this section.[3]

1. 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.
2. 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.
3. See section 1916(j) of the Act