All-State Medicaid and CHIP Call
January 27, 2026

Agenda

- Rural Health Transformation Program
- CMCS Informational Bulletin: Prohibition on Termination of Enrollment Due to Incarceration (Division G, Title I, Section 205, of the Consolidated Appropriations Act, 2024)
- Overview: Section 71121 of the Working Families Tax Cut (WFTC) Legislation
- Q&A

RURAL HEALTH TRANSFORMATION

Office of Rural Health Transformation

Alina Czekai

Director

Kate Sapra

Acting Deputy Director

In addition to Office leadership, the Office of Rural Health Transformation (ORHT) consists of a strong team of program officers and other support staff to ensure successful implementation of the Rural Health Transformation Program.

RURAL HEALTH TRANSFORMATION

RHT Program At-A-Glance

Authorized by the Working Families Tax Cuts Legislation, the RHT Program empowers States to strengthen rural communities by improving healthcare access, quality, and outcomes through transformation of the healthcare delivery ecosystem.

- The recipient of each award is a single State.
- All 50 states received funding on December 29, 2025.

Strategic Goals

The RHT Program helps State governments improve rural health by laying the foundation for **sustainable access to high-quality care** through **workforce development, innovative system-wide change, and technological innovation.**

60M | **1 in 5**

Americans live in rural areas

$50B

Total funding **allocated over 5 years**
FY26 - FY30

$10B

Allocated per fiscal year:

- 50% of annual funding **distributed equally** among approved States
- 50% allocated based on **Rural Health Metrics and initiatives**

RHT Program Goals

- Across the country, the Office of Rural Health Transformation saw a strong commitment to the RHT Program's 5 Strategic goals. There is tremendous variety in the types of initiatives being proposed, with modernizing care delivery, improving population health, and strengthening the workforce at the forefront.
- Most States demonstrated a strong commitment to stakeholder engagement in the development of their proposals (e.g., Tribes, Hospital/Providers, Commerce, Agriculture, etc.).

1. Make Rural America Healthy Again

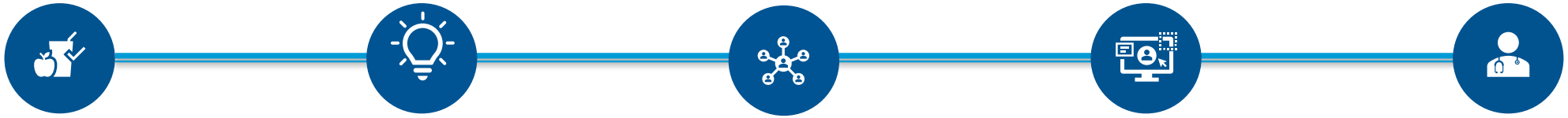
Support health innovations and new access points to promote preventive health and address root causes of diseases

2. Sustainable Access

Help rural providers become long-term access points for care by improving efficiency and sustainability

3. Workforce Development

Attract and retain a high-skilled health care workforce by strengthening recruitment and retention of healthcare providers in rural communities



4. Innovative Care

Spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements

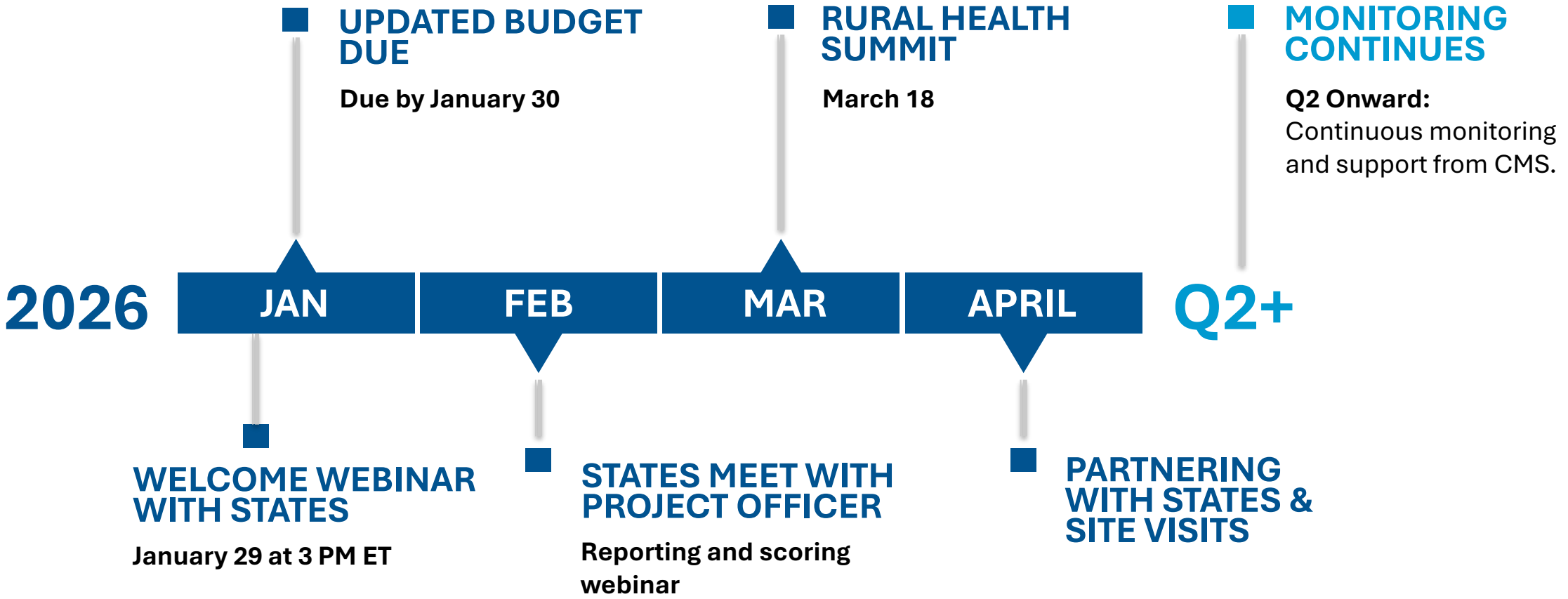
5. Tech Innovation

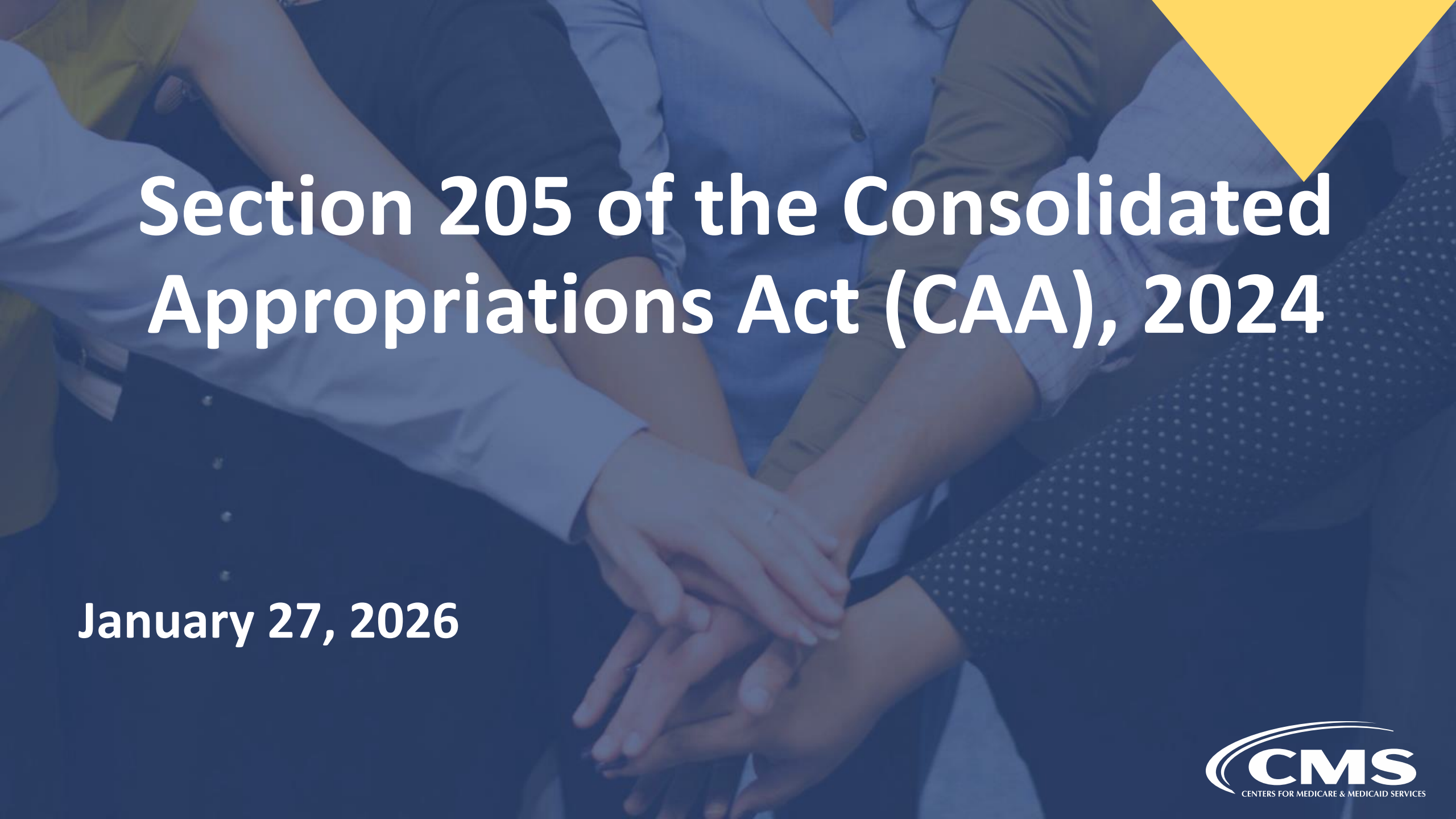
Foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients

Key Themes

- **Driving Structural Efficiency & Empowering the Workforce:** Streamlining operations & empowering local entities to manage resources more effectively. This includes tailored hub-and-spoke models, establishing rural regional centers of excellence, comprehensive data-sharing platforms, establishing Certified Community Behavioral Health Clinics (CCBHCs), etc.
- **Market-Driven Technology & Measurable Productivity Improvement:** States are leveraging capital investment in advanced technology, including AI, telehealth, and consumer-focused technology, to boost provider productivity, control costs, and increase patient healthcare access.
- **Chronic Disease & Population Health:** To achieve the goal of "Make Rural America Health Again," states are focused on deploying structural and technology-enabled solutions that proactively manage health and address preventive health needs at scale. Maternity care and behavioral health are two of the most common themes, with most States placing an emphasis on these areas.
- **Value-Based Care:** The most impactful proposals create clear, measurable paths to financial sustainability, ensuring RHT Program funds are used as seed capital to transition the system to one that is focused on value. Generally seeing more of an appetite for exploring value-based care readiness.
- **Stakeholder Engagement:** States are leaning into the power of partnerships, working with stakeholders across the community, including schools, local businesses, farms, Tribes, etc.

Q1 Dates


2026
JAN
FEB
MAR
APRIL
Q2+
UPDATED BUDGET DUE
Due by January 30
RURAL HEALTH SUMMIT
March 18
MONITORING CONTINUES
Q2 Onward:
Continuous monitoring and support from CMS.
WELCOME WEBINAR WITH STATES
January 29 at 3 PM ET
STATES MEET WITH PROJECT OFFICER
Reporting and scoring webinar
PARTNERING WITH STATES & SITE VISITS



Section 205 of the Consolidated Appropriations Act (CAA), 2024

January 27, 2026

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Overview

- The Consolidated Appropriations Act, 2024 was signed into law on March 9, 2024 as Public Law 118-42.

- Division G, title I, Section 205 of the CAA, 2024, *Prohibition on Termination of Enrollment Due to Incarceration,* went into effect on **January 1, 2026,** and impacts termination/suspension policies for Medicaid and CHIP.

- On December 23, 2025, CMS released a CIB to highlight the statutory changes and various operational considerations for states.

Medicaid Suspension

- Section 205 of the CAA, 2024 amends Section 1902(a)(84)(A) of the Social Security Act (the Act) to prohibit states from terminating Medicaid eligibility for *all* individuals during periods of incarceration.

- To effectuate this requirement, states may use either an eligibility suspension or a benefits suspension.

- States are *not* required to submit a Medicaid SPA to notify CMS of the suspension approach(es) used.

Eligibility vs. Benefits Suspension

- Eligibility Suspension
  - Eligibility is not terminated but is effectively paused
  - States may, but are not required, to conduct regular renewals or redetermine eligibility based on changes in circumstances while eligibility is suspended.
  - When the suspension needs to be lifted, states must ensure the individual's eligibility has been determined or redetermined within the applicable eligibility period.

- Benefits Suspension
  - Enrolled but coverage is limited to services for which the inmate payment exclusion does not apply
  - States must continue to conduct regular renewals and redeterminations during suspension

CHIP Suspension

- Section 205 of Subtitle B of the CAA, 2024 also amends Section 2102(d)(1)(A) of the Act to prohibit the termination of Children Health Insurance Program (CHIP) eligibility for targeted low-income pregnant women (TLIPW) who are inmates of a public institution.

- Effective January 1, 2026, states may no longer terminate CHIP eligibility when any targeted low-income child or pregnant woman is incarcerated.

- States may suspend coverage for TLIPW during periods of incarceration using the same options as Medicaid, but the scope of benefits may differ.

- States *are required* to submit a SPA to assure they are meeting this new requirement and to document their suspension strategy for TLIPW.

Section 71121 of the Working Families Tax Cut Legislation

1915(c)(11) Waivers

Division of Long-Term Services and Supports (DLTSS)

Medicaid Benefits and Health Programs Group (MBHPG)

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Overview of Section 1915(c)(11)

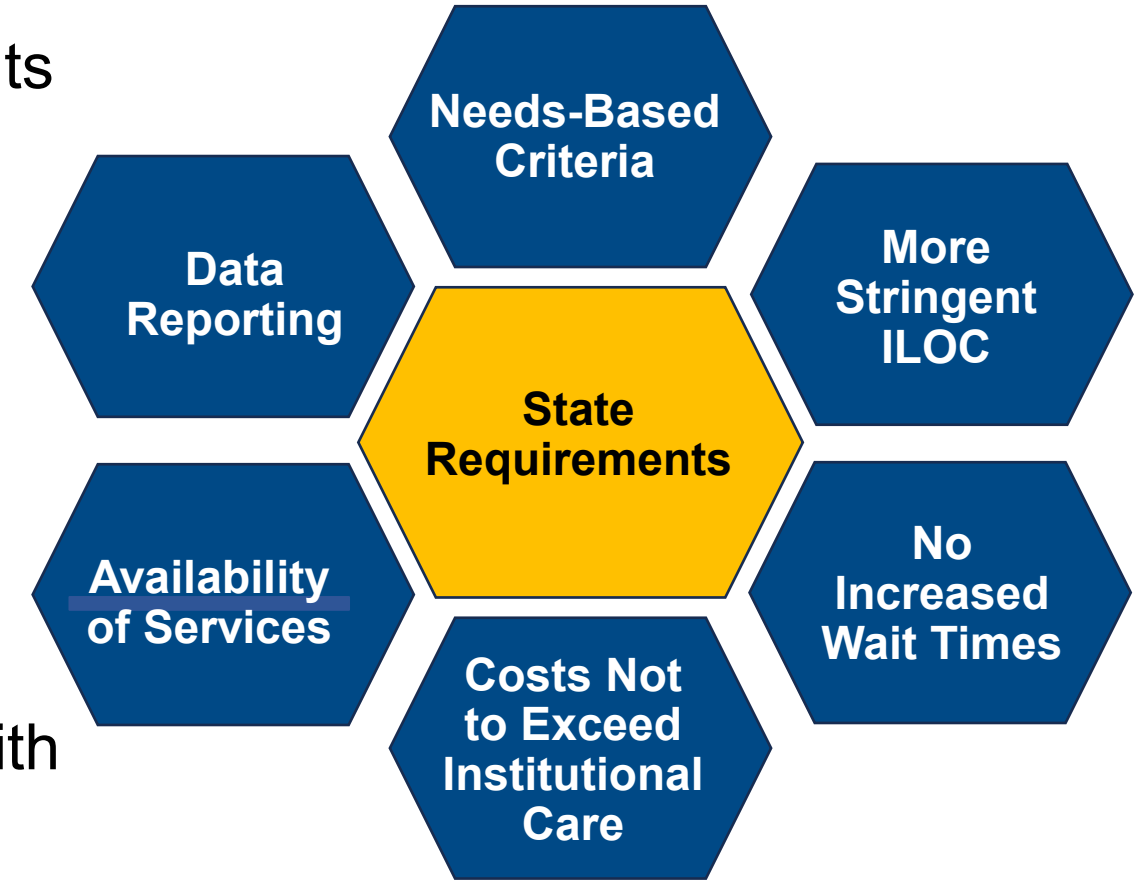
Enacted July 4, 2025, Section 71121 of the Working Families and Tax Cut Legislation (WFTCL) added paragraph (11) to Section 1915(c) of the Social Security Act, it authorizes:

- A new section 1915(c) HCBS waiver option, referred to as 1915(c)(11), created to provide HCBS services to individuals who do not meet the traditional institutional level of care requirement under section 1915(c).
- Provides $50 million to CMS for implementation for purposes of carrying out Section 71121.
- Provides $100 million to states to support state systems to deliver home or community-based services under section 1915(c) or under section 1115.

1915(c)(11) State Requirements (1 of 3)

The state must meet the following requirements as a condition of waiver approval:

- ❑ The state will establish **needs-based criteria** for determining eligibility.
- ❑ **Institutional level of care must be more stringent** than the established 1915(c)(11) needs-based criteria.
- ❑ The 1915(c)(11) waiver **will not result in an increase in wait time** for individuals with an ILOC to receive HCBS waiver services.



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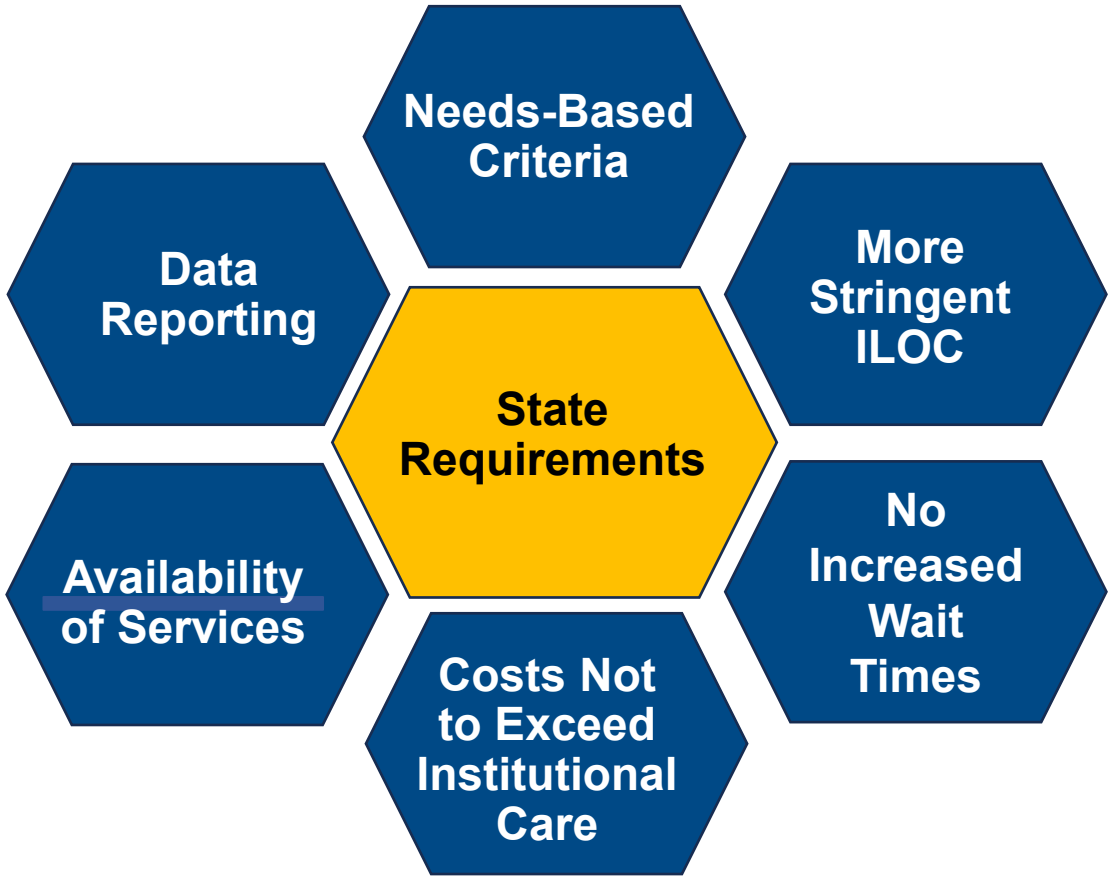
1915(c)(11) State Requirements (2 of 3)

Additionally,

- ❑ The state attests that its 1915(c)(11) average per capita expenditure will not exceed its **institutional care average per capita expenditure**.
- ❑ The state will provide to CMS the **number of individuals to whom the state will make 1915(c)(11) services available**.



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1915(c)(11) State Requirements (3 of 3)

The state also agrees to **provide CMS with data from the preceding year** no less frequently than annually**.**

These data will include:

- The **costs of services**, broken down by service
- The **length of time individuals received each type of HCBS** provided under the 1915(c)(11) waiver
- A **comparison between** the cost of services for individuals **receiving 1915(c)(11) services,** individuals meeting ILOC and receiving waiver services, and individuals **receiving institutional care.**
- The **number of individuals** who have received 1915(c)(11) HCBS during the preceding year.

Implementation Funding

- FY 2026: $50M is appropriated for carrying out the provisions and the amendments made by the legislation
- FY 2027: $100M is appropriated to support state systems to deliver HCBS under section 1915(c) or under section 1115
- Payments will be made available based on state HCBS eligible population:
  - Proportion of population of the state that is receiving HCBS under section 1915(c) or under section 1115 as compared to all states.

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Questions