Topic	Summary	Effective Date	Funding
Medicaid Rules			
Medicaid Rule Implementation (Secs. 71101, 71102, 71111)	Prohibits the implementation and enforcement of the Medicare Savings Program (MSP) eligibility, Medicaid and CHIP eligibility and enrollment, and nursing home staffing rules until September 30, 2034.	July 4, 2025	$1 million in implementation funds for CMS for FY 2026 for the MSP and Medicaid/CHIP eligibility rules
Medicaid: Provider Taxes and State Directed Payments			
Provider Taxes (Secs. 71115, 71117)	Freezes the current provider tax thresholds for all states for two years and reduces the allowable level of provider taxes for expansion states by 0.5% each year until it reaches 3.5% in FY 2032. Modifies the criteria for determining provider taxes are generally redistributive.	Oct 1, 2027, for the tax thresholds July 4, 2025, for the generally redistributive requirement	$20 million in implementation funds for CMS for FY 2026
State-Directed Payments (Sec. 71116)	Sets the payment limit for state directed payments to 110% of Medicare rates for non-expansion states and 100% of Medicare rates for expansion states. For states that newly expand Medicaid, all state directed payments will be subject to this provision, even if previously approved. Existing state directed payment limits would be reduced by 10% annually to reach the Medicaid allowable rate.	July 4, 2025 Grandfathered payments will begin to reduce by 10% annually with the rating period on or after Jan 1, 2028	$7 million in implementation funds for each fiscal year 2026-2033
Medicaid Expansion Population			
Redetermination (Sec. 71107)	Requires semi-annual redeterminations for the expansion population.	Jan 1, 2027	$75 million in implementation funds for CMS for FY 2026
Community Engagement Requirements (Sec. 71119)	Requires states to establish community engagement requirements as a condition of eligibility for able-bodied adults between 19 and 64 years old. Requires 80 hours of work or equivalent qualifying activity in the month(s) preceding eligibility determinations and between redeterminations. Includes mandatory and optional exceptions, expectations for state communication and verification processes, and grants to states for creating needed systems.	The U.S. Department of Health and Human Services (HHS) Secretary must promulgate guidance by June 1, 2026. States must establish community engagement requirements beginning Jan 1, 2027. (With the exception of one year delay for hardship good faith effort if granted by the HHS Secretary)	$200 million in grants to states for FY 2026 ($100 million based on proportion of impacted individuals; $100 million distributed equally); and $200 million in implementation funds for CMS for FY 2026
Cost-Sharing Requirements (Sec. 71120)	Requires states to impose cost-sharing on certain services for Medicaid expansion adults with incomes above 100% of the Federal Poverty Level (FPL). Cost-sharing will be at a rate determined by the state and must be above $0 but may not exceed $35 per service. The total aggregate amount for the family may not exceed 5% of the family income. Certain types of services will be exempted, including primary care, prenatal care, pediatric care, emergency room care (except for non-emergency care provided in an emergency room), mental health and substance use disorder services, and services to certain community health centers.	Oct 1, 2028	$15 million in implementation funds for CMS in FY 2026
Expansion FMAP Incentive (Sec. 71114)	Sunsets the 5% enhanced FMAP incentive for the traditional Medicaid population for states that expand Medicaid after Jan 1, 2026.	Jan 1, 2026	N/A
Medicaid Eligibility and Enrollment Requirements and Procedures			
Retroactive Coverage (Sec. 71112)	Limits retroactive coverage for the traditional Medicaid population to the two months preceding enrollment and to the month preceding enrollment for the expansion population.	Jan 1, 2027	$10 million in implementation funds for CMS in FY 2026
Deceased status checks (Secs. 71104, 71105)	Requires quarterly deceased status checks and disenrollment for beneficiaries and providers.	Jan 1, 2027, for beneficiaries; Jan 1, 2028, for providers	N/A
Multi-state enrollment (Sec. 71103)	Adds a requirement for HHS to create a system to prevent individuals from being enrolled in Medicaid in multiple states, and for states to submit social security numbers to such a system and to verify addresses and act when multiple state enrollment is identified.	Process established by Jan 1, 2027, with states submitting information by Oct 1, 2029	$30 million in implementation funds for CMS for FY 2026-FY2029
Reduction of good faith waiver (Sec. 71106)	Annually, HHS issues estimates of improper payment rates in Medicaid based on a review of states' programs through the Payment Error Rate Measurement (PERM) program. Currently, states are required to repay HHS if their error rate is above 3%, or they may work with HHS to correct the errors through corrective action plans through a "good faith waiver." The new law reduces the amount of erroneous excess payments the HHS Secretary may waive and expands the definition or erroneous excess payments to include services to individuals who are ineligible for federal reimbursement. In addition, the law limits the ability of the HHS Secretary to waive payments associated with administrative errors of the state. This change may result in additional federal recoupments and affect state cost-sharing levels.	Oct 1, 2029	N/A
Asset Ceiling (Sec. 71106)	Creates a non-waivable ceiling of $1 million home equity values for allowable assets for LTC eligibility.	Jan 1, 2028	N/A
Medicaid Waivers			
1115 Budget Neutrality (Sec. 71118)	Requires all applications for new or renewed 1115 Demonstrations to be certified budget neutral by the Chief Actuary at CMS in order to be approved.	Jan 1, 2027	$5 million in each fiscal year 2026 and 2027 in implementation funds for CMS
HCBS Waiver Option (Sec. 71121)	Creates a new 1915(c) waiver option for states that would allow coverage of HCBS for individuals based on state established criteria that defines whether individuals would otherwise need hospital, nursing home, or intermediate care facility level of care.	July 1, 2028	$50 million in FY 2026 in implementation funds for CMS and $100 million in FY 2027 for payments to states
Marketplace Eligibility and Enrollment Requirements and Procedures			
Pre-enrollment Verifications (Sec. 71303)	Requires Marketplaces to pre-verify eligibility for Advanced Premium Tax Credits (APTCs) and cost-sharing reductions (CSRs) against documentation actively submitted by applicants. Elements that must be verified include: income, immigration status, health coverage status, place of residence, and family size. Allows the HHS Secretary to waive requirements in the case of households enrolling during a special enrollment period triggered by a change in family size.	Jan 1, 2028	N/A
Individuals Subject to Community Engagement Requirements (Sec. 71119)	Prohibits APTC and CSR eligibility for individuals who are not enrolled in Medicaid because of failure to meet community engagement requirements.	No later than the first of the first quarter beginning after Dec 31, 2026 (earlier at option of the state)	N/A
Income-based Special Enrollment Periods (Sec. 71304)	Prohibits income-based special enrollment periods.	Jan 1, 2026	N/A
Tax Reconciliation Procedures (Sec. 71305)	Prohibits eligibility for PTCs unless an individual filed taxes and reconciled APTC for the prior tax year.	Jan 1, 2026	N/A
Immigrant Coverage			
Emergency Medicaid FMAP (Sec. 71110)	Reduces the FMAP for emergency Medicaid services provided to "unlawfully present aliens" that would otherwise qualify for Medicaid expansion to the standard FMAP, rather than the expansion FMAP of 90%.	Oct 1, 2026	$1 million in implementation funds for CMS for FY 2026
Medicaid Eligible Populations (Sec. 71109)	Limits Medicaid eligibility to US citizens, lawful permanent residents, certain Cuban or Haitian immigrants, and individuals living in the US through a compact of free association.	Oct 1, 2026	$15 million in implementation funds for CMS in FY 2026
Marketplace Eligible Populations (Sec. 71301)	Limits premium tax credit eligibility for lawfully present immigrants to only a category of "eligible alien," which is defined as: an individual who is an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act; an alien granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association.	Jan 1, 2027	N/A
Medicare Eligible Populations (Sec. 71201)	Limits Medicare eligibility to only citizens or individuals lawfully admitted for permanent residence under the Immigration and Nationality Act; an alien granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association.	Jan 4, 2027	N/A
Tax Credit Eligibility for Individuals Subject to the 5-year bar (Sec. 71302)	Prohibits premium tax credits for individuals under 100% FPL subject to the 5-year bar under Medicaid.	Jan 1, 2026	N/A
Other			
Rural Provider Relief Fund (Sec. 71401)	Appropriates $50 billion to states to support rural providers. Requires a rural health transformation plan and approval of awards.	Approval of awards by Dec 31, 2025, for funding allocated to states FY2026-2030	$50 billion for states for FY2026-2030; $200 million in implementation funds for CMS
Family Planning Service Providers (Sec. 71113)	Prohibits federal funding for specified family planning and abortion service providers.	July 4, 2025-July 3, 2026	$1 million in implementation funds for CMS for FY 2026
Extension of Telehealth Deductible (Sec. 71306)	Permanently establishes that lack of a deductible for telehealth and remote care will not prohibit a plan from being treated as a high-deductible plan.	Jan 1, 2025	N/A
Flexibility for use of High-Deductible Plans and Direct Primary Care (DPC) under Health Savings Accounts (HSAs) (Secs. 71307, 71308)	Redefines high-deductible health plans to include bronze and catastrophic plans available as individual coverage through a marketplace for the purposes of being paired with an HSA. Establishes an exemption for DPC so that they are not disqualifying coverage for HSAs. Spending on DPC must fall below a specified cap and may not include certain services such as procedures requiring anesthesia, prescriptions, or certain laboratory services. Allows DPC to be an allowable expense covered by HSAs.	Jan 1, 2026	N/A