Section Number	Proposed Change	Effective Date	Potential Impact to State Program Costs	Potential Impact to Federal Funding (via either 50% Administrative Cost Matching % or Services Cost that Invoke State-specific FMAP)	Notes
44101& 44102	Moratorium on Final Rules for Eligibility Determination Issued 9/21/23 and 4/2/24		Low Administrative	Low Administrative	It also requires that MCO contracts signed after January 1, 2027 require that MCO report undeliverable mail addresses to the State program office. Per the KFF, 34 states already require this communication from MCOs. It also requires that MCO contracts signed after January 1, 2027 require that MCO report undeliverable mail addresses to the State program office. Per the KFF, 34 states already require this communication from MCOs.
44103	Cross State Enrollment Checks	State Activity: October 1, 2029	Moderate Administrative	Moderate Administrative	Requires that States check with a new database to be run by CMS that will track enrollees and address changes to identify members enrolled in multiple states. Where duplicates are found, *states* need to identify which state is correct and unenroll from the other.
44104	Quarterly Enrollee Death Master File validation	1-Jan-28	Low Administrative	Low Administrative	Requires that states validate enrollees against the Death Master File to remove deceased enrollees at least quarterly.
44105	Provider Monthly Termination Check	1-Jan-28	Low Administrative	Low Administrative	Requires that states, during provider enrollment or reenrollment, validate the provider against a list of providers that have had their participation terminated by CMS or another state.
44106	Screen Providers Against the Death Master File	1-Jan-28	Low Administrative	Low Administrative	Requires that states validate enrollees against the Death Master File to remove deceased enrollees at least quarterly.
44107	Modify Good Faith Waiver (see also 44110)	FY2030	Low Administrative Potential for Increased Services depending on treatment of presumptive eligibility	Low Administrative Reduced services cost for some presumptive eligibility costs	Currently under the Good Faith Waiver, states and providers (such as hospitals) grant presumptive eligibility to patients (such as in a hospital) who attest to being eligible for Medicaid based on citizenship/immigration status, age and income. These presumptively eligible people are then given time to prove their eligibility, but Medicaid covers care costs until the formal eligibility determination is made. For patients that are later determined to not be eligible for Medicaid, as long as the total amount of erroneous payments made is less than 3% of the state's total payments, the federal financial participation will still be provided. In some cases the Secretary can waive that 3% threshold, and cover a higher percentage of ineligible costs. This new rule would prevent the Secretary from waiving the 3% threshold when the error rate is increased by payments on behalf of individuals that are eligible for a program funded entirely by the state, but not funded with FFP. The primary impact of this will be to prevent the Secretary from waiving the 3% error rate cap for states with state plans that cover immigrants ineligible under plans that include FFP.
44108	Eligibility Redetermination for Expansion Population every 6 months	1-Oct-27	Increased Administrative Costs for Redetermination and Churn Decreased services costs related to lower enrollment	FFP remains the same, lower federal services costs related to lower enrollment	States will be required to redetermine eligibility for the expansion population every 6 months (previously annually).

44109	Home Equity Limit for LTCC	1-Jan-28	Increases Services Costs	Increases Services Costs	Increases the home equity limit from $500,000 or $750,000 to $1M
44110	No FFP for Those without Verified Legal Status	October 1 2026	Decrease costs of services for states not electing to provide coverage during the "reasonable opportunity period." Increased cost of services for states electing to provide services to individuals who are later ineligible due to immigration status.	Decreased cost of services	States are not required to provide coverage during the "reasonable opportunity period" for an applicant to provide proof of citizenship/immigration status eligibility. If a state chooses to provide coverage during that "reasonable opportunity period," or during the period that the state attempts to verify citizenship/immigration status through other means, there will be no FFP for services provided during this period unless they are ultimately determined to have citizenship or an eligible immigration status.
44111	Reduce Expansion FMAP to 80% if the State Provides State Programs to Immigrants Not Federally Eligible	10/1/27	Significant Service cost increase for impacted states	Reduced FMAP for either 39 states+DC or 7 staets + DC	For states that provides financial assistance for immigration-status ineligible (including those with legal status but who aren't qualified aliens for the purposes of Medicaid), or that provide "any form of comprehensive health benefits coverage" to immigration-status ineligible people, the FMAP for the expansion population will be reduced to 80%. As currently written, this may impact 39 states + DC, which cover some children and/or pregnant individuals who are lawfully present but don't have qualified status (Kaiser Family Foundation, 2025). If we assume that only those states that specifically cover immigrants without a lawful presence, then 7 states plus DC are impacted (California, Colorado, Illinois, Minnesota, New York, Oregon, Washington).
44121	Moratorium on Staffing Standards for LTC Facilities	Upon enactment	N/A	N/A	New regulations, originally planned to go into effect in June 2028, required states to "collect and report on the percent of Medicaid payments that are spent on compensation for direct care workers and support staff delivering care in nursing facilities and intermediate care facilities, for individuals with intellectual disabilities (Elizabeth Hinton, 2024)." This provision is paused.
44122	Retroactive Coverage Under Medicaid and CHIP	1-Oct-26	State savings	Federal savings	Currently, when enrolled in Medicaid, coverage is retroactive for 3 months prior to the date of enrollment Change retroactive to the month of application, rather than 3 months.
44123	Survey of Retail Pharmacy Prices by Federal HHS, State to Require Participation by Pharmacies.		Minor Administrative Burden on States	N/A	HHS will be required to collect and maintain a database/survey of retail pharmacy prices. States will be required to include the requirement to participate in this survey for participating pharmacies.
44124	PBMs and Managed Care Entities Spread Limited to Reasonable Admin Fees	Goes into effect as existing contracts expire and are renegotiated/rebid.	Lower State Services Cost	Lower Federal Services Costs	Private sector cost controls designed to lower costs for both state and federal entities. This increases regulations on profits/administrative costs available to Pharmacy Benefit Managers and Managed Care Organizations providing services to state Medicaid agencies. The Rulemaking process of Administrative Procedure Act is waived for implementation of this section

44125	No FFP for Gender Transition for Minors		Minor to no savings for states that will elect not to cover. For states that elect to cover, increased state cost.	Federal savings	Prohibits federal funding for medical care associated with gender transition (including hormones, surgery, etc.) for recipients under age 18.
44126	No Federal "Direct Spending" to Entities That Received More Than 1M from Medicaid and Are Primarily Engaged in Family Planning If They Provide Abortion	Date of enactment	For states that elect to cover such providers, increased state cost.	Lower federal costs (attributable to no FFP for states that continue to cover such providers)	Specific service providers that are primarily engaged in family planning and that provide abortion, if they received over $1M in Medicaid reimbursements (usually viewed as targeting Planned Parenthood) will not be eligible providers for Medicaid services that include federal funding participation.
44131	New States Adopting Expansion After Effective Date Will Receive the Same FMAP as Other Coverage Populations.	1-Jan-26	N/A	N/A	Costs are not considered for this change, since it's a change to baseline process for expansion
44132	No FFP for Any New or Increased Provider Taxes	Date of enactment	High State Services Cost	Lower Federal Sevices Costs	This section must be read in the context of 44134, and this is a potential major impact to state funding that may require immediate state legislative action.
44133	Total Payment Rates for Payments to MCO, PIHP, or PAHPs are Limited to 100% of the Published Medicare Rate, Unless Written Grandfathering is Provided.	Rating periods after the date of enactment	Lower State Services Costs	Lower Federal Services Costs	Private sector cost controls. There may be market impacts that will impact state ability to contract with private sector payers.
44134	Changes to the Waiver Process for Provider Uniform Tax Requirements		Significant potential state cost	Lower Federal Services Costs	This section must be read in the context of 44132, and this is a potential major impact to state funding that may require immediate state legislative action. Please see the detailed description above.
44135	1115 Waivers Must be Budget Neutral	Date of enactment	N/A	N/A	
44141	Work Requirements	1-Jan-29	There have been multiple changes to this section, analysis will be updated soon.	There have been multiple changes to this section, analysis will be updated soon.	

44142	Premiums for Expansion Individuals with Incomes Above the Poverty Line (So for those at 100-138)	1-Oct-28	Significant Administrative Costs	Significant Administrative Costs	$35 and 5% of family income cap. Special rules for Prescription drugs. Providers can waive the copays.
44201	ACA Exchange Enrollment Periods		N/A		Open Enrollment period will be from Nov 1 through Dec 15 and subject to Income Verification
44301	Orphan Drugs				
44302	Sreamlined Enrollment for Out of State providers	4 years after the date of enactment			This modifies rules to make it easier for state Medicaid providers to enroll eligible providers already qualified by another state's Medicaid program.
44303	Delaying Reductions in Disproportionate Hospital Share payments		State savings	Federal cost increases	Extends DHS payments 3 years.