Budget Reconciliation Issue Brief: Impact on People with Disabilities

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## Introduction

### Overview of Bill Status and Scope

This brief provides an analysis of the House-passed version of the Budget Reconciliation Bill as of June 6, 2025, incorporating updates from Senate committee text released through June 17, 2025.

At the time of publication, the Senate has not yet finalized its full proposal. Additional changes are expected as the bill moves through the legislative process. This brief will be updated to include any major revisions that could affect the disability community.

### Legislative Update: Senate Committee Text Released

On June 11, 2025, the Senate Committee on Agriculture, Nutrition, and Forestry released its legislative text, building on the House-passed [Budget Reconciliation Bill](https://www.congress.gov/bill/119th-congress/house-bill/1). This was followed by the Senate Finance Committee’s release on June 16, 2025. The Finance Committee’s version introduces new provisions and revisions impacting Medicaid, the Affordable Care Act (ACA), and related health care programs.

While the Senate draft retains many of the proposed program cuts, it also introduces changes that could affect access, enrollment, and coverage for individuals with disabilities and other low-income populations.

The Agriculture Committee’s text includes additional provisions and revisions related to the Supplemental Nutrition Assistance Program (SNAP).

Further modifications are likely as the bill continues to evolve.

### Ongoing Developments and Next Steps

This issue brief reflects the legislative texts as released on June 11 and June 16, 2025. These proposals are subject to change as the reconciliation process continues. We anticipate further amendments and negotiations in the coming weeks. We will continue to monitor developments closely and release updated versions of this brief at regular intervals.

Summaries of Senate-specific changes are provided in **Appendix A** (Health Provisions) and **Appendix B** (Nutrition Provisions).

### Executive Summary

The proposed budget reconciliation bill introduces substantial changes to critical programs that support individuals with disabilities, including the Supplemental Nutrition Assistance Program (SNAP), Medicaid, and the Affordable Care Act (ACA). These changes are expected to significantly affect food security, access to healthcare, and the overall financial well-being of people with disabilities.

### Purpose of the Brief

This brief is intended for policymakers and disability advocates. Its goal is to inform and support a deeper understanding of how the proposed budget reconciliation bill may impact the lives of people with disabilities. It also offers policy recommendations aimed at strengthening protections and improving outcomes for the disability community.

As of June 6, 2025, H.R. 1 has passed the U.S. House of Representatives and is currently under consideration in the U.S. Senate. Senate Republicans have expressed their intent to finalize a version of the bill and return it to the House for approval, aiming to deliver the legislation to the President’s desk by July 4, 2025.

The bill proposes significant changes to key federal programs, including the **Supplemental Nutrition Assistance Program (SNAP)**, **Medicaid**, and the **Affordable Care Act (ACA)**. These changes would directly affect eligibility criteria for SNAP and Medicaid, particularly for individuals with disabilities. Notably, the bill introduces work requirements as a condition of eligibility, which could restrict access to essential services for many in the disability community.

## Food Assistance

### Section 10001

#### Summary

**Section 10001: Thrifty food plan.**

This section would limit how much food assistance (SNAP) benefits can go up each year.

#### Explainer

**Section 10001: Thrifty food plan.**

The federal government uses the **Thrifty Food Plan** to decide how much food assistance people can get for buying approved foods. This plan is based on what it costs to buy healthy food for a household, and it’s reviewed every few years to keep up with **real food prices**.

Right now, SNAP benefits can go up when food prices go up. But this new rule would change that. It says SNAP benefits can only go up as much as the general inflation rate. Inflation is based on the cost of many things, **not just food**. Since food prices often rise faster than inflation[[1]](#footnote-1), SNAP benefits would not keep up with the real cost of groceries.

Starting in 2027, people will get less in food assistance each month than they would under the current rules. Right now, the average food assistance benefit is only $6.31 per person per day, which is not enough for a basic meal in many states.[[2]](#footnote-2) By 2034, the average monthly benefit is expected to be 6.6% lower than under the current law. This change will reduce overall food assistance benefits by $37 billion between 2027 and 2034.[[3]](#footnote-3)

#### Likely Impact on Disability Community

**Increased Food Insecurity:** Research shows that people with disabilities are more likely to live in poverty, often due to barriers to employment, education, and healthcare. For example, ten years after the onset of a chronic and severe disability, average earnings drop by 76% and family income declines by 28%.[[4]](#footnote-4)

Households that include adults with disabilities experience significantly higher rates of food insecurity. In fact, about 38% of households with very low food security include an adult with a disability.[[5]](#footnote-5)

**Program Participation:**Participation in food assistance programs, such as the School-Based ACCESS Program (SBAP), makes a measurable difference. Multiple studies have found that participants receiving SNAP food assistance are **5–20 percentage points less likely**to experience food insecurity compared to those who are eligible but not enrolled in the program.[[6]](#footnote-6)

Therefore, reducing the amount of food assistance across the board is likely to have a **disproportionate impact** on people with disabilities and their ability to access adequate nutrition. This is particularly important given that people with disabilities make up a significant portion of food assistance recipients. More than **one in four** individuals receiving food assistance report having a disability or a work limitation.[[7]](#footnote-7)

**Worsening Health and Increased Healthcare Costs:** Reduced access to nutritious food will also lead to poorer health and higher healthcare costs for persons with disabilities. Research shows that children with intellectual and developmental disabilities who face food insecurity are more likely to have **worse overall health, behavioral challenges**, and **functional limitations**, especially when food insecurity is moderate to severe.[[8]](#footnote-8) Another study found that people experiencing food insecurity had significantly higher healthcare costs, spending an estimated additional $1,863 annually.[[9]](#footnote-9)

**Disproportionate Impact for Persons with Disabilities:** Many people with disabilities also spend more on food because they may need special diets, such as allergy-friendly or medical diets, that cost more.[[10]](#footnote-10)

For instance, a report found that medically necessary diets, such as the Dietary Approaches to Stop Hypertension (DASH) diet, cost approximately 41% more than the food assistance benefit at the time of the study. Additionally, the report noted that individuals with conditions such as malabsorption may require a higher caloric intake, leading to increased food expenses.[[11]](#footnote-11)

Despite these needs, SNAP does not provide additional support for people who require more expensive food diets due to a disability or illness. Across-the-board benefit reductions would worsen this gap, making it harder for people with disabilities to access the food they need to stay healthy. This, in turn, is likely to lead to **worsening health outcomes** and **increased healthcare costs**.

#### Gaps or Concerns

**The Cost of Inflation Is Not Sufficiently Considered**

Slowing the annual increase in food assistance benefits will make it harder for people with disabilities and other vulnerable groups to afford enough food, especially given the already high rates of food insecurity and the higher food costs some face due to medical or dietary needs.

The proposed rule also fails to reflect the reality of grocery prices, which have risen significantly in recent years. In 2025, for example, egg prices increased by 49.3 percent.[[12]](#footnote-12)

Given these realities, food assistance benefits should be adjusted based on **real food price trends**, not reduced or limited by broader inflation measures that don’t reflect the true cost of eating well.

#### Recommendations

* **Remove Section 10001 as currently written**. The proposed cap on SNAP benefit increases does not reflect the real cost of food and would disproportionately harm people with disabilities.
* **Allow SNAP benefits to increase annually based on actual food costs and levels of need**. Adjustments should reflect the resources required to effectively reduce food insecurity, not just general inflation.

**Ensure that benefit levels are sufficient** for individuals with higher food costs resulting from disability or chronic illness. This includes accounting for medically necessary diets and other nutrition-related needs that are not currently addressed in benefit calculations.

### Section 10002 and Section 10003

#### Summary

**Section 10002: Work requirements for able-bodied adults without dependents.**

This section expands work requirements for individuals classified as *able-bodied adults without dependents* (ABAWDs) who receive SNAP benefits. Under the proposed changes, these individuals must work—either in paid employment or approved unpaid activities—for at least **80 hours per month** to remain eligible for food assistance.

The new rules would broaden the group of people subject to these requirements, meaning **more individuals would need to meet work thresholds** to continue receiving SNAP benefits.

**Section 10003: Able-bodied adults without dependents waivers.**

This section restricts states’ ability to waive SNAP work requirements for *able-bodied adults without dependents* (ABAWDs). Under current law, states can request waivers in areas where there are not enough jobs available.

However, Section 10003 would significantly narrow this flexibility. States would only be allowed to apply for a waiver if the **unemployment rate in a given area exceeds 10%**—a much higher threshold than current standards. This change would make it significantly more difficult for states to exempt individuals from work requirements, even in areas with limited job opportunities.

#### Explainer

**Section 10003: Able-bodied adults without dependents waivers.**

**Work Requirements for Older Adults Without Children**

This section says that more adults without children will have to work to get food assistance (right now, people age 54 and older don’t have to work to get SNAP (food assistance). This bill would change that. People up to age 65 would have to work at least 80 hours a month to keep getting SNAP. This work could be a job, job training, or volunteering.

**Work Requirements for Parents and Caregivers**

Today, parents and caregivers of children under 18 don’t have to meet work rules to get SNAP. **This bill would change that**. Parents would have to work 80 hours a month, unless their child is 6 years old or younger. If two parents live together, only one of them would need to meet the work rule.

**Work Requirements for Vulnerable Populations**

Right now, some people don’t have to meet work rules, like:

* Veterans
* People experiencing homelessness

Young adults leaving foster care

This bill would remove those exceptions. These groups would now have to work 80 hours a month to keep getting SNAP.

**Work Requirements Despite Insufficient Jobs**

Right now, states can ask to skip the work rule if there aren’t enough jobs in an area. This bill makes that harder. States could only ask for a waiver if the unemployment rate is over 10%.

#### Likely Impact on Disability Community

**Unfit For Work Certifications**: To be exempt from SNAP work requirements due to disability, a person must be certified by a doctor as “unfit for work.” However, many low-income individuals with disabilities may not have access to the healthcare needed to obtain this certification. Even when they do, the term “unfit for work” often fails to reflect the real challenges people with disabilities face in the job market.

Research shows that people with disabilities often face serious barriers to employment[[13]](#footnote-13)—not because they are incapable of working, but because of barriers including discrimination, bias, and stigmatization due to disability, limited workplace accommodations, and inaccessible job settings.

For example, some studies show that job seekers with mental health disabilities who request a modification or accommodation during the hiring process are less likely to be hired than those who do not. Additionally, people with disabilities are more likely to experience long-term unemployment once they lose a job.[[14]](#footnote-14)

Many people with disabilities may be able to work in theory but are not given the opportunity in practice. As a result, they may not qualify for the “unfit for work” exemption, even though their disability prevents them from obtaining paid employment.

**Hourly Requirements:**Requiring people to complete **80 hours per month** of unpaid work or job training may:

* Reduce the time and flexibility they need to search for meaningful, paid employment
* Fail to address the **real reasons** why people with disabilities struggle to find or keep jobs
* Place additional burdens on individuals already navigating complex health and accessibility challenges

In some cases, these mandatory activities may do more harm than good, making it harder for people with disabilities to pursue long-term employment opportunities that match their skills and needs.

**Older Adults and Disability:** Under the proposed bill, adults without children would be required to work 80 hours per month to receive SNAP benefits until they reach the age of 65. This change would affect many middle-aged and older adults, even though **disability becomes more common after age 50**.[[15]](#footnote-15) Another study analyzing cross-country data also found that individuals aged 55–65 exhibit higher rates of disability compared to younger age groups.[[16]](#footnote-16)

**Non-Identification of Disability in Adults Aged 55+:** Despite the increasing prevalence of disability, many adults aged 55 do not identify themselves as having a disability. Various factors, including societal perceptions and personal beliefs about disability and aging, can influence this underreporting.

For instance, a study published in *Disability Studies Quarterly* found that older adults often perceive disability as a label for severe limitations, leading them to dismiss their functional difficulties as a regular part of aging rather than a disability.[[17]](#footnote-17)

Those over 55 are therefore likely to associate the certification of “unfit for work” with severe impairment, leading them to dismiss their difficulties in meeting work requirements.

The process of applying for the “unfit to work” certification through a physician can also be complex, which is likely to discourage many individuals with disabilities from applying for a work requirement exemption.

**Difficulties Finding Employment in Later Life:** Older adults also commonly face greater challenges finding employment than younger workers, often due to ageism in hiring practices and other factors. A 2025 report from the Government Accountability Office found that **41% of displaced workers aged 55 and older**had not returned to work three years after job loss, nearly double the rate for workers aged 25–54.[[18]](#footnote-18) Many adults over age 55 who need food assistance are willing to work, but may face challenges finding employment because of **discrimination based on age or disability**. Requiring them to perform 80 hours of unpaid work each month does not address these underlying barriers.

**Lack of Exemptions for Disabled People in Vulnerable Populations:** Although the bill allows exemptions for people who are medically certified as “unfit for work,” many people with disabilities may face challenges providing the required documentation. This is especially true for individuals who are unhoused or for young adults transitioning out of foster care. These obstacles will likely result in the most vulnerable people with disabilities, who are eligible for food assistance, losing access due to barriers in completing and submitting the supporting documentation.

Furthermore, approximately **1.2 million low-income** **veterans** receive SNAP.[[19]](#footnote-19) Many of those face unique barriers to employment, including **service-connected disabilities, mental health** disabilities such as post-traumatic stress disorder (PTSD), and other **challenges transitioning to civilian jobs**. Requiring 80 hours of work per month does not address these barriers and may lead to loss of benefits for those who need them most.

**Lack of Exemptions for Children with Disabilities:** Under the bill, parents of children over 6 years old would be required to meet the 80-hour-per-month work requirements, even if they can’t afford childcare.[[20]](#footnote-20) For many low-income families that rely on food assistance, particularly single-parent households, childcare is unaffordable and difficult to find. In many states, it is illegal or unsafe to leave a 7-year-old home alone, yet parents will be required to work 20 hours a week to maintain access to food assistance.[[21]](#footnote-21) While parents of children with disabilities are exempt if they are caring for a person who is “incapacitated,” this definition does not cover **all children with disabilities**. As a result, some families may lose food assistance if they can’t find or afford childcare to cover 80 hours a month.

**Grandparents Caring for Grandchildren:** Many grandparents provide unpaid childcare for their families. Under the bill, grandparents under age 65 would still be required to meet the 80-hour-per-month work rule—even if they are caring for grandchildren. This could especially hurt families of children with disabilities who rely on grandparents (who receive food assistance) for support.

**People with Disabilities Encounter Extra Challenges When Seeking Employment:**Currently, states can ask for a waiver if there aren’t enough jobs in an area. Under the new rule, they could only do this if the **unemployment rate is over 10%**, which is rare.[[22]](#footnote-22) This change would make it harder for people with disabilities—who already face **discrimination**, **lack of accommodations**, and **inaccessible workplaces**—to meet work requirements, especially in areas with few job opportunities.

#### Gaps or Concerns

**Disability Misclassification and Documentation Barriers**

Many individuals with disabilities do not qualify for the “unfit for work” exemption due to:

* Stigma and self-perception, especially among older adults
* The narrow definition of disability and complex medical certification process

Inability to obtain certification documentation from a doctor due to inaccessible or unaffordable healthcare

**Older Adults Facing Structural Employment Barriers**

Adults ages 55–64 are:

* More likely to experience disability
* Less likely to self-identify as disabled

Disproportionately affected by ageism and unable to find work[[23]](#footnote-23)

**No Consideration for Caregivers of Children with Disabilities**

* Parents of children over 6 years old must meet work requirements regardless of caregiving responsibilities.

The definition of “incapacitated” does not cover all children with disabilities, excluding many families from exemptions.

**Negative Impact on Vulnerable Subpopulations with Disabilities**

* Veterans, unhoused individuals, and youth aging out of foster care with disabilities may face added barriers to obtaining exemptions due to documentation difficulties.[[24]](#footnote-24)

These groups already face compounded barriers to employment.

**Undermining Job Search and Economic Advancement**

Requiring 80 hours a month of unpaid work or training may:

* Interfere with real job search efforts and distract from long-term employment goals; and

Fail to address underlying discriminatory or structural barriers to employment faced by people with disabilities.

**Grandparent Caregivers Penalized**

Grandparents under 65 who care for grandchildren (including children with disabilities) may lose access to food assistance despite fulfilling a critical family support role.

**Disabled Job Seekers Penalized**

When jobs are scarce, persons with disabilities who do not certify as “unfit for work” will be forced to meet work requirements, putting their access to food assistance at risk and reducing the time and flexibility they may need to search for work.

#### Recommendations

* **Remove Sections 10002 and 10003 as currently written.** These provisions would impose rigid work requirements that fail to account for the realities faced by older adults, people with disabilities, and caregivers.
* **Eliminate work requirements for individuals with disabilities, regardless of whether they are officially certified as “unfit for work.”** Many people with disabilities face real barriers to employment but may not meet narrow medical exemption criteria.
* **Remove work requirements for households that include:**
	+ A person with a disability
	+ A child under 18

An adult aged 50 or older

These groups face unique challenges that make rigid work requirements especially harmful.

**Allow a set of more flexible work requirement waiver criteria** that considers not just county-wide unemployment, but also local economic conditions, job availability, and the employment barriers faced by households that include persons with disabilities and other vulnerable populations.

### Section 10006, Section 10007, and Section 10010

#### Summary

**Section 10006: Matching funds requirements.**

Imposes a 5% state match for food assistance benefit costs starting in FY 2028, with penalties for high payment error rates.

**Section 10007: Administrative cost sharing.**

Reduces the federal share of administrative food assistance benefits costs from 50% to 25%, shifting the costs to the states.

**Section 10010: Quality control zero tolerance.**

Sets food assistance benefit payment accuracy incentive funding to $0 starting in FY 2026.

#### Explainer

**Section 10006: Matching funds requirements.**

Starting in **2028**, states will have to pay for **5% of the cost** of SNAP (food assistance) benefits. Right now, the federal government pays for all SNAP benefits. This change means states will have to start sharing the cost. If a state makes too many mistakes in how it gives out SNAP benefits—called **payment errors**—it could face **penalties**. That means the state might have to pay even more money.

**Section 10007: Administrative cost sharing.**

The federal government pays for **half (50%)** of the cost to run the SNAP (food assistance) program—things like staff, computers, and paperwork. This section would cut that support in half.

Starting soon, the federal government would only pay **25%**, and states would have to pay the rest. This means states would have to spend **more of their own money**to keep SNAP running.

**Section 10010: Quality control zero tolerance.**

States can get **extra funding** if they do a good job of making sure SNAP benefits go to the right people and in the right amounts.

This section would end that. Starting in 2026, the federal government will stop giving money to states as a reward for accurately processing food assistance cases. This is known as quality control incentive funding. This could make it harder for states to invest in systems that prevent mistakes and improve service.

#### Likely Impact on Disability Community

**Increased Financial Pressure on States:** These provisions shift significant costs from the federal government to the states. Many states may not have the resources to absorb these new expenses, which could lead to **cuts in food assistance programs**. This would disproportionately affect people with disabilities who rely on SNAP to meet basic nutritional needs.

**Reduced Support During Economic Downturns:** SNAP plays a crucial role in supporting families during recessions and periods of economic hardship. Reducing federal funding and administrative support could weaken the program’s ability to respond to future crises. This would have **broad economic consequences**, especially for people with disabilities and their families, who are often among the most economically vulnerable.

#### Gaps or Concerns

**Impact on Low-Income States**

The shift in SNAP costs from the federal government to the states will **disproportionately impact low-income states** and those with **larger food assistance caseloads**.

These states may already struggle with limited budgets and high demand for services. Without additional federal support, they may be forced to reduce benefits, restrict eligibility, or cut administrative resources, placing vulnerable populations, including people with disabilities, at even greater risk of food insecurity.

#### Recommendations

* **Remove this provision as written.**Shifting the financial burden of SNAP to states threatens the stability and accessibility of food assistance programs, especially in states with limited resources.

**Maintain a strong federal cost share**for both benefit and administrative expenses. This is essential to ensure that SNAP remains **equally accessible across all states**, particularly during times of economic downturn or public health emergencies when demand for assistance increases.

## Healthcare

### Section 44101, Section 44102, and Section 44103

#### Summary

**Section 44101: Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs.**

This section would place a temporary moratorium on a recent federal rule that aims to simplify eligibility and enrollment for Medicare Savings Programs. The rule is intended to help more low-income Medicare beneficiaries receive assistance with premiums and cost-sharing. If enacted, this section would prevent the rule from being implemented until at least January 1, 2035.

**Section 44102: Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program.**

This section would delay implementation of a separate final rule designed to streamline application, eligibility, enrollment, and renewal processes for Medicaid, the Children’s Health Insurance Program (CHIP), and the Basic Health Program (BHP). These improvements—including simplified paperwork and more consistent renewal procedures—have been finalized by CMS but are not yet in effect. This provision would block their implementation until January 1, 2035.

**Section 44103: Ensuring appropriate address verification under the Medicaid and CHIP programs.**

This section requires states to take additional steps to ensure that individuals enrolled in Medicaid and the Children’s Health Insurance Program (CHIP) reside at the addresses they provided. It pushes for more aggressive address verification, which could lead to people being removed from coverage if their address can’t be confirmed.

#### Explainer

**Section 44101: Pause on New Medicare Savings Program Rule**

This section **puts a temporary stop** on a new rule that was supposed to make it **easier for low-income people on Medicare** to get help paying for things like:

* Monthly premiums
* Deductibles

Copayments

The rule has been finalized but is not yet in effect. If this bill becomes law, it would **stop the rule from moving forward**, meaning those improvements would be delayed until at least 2035.

**Section 44102: Pause on New Medicaid, CHIP, and Basic Health Program Rule**

This section also **pauses a rule** that would have made it **simpler for people to qualify for and stay enrolled in**:

* **Medicaid**
* **CHIP** (Children’s Health Insurance Program)

**Basic Health Program** (a low-cost insurance option in some states)

“The rule has been finalized but has not yet taken effect. If this bill passes, it would **prevent those improvements from being implemented** until at least 2035.”

**Section 44103: Stricter Address Checks for Medicaid and CHIP**

This section instructs states to **verify that individuals on Medicaid and CHIP reside where they claim to be living**. If someone’s address **can’t be confirmed**, they might **lose their health coverage**.

#### Likely Impact on Disability Community

**Delays to Centers for Medicare & Medicaid Services (CMS):**The reconciliation bill would delay CMS’ proposed enrollment streamlining and implementation until January 1, 2035, which would be harmful to the disability community.

**Coverage Loss:**Approximately 1 in 10 Medicaid enrollees lose coverage and then re-enroll within a year—this phenomenon is known as “churn.”[[25]](#footnote-25) According to the Kaiser Family Foundation, about 10.3% of full-benefit Medicaid beneficiaries experienced a gap in coverage of less than a year in 2018. This churn often results from short-term changes in income or administrative hurdles during the renewal process.

**Many lose coverage simply because they submit incomplete paperwork or don’t understand the renewal process**, not because they’re no longer eligible. A significant portion of Medicaid disenrollments are due to procedural reasons rather than actual ineligibility.[[26]](#footnote-26)

For instance, data indicate that in California, approximately 87.4% of those who lost Medi-Cal coverage between June 2023 and February 2024 did so because they failed to complete the renewal paperwork or had incorrect or missing information.

Some states drop people from coverage as soon as mail is returned, even if they’re still eligible. This rule would require more effort to keep people covered.

#### Gaps or Concerns

**Impact on Low-Income Populations**

Low-income individuals with disabilities face significant barriers to accessing healthcare, including:

* Economic and housing instability
* Language and literacy challenges
* Limited digital access

Complex enrollment systems

These challenges make it harder to navigate paperwork and maintain continuous coverage in programs such as Medicaid, CHIP, and Medicare Savings Programs (MSPs).

#### Recommendations

* **Remove Sections 44101–44103 from the reconciliation bill and allow the CMS Eligibility and Enrollment final rules to move forward as planned.** These rules were designed to:
	+ Reduce administrative burdens
	+ Streamline enrollment and renewal for Medicaid, CHIP, and Medicare Savings Programs (MSPs)

Prevent unnecessary loss of coverage, particularly for individuals who face barriers due to disability, language access, unstable housing, or limited digital access.

* Delaying these improvements until **2035** would:
	+ Prolong gaps in coverage
	+ Increase churn due to paperwork errors or lost mail

Disproportionately harm people with disabilities who rely on continuous coverage for services such as personal care, long-term supports, and medications

* **Provide Alternative Solutions to Address Program Integrity:**If concerns about program integrity remain, Congress and CMS can address them through targeted oversight and data-driven enforcement – not by halting systemwide improvements.
* **In the interim:**
	+ **Require states to use existing federal data** (such as LIS/SSI records) to automate enrollment for eligible individuals with disabilities;
	+ **Provide funding for accessible enrollment assistance**, including navigators and disability service providers;
	+ **Mandate safeguards for returned mail disenrollments**, such as outreach via phone, text, or case management prior to termination; and

**Monitor and publicly report** churn rates and coverage loss, disaggregated by disability status. Maintaining and expanding enrollment streamlining measures will strengthen program efficiency, reduce disparities, and ensure stable care for individuals with disabilities.

### Section 44104

#### Summary

**Section 44104: Modifying certain State requirements for ensuring deceased individuals do not remain enrolled.**

This section requires state Medicaid programs to regularly check the Social Security Administration’s Death Master File on at least a quarterly basis to determine whether Medicaid enrollees are deceased and to disenroll individuals who are determined to be deceased from Medicaid coverage.

#### Explainer

This section requires states to **regularly check** if anyone enrolled in Medicaid has passed away. Specifically, states must:

* Use the **Social Security Administration’s Death Master File**
* Check it **at least every three months**

**Disenroll** anyone who is confirmed to be deceased

The goal is to make sure that **Medicaid funds are only used for living individuals** and to prevent **fraud or administrative errors**.

#### Likely Impact on Disability Community

**Barriers to Reinstatement:**For some individuals, a disability can create challenges when completing all necessary steps for reinstatement in a timely manner.

**For individuals with disabilities who are mistakenly terminated:**

* Re-enrollment can be bureaucratically difficult, particularly for those with cognitive disabilities, limited mobility, or limited English proficiency.
* **Even short-term loss of Medicaid coverage can result in harmful disruptions, including:**
	+ Loss of access to **personal care attendants** who assist with daily living activities.
	+ Inability to obtain or maintain **durable medical equipment**, such as wheelchairs or ventilators.

Missed or delayed **prescription medications** can lead to serious health complications.

These disruptions can have long-term consequences, including hospitalization or institutionalization, especially for those who rely on continuous care.

#### Gaps or Concerns

**Risk of Mistaken Identity**

People with disabilities, especially those with similar names or SSNs to deceased individuals, may be wrongly flagged and erroneously disenrolled.

**Data Inaccuracy**

Past audits have shown that mistaken death identifications do occur due to inaccurate or incomplete data in the DMF.[[27]](#footnote-27)

#### Recommendations

To reduce the risk of erroneous disenrollment, **CMS should require states to**:

* **Verify matches through multiple data sources** before terminating coverage (e.g., state vital records, returned mail, or lack of recent service use);
* **Notify individuals and provide a response period** before disenrollment, allowing living individuals to dispute an incorrect death match;
* **Ensure rapid reinstatement** of benefits and backdating of coverage if an individual is found to have been wrongly terminated;
* **Track and report disenrollment errors**, with a focus on patterns affecting individuals with disabilities, dual eligibles, and those receiving long-term services and supports (LTSS); and

**Provide accessible dispute resolution support**, including assistance for individuals with cognitive impairments or limited English proficiency.

**With these protections in place, Section 44104 can meet its goal of improving accuracy in Medicaid enrollment without jeopardizing the health and stability of vulnerable populations.**

### Section 44105 and Section 44106

#### Summary

**Section 44105: Medicaid provider screening requirements.**

This section requires states to conduct monthly checks of databases or similar systems to determine whether HHS or another state has already terminated a provider or supplier from participating in Medicaid and to also disenroll them from the state’s Medicaid program.

**Section 44106: Additional Medicaid provider screening requirements.**

This section codifies the requirement that state Medicaid programs check, as part of the provider enrollment and re-enrollment process and on a quarterly basis thereafter, the Social Security Administration’s Death Master File to determine whether providers are deceased and enrolled in the state’s Medicaid program.

#### Explainer

**Section 44105**: This section requires states to conduct monthly checks to determine if any Medicaid providers or suppliers have been terminated by another state or by the federal government (e.g., Health and Human Services); if so, the provider must be removed from the state’s program.

**Section 44106**: This section mandates quarterly checks using the Social Security Administration’s Death Master File to identify and disenroll deceased Medicaid providers.

#### Likely Impact on Disability Community

**Intent vs. Reality**: While the intent behind these provisions is to reduce fraud and ensure provider integrity, they risk unintended harm, particularly for Medicaid beneficiaries with disabilities.

**Reduced Access to Care Due to Provider Shortages**: Many providers already **hesitate to accept Medicaid due to low reimbursement rates**. Automatically removing providers flagged by other states—without due process—could lead to false positives and discourage participation. This is especially concerning in areas with limited provider networks, such as rural or underserved communities.

**Risk of Errors and Over-Removal**: These provisions depend on large federal databases like the SSA’s Death Master File, which have known data quality issues.[[28]](#footnote-28) The Government Accountability Office (GAO) has documented inconsistencies in how states track and share provider terminations across jurisdictions. Without a clear appeals or correction process, providers may be wrongly removed, disrupting care for thousands, especially in Home and Community-Based Services (HCBS).

**Chilling Effect on Medicaid Provider Participation**: Increased administrative scrutiny and risk of mistaken termination may deter providers from enrolling or continuing in Medicaid.

This could reduce access to essential services for people with disabilities, including:

* Personal care aides
* Home health nurses

Behavioral health specialists

**No Built-In Patient Safeguards:**

Sections 44105 and 44106 **do not require:**

* Advance notice to patients when their provider is terminated.
* Transition periods to find new providers.

Appeals or reconsideration processes for providers.

**Risk to Medicaid Enrollees**: Although aimed at reducing fraud, Sections 44105 and 44106 risk harming Medicaid enrollees with disabilities by:

* Shrinking the provider network;
* Removing trusted providers due to database errors;
* Disrupting continuity of care; and

Increasing administrative barriers for providers who serve marginalized communities.

**Without built-in patient protections and error-correction mechanisms**, these provisions may worsen access to care for people with disabilities and deepen structural inequities in Medicaid.

#### Gaps or Concerns

**No Notification to Enrollees**

The law does **not require notifying Medicaid enrollees** when their provider is removed due to monthly or quarterly screenings. This lack of notice can result in sudden disruptions to care, especially for people with disabilities who rely on long-standing relationships with specialists, behavioral health providers, or personal care attendants. Without timely communication, patients may show up to appointments only to learn their provider is no longer authorized to deliver care.

**No Transition Periods for Provider Replacement**

There is **no mandated grace period** or structured transition plan for enrollees whose providers are terminated. This abrupt termination leaves people, especially those receiving **long-term services and supports (LTSS)**, with no opportunity to safely transition to alternative providers. The resulting gaps in care may:

* Lead to hospitalization or institutionalization
* Jeopardize independent living arrangements

Overwhelm remaining providers, worsening access for others

**No Appeals or Correction Mechanism for Providers**

There is **no embedded appeal or error-correction process** if a provider is incorrectly flagged due to faulty data (e.g., from another state or the Death Master File). Providers may be unjustly disenrolled due to:

* Name mismatches or duplicate identifiers;
* Delayed updates in federal databases;

Errors in other states’ termination listings.

#### Recommendations

**Specifically, CMS should require states to**:

* **Establish an appeals or verification process** before finalizing provider terminations flagged by other jurisdictions or databases such as the SSA Death Master File;
* **Notify patients in advance** when a provider is at risk of termination and provide information on alternative providers;
* **Guarantee transition periods** for patients with disabilities to secure new providers, particularly for Home and Community-Based Services (HCBS) and long-term services and supports (LTSS);
* **Monitor and publicly report on the impacts**of access to care for high-need populations following provider terminations; and

**Engage disability and provider advocacy groups** in developing implementation safeguards.

By embedding these protections into implementation guidance, **CMS can reduce fraud while preserving access to critical care**. These changes would help uphold both **program integrity**and **health equity** for Medicaid beneficiaries with disabilities.

### Section 44107

#### Summary

**Section 44107: Removing good faith waiver for payment reduction related to certain erroneous excess payments under Medicaid.**

This section eliminates the ‘good faith’ exemption for states to avoid penalties related to excess Medicaid payments.

According to KFF, Federal law directs CMS to recoup federal funds for erroneous payments made for ineligible individuals and overpayments for eligible individuals if the state’s eligibility “error rate” exceeds 3%,[[29]](#footnote-29) CMS may waive the recoupment if the Medicaid agency has taken steps to demonstrate a “good faith” effort to get below the 3% allowable threshold.

#### Explainer

Under current law, if a state makes too many mistakes in determining who qualifies for Medicaid—specifically, if more than **3% of eligibility decisions are wrong**—the federal government (CMS) can **take back some of the money** it gave the state.

However, if the state can show that it made a **“good faith” effort** to fix the problem—like improving its systems or staff training—CMS can **waive the penalty** and let the state keep the money.[[30]](#footnote-30)

This section **removes that waiver**. That means:

* Even if a state is trying hard to fix its mistakes,
* And even if the errors are unintentional,

**CMS must still take back the money** if the error rate is over 3%

#### Likely Impact on Disability Community

This rule can significantly impact the disabled community in several ways:

**Risk of Losing Coverage**: If a state has a high error rate, it may become more aggressive in reviewing eligibility to avoid financial penalties. This could lead to disabled individuals being wrongly removed from Medicaid, even if they’re still eligible.

**Access to Care**: Individuals with disabilities often rely heavily on Medicaid for medical services, personal care, and support. Losing coverage or facing delays due to eligibility reviews can disrupt their access to critical care.

**Increased Paperwork and Burden**: States may tighten their verification processes, resulting in more paperwork and complex procedures that can be challenging for individuals with disabilities to navigate without assistance.

**State Focus on Compliance Over Care**: States may prioritize addressing error rates to avoid penalties over improving services, potentially sidelining the needs of the disabled community.

While Section 44107 is intended to improve payment accuracy, it may unintentionally harm people with disabilities by:

* Increasing the risk of wrongful disenrollment
* Disrupting access to essential services
* Adding administrative hurdles

Shifting focus away from patient-centered care

#### Gaps or Concerns

**No Safeguards to Prevent Over-Removal of Eligible Enrollees**

The policy removes the ability of states to avoid federal repayment penalties, even when they act in good faith to fix eligibility problems.

To avoid financial punishment, states may err on the side of **denying or terminating coverage** for anyone whose eligibility is in question, even if the individual is ultimately eligible.

These risks include:

* **Improper disenrollment** of people with disabilities due to minor clerical or documentation issues
* **Interrupted care** for those who require continuity, especially for long-term services and supports (LTSS)
* **No Individual Due Process Protections:** Section 44107 focuses on state accountability but **does not include any due process guarantees** for individuals whose coverage may be terminated during error-reduction campaigns.
* Beneficiaries may be removed from Medicaid without:
* Adequate notice
* Time to gather documents

Access to appeals

**Ignores Structural Causes of State Error Rates**

The provision assumes states are always able to keep eligibility error rates below 3% and penalizes them if they cannot, even if errors stem from federal policy complexity or outdated technology systems.

State systems often lack:

* Updated IT infrastructure
* Adequate staff to process renewals and redeterminations.

Language access for non-English speakers and those with communication disabilities

Rather than receiving support to improve these systems, states are now **punished regardless of effort**, which can translate into **strict and harmful eligibility practices**.

**Prioritizes Fiscal Compliance Over Health Outcomes**

There is **no balancing mechanism** to ensure that state actions taken to meet error-rate targets do not negatively affect health outcomes or increase racial, disability, or income-based disparities.

States may:

* Focus on reducing statistical error rather than serving high-risk populations
* Avoid enrolling individuals with complex needs who might raise error risk

Cut corners on community outreach or application assistance

**Disincentivizes Innovative Eligibility Strategies**

The removal of the good-faith waiver **penalizes states even if they’re piloting new programs or outreach strategies** that may initially increase errors but ultimately promote equity and access.
States may avoid innovation—such as auto-enrollment for dual eligibles or streamlined applications for those with disabilities—if those systems increase short-term audit risk.

#### Recommendations

* **Prohibit Overly Aggressive Redetermination** **Practices**: Congress and CMS should prohibit states from adopting overly aggressive eligibility redetermination practices that increase the risk of disenrolling eligible individuals, particularly those with disabilities, cognitive impairments, or limited support networks.
* **Require Equity-Focused Corrective Action Plans**: If financial penalties are applied due to high error rates, CMS should require states to include corrective action plans that prioritize equity and access, including:
	+ Disability-informed safeguards in eligibility systems
	+ **Simplified documentation** processes for individuals with chronic or disabling conditions
	+ **Accessible communication** methods, including plain language notices and disability accommodations

**Partnerships with disability advocates and navigators** to support affected individuals during eligibility reviews

**Mandate Transparent Impact Reporting**: CMS should also require transparent reporting on how corrective efforts impact people with disabilities, to ensure the enforcement of program integrity does not come at the cost of healthcare access for those most in need.

### Section 44108

#### Summary

**Section 44108: Increasing frequency of eligibility redeterminations for certain individuals.**

This section requires redetermination of eligibility at least every six months for certain adult Medicaid enrollees.

**Current Federal Law:** States must review whether people still qualify for Medicaid at least once every 12 months.

According to CMS, states must renew Medicaid eligibility every 12 months.[[31]](#footnote-31)

For people whose eligibility is based on income, such as children, pregnant individuals, parents, and expansion adults, states use Modified Adjusted Gross Income (MAGI) rules to assess eligibility. The same 12-month renewal rule applies to people who qualify based on age (65+) or disability. If a person’s circumstances change before the renewal date, states must reassess eligibility sooner.

#### Explainer

This section requires states to **re-check eligibility every six months** for certain adult Medicaid enrollees. That means instead of reviewing eligibility once a year (as is currently standard), some adults will now have to go through the process twice a year to prove they still qualify.

#### Likely Impact on Disability Community

**Greater Risk of Losing Coverage Due to Administrative Barriers**: People with disabilities often rely on consistent Medicaid coverage for essential services, such as personal care assistance, durable medical equipment, mental health care, and long-term supports. Shortening the renewal window increases the risk of **procedural terminations,**which occur when individuals lose coverage not because they’re ineligible but because of missing or misunderstood paperwork.

According to *Health Access California*, frequent renewals increase churn, which leads to gaps in care that are especially dangerous for individuals with chronic or disabling conditions.[[32]](#footnote-32) These risks are even greater for individuals with cognitive disabilities, limited literacy, or limited English proficiency (LEP).[[33]](#footnote-33)

A study of Medicaid enrollees with LEP in Illinois found that they were over five times more likely to be disenrolled than English-proficient individuals.[[34]](#footnote-34) The majority of LEP respondents reported difficulties understanding renewal notices and completing the required forms, primarily because the communications were in English and not translated into their preferred language.

**Disruption of Long-Term Services and Supports (LTSS)**: Many individuals with disabilities rely on Medicaid-funded LTSS to remain in their homes or communities. Frequent renewals can jeopardize the continuity of these services, potentially leading to institutionalization or hospitalization if care is interrupted.

**Risk of Institutionalization**: The Centers for Medicare & Medicaid Services (CMS) has highlighted that the loss of Home and Community-Based Services (HCBS) can pose significant health risks and may lead to institutionalization.[[35]](#footnote-35)

In 2021, 86% of individuals utilizing Medicaid LTSS were served in home and community-based settings.[[36]](#footnote-36) Maintaining continuous eligibility is crucial to prevent unnecessary transitions to institutional care.

**Increased Healthcare Expenditures**: Research indicates that initiating care in nursing facilities leads to higher monthly healthcare expenditures compared to starting with HCBS. Specifically, those beginning care in nursing facilities incurred, on average, $2,919 more in monthly healthcare costs, primarily due to increased long-term services and supports (LTSS) spending.[[37]](#footnote-37)

**Administrative Challenges**: Frequent renewals can strain administrative resources, potentially leading to delays or errors in processing eligibility, which in turn disrupts service delivery. Such disruptions can have cascading effects on the health and well-being of individuals who rely on consistent LTSS.

**Inequity and Discrimination**: People with disabilities are already more likely to experience **economic insecurity, housing instability, and limited digital access**, all of which make it harder to meet paperwork requirements under compressed renewal schedules.

#### Gaps or Concerns

**No Protections Against Procedural Terminations**

The policy mandates more frequent (every 6 months) eligibility redeterminations but does not include safeguards to prevent eligible individuals—especially those with disabilities—from losing coverage due to paperwork errors or communication barriers.

People with disabilities, especially those with cognitive impairments, limited literacy, or limited English proficiency (LEP), are at higher risk of procedural terminations. They may not understand or receive renewal notices, which are often inaccessible or untranslated. This leads to wrongful loss of coverage and dangerous disruptions in care.

**No Continuity-of-Care Protections for LTSS Users**

There is no requirement to maintain continuity of long-term services and supports (LTSS) during redetermination periods or following unintended disenrollments.

People with disabilities who rely on Medicaid-funded LTSS face devastating consequences if services are interrupted. This includes increased risk of institutionalization, health deterioration, and higher system costs, as HCBS disruptions often result in emergency admissions or nursing facility placements.

**Disproportionate Burden on Structurally Marginalized Individuals**

The provision does not account for barriers faced by Medicaid enrollees who experience poverty, housing instability, digital exclusion, or limited access to in-person support.

Disabled individuals in these groups will likely struggle to comply with compressed renewal timelines, resulting in higher coverage churn and increased disparities. Without accommodations or outreach infrastructure, the policy reinforces structural discrimination against the very people Medicaid is intended to serve.

#### Recommendations

* **Preserve 12-Month Medicaid Renewal Standard**
* **Protect the continuity of care** for people with disabilities. **States should retain the current 12-month eligibility renewal period** rather than adopting mandatory six-month redeterminations for Medicaid expansion adults.[[38]](#footnote-38)
* **Reducing the renewal period increases the risk of procedural terminations**, especially for individuals with cognitive disabilities, limited English proficiency, or those lacking consistent housing or internet access, who may miss paperwork deadlines **despite continued eligibility**.
* This can lead to **severe care disruptions**, particularly in long-term services and supports, potentially resulting in institutionalization or costly hospitalizations.
* If federal policy changes proceed, **Congress and CMS should require states** to implement safeguards, including:
	+ Automatic renewals (ex parte) when possible, especially for individuals with stable income.
	+ Waivers or hardship exemptions for people receiving HCBS or other disability-related services.
	+ Multilingual and accessible communication materials to reduce disenrollment among people with limited English proficiency or disabilities.
	+ Robust outreach and assistance infrastructure, including funding for disability advocates and navigators to help with renewals.
	+ Monitoring and public reporting of termination rates and coverage loss among disabled enrollees.

Maintaining annual renewals or, at a minimum, exempting people with disabilities from more frequent redeterminations would promote health equity, prevent gaps in life-sustaining care, and ensure Medicaid continues to fulfill its role as a reliable safety net.

### Section 44109

#### Summary

**Section 44109: Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.**

This section lowers the maximum home equity limit a state may set when determining Medicaid eligibility for long-term care services, reducing the maximum home equity limits to approximately $1,000,000.

**States Can Raise the Home Equity Limit (Up to $1 Million):**
States are usually required to treat everyone equally when it comes to Medicaid rules (this is known as “state wideness” and “comparability”). However, this section allows states to make an exception:

A state can choose to let people keep more equity in their home (up to $1 million) and still qualify for Medicaid long-term care. This applies even if the home does not meet certain standard exemptions, such as being the person’s primary residence.[[39]](#footnote-39)

But no matter what, the limit can’t go over $1 million.

**Clarifying How These Rules Apply**

**Non-Farm Homes and the $1 Million Cap**: There is a specific rule for homes that are not used for farming. If the equity value in one of these homes is more than $1 million, it will still be treated as exactly $1 million for Medicaid eligibility purposes. This makes sure no one can qualify by claiming home values over the federal limit.

**States Can’t Skip These Limits**: This section changes another part of the law (Section 1902 of the Social Security Act) to make it clear that states must follow the home equity limit when deciding if someone qualifies for Medicaid-covered nursing home care or other long-term care services.

States cannot use loopholes to get around the home equity cap.

**Further Clarification in Other Sections:**Another part of the Medicaid rules (Section 1902(e)(14)(D)(iv)) is updated to say clearly that the home equity limit under Section 1917(f) applies when deciding if someone can get help from Medicaid for nursing home care or long-term services.[[40]](#footnote-40) These rules go into effect on January 1, 2028.

#### Explainer

This section **reduces the maximum home equity limit** that states can use when deciding if someone qualifies for **Medicaid long-term care services** (like nursing home care or home-based supports).

* Previously, states could set this limit **as high as $1,071,000** (adjusted annually).[[41]](#footnote-41)

Under this provision, the limit is **capped at approximately $1,000,000**.

#### Likely Impact on Disability Community

**Property Owners**: If your home equity is over the limit, **you may not qualify for Medicaid** long-term care, even if you have no other resources.

People who own property but live on a fixed income (like many older adults and people with disabilities) may be forced to sell or borrow against their home to afford care. States will have some flexibility, but only within the federal cap of $1 million.

#### Gaps or Concerns

**Risk of Housing Instability for People with Disabilities on Fixed Incomes**

* Many individuals with disabilities may own homes with high equity, especially in gentrifying or urban areas, but lack the income to pay for long-term care out of pocket.

Suppose their home equity exceeds the $1 million cap. Disabled people may be denied Medicaid-covered services unless they sell or borrow against their home, risking homelessness or institutionalization.

**No Adjustment for Regional Housing Costs**

The $1 million cap does not account for geographic disparities in home values. In high-cost areas like Los Angeles or New York City, modest homes may exceed the cap, unfairly penalizing residents in these regions.[[42]](#footnote-42) This results in inequitable access to Medicaid long-term care based solely on where someone lives.

**No Hardship Waiver or Disability-Based Exceptions**

* The policy lacks a clear process for appealing or requesting exemptions, even in cases where selling or borrowing against the home would be a hardship due to the person’s disability.

There are no carveouts for accessibility-related renovations, caregiving needs, or sudden shifts in property value, leaving vulnerable individuals without a safety net.

#### Recommendations

* **Adjust the Home Equity Cap for Regional Cost of Living**: Allow states to set higher home equity limits in areas with high housing costs (e.g., California or New York), subject to federal approval. This would prevent homeowners with modest incomes but valuable homes from being excluded unfairly.
* **Protect Primary Residences for Medically Vulnerable Populations**: Exempt the primary home from the equity limit for applicants who are disabled, elderly, or receiving Home and Community-Based Services (HCBS). This would support independent living and reduce unnecessary institutionalization.
* **Create a Waiver or Hardship Exemption Process**: Implement a federal hardship exemption that states can offer when denying coverage would cause significant harm, such as forcing the sale of a home or disrupting continuity of care for a person with a disability.
* **Expand Access to Legal and Financial Counseling**: Fund state-based programs to provide legal and financial counseling for Medicaid applicants facing asset eligibility issues. Many older adults and people with disabilities may be unaware of reverse mortgage options, home exemptions, or spend-down rules.

**Delay Implementation for Further Impact Study**: Extend the January 1, 2028, implementation date to allow time for comprehensive data collection and stakeholder input, particularly from disability and elder advocacy organizations.

### Section 44110

#### Summary

**Section 44110: Prohibiting Federal financial participation under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status.**

This section, starting October 1, 2026, and onwards, would eliminate federal Medicaid and CHIP matching funds for coverage provided during the “reasonable opportunity period.”[[43]](#footnote-43) This period currently allows people to verify their citizenship or immigration status after applying for benefits. If states choose to keep providing coverage during this time, they must do so entirely at their own expense, without federal reimbursement.

#### Explainer

This provision would stop the federal government from helping states pay for Medicaid or CHIP coverage for people who haven’t verified their citizenship or immigration status.

#### Likely Impact on Disability Community

**Loss of Coverage During Verification Delays:**People with disabilities often face complex documentation issues, such as missing records, outdated IDs, or disruptions due to hospitalization or institutionalization. If their status is not verified quickly, they could lose Medicaid or CHIP coverage—even if they are fully eligible.

These delays could result in interrupted care, loss of medications, or missed personal care services, which are often lifesaving or necessary for independence.

**Increased Institutionalization Risk:**Without Medicaid, many individuals with disabilities might lose access to Home and Community-Based Services (HCBS), which enable them to live independently.

Lack of these supports may lead to unnecessary institutionalization, contrary to the goals of the Americans with Disabilities Act and the *Olmstead v. L.C.* Supreme Court decision, which guaranteed that people with disabilities would have the right to receive services in the most integrated setting appropriate to their needs, rather than being unnecessarily institutionalized.

**Administrative and Legal Barriers:**Individuals with disabilities who are also non-citizens or naturalized citizens may face additional barriers to verification, such as requiring a legal guardian to access documents. This provision doesn’t provide accommodations for individuals with cognitive impairments, communication disabilities, or limited access to legal aid.

**Disproportionate Impact on Mixed-Status Families:**Many disabled children and adults live in mixed-status households (e.g., U.S. citizen children with non-citizen parents). These families may avoid applying for coverage altogether, even for eligible members, due to fear, confusion, or misinformation. This creates a “chilling effect” that deepens inequity and worsens health outcomes.

**State Financial Pressure Decreases Flexibility:**States would have to fully fund Medicaid or CHIP for unverified individuals. As a result, many states may choose to terminate coverage immediately if the necessary documents are missing, even if the person is otherwise eligible. People with disabilities in those states would have no safety net to fall back on, even temporarily.

#### Gaps or Concerns

**Loss of Lifesaving Coverage Due to Verification Delays**

Many people with disabilities face real, documented challenges in gathering proof of citizenship or immigration status**,**such as missing paperwork, hospitalization, cognitive impairments, or needing a legal guardian to act on their behalf.[[44]](#footnote-44)

This section eliminates federal matching funds during the reasonable opportunity period, making it likely that states will cut off coverage prematurely, even for individuals who are eligible.

**Increased Risk of Institutionalization**

Without Medicaid or CHIP, individuals may lose access to Home and Community-Based Services (HCBS) that allow them to live independently.

The loss of these supports could lead to unnecessary institutionalization, violating the spirit of the Americans with Disabilities Act (ADA) and the *Olmstead* decision, which guarantee the right to receive services in the most integrated setting.

**No Disability Accommodations in the Verification Process**

People with disabilities may need help communicating, understanding forms, accessing documents, or navigating systems.

Section 44110 includes no requirement that states offer reasonable accommodations during the verification process, leaving many unable to complete verification through no fault of their own.

#### Recommendations

* **Reinstate Federal Matching Funds for People with Disabilities During the Verification Period.**
* **Amend Section 44110 to preserve federal financial participation (FFP)** during the reasonable opportunity period for people with disabilities, older adults, and children to ensure continuity of care. Many people with disabilities experience unavoidable delays in verifying citizenship or immigration status due to hospitalization, cognitive impairments, or guardianship needs.
* **Require Disability Accommodations in the Verification Process.**
	+ Applicants with disabilities may face additional barriers—such as needing assistive technology, communication supports, or legal help—to submit documents on time.
	+ Mandate that states provide **reasonable ADA and Section 504 accommodations**, including extended timelines, assistance from navigators, and accessible communications.
* **Create Federal Incentives for States to Continue Coverage During Verification**: Without federal funds, states may terminate coverage prematurely, even for eligible individuals

**Establish a federal grant or enhanced match program** for states that voluntarily continue coverage during verification for at-risk populations, including those with disabilities.

### Section 44111

#### Summary

**Section 44111: Reducing expansion Federal Medical Assistance Percentage for certain States providing payments for health care furnished to certain individuals.**

This section states that starting in fiscal year 2028, the federal Medicaid match rate will be reduced by 10 percentage points (from 90% to 80%) for **Medicaid expansion states that provide full health coverage or financial assistance to undocumented adults**—individuals who are not lawfully present in the U.S.

This penalty applies **regardless of how the state pays for the coverage**, including if it uses **state-only funds**.

The provision **does not apply** to states that cover:

**Children or pregnant women who are lawfully residing in the U.S.** and are covered under the **federal Medicaid or CHIP option**.

However, it **does apply** to coverage for **undocumented individuals**, including undocumented children and pregnant women, if funded by the state.

This policy would **shift costs to the states** and could lead to **coverage losses**, particularly in states that have chosen to support broader access to care using their own resources.

#### Explainer

**Section 44111: Reducing expansion Federal Medical Assistance Percentage for certain States providing payments for health care furnished to certain individuals.**

This section refers to a provision in proposed legislation related to reducing the Federal Medical Assistance Percentage (FMAP) for Medicaid expansion in certain states.

Some states choose to help people who live in their communities but are not legally present in the U.S. by using their own money to provide health coverage. These programs are often created to make sure everyone can get medical care, especially in emergencies or to manage chronic conditions.

But starting in 2028, a new rule—Section 44111—would make it harder for states to do this. If a state gives full health coverage or financial help to undocumented adults, the federal government will reduce the amount of Medicaid funding it gives that state. Specifically, the federal share of Medicaid costs for low-income adults would drop by 10 percentage points.

This rule does not apply to children or pregnant women who are lawfully living in the U.S. and are covered through federal Medicaid or CHIP programs. But it does apply to undocumented adults, even if the state is paying for their care entirely with its own money.

This change could force states to make difficult decisions. They may have to spend more of their own money to keep helping people, or they might stop offering that help altogether. If that happens, more people could lose health coverage, and fewer people might be able to get the care they need—especially in communities that already face barriers to healthcare.

#### Likely Impact on Disability Community

**Immigrants and Mixed Status Families Face Loss of Coverage**: Section 44111 proposes reducing the federal Medicaid expansion match rate (FMAP) from 90% to 80% for any state that uses state-only funds to provide health coverage to undocumented immigrants or others not classified as “qualified aliens.”

While the provision is framed around immigration policy, it would have significant and far-reaching consequences for immigrants with disabilities and mixed-status families.

**Loss of State-Funded Coverage**: States such as California, New York, and Illinois use their own funds to cover noncitizen residents, including people with disabilities.[[45]](#footnote-45) This policy would penalize those states, shifting billions in costs to state budgets; for example, California could face an additional $30 billion over 10 years.[[46]](#footnote-46) States may respond by cutting coverage entirely, leaving disabled immigrants uninsured.

**Threats to HCBS**: Without Medicaid, undocumented or otherwise excluded immigrants with disabilities may lose access to essential services like in-home personal care. These cuts could force individuals into institutional settings or result in no care at all.[[47]](#footnote-47)

**“Chilling Effect” on Mixed-Status Families**: This policy may deter families from seeking coverage for eligible children or adults with disabilities, especially in households with undocumented members. This could result in delayed diagnoses, missed therapies, and worsened health outcomes.[[48]](#footnote-48)

#### Gaps or Concerns

**Penalizes States for Inclusive Disability Coverage**

Section 44111 reduces federal Medicaid expansion funding (FMAP) for states that use their own funds to cover undocumented individuals.

This punishes states like California and New York for providing critical care—including disability services—and may force them to cut or eliminate programs that support immigrants with disabilities.

**Loss of Essential Disability Services and Risk of Institutionalization**

Undocumented immigrants with disabilities rely on state-funded services like Home and Community-Based Services (HCBS) to live independently.

Without Medicaid support, these services may be cut, leading to institutionalization or complete loss of care, violating ADA protections and the *Olmstead* mandate for integrated services.

**Chilling Effect on Mixed-Status Families**

Many mixed-status households include U.S.-citizen children with disabilities and undocumented parents.[[49]](#footnote-49) This policy may deter families from applying for Medicaid or CHIP due to fear or confusion, even among eligible citizens, resulting in delayed care, missed therapies, and worsened health outcomes.

#### Recommendations

* **Remove or Modify the Provision**: Policymakers should consider eliminating or amending Section 44111 to prevent reductions in the federal Medicaid match rate (FMAP) for states that use their own funds to provide health coverage to certain noncitizen populations. This would preserve state flexibility in supporting vulnerable communities.
* **Exempt Disability-Related Services**: If the provision remains, Congress should exempt disability-related services—such as Home and Community-Based Services (HCBS)—from FMAP penalties. This would help ensure continued access to essential care for individuals with disabilities, regardless of immigration status.
* **Support State Programs Serving Medically Vulnerable Populations**: By maintaining full FMAP for inclusive state programs, Congress can help states avoid financial strain and continue offering critical services to residents with disabilities, including those in immigrant communities.
* **Enhance Outreach to Mixed-Status Families**: Federal agencies should provide clear guidance and culturally competent outreach to help mixed-status families understand their eligibility and rights. This would reduce confusion and fear, helping ensure that eligible individuals, especially children and people with disabilities, receive the care they need.

**Require Impact Reporting**: Congress should mandate federal reporting on the implementation and effects of Section 44111. Data on enrollment, service access, and health outcomes would support evidence-based policymaking and help identify unintended consequences.

### Section 44121

#### Summary

**Section 44121: Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.**

This section pauses the enforcement of a federal rule issued by the Centers for Medicare and Medicaid Services in May 2024, which set minimum staffing standards for nursing homes and other long-term care facilities.

The rule made it mandatory to have a minimum number of nursing staff, such as registered nurses (RNs) and nursing aides to be present at long-term care facilities. The rule said that at least one RN must be present at any given time, with an exemption for up to 8 hours per day under limited conditions.

Under this bill, the rule cannot be enforced until at least January 1, 2035; a delay of nearly ten years. The original rule allowed up to 5 years for rural facilities and 3 years for non-rural facilities to phase in the requirements. With this delay, full implementation of this rule may not occur for up to 15 years in some areas.

**Medicaid Payment Reporting:** The rule requires state Medicaid programs to report how much of their payments to nursing homes and Intermediate Care Facilities for Individuals with intellectual disabilities are used to pay direct care workers and support staff. This is meant to help track whether Medicaid funding is supporting adequate staffing and quality care. States must follow this requirement within four years of the rule’s effective date.

#### Explainer

This section pauses the enforcement of a federal rule issued by the Centers for Medicare and Medicaid Services in May 2024, which set minimum staffing standards for nursing homes and other long-term care facilities.

The rule made it mandatory to have a minimum number of nursing staff, such as registered nurses (RNs) and nursing aides to be present at long-term care facilities. The rule said that at least one RN must be present at any given time, with an exemption for up to 8 hours per day under limited conditions.

Under this bill, the rule cannot be enforced until at least January 1, 2035; a delay of nearly ten years. The original rule allowed up to 5 years for rural facilities and 3 years for non-rural facilities to phase in the requirements.

With this delay, full implementation of this rule may not occur for up to 15 years in some areas. Medicaid Payment Reporting: The rule requires state Medicaid programs to report how much of their payments to nursing homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities are used to pay direct care workers and support staff.

This is meant to help track whether Medicaid funding is supporting adequate staffing and quality care. States must follow this requirement within four years of the rule’s effective date.

#### Likely Impact on Disability Community

**Chronic Understaffing Will Harm Residents:** The rule on minimum staffing standards for nursing homes was created in response to longstanding and well-documented concerns about the impact of chronic understaffing on the quality and safety of care in long-term care facilities.[[50]](#footnote-50) Long-term care facilities are one of several settings where people with disabilities receive support services, often due to limited access to home- and community-based alternatives.

Studies and reports have shown that understaffed nursing homes are associated with serious health risks for disabled long-term care residents, including higher rates of pressure ulcers, infections, weight loss, emergency room visits, and even death.[[51]](#footnote-51)[[52]](#footnote-52) According to one study, “Nursing home staff, residents, and family members report that quality of life, quality of care, and resident safety are adversely affected when nursing homes are short-staffed. Personal hygiene, especially bathing and mealtime routines, are often affected. Short staffing also affects staff physical and mental health.”[[53]](#footnote-53) Without the rule, chronic understaffing and safety issues in long-term care facilities will continue.

**National Inconsistency and Uneven Standards:** Staffing levels vary significantly depending on the location, size, and ownership type of a nursing home. While federal rules require nurses to be available 24 hours a day, they don’t specify a minimum number of staff. Only 38 states and Washington, D.C. have their own minimum staffing rules.[[54]](#footnote-54) Without clear national minimums, the quality of care for people with disabilities varies greatly depending on which state they live in and which nursing facility they have access to.

#### Gaps or Concerns

**Delays Could Cause Long-Term Consequences**

A 10-year delay in enforcement means **disabled residents of long-term care facilities may continue to experience unsafe conditions** with no federal floor to ensure basic staffing levels.

Nursing home leaders say they’re struggling to find and keep direct care workers. This is due to overall staffing shortages and because many workers are leaving for jobs that offer higher pay, such as positions with staffing agencies.[[55]](#footnote-55)

#### Recommendations

* **Remove this section in its entirety.**

**Consider the ongoing shortage of direct care workers and nursing professionals in** long**-term care facilities**and explore solutions to help fill these jobs, such as creating work visa options for immigrants who want to work in this field.

### Section 44122

#### Summary

**Section 44122: Modifying retroactive coverage under the Medicaid and CHIP programs.**

This section shortens the allowable period for retroactive Medicaid and the Children’s Health Insurance Program (CHIP) eligibility from 90 days to 30 days before the date of application approval. The stated goal is to reduce program costs. This would be effective as of December 31, 2026.

#### Explainer

Currently, Medicaid and the Children’s Health Insurance Program (CHIP) can pay for medical care a person received up to 90 days before they applied, as long as they would have been eligible during that time.[[56]](#footnote-56) This helps individuals and parents who didn’t know they were eligible or couldn’t apply right away. This bill would reduce that window to only 30 days, meaning Medicaid and the CHIP would only cover care received in the 30 days before someone’s application was submitted.

#### Likely Impact on Disability Community

**Retroactive Coverage:**Reducing retroactive coverage from 90 days to 30 days creates a barrier for individuals who are eligible for Medicaid and CHIP but may not be able to immediately navigate the application process. Many individuals cannot apply the moment they become eligible, particularly those who have just experienced a serious injury, received a new diagnosis, or developed a chronic illness.

The retroactive period also facilitates long-term institutional placements for people being discharged from the hospital who have not yet applied for Medicaid and covers hospital charges for Medicaid-eligible newborns before their enrollment has been processed.[[57]](#footnote-57)

**Barriers Accessing Care:** The medical bills for these services can quickly become astronomical, especially when a new injury occurs or a serious diagnosis, such as cancer, is received. In these moments, navigating bureaucratic processes often takes a back seat to managing health crises. Lack of access to Medicaid during such a crisis can lead to delayed access to treatment and the potential worsening of the individual’s medical condition.

People with intellectual, developmental, and cognitive disabilities are especially impacted, because of systemic failures, such as:

* Confusing eligibility criteria
* Inaccessible systems
* Lack of timely support
* Confusing application procedures, which make it more difficult to apply.[[58]](#footnote-58)

In fact, adults with disabilities are almost twice as likely to report unmet health care needs due to barriers they face in accessing care.[[59]](#footnote-59) These structural barriers are often compounded for people with psychiatric disabilities, traumatic brain injuries, or intellectual and developmental disabilities, who may need time, support, or accommodations to engage with eligibility systems.

**Loss of Coverage:** Individuals who lose employment due to illness or injury may not immediately realize they qualify for Medicaid. Thirty days is rarely sufficient to recover, become aware of coverage options, gather documentation, and apply. In summary, limiting retroactive coverage can result in individuals with newly acquired disabilities being unable to access necessary care during the crucial period when they are still adjusting to new health challenges and navigating eligibility systems.

#### Gaps or Concerns

**Changes to Retroactive Eligibility**

Reducing retroactive Medicaid and Children’s Health Insurance Program coverage from 90 days to 30 days significantly weakens one of the few existing safety-net protections for individuals and families experiencing health emergencies or sudden financial hardship.

Retroactive eligibility exists precisely because life, illness, and disability are unpredictable, and systems are often slow. Without it, even individuals who ultimately qualify for Medicaid may find themselves saddled with thousands of dollars in medical debt for care received right before their application was submitted. **This undermines the very purpose of public health coverage as a backstop during periods of vulnerability.**

**Increase in Financial Strain for Disabled People**

The policy change could also increase financial strain on healthcare providers, especially safety-net hospitals and community clinics, which often treat patients regardless of their insurance status. When Medicaid cannot retroactively reimburse providers for eligible services, those costs are absorbed by the provider or passed along to the broader health system in the form of higher prices or reduced services.[[60]](#footnote-60)

No comprehensive cost–benefit analysis has been presented that evaluates the long-term consequences of shortening retroactive coverage. Although **reducing coverage from 90 to 30 days may produce short-term savings, evidence suggests this policy could increase overall costs**. Specifically, administrative burdens from more coverage denials and appeals, uncompensated care shifted to hospitals and clinicians, and delayed access to preventive or early treatment—leading to late-stage interventions—can all drive up expenditures over time.[[61]](#footnote-61)

Most critically, limiting retroactive eligibility increases the likelihood that people will delay seeking medical attention or fail to receive timely diagnoses and treatment. **These delays can lead to worsening health outcomes, particularly for individuals with new, undiagnosed, or rapidly progressing conditions**. Ultimately, the provision risks doing more harm than good by narrowing access to coverage at a moment when people are least prepared to navigate complex eligibility systems.

#### Recommendations

* **Preserve the 90-Day Retroactive Coverage Period:** Maintain the current 90-day retroactive eligibility window for Medicaid and CHIP. This ensures that individuals who are eligible—but unable to apply immediately due to illness, disability, or other barriers—can still access coverage for critical care received during that time.

**Invest in Outreach and Application Support:** Strengthen outreach efforts and provide navigation assistance to help individuals understand their eligibility and apply for coverage as early as possible. This can reduce reliance on retroactive coverage while ensuring that people are not left without care during emergencies.

### Section 44132

#### Summary

**Section 44132: Moratorium on new or increased provider taxes.**

This section places a freeze on Medicaid provider taxes. Specifically, it prohibits states from creating any new provider taxes or increasing existing ones after the bill is enacted.

Medicaid is funded by both the state and federal governments. Each state pays part of the cost, and the federal government covers the rest under the Federal Medical Assistance Percentage (FMAP). Sometimes, states raise money for their share through specific taxes, like taxes on hospitals or health care providers, known as provider taxes.[[62]](#footnote-62) When they do, the federal government usually matches that money to help cover Medicaid costs. All states (other than Alaska) use provider taxes to raise money to cover the cost of their Medicaid programs.[[63]](#footnote-63) [[64]](#footnote-64)

Under this bill provision, any funds raised from any new or increased provider taxes, would not qualify for federal matching payments. This will make it harder for states to raise enough taxes to receive the federal Medicaid funds they rely on to run their Medicaid programs. It would be especially challenging for states with more low-income residents, since they rely more heavily on federal Medicaid funding than states with higher income residents.

#### Explainer

Section 44132 puts a pause on states’ ability to create new taxes on health care providers or raise the ones they already have. These provider taxes are often used by states to help fund Medicaid, the public health insurance program for people with low incomes or disabilities. By collecting these taxes from hospitals, nursing homes, and other providers, states can bring in more money and qualify for additional federal funding to support their Medicaid programs.

Under this new rule, states can keep using the provider taxes they already have in place, but they can’t increase the rates or change how those taxes work. They also can’t introduce any new provider taxes going forward. This restriction could make it harder for states to fund their share of Medicaid costs, especially during times of economic stress or rising health care needs. Without the flexibility to adjust these taxes, states may face tough decisions, such as cutting services, reducing payments to providers, or limiting who can get Medicaid coverage.

#### Likely Impact on Disability Community

**Loss of State Funding Could Threaten HCBS**: If states lose money because they can no longer get federal matching funds for provider taxes, they’ll have to find other ways to make up the difference. In the past, when states needed to cut their Medicaid budgets, they often reduced funding for HCBS, such as cutting the number of hours of care people could receive. Home and Community-Based Services help people with disabilities and older adults live at home safely. These services include assistance with daily tasks such as bathing, dressing, preparing meals, managing medications, and transportation to work or appointments.[[65]](#footnote-65)

In 2011, when extra federal Medicaid funding from the 2009 stimulus ended, many states were still struggling financially. As a result, they quickly cut **HCBS**spending by either limiting who could receive services or reducing the amount of help each person could receive. In 2017, more than half (51 percent) of what states spent on optional Medicaid services went to HCBS, illustrating the significant reliance on this funding; therefore, cuts to state budgets will likely result in reductions to this vital care.[[66]](#footnote-66)

#### Gaps or Concerns

**The Moratorium Can Limit States**

The moratorium on new or increased Medicaid provider taxes would severely limit states’ ability to generate the non-federal share of Medicaid funding. Since nearly all states rely on provider taxes to draw down essential federal Medicaid dollars, this restriction could lead to large funding gaps, particularly in states with smaller tax bases or higher rates of poverty. States that are already under fiscal strain may be forced to cut Medicaid services, reduce eligibility, or lower provider payments.

For the disability community, this poses a significant threat. Home and Community-Based Services (HCBS), which are optional under federal Medicaid rules and therefore easier to cut, are likely to be among the first areas targeted for reductions. Cuts to HCBS would result in fewer care hours, reduced access to personal assistance, and increased risk of institutionalization for people with disabilities.[[67]](#footnote-67) Because HCBS are essential for helping people with disabilities live safely, maintain employment, and participate in community life, funding reductions in this area could be devastating, potentially rolling back decades of progress toward integration and autonomy.

Additionally, this provision creates a long-term structural barrier to Medicaid financing innovation at the state level. It may also disproportionately impact states where residents have lower incomes on average or rural areas, where provider taxes are a critical tool for maintaining Medicaid infrastructure. This is particularly important during times of economic downturn or public health crisis.

#### Recommendations

* **Strike the Moratorium Provision**: Remove the moratorium on new or increased provider taxes entirely. States must retain the flexibility to use provider taxes as a financing tool to meet their Medicaid funding needs, especially during times of economic uncertainty or rising healthcare costs.
* **Protect HCBS Funding**: Congress should include explicit protections for HCBS funding and make HCBS mandatory. These services are vital for helping people with disabilities live safely in their homes and communities. Safeguarding HCBS from budget cuts will help prevent unnecessary institutionalization and preserve community integration.
* **Allow Flexibility for Economic Conditions**: The legislation should permit states to implement or increase provider taxes during recessions, public health emergencies, or other periods of fiscal stress. This flexibility is essential to ensure that Medicaid programs can respond to increased demand without sacrificing coverage or care quality.

**Commission an Impact Study**: Congress should direct the Government Accountability Office (GAO) to conduct a comprehensive study on how restrictions on provider taxes could affect Medicaid access. The study should focus on impacts to HCBS, rural health care networks, and services for people with disabilities, providing data to guide future policy decisions.

### Section 44135

#### Summary

**Section 44135: Requiring budget neutrality for Medicaid demonstration projects under Section 1115.**

This section would require that all Medicaid demonstration projects approved under Section 1115 of the Social Security Act be budget-neutral. This means that any new project or waiver cannot cost the federal government more than what it would have spent without the waiver.

This change could significantly limit states’ flexibility to test innovative approaches to Medicaid coverage, especially those that might involve upfront investments—such as expanding services for people with disabilities or addressing social determinants of health—that could save money in the long term but increase short-term spending.

#### Explainer

Section 44135 says that when a state wants to try something new with its Medicaid program—like testing a new way to deliver care or expanding services—it can only do so if the new idea doesn’t cost the federal government any more money than usual. This rule is called “budget neutrality.”

States often use special permission, called a Section 1115 waiver, to test new ideas in Medicaid. These ideas can help people get better care, especially people with disabilities or those with complex health needs. Sometimes, these new programs cost more at first but save money later by keeping people healthier and out of the hospital.

But under Section 44135, if a new idea costs more in the short term—even if it could save money in the long run—it might not be allowed. This could stop states from trying programs that help people live at home instead of in institutions, or that provide extra support for people with disabilities.

This rule could make it harder for states to improve Medicaid. It might stop them from offering better services or trying new ways to help people stay healthy. For people who rely on Medicaid, especially those with disabilities, this could mean fewer choices, less support, and slower progress in making care more fair and effective.

#### Likely Impact on Disability Community

**Strict Budget Neutrality Can Be Harmful**: Section 44135’s requirement for strict budget neutrality in Medicaid Section 1115 demonstration projects could have several consequences for the disability community, particularly if it limits states’ ability to test or expand services that don’t produce immediate cost savings.

**Limits Innovation in Disability Services**: Many Medicaid 1115 waivers are used to expand access to community-based services, such as Home and Community-Based Services (HCBS), pilot housing and employment supports, or cover services that address social determinants of health, particularly for individuals with complex needs, including those with disabilities.[[68]](#footnote-68) However, if a demonstration cannot show immediate savings, it may be rejected or scaled back, even if the long-term benefit for disabled individuals is clear.

**Jeopardizes “Costs Not Otherwise Matchable” (CNOM) Benefits**: Disabled people often benefit from services funded under “Costs Not Otherwise Matchable (CNOM)”—these include things like peer supports, respite care, or non-medical transportation.[[69]](#footnote-69)

If Section 44135 results in stricter limitations on how waiver savings are defined or used, states may be blocked from funding these services under their 1115 waivers.

**Reinforces Institutional Bias by Undermining HCBS Expansion**: Institutional care (including nursing homes) is a mandatory benefit in Medicaid. However, HCBS is optional, and budget-neutrality rules can make it more challenging for states to expand community-based services that help people with disabilities live independently.

States attempting to shift toward community care may find it challenging to demonstrate cost savings upfront, particularly if budget neutrality must be achieved in the short term.

**Limits State Flexibility to Address Disability-Specific Needs**: If HHS applies a strict budget-neutrality methodology, states may have fewer tools to pilot services uniquely needed by disabled people, such as:

* Behavioral support for developmental disabilities
* Assistive technology programs

Direct care worker training and compensation

#### Gaps or Concerns

**Serious Concerns for the Disability Community**

Section 44135 presents several serious concerns for the disability community and for states seeking to innovate within Medicaid. Most notably, the provision lacks any explicit protections for people with disabilities or equity-focused safeguards. **There is no carve-out or prioritization for HCBS, which are essential for helping individuals live independently and avoid institutionalization.**

The requirement for strict budget neutrality also fails to account for long-term savings or the value of innovation. Many programs that improve health outcomes and reduce costs over time may not show immediate savings, making them vulnerable under this policy. Additionally, **there is no transparency or opportunity for public input in how budget neutrality calculations are made**, leaving stakeholders—including people with disabilities—without a voice in decisions that directly affect their care.

The provision also lacks flexibility for emergencies or unexpected cost increases, such as during public health crises or natural disasters. It does not include protections for services funded under “Costs Not Otherwise Matchable” (CNOM), which are often critical for people with disabilities.

**No Mechanisms in Place to Prevent Cuts**

There are no mechanisms in place to prevent cuts to essential services if states are unable to meet strict budget neutrality requirements.

Together, these gaps could lead to reduced access, weakened supports, and greater risk of institutionalization for people with disabilities.

#### Recommendations

* **Allow Flexibility for Long-Term Cost-Saving Innovations:** Congress or HHS should create clear exemptions or phased-in requirements for programs that benefit people with disabilities but may not yield immediate cost savings. Many disability-focused services—such as housing supports, employment programs, and Home and Community-Based Services (HCBS) can reduce costs over time but require upfront investment. Allowing longer budget neutrality windows (e.g., 7–10 years) or phased cost analysis would help protect these essential innovations.
* **Protect and Expand “Costs Not Otherwise Matchable” (CNOM) Uses:** HHS should explicitly safeguard the use of waiver savings for CNOM-funded services that are critical to people with disabilities. These include peer supports, respite care, assistive technology, and caregiver stipends. Though not traditionally covered by Medicaid, these services are often life-changing and essential for independent living.
* **Require Disability Impact Assessments for All New Waivers:** Congress should mandate that states and CMS conduct a “Disability Equity Impact Statement” when submitting or approving Section 1115 waivers under the new budget neutrality rules. This would ensure that the needs of disabled populations are considered and that waiver proposals do not unintentionally reduce access to critical services.
* **Safeguard Home and Community-Based Services (HCBS):** Congress should pair Section 44135 with legislative protections for HCBS. This could include making certain community-based services a mandatory Medicaid benefit or creating a carve-out from strict neutrality enforcement. Budget neutrality should not prevent states from rebalancing long-term services away from institutional care and toward inclusive, community-based models.
* **Promote Transparent and Inclusive Rulemaking:** HHS should establish a public rulemaking process to define how savings and cost baselines will be calculated under Section 44135. This process must include formal input from disability advocacy organizations to ensure that people with disabilities and their allies have a voice in shaping the rules that govern their access to care.
* **Expand Data Collection and Monitoring of Disability Outcomes:** Congress should require states to report on how Section 1115 demonstrations affect access, outcomes, and equity for people with disabilities—especially when services are reduced or restructured due to budget neutrality constraints. Tracking outcomes such as institutionalization rates, service delays, and unmet needs is essential for accountability and for identifying when policies are causing harm.

### Section 44141

#### Summary

**Section 44141: Requirement for States to establish Medicaid community engagement requirements for certain individuals.**

This section requires all states to implement Medicaid community engagement (or work) requirements starting January 1, 2029. Under this provision, certain Medicaid enrollees must complete at least 80 hours per month of work, education, job training, or community service to maintain their coverage. States must notify individuals of the new rules, provide a 30-day grace period before terminating coverage, and check if individuals qualify for Medicaid under another category before ending their benefits.

#### Explainer

This section requires that, starting in 2029, people on Medicaid who meet certain criteria must prove that they are working, in school, volunteering, or doing similar activities for at least 80 hours each month. If someone doesn’t follow the rule or claim an exemption, for example due to disability, they can lose their health coverage. States will send notices to current Medicaid recipients explaining the new rules, give people a chance to prove they qualify for an exemption, and check if they’re eligible for any other coverage before cutting them off.

This rule could make it harder for some people to stay on Medicaid, especially if they face barriers to working or reporting their hours. States won’t be allowed to skip or change the rule, even if they think it would help people in their state.

#### Likely Impact on Disability Community

**Proving Disability Exemptions**: Under the proposed federal work requirement rules, states must notify Medicaid enrollees about the new work or community engagement requirements and provide a 30-day grace period before ending anyone’s coverage.

During this time, individuals can either show they meet the requirement or qualify for an exemption. **Medicaid benefits will continue throughout the grace period.** If the individual doesn’t respond, the state must first check whether they continue to qualify for Medicaid before taking steps to terminate their coverage. States are also required to provide enrollees with a written notice of denial and the opportunity for a fair hearing.

States will be instructed to use existing data systems, such as payroll records or information from federal databases, to confirm whether someone is complying with work requirements or is exempt. For individuals with disabilities, certain exemptions are more straightforward to verify, for example, those who receive Supplemental Security Income (SSI) or are enrolled in Medicare.

However, many people with disabilities are not automatically captured by these systems. For example, individuals with disabilities who earn more than the federal SSI income threshold ($11,604.53 for an individual in 2025)[[70]](#footnote-70) are not eligible for SSI and will not be recognized as exempt by default.[[71]](#footnote-71)

In most cases, people who become eligible for Medicare due to a disability must first receive Social Security Disability Insurance (SSDI) for 24 months—an additional two-year period after their disability benefits begin—before being approved for Medicare. SSDI itself requires a work history with sufficient Social Security contributions (typically 20 to 40 work credits based on age), meaning many people with disabilities, especially those with limited or intermittent employment, do not qualify for Medicare this way.[[72]](#footnote-72) As a result, individuals with disabilities who rely on Medicaid but do not qualify for SSI or Medicare may not be flagged for an exemption.

These verification challenges place people with disabilities at significant risk of losing coverage, not because they are ineligible, but because the systems fail to recognize them as exempt. Without adequate support or clear procedures, many of them may not realize they need to act or may be unable to respond in time.

In Arkansas, when similar rules were tested, over 18,160 people lost coverage in just five months before the courts halted the policy. This coverage loss included many who should have been exempt.[[73]](#footnote-73) Medicaid provides critical services like personal care assistants and home health for many people with disabilities. Losing this coverage can mean losing essential support.

**Disabled Veterans**: Medicaid is a means-tested program, so low-income veterans who meet eligibility criteria, such as age or disability, can qualify for Medicaid even if they also receive care through the Department of Veterans Affairs (VA). Veterans are allowed to be enrolled in both Medicaid and VA healthcare programs. However, under the proposed Medicaid work requirements, only veterans with a total (100 percent) disability rating from the VA would be automatically exempt from those requirements. The VA assigns disability ratings in 10% increments based on the severity of service-connected conditions. A veteran with a 100% rating is considered totally disabled. In 2022, there were 5.3 million disabled veteran beneficiaries in the United States.[[74]](#footnote-74) However, only about 986,000 veterans are classified as 100% disabled at any given time (around 18%).[[75]](#footnote-75)

Importantly, a total disability rating from the VA is not always permanent. For example, a veteran rated 100% disabled during cancer treatment may be reevaluated six months after treatment ends and found to be no longer totally disabled, potentially losing their exemption from work requirements and even their healthcare coverage.[[76]](#footnote-76) This means that many veterans with serious but fluctuating conditions may repeatedly lose and regain exemption status.

As a result, approximately 82% of disabled veterans could face coverage disruptions and be subject to work reporting requirements despite being low-income and in need of ongoing health care.

Many of these veterans live with post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), or other chronic health conditions.[[77]](#footnote-77) Requiring these individuals to meet work requirements to retain Medicaid coverage could create significant barriers to accessing care.

#### Gaps or Concerns

**Navigating the Exemption Process**

Many people with disabilities may struggle to navigate the exemption process. Challenges include knowing when to apply, understanding the required paperwork, dealing with errors in state systems, and navigating other administrative hurdles.

**Not all people with disabilities qualify for Medicare** or meet the strict SSI standard of disability.

State systems may not be prepared to identify exempt individuals accurately or in time to prevent termination. Reporting burdens can cause people to lose coverage even when they meet the requirements.

Veterans with disabilities only qualify for a work requirement exemption if rated 100% disabled by the VA, but that category includes just 18% of disabled veterans.[[78]](#footnote-78)

#### Recommendations

* **Remove Section 44141 in its entirety.**
* Mandating work or community engagement requirements as a condition for Medicaid coverage creates unnecessary barriers to care, especially for individuals with disabilities and others facing complex life circumstances.
* **Policymakers must recognize that many people with disabilities are not formally recognized** under Social Security Administration (SSA) rules but still experience significant barriers to employment. These individuals may not qualify for official exemptions yet still need consistent access to health care to manage their conditions and maintain stability.
* **Keep Medicaid a health coverage program, not a work program.** Work requirements have been shown to reduce coverage without increasing employment.[[79]](#footnote-79) Congress should prohibit Medicaid work requirements in all states to ensure that access to health care is based on need, not employment status.

### Section 44142

#### Summary

**Section 44142: Modifying cost-sharing requirements for certain expansion individuals under the Medicaid program.**

This section states beginning October 1, 2028, states will be required to impose cost-sharing on Medicaid expansion enrollees with incomes above 100% of the federal poverty level. Under this provision, individuals may be charged up to $35 per service, with a cap of 5% of household income over a monthly or quarterly period.

Certain services may be exempt from cost-sharing, including emergency care, primary care, prenatal and pediatric care, and mental health and substance use disorder treatment. However, states may allow providers to withhold non-exempt services if the enrollee does not pay the required amount.

This change marks a significant shift in Medicaid policy by introducing mandatory out-of-pocket costs for low-income adults in the expansion population, potentially creating new barriers to accessing care.

#### Explainer

Starting October 1, 2028, some people who get Medicaid through the expansion program will have to start paying small fees when they get medical care. This applies to adults who make a little more than the federal poverty level, for example, someone earning just over $15,000 a year.

These fees, called copayments, could be as much as **$35 for each medical service**. But there’s a limit: no one will have to pay more than **5% of their household income** in a month or over a few months.

Some types of care will still be free. People won’t have to pay for:

* Emergency room visits
* Regular doctor checkups (primary care)
* Care during pregnancy
* Children’s healthcare

Mental health or substance use treatment

But for other services, if individuals don’t pay the fee, the doctor or clinic might be allowed to say no to treating them.

This is a big change. Until now, Medicaid usually made sure people could get care even if they couldn’t afford to pay at the time. This new rule means some low-income adults will now have to pay out of pocket, which could make it harder for them to get the care they need.

#### Likely Impact on Disability Community

**Penalizes Low-Income People with Disabilities Not on SSI or SSDI**: Section 44142 applies cost-sharing rules to Medicaid expansion enrollees with incomes between 100% and 138% of the federal poverty level (FPL). While those officially enrolled through disability-based eligibility pathways (such as SSI or SSDI) are excluded, many people with disabilities fall into a coverage gap:

* They have a disabling condition but do not qualify as “disabled” by Social Security standards, which are strict and difficult to meet.

They may be awaiting a disability determination or have never applied due to barriers like complex paperwork, language access, or limited health documentation.

Effect: These individuals—though functionally disabled—would now face up to $35 per service in copays, up to 5% of their annual income, potentially causing them to forgo necessary care.

**Threatens Continuity of Care for Chronic and Complex Conditions**: Many people with disabilities require frequent interactions with the healthcare system, including routine primary care, specialists, diagnostics, durable medical equipment, and therapies such as physical therapy (PT), occupational therapy (OT), or speech therapy.

Section 44142 exempts primary care and behavioral health from copays. However, it does not exempt visits to specialists, imaging (e.g., MRIs), physical therapy, or durable medical equipment—all critical for people managing disabling conditions**.**

**Continuing Expense Could Lead to Further Disparities:** Individuals with disabilities could quickly hit the 5% out-of-pocket cap, leading to delays in care early in the year or accumulating unpayable medical debt if unable to make copays upfront.

**Creates a Barrier for Preventive and Maintenance Services**: Copayments are known to reduce utilization of necessary, routine, or preventive care, especially for those with limited incomes.

Research consistently shows that even modest fees (as low as $3–$5) reduce medical utilization among low-income individuals.[[80]](#footnote-80)

For people with disabilities, interruptions in care can lead to rapid health deterioration, emergency room visits, or even institutionalization.

New cost-sharing could undermine care continuity, functional independence, and result in worsening health outcomes for disabled individuals, especially those who need ongoing outpatient or specialty services.

**Encourages Provider Denial of Services**: Section 44142 permits providers to refuse treatment if a patient is unable to pay the required copayment. While this is common in private insurance, Medicaid historically prohibited the denial of care due to inability to pay for low-income enrollees.

**People with disabilities may face greater barriers to navigating alternative providers** or appealing a denied visit. Those unable to pay upfront could be turned away, causing delayed care or reliance on more costly emergency services.

**Disincentivizes Participation in Medicaid**: If Medicaid becomes less affordable or predictable, people with disabilities who don’t meet SSI/SSDI thresholds may opt out of Medicaid coverage altogether.

The psychological and financial stress of possibly owing copays—even with a cap—can deter enrollment.

This may be especially true for those with nonapparent or episodic disabilities, who might already face stigma or skepticism when seeking care. Increased cost-sharing could lead to reduced enrollment or coverage churn among disabled individuals, worsening disparities in access and outcomes.

**Pushes People Toward Disability Determination Systems**: To avoid cost-sharing, some people may attempt to qualify for disability-based Medicaid, where cost-sharing is minimal or nonexistent. This places more pressure on an already backlogged SSI/SSDI determination system.

It may also lead to delays in accessing services while individuals wait for determination and cause frustration for those who are ultimately denied. Section 44142 could inadvertently shift people into a more burdensome and complex bureaucratic system, rather than supporting health through timely access.

**Increases Health Disparities for Multiply Marginalized Disabled People**:

People with disabilities who are also

* People of Color;
* Immigrants;
* LGBTQIA+; or

Unhoused or unstably housed

are more likely to face unequal access to care**already**. Adding copays worsens financial and systemic barriers. Section 44142 could increase disparities by introducing new, unnecessary cost barriers to care for underserved disabled communities.

#### Gaps or Concerns

**Continuing Barriers To Healthcare**

People with disabilities who also encounter economic and linguistic barriers will face significant and complex challenges in obtaining essential healthcare and health coverage.

#### Recommendations

* **Exempt Individuals with Functional Disabilities from Cost-Sharing**: Amend or administratively interpret Section 44142 to exempt low-income individuals with functional disabilities, even if they are not formally designated as “disabled” by the Social Security Administration (SSA). Many individuals with significant limitations do not meet SSA’s strict disability criteria. They should not face cost-sharing that could jeopardize their health and independence.
* **Expand the List of Copay-Exempt Services**: Include services essential to people with disabilities in the exemption list, such as:
	+ Specialist visits related to chronic or disabling conditions
	+ Durable medical equipment (DME)
	+ Outpatient rehabilitation (e.g., physical, occupational, or speech therapy)
	+ Home and Community-Based Services (HCBS)
* **Prohibit Denial of Care for Inability to Pay**: Reinstate the Medicaid policy that prohibits providers from denying care to individuals with income below 138% of the federal poverty level due to inability to pay a copayment.
* **Require States to Implement a “Disability Screening and Flag” System**: Require states to screen for functional limitations at enrollment and flag expansion enrollees with disabilities to ensure they are routed to appropriate protections and care pathways.
* **Create a Waiver or “Good Cause” Exception Process**: Allow Medicaid enrollees to request a hardship waiver or exemption from cost-sharing based on disability status, serious health needs, or financial hardship.
* **Strengthen Data Collection and Oversight**: Require states to report on the impact of cost-sharing on disabled populations, including:
	+ Care delays or reductions
	+ Increases in emergency department use
	+ Changes in health outcomes
	+ Disenrollment or coverage disruptions
	+ Data will help ensure accountability and allow for course correction if negative outcomes are observed.
* **Support Outreach and Education for Affected Populations**: Fund community-based organizations to provide outreach, education, and navigation support for Medicaid enrollees with disabilities, particularly those in the expansion population.

**Encourage Transition to Disability-Based Eligibility When Appropriate**: Provide funding and technical assistance for states to help eligible individuals transition to traditional Medicaid through disability-based categories when appropriate.

### Section 44201

#### Summary

**Section 44201: Addressing waste, fraud, and abuse in the ACA Exchanges.**

This section announces the end of the year-round enrollment option—known as the Special Enrollment Period (SEP) for individuals with incomes at or below 150% of the federal poverty level. Moving forward, these individuals can only enroll during the regular open enrollment period or if they experience a qualifying life event. Additionally, before enrolling, individuals must have their income and eligibility verified to ensure they meet the requirements for coverage.

#### Explainer

This provision takes away a special rule that currently allows people with low incomes to sign up for health insurance through the Affordable Care Act (ACA) Marketplace at any time during the year.

The ACA Marketplace provides financial assistance to people with low incomes to help them obtain health insurance.

Right now, if a person’s income is at or below 150% of the federal poverty level (about $27,387.50 a year for a single person in 2025), they qualify for what’s called a Special Enrollment Period (or SEP).[[81]](#footnote-81) This Special Enrollment Period lets people with low incomes enroll in a health plan year-round, without having to wait for the regular Open Enrollment window in the fall.

People’s income and eligibility will have to be assessed before they can sign up for some types of coverage. This means they won’t be able to enroll first and have their eligibility assessed later.

#### Likely Impact on Disability Community

**Widening the Income Gap:** People with disabilities who earn less than 138% of the federal poverty level (about $21,597 in 2025)[[82]](#footnote-82) are at risk of losing Medicaid coverage under the work requirement policy in Section 44101 of the bill.

If that should occur, they will not be able to enroll in health coverage through the Affordable Care Act (ACA) Marketplace **until the next open enrollment period**. This means people with disabilities who have very low incomes, and often need regular medical care, could go without access to any healthcare coverage for up to a year.

The requirement to have an individual’s income and eligibility assessed and **verified before they can sign up for coverage** will likely further delay access to healthcare for persons with disabilities. People with disabilities often rely on Medicaid not just for doctor visits, but for things like personal care aids, mental health support, and medications. Losing coverage—even for a short time—can seriously harm their health and independence.

#### Gaps or Concerns

**Creating Coverage Gaps**

If disenrolled in Medicaid due to work requirements, people with disabilities would not be eligible to sign up for ACA Marketplace coverage until the next annual open enrollment period. This creates a coverage gap that could last for several months, during which individuals may be unable to afford or access the care they need to manage chronic conditions, prevent hospitalizations, or maintain stability in daily life.

These disruptions pose a serious risk to health outcomes and disproportionately affect individuals already facing systemic barriers to employment and healthcare access.

#### Recommendations

* **Remove Section 44101 in its entirety:** This provision imposes harmful work requirements on Medicaid expansion enrollees, disproportionately affecting individuals with disabilities and other vulnerable populations. It risks significant coverage losses and undermines the core purpose of Medicaid as a safety net program.
* **Preserve the Special Enrollment Period (SEP) for low-income individuals:** Eliminating year-round enrollment for those earning up to 150% of the federal poverty level would create unnecessary barriers to coverage, particularly for individuals with unstable incomes or complex health needs.

**Uphold key protections under the Affordable Care Act:** Maintain the ACA’s foundational principles of accessibility, affordability, and equity in healthcare coverage. This includes ensuring timely access to coverage and minimizing administrative burdens that delay or deny care.

### Section 44302

#### Summary

**Section 44302: Streamlined enrollment process for eligible out-of-state providers under Medicaid and CHIP.**

This section intends to make out-of-state providers eligible for Medicaid and CHIP services.

#### Explainer

This provision makes it easier and faster for doctors and other health care providers to enroll in another state’s Medicaid or Children’s Health Insurance Program (CHIP) when treating a child across state lines.

Right now, if a child on Medicaid or CHIP needs care from a specialist or hospital in another state, the provider must go through a long and complicated enrollment process with the child’s home state before getting paid. This can cause delays in care or discourage providers from treating children from other states at all.

This provision fixes that problem by creating a simplified, streamlined enrollment process that:

* Allows out-of-state providers to enroll using basic information (such as their name and national ID number)
* Allows states to skip duplicating background checks and paperwork if the provider is already screened by Medicare or their home state’s Medicaid program
* Keeps the provider enrolled for five years, unless they’re removed for misconduct

Applies to children under age 21 in both Medicaid and CHIP

#### Likely Impact on Disability Community

**Impacts on Children with Complex Health Needs:** Children with complex health needs often have to travel out-of-state for care because the appropriate specialist or children’s hospital isn’t nearby.

Under current rules, **this care is frequently delayed**—or even denied—due to burdensome paperwork and state-specific provider enrollment requirements.

This policy change would enable children to access the care they need more quickly, particularly those residing in rural areas, near state borders, or with rare or serious health conditions.

It would also reduce administrative burdens on providers, allowing doctors and hospitals to spend more time caring for patients and less time navigating red tape.

#### Gaps or Concerns

**The Streamlining Process**

* During the streamlining process, the quality of care may be compromised for the sake of expediency. Providers that have less than a satisfactory track-record for standard of care might be approved without a sufficient background check.

#### Recommendations

**Establish implementation guidelines** that explicitly protect and prioritize access to out-of-state specialty care for children with complex disabilities.

This will ensure Section 44302 doesn’t just reduce red tape broadly but specifically helps **children with disabilities access the full range of out-of-state specialty care** they need—more efficiently, equitably, and without administrative delays that could compromise their health outcomes.

### Section 44134

#### Summary

**Section 44134. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.**

This section changes the rules around how states can use taxes on healthcare providers (like hospitals or nursing homes) to help pay for their share of Medicaid spending.

#### Explainer

States are allowed to **tax healthcare providers** (like hospitals, nursing homes, and clinics) and then use that money as part of their **state share** to draw **federal Medicaid matching funds (FMAP)**.

However, there are rules in place to ensure fairness; one key rule is that these taxes must be **uniform**. That means the tax must apply uniformly to all providers in a specific category (e.g., all hospitals or all nursing homes).

Sometimes, however, states ask the federal government for a **waiver** from this “uniform tax” rule, saying: “We want to tax some providers differently than others.” **Section 44134 outlines the requirements for granting these waivers.**

Under current law, States are permitted to finance the non-federal share of Medicaid spending through multiple sources, including state general funds, health care-related taxes (or “provider taxes”), and local government funds.[[83]](#footnote-83) Federal rules specify that provider taxes must be broad-based and uniform (i.e., states can’t limit provider taxes to only Medicaid providers) and may not hold providers “harmless” (i.e., guarantee providers receive their money back).[[84]](#footnote-84)

The hold harmless requirement does not apply when tax revenues comprise 6% or less of providers’ net patient revenues from treating patients (referred to as the “safe harbor” limit).

**Section 44134 outlines the requirements for granting these waivers.**

* Prohibits states from establishing any new provider taxes or from increasing the rates of existing taxes.
* Revises the conditions under which states may receive a waiver of the requirement that taxes be broad-based and uniform, such that some currently permissible taxes, such as those on managed care plans, will not be permissible in future years.
* Provision overlaps with a proposed rule released May 12, 2025.[[85]](#footnote-85) Upon enactment, but states may have at most 3 fiscal years to transition existing arrangements that are no longer permissible.

#### Likely Impact on Disability Community

**Threat to Funding for Critical Disability Services**: States often use targeted provider taxes (e.g., on managed care plans or nursing homes) to generate funding for essential Medicaid services.

By restricting these options, Section 44134 could force states to cut back on **Home and Community-Based Services (HCBS)**, **personal care attendants**, **mental health care**, and **long-term supports**—all vital to people with disabilities.

**Risk of Service Reductions and Longer Waitlists:** Without the ability to increase revenue, states facing budget shortfalls may cut Medicaid eligibility, reduce provider payments, or eliminate optional services.

This could lead to **staff shortages**, **longer waitlists**, and **limited access** to in-home care or transportation services, especially in rural or under-resourced areas.

**No Guarantees to Protect Disability Services During Transition:** Although states are given three years to comply, there are no requirements to **maintain current levels of funding** for disability-related services during the transition.

Without **federal safeguards or oversight**, people with disabilities could experience sudden and destabilizing disruptions in care.

#### Gaps or Concerns

**Limits State Flexibility to Fund Medicaid Services**

* Section 44134 **prohibits new provider taxes** and restricts states from increasing existing tax rates, even if these are necessary to sustain Medicaid programs or fill funding gaps.
* This inflexibility may force states to reduce Medicaid benefits, cut provider payments, or restrict eligibility.

Since people with disabilities disproportionately rely on Medicaid for long-term services, personal care, and mental health, they may face **service reductions, longer waitlists, or provider shortages** because of funding constraints.

**Elimination of Waiver Flexibility Without Protections**

* The section **revises or eliminates the waiver process** that previously allowed states to impose non-uniform provider taxes—such as taxes targeting managed care plans or nursing homes—without violating federal rules.

Removing this flexibility, the provision could **disrupt long-standing financing arrangements** that support services used by disabled populations. For example, some states rely on targeted provider taxes to sustain **Home and Community-Based Services (HCBS).** Losing this flexibility could jeopardize state investments in disability-related services.

**No Safeguards to Protect Disability Services During Transition**

* Although states are given up to 3 fiscal years to transition, **there are no provisions to ensure continuity of care or protect vulnerable populations** during the shift away from now-restricted financing models.
* Without federal guardrails or maintenance-of-effort protections, states may rebalance Medicaid budgets in ways that **cut optional services**, especially those not federally mandated but crucial to people with disabilities (e.g., dental care, transportation, HCBS enhancements).

This creates **unintended service disruptions** and widens access disparities.

#### Recommendations

* **Preserve Waiver Flexibility for States Supporting Disability Services**: Amend Section 44134 to allow states to continue using non-uniform provider taxes—such as targeted taxes on managed care plans or nursing homes—when the revenue supports essential services for people with disabilities, like Home and Community-Based Services (HCBS).
* **Permit Targeted Tax Adjustments Within Safe Harbor Limits**: Allow states to raise provider tax rates or introduce new taxes, as long as they remain within the federal “safe harbor” threshold (6% of net patient revenue) and the revenue supports Medicaid services.
* **Require Safeguards to Protect Disability Services During the Transition Period**: Require states to maintain existing funding for disability-related Medicaid services during the three-year transition period.

**Include maintenance-of-effort requirements and federal monitoring to ensure no service reductions occur as a result of shifting financing models:** Without explicit protections, states may rebalance budgets in ways that reduce access to non-mandated but critical services such as dental care, transportation, or in-home supports.

### Additional Cuts Triggered by House Reconciliation Bill’s Passage

**PAYGO**, short for “Pay-As-You-Go,” is a federal budget rule that says any new law that increases mandatory spending or cuts taxes must be paid for.[[86]](#footnote-86) That means Congress has to either raise other revenues or cut spending elsewhere to make sure the new law doesn’t add to the federal deficit.

Because the House reconciliation bill includes new spending that isn’t fully offset, **PAYGO rules are triggered**. This means automatic cuts—called **sequestration**—could happen in other federal programs to balance the budget. These cuts are across-the-board and can affect a wide range of services, including some that support people with disabilities, older adults, and low-income families.

There are two main forms of PAYGO:

1. **Statutory PAYGO**, established by the **Statutory Pay-As-You-Go Act of 2010**, is a federal law enforced by the **Office of Management and Budget (OMB)**. If Congress passes a law that increases the deficit without offsets, the OMB is required to implement **automatic, across-the-board spending cuts** (known as sequestration) to certain mandatory programs.[[87]](#footnote-87)
2. **Congressional PAYGO** is a procedural rule used in the House and Senate. While similar in intent, it is **not legally binding** and can be waived by a majority vote in either chamber.

**Key Risks of PAYGO-Triggered Medicare Cuts**

* **Potential for Mandatory Medicare Cuts**: The House-passed reconciliation bill, estimated to increase the federal deficit by at least $2.3 trillion over 10 years, could trigger mandatory across-the-board cuts to Medicare spending due to the Statutory Pay-As-You-Go Act of 2010 (PAYGO).[[88]](#footnote-88)
* **Magnitude of Cuts**: The CBO projects these cuts could total approximately $500 billion between 2026 and 2034, including a 4% reduction in payments to hospitals and other providers.[[89]](#footnote-89)
* **Impact on Medicare Spending**: The mandatory 4% reduction would apply to most Medicare spending, including payments to hospitals, physicians, health care providers, Medicare Advantage plans, and standalone prescription drug plans.[[90]](#footnote-90)
* **Preventing the Cuts**: Preventing the PAYGO cuts from taking effect would likely require Congress to either include a provision exempting the bill from the PAYGO scorecard within the bill itself or enact separate legislation to prevent or delay the effects.

**Potential Consequences of the Cuts**: If the cuts are not averted, they could significantly impact Medicare beneficiaries, potentially leading to lower reimbursement rates for providers, reduced access to care, and higher out-of-pocket costs.

## Conclusion

### Cross-Cutting Themes

**Administrative Burdens Could Become Barriers to Access**: Provisions related to work requirements, benefit eligibility, and program compliance introduce new administrative hurdles. Without built-in supports or streamlined processes, these requirements risk creating barriers for people with disabilities—particularly those who struggle with documentation, transportation, or access to legal/medical verification.

**Disability Protections Are Inconsistent or Unclear**: While some sections of the bill include language about exemptions or accommodations, the details are vague or absent. This inconsistency makes it difficult to assess how people with disabilities will be protected or supported and may lead to uneven implementation across states.

**Potential Rollbacks to Critical Programs**: Proposed changes to SNAP and Medicaid could reduce access or create harmful gaps in services, especially for individuals with non-apparent disabilities, those with undiagnosed conditions, or those living in poverty who rely on these supports to live independently.

**Lack of Disability-Focused Data or Oversight Mechanisms**: The bill does not appear to include strong measures for collecting or analyzing disaggregated disability data. Without targeted oversight or enforcement mechanisms, it may be difficult to identify whether reforms are helping or harming disabled people, or to course-correct if unintended consequences arise.

**Disability Documentation Impacts**: Policies relying on medical verification, for example, unfit-for-work certifications under the SNAP food assistance program, fail to recognize systemic barriers to obtaining documentation. Many people with disabilities lack healthcare access, while others have conditions that fluctuate or don’t fit binary disability classifications. The Death Master File checks risk erroneous disenrollments due to database errors. Our recommendations emphasize secondary verification.

These cross-cutting themes underscore the need for a disability equity lens to be applied throughout the legislative process. Strengthening language around exemptions, streamlining administrative processes, and centering lived experience in implementation will be critical to ensuring this bill does not deepen systemic inequities.

### Overall Impact on Disability Community

The bill presents a harmful impact on people with disabilities. Most of the provisions that will affect people with disabilities threaten access to essential services, increase financial instability, and deepen systemic inequities.

Key concerns include:

**1) Loss of Critical Benefits**: Stricter SNAP work requirements, Medicaid eligibility checks, and FMAP cuts will likely lead to wrongful terminations, particularly for disabled individuals who struggle with documentation or fluctuating conditions. Reduced federal support for state programs like Home and Community-Based Services may force rationing of care and increased institutionalization of people with disabilities and older adults.

**2) Increased Financial Hardship**: The combination of pre-existing asset tests imposed on disabled people and the cost-sharing shifts in this bill could force them to impoverish themselves to qualify for care.

**3) Administrative Burdens**: Frequent redeterminations, complex verification rules, and a lack of disability accommodations in administrative processes create insurmountable barriers for many individuals with disabilities.

**4) Discriminatory Design Flaws**: Policies often ignore episodic disabilities, housing instability, and caregiving needs, favoring rigid, one-size-fits-all approaches that disparately impact the disability community.

**5) Erosion of Community Living**: Cuts to SNAP and Medicaid, including its effects on Home and Community-Based Services, undermines the protections in the *Olmstead v. L.C.* Supreme Court decision, risking a return to institutionalization for many individuals with disabilities.

### Additional Recommendations

**1) Protect and Expand Disability-Specific Safeguards**: Exempt disabled people from harmful work requirements and frequent redetermination.

**2) Fix Flawed Verification Systems**: Automate approvals for SSI/SSDI recipients in Medicaid and SNAP. Ban punitive address checks and allow alternative documentation options.

**3) Invest in Community-Based Care**: Reject FMAP cuts and increase HCBS funding to prevent institutional bias. Require states to report on how cuts impact disabled people.

**4) Monitor and Repair Harm**: Mandate disability impact assessments for all future legislation. Fund independent oversight of enrollment/disenrollment trends.

### What’s Next in the Legislative Process

The Budget Reconciliation Bill has been passed in the House (H.R.1) and a separate version of the bill is being considered in the Senate. Here’s what to expect in the coming weeks:

**Senate Floor Debate and Vote**: The bill will soon head to the Senate floor for debate and a vote. Because reconciliation bills require only a simple majority, the process will likely move quickly once it reaches this stage.

**House Consideration**: If the Senate passes the bill, the House will review it. The House may accept the Senate version or propose changes, which could require further reconciliation between the chambers.

**Final Passage and Enactment**: After both chambers pass the same version of the bill, it goes to the President for signature or veto.

This process may evolve rapidly, so staying prepared is essential. Disability Belongs™ will continue to monitor the bill’s progress, engage with key stakeholders, and advocate for changes that uphold the rights and access of people with disabilities.

### About Disability Belongs™

Disability Belongs™ is a diverse, disability-led nonprofit that works to create systemic change in how society views and values people with disabilities, and that advances policies and practices that empower people with disabilities to have a better future. Our mission is to drive cultural and policy change to ensure our full representation and influence, creating a more accessible, equitable, and inclusive society.

## Appendix A: Senate Finance Committee Revisions to the Reconciliation Bill

### Summary of Senate-Specific Revisions (as of June 17, 2025)

The Senate Finance Committee’s draft introduces several changes to the House-passed Budget Reconciliation Bill. These changes affect Medicaid, the Affordable Care Act (ACA), and other federal health care programs. The summary below reflects new or revised provisions in the Senate text, including removed or dropped policies.

### Medicaid-Related Changes

**Provider Tax Threshold Lowered:** Reduces the allowable Medicaid provider tax threshold from 6% to 3.5% (excluding nursing homes and intermediate care facilities), resulting in lower federal matching funds and potentially reduced hospital payments.

**State-Directed Payment Adjustments:** Scales back existing Medicaid payment arrangements by capping rates at 100% of Medicare for expansion states, 110% for non-expansion states, and 150% for rural providers. Requires states to phase down current payments to meet these levels.

**Family Planning Provider Funding Restrictions:** Lowers the federal threshold for excluding certain family planning providers from Medicaid, which could impact access to services such as cancer screenings and reproductive health care.

**Expanded Work Reporting Requirements:** Extends Medicaid work-related requirements to parents of children over age 14 and makes technical implementation changes. These changes could lead to eligible individuals losing coverage.

**Emergency Medicaid Matching Funds Reduced:** Lowers the federal match for life-saving emergency Medicaid for individuals excluded due to immigration status.

**Clarification on Immigration Penalties:** Specifies that the penalties apply only to state-funded coverage for undocumented adults, not to coverage for lawfully present immigrants.

**Retroactive Coverage Limitations Expanded:** Applies limitations on retroactive Medicaid coverage more broadly, affecting older adults and people with disabilities.

### Affordable Care Act (ACA)­–Related Changes

**Verification Requirements Retained:**Keeps House-passed provisions that introduce new eligibility and enrollment verification rules, which may create administrative barriers to ACA Marketplace enrollment and retention.

**State Marketplace Constraints:**Retains restrictions that could limit state autonomy in operating ACA Marketplaces, which may lead to instability or closure in some state-run systems.

**Premium Increases and Reproductive Coverage Restrictions:**The Senate HELP title (combined with Finance) includes provisions that may increase Marketplace premiums and limit access to reproductive health coverage.

**Premium Tax Credits Not Extended:** The bill does not extend enhanced ACA premium tax credits, which may result in coverage loss for Marketplace enrollees who rely on subsidies.

### Policies Removed or Dropped in Senate Version

* Expansion of Health Savings Accounts (HSAs), including 10 policies totaling $41 billion in cost.
* Rare disease (“orphan”) drug exemption from Medicare drug price negotiations.
* Pharmacy Benefit Manager (PBM) reforms to increase transparency and prohibit price-based compensation in Medicare Part D.
* Increased Medicare payments for physicians (previously created a future payment cliff).
* Medicare funding for contracts with Artificial Intelligence (AI) vendors.
* Delay in Medicaid Disproportionate Share Hospital (DSH) payment reductions.
* Medicaid/CHIP out-of-state care access for children.
* Codification of CHOICE Arrangements and changes to Individual Coverage Health Reimbursement Arrangements (ICHRAs).

Expansion of rural hospital conversions to Rural Emergency Hospitals (REHs).

## Appendix B: Senate Committee on Agriculture, Nutrition, and Forestry Revisions to the Reconciliation Bill

The Senate version of the bill differs from the House-passed H.R.1 in relation to the Supplemental Nutrition Assistance Program (SNAP) in a few key areas:

* **Administrative Costs:** Both versions would reduce the federal government’s share of administrative costs from 50% to 25%. This means states and counties would have to cover 75% of those costs. However, the Senate bill would delay this change until fiscal year 2027, while the House version would begin in fiscal year 2026.
* **State Share of Benefit Costs Based on Error Rates:**The House bill would require states to pay between 5% and 25% of benefit costs depending on their payment error rates. In contrast, the Senate bill would exempt states with error rates below 6% and set a lower maximum cost share of up to 15% for states with higher error rates.
* **Error Rate Tolerance Threshold:**The House bill would eliminate the current threshold for allowable payment errors by lowering it from $57 to $0. The Senate bill would leave the existing $57 threshold in place.

**Work Requirements for Certain Adults:**Both bills would expand work requirements for adults without dependents by increasing the eligible age range from 18-54 to 18-64. The Senate bill would also apply these requirements to adults with children over age 9, while the House version applies them to those with children over age 6.

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