Budget Reconciliation Act Implementation Dates, Funding, and Authorities for Medicaid & Select Health Provisions

by Geraldine Doetzer

Notes:

- These charts provide information about the implementation of **select** health provisions of enrolled version of the budget reconciliation bill that was signed into law on July 4, 2025.
- Provisions are ordered according to the section number of the bill. A single provision may have more than one implementation date to reflect multi-stage implementation.
- The charts identify relevant implementation dates, funding, and new CMS/HHS authorities for key Medicaid (Table 1), Medicare (Table 2), Marketplace (Table 3), and Rural Health Transformation Fund (Table 4) provisions.
- State requirements apply to the 50 States and the District of Columbia, unless otherwise specified.

Table 1. Medicaid Provisions

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
71101	Moratorium on Implementation of the Rule Relating to Eligibility and Enrollment in Medicare Savings Programs	**Date of enactment through 9/30/34**	**Secretary of Health and Human Services (Secretary)**[2] shall not **implement, administer, or enforce** the amendments made by the provisions of the final rule published by the CMS on September 21, 2023 (88 Fed. Reg. 65230) to the regs specified in statute.	Combined $1 mil for FY2026 for 71101 and 71102 to **Administrator of CMS**	N/A

[1] All funding "to remain available until expended" unless otherwise specified

[2] "Secretary" refers to the Secretary of Health and Human Services (HHS) unless otherwise specified.

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
71102	Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and BHP	**Date of enactment through 9/30/34**	**Secretary** shall not **implement, administer, or enforce** the amendments made by the provisions of the final rule published by the CMS on April 2, 2024 (89 Fed. Reg. 22780) to the regs specified in statute.	Combined $1 mil. for FY2026 for 71101 and 71102 to **Administrator of CMS**	N/A
71103	Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs	**1/1/27:** State plan must provide for a process to obtain specified enrollee information **1/1/27**: Each MCO/PIHP contract must provide that the entity shall transmit address info to the State **10/1/29**: **Secretary** shall establish system to prevent simultaneous enrollment, including providing for receipt of info	- Not later than 1/1/27, state plan must provide for a process to "regularly" obtain address information. - Not later than 10/1/29 state plan must provide for process to submit to the system established by the **Secretary** not less than one a month and during eligibility/redetermination the **SSN** and "such other information with respect to such individual **as determined necessary by the Secretary** for purposes of preventing individuals from simultaneously being enrolled under State plans (or waivers…) of multiple States." Plan must provide for the use of such system and provide for "the taking of appropriate action **as determined by the Secretary**" to disenroll individuals that do not reside in the state, unless the individual meets an exception **specified by the Secretary**. - Not later than 10/1/29 **Secretary** shall establish a system to be used by Secretary	To the **Administrator of CMS:** FY26: $10 mil. To establish systems and standards FY29: $20 mil. To maintain such system	Secretary must develop standards for information and systems.

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
		from States and transmission to States duplicate enrollment info not less than monthly **10/1/29**: State plan must provide for process to submit data to plan est. by **Secretary** **10/1/29**: **Secretary** may determine that a state is exempt	and States to prevent simultaneous enrollment. - **Secretary** shall establish "such standards as determined necessary by the Secretary to limit and protect" submitted info and ensure privacy.		
71104	Ensuring deceased Individuals Do Not Remain Enrolled	**1/1/27**	States must conduct quarterly screenings against Death Master File to verify enrollee status, disenroll individuals identified in DMF as deceased, and reinstate coverage in the event of error.	N/A	N/A
71105	Ensuring Deceased Providers Do Not Remain Enrolled	**1/1/28**	States must conduct verification against the Death Master File as part of enrollment or reenrollment of a provider or supplier in Medicaid and not less than quarterly during period of enrollment to determine whether provider/supplier is deceased.	N/A	N/A

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
71106	Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid	**10/1/29** **(FY 2030)**	**Secretary** must reduce federal Medicaid payments for states with erroneous excess Medicaid payments over the allowable error rate of 3% by the amount that exceeds the threshold for audits conducted by **Secretary** or state (at **Secretary's** option); expands definition of improper payments to include payments where insufficient information is available to confirm eligibility.	N/A	Requires **Secretary** to reduce Medicaid payments but retains discretion to waive in specified circumstance if state fails to meet target despite "good faith effort".
71107	Eligibility Redeterminations	**1/1/27** **Guidance no later than (NLT) 180 days after enactment**	With respect to determinations for Medicaid expansion enrollees scheduled on or after 1/1/27, state must provide for redeterminations every 6 months.	$75 mil. to **CMS Administrator** for FY26	NLT than **180 days after enactment, CMS Administrator** must issue "guidance"
71108	Revising Home Equity Limit for Determining Eligibility for LTC Services Under the Medicaid Program	**1/1/28**	Eliminates inflation indexing and caps home equity limits at $1 mil. regardless of inflation, with an exemption for certain agricultural lots. Prohibits states from excluding certain income or assets when determining the eligibility of an individual for nursing facility or LTC services.	N/A	N/A

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
71109	[Immigrant] Medicaid Eligibility	**10/1/26**	Restricts eligibility to residents of the 50 States, D.C., or territories who are citizens or nationals of the United States, lawful permanent residents (green card holders), Cuban/Haitian entrants & COFA migrants. Rescinds eligibility for Medicaid from all other lawfully present immigrants, including asylees, refugees, people granted withholding of removal, trafficking survivors, survivors of domestic violence, and persons granted humanitarian parole for a period of at least 1 year.	$15 mil to **CMS Administrator** for FY26	N/A
71110	Expansion FMAP for Emergency Medicaid	**10/1/26**	Reimbursement for emergency-only Medicaid based on state's baseline FMAP, not 90% match for individuals who would have been eligible through Medicaid expansion.	$1 mil. to **CMS Administrator** for FY26	N/A
71111	Moratorium on Implementation of Rule Relating to Staffing Standards for LTC Facilities	**Date of enactment through 9/30/34**	The **Secretary** shall not, during the period beginning on the date of the enactment of this section and ending September 30, 2034, **implement, administer, or enforce** the amendments made by the provisions of the final rule published by the CMS on May 10, 2024 (89 Fed. Reg. 40876) to regs specified in statute.	N/A, unlike the E&E or MSP moratoria	N/A
71112	Reducing State Medicaid Costs	**1/1/27** (Applications made on or after this date)	Limiting retroactive Medicaid to 1 month prior to application for expansion population and 2 months prior to application for non-expansion and CHIP.	$10 mil. to **CMS Administrator** for FY26	NA

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
71113	Federal Payments to Prohibited Entities	**Date of enactment (one year sunset)**	Defunding Planned Parenthood (and other "prohibited entities") for one-year period beginning upon date of enactment.[3]	$1 mil. to **CMS Administrator** for FY26	N/A
71114	Sunsetting Increased FMAP Incentive	**1/1/26**	Eliminates the 5% increase to the FMAP rate for states newly implementing the ACA's Medicaid expansion.	N/A	N/A
71115	Provider Taxes	**Date of enactment:** Prohibition on new provider taxes in all states; changes to uniform tax waiver requirements (subject to a transition period set by the **Secretary**, not to exceed 3 years); freeze on "hold harmless" safe harbor for non-expansion states	• All states: effectively prohibits new provider taxes by eliminating the "hold harmless" safe harbor for any new taxes. • Non-expansion states: freezes provider taxes at current rates. • Expansion states: beginning 10/1/27 (FY 20208), current 6% "hold harmless" safe harbor maximum must be reduced by 0.5% until reaching 3.5% on 10/1/31 (FY 2032), except with respect to provider taxes in effect on 5/1/25 that apply to nursing facilities or intermediate care facilities.	$20 mil. to **CMS Administrator** for FY26	N/A

[3] Enforcement or application of this provision is currently enjoined subject to a temporary restraining order issued by the U.S. District Court for the District of Massachusetts. *Planned Parenthood Federation of America, Inc. v. Kennedy*, 1:25-cv-11913, (D. Mass. Jul 07, 2025).

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
		10/1/27-9/30/32: Expansion state provider tax reductions: FY28: 5.5% FY29: 5.0% FY30: 4.5% FY31: 4.0% FY32+: 3.5%			
71116	State Directed Payments	**Date of enactment:** New SDPs subject to 100% (expansion) and 110% (non-expansion) Medicare rate cap **1/1/28** Grandfathered payments are subject to reductions (to 100% Medicare in expansion states, 110% in non-expansion)	Limits payment rates under new State Directed Payments (SDPs) to 100% Medicare (expansion state) or 110% Medicare (non-expansion state). Grandfathering clause: if prior approval provided by **Secretary** before 5/1/25 (or in the case of an SDP for a rural hospital, by date of enactment), total amount of payment must be reduced by 10% per year until 100% of Medicare payment rate is reached (or 110% in non-expansion state). State plan rate applies if no published Medicare payment rate (*e.g.,* adult dental).	For each FY 2026-2033, $7 mil. "for purposes of carrying out this section" ($56 mil total) Recipient not specified, but likely **CMS**	**Secretary** shall revise 42 C.F.R. § 438.6(c)(2)(iii). Presumably will be delegated to CMS.

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
71117	Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax	Upon date of enactment, but **Secretary** may provide a transition period of up to 3 years **(July 2028)**	Narrows definition of "generally redistributive" and thereby limits circumstances in which **Secretary** can waive uniform tax requirement which requires the same tax for all providers within a specified class. Provider taxes would not be considered generally redistributive if: ● tax rate is lower for providers with a lower volume or percentage of Medicaid taxable units; or ● the tax rate on Medicaid taxable units is higher than the tax rate imposed on non-Medicaid taxable units.	N/A	Subject to a transition period established by **Secretary** not to exceed 3 fiscal years from date of enactment.
71118	Requiring Budget Neutrality for Medicaid Demos under Sec. 1115 (of the Social Security Act)	**1/1/27**	Beginning 1/1/27, **Secretary** may not approve a Sec. 1115 application, renewal, or amendment unless Chief Actuary of CMS certifies the project (or duration of preceding waiver, if renewal) is not expected to increase Federal expenditures.	$5 mil per year for each of FY 2026 and 2027 to **Administrator of CMS**	If **CMS Actuary** determines there were savings, **Secretary** shall specify the methodology to be used for purposes of taking the difference between such expenditures into account for subsequent approvals.

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
71119	Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individual	**6/1/26**: **Secretary** issues Interim Final Rule (IFR) **1/1/27**: Deadline to implement, although states may implement earlier under approved Sec. 1115 waiver **+3 months after implementation and "periodically" thereafter**: States must notify applicable individuals **1/1/29:** Last possible implementation date under one-time good faith extension at discretion of **Secretary**	For Medicaid expansion applicants/enrollees: Establishes work/community engagement requirements, provides limited mandatory exceptions, and optional exceptions for a short-term hardship event; work requirement must be met prior to enrollment; verification frequency no less than at each required eligibility redetermination; requires state to establish processes for ex parte verifications; notice requirements; outreach beginning NLT 12/31/26.	**Secretary** shall issue Development of Government Efficiency Grants to States: FY26: $100 mil (allocated based on Medicaid pop levels) FY27: $100 mil (evenly distributed across states and D.C.) Separately, $200 mil in FY26 to **Administrator of CMS** for implementation	**Secretary** shall promulgate interim final rulemaking no later than 6/1/26. **Any action taken to implement the provisions of the section are not subject to 5 USC 553 (APA rulemaking)**. Standards for optional short-term hardship event exception, frequency of verification, ex parte verifications, notice, and outreach are all subject to standards specified by the **Secretary**.

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
					Under a special exemption rule, the **Secretary** may exempt a state from compliance, in response to state request made in form and manner established by **Secretary**, if **Secretary** determines state is demonstrating a "good faith effort to comply". Exemption time limited and subject to progress reporting.
71120	Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid	**10/1/28**	Prohibits imposition of premiums or similar fees; requires States to impose "deductions, cost-sharing, or such similar charge" determined appropriate by the state in an amount greater than $0 and not to exceed $35 per service on Medicaid expansion population (exceptions for services for individuals under 18 (or at state	$15 mil to **Administrator of CMS** for implementation	N/A

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
	Program		option, under 19, 20, or 21 or another reasonable category over 18), services furnished to an institutionalized person required to spend all but minimal personal needs allowance on medical care, primary, prenatal, pediatric, mental health/substance use disorder services, emergency room services except for non-emergency services in ER; services provided by a Federally qualified health center, certified community behavioral health clinic, or rural health clinic. Limits aggregate cost sharing for all individuals in a family to no more than 5% of family income (quarterly or monthly, as specified by State). Permits providers to condition provision of care on payment and to reduce or waive cost sharing.		
71121	Making Certain Adjustments to Coverage of HCBS Under Medicaid	**7/1/28**	Authorizes **Secretary** to approve waiver for payment of HCBS services to individuals that do not need an institutional level of care. Approvals apply for an initial 3-year term extended at state request for additional 5-year periods unless **Secretary** determines requirements are not met. Among other requirements, a state must attest that average per capita expenditure under the waiver would not exceed average per capita expenditure for individuals receiving institutional	Implementation funding to **Administrator of CMS**: FY2026: $50 mil. to carry out this section FY2027: $100 mil. to make	Approval of waiver, determination of when certain standards are inapplicable, form and manner of reporting and documents, and definition of "cost" are to be

Section	Title	Implementation Date	Summary/Relevant Language	Implementation Funding[1]	New HHS/CMS Authority
			care.	payments to States to support state systems to deliver HCBS under Secs. 1915(c), 1396n(c), or 1115, based on proportion of state population receiving HCBS.	specified by the **Secretary**.

Table 2—Medicare

Section	Title	Applicability Date	Summary/Relevant Language	Implementation Funding	New HHS/CMS Authority
71201	Limiting Medicare Coverage of Certain Individuals	**Eff. date:** For newly eligible beneficiaries **NLT 1 year after enactment**: Commissioner of Social Security shall complete a review of individuals entitled to or enrolled for Medicare benefits for purposes of	Restricts Medicare eligibility to citizens or nationals of the United States, lawful permanent residents (green card holders), Cuban/Haitian entrants & COFA migrants. Rescinds eligibility for Medicare from all other lawfully present immigrants, including asylees, refugees, people granted withholding of removal, trafficking survivors, survivors of domestic violence, and persons granted humanitarian parole for a period of at least 1 year.	N/A	

		identifying individuals who do not meet newly restrictive criteria and notify each individual that their benefits will be terminated. Notification should be “as soon as practicable after such identification” **18 months after enactment:** Current beneficiaries that do not meet new criteria are terminated			

Table 3—Marketplace

Section	Title	Applicability Date	Summary/Relevant Language	Implementation Funding	New HHS/CMS Authority
71301	Permitting Premium Tax Credit Only for Certain Individuals	**1/1/27**	Limits non-citizen eligibility for PTCs to lawful permanent residents (green card holders), Cuban/Haitian entrants & COFA migrants.	N/A	N/A

			Rescinds eligibility for PTCs from all other lawfully present immigrants, including asylees, refugees, people granted withholding of removal, trafficking survivors, survivors of domestic violence, and persons granted humanitarian parole for a period of at least 1 year. Separately a recent Marketplace final rule excludes DACA recipients from definition of "lawfully present," effective **8/25/25**.		
71302	Disallowing Premium Tax Credits During Periods of Medicaid Ineligibility Due to [Immigrant] Status	**1/1/26**	Prohibits lawfully present non-citizens with incomes under 100% FPL who are not eligible for Medicaid from qualifying for PTC.	N/A	N/A
71303	Requiring Verification of Eligibility for Premium Tax Credit	**1/1/28** (however, Marketplace must provide a process for pre-verification no later than **8/1/27**)	Requires that Marketplace conduct pre-enrollment verification of household income, immigration status, health coverage/eligibility status, place of residence, family size, or other info determined by the Secretary of the Treasury in consultation with **Secretary**. Marketplaces must provide process to pre-verify no later than August 1 prior to the relevant tax year. **Secretary** may waive verification for change in family size SEP enrollment.	N/A	**Secretary** has consultative role with regards to additional required data elements.

			Marketplaces may use third-party data sources. Separately, a recent Marketplace final rule implements a number of enrollment and verification changes with various start and end dates: **8/25/25 (permanent):** New coverage can be conditioned on payment of past-due premiums; end of 60-day automatic extension to resolve income inconsistency. **8/25/25 (12/31/26 sunset)**: Pause on 150% FPL SEP; income verification when tax data unavailable or sources indicate income >100% FPL. **PY 2026 only (12/31/26 sunset):** $5 penalty for auto-enrollment if $0 premium (FFM only); reinstates 1-year failure to file-and-reconcile policy that renders a tax filer ineligible for APTC if they did not file federal taxes and reconcile APTC in a prior year; eligibility verifications for SEPs (FFM only). **PY 2026 (permanent)**: Ends automatic re-enrollment hierarchy; limits Annual Open Enrollment Period		

71304	Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During Special Enrollment Period	**1/1/26**	Prohibits individuals who enroll under an income-based SEP from qualifying for PTCs.	N/A	N/A
71305	Eliminating Limitation on Recapture of APTCs	**1/1/26**	Requires repayment of full amount of APTCs (rescinding caps for people with incomes under 400% FPL). Note: "safe harbor" for people with actual income <100% FPL remains in place at 26 C.F.R. § 1.36B-2(b)(6)(i).	N/A	N/A
71308	Treatment of Direct Primary Care (DPC) Service Arrangements	**1/1/26**	DPC arrangements will not be considered health plans, allowing individuals to be eligible for tax-preferred HSA if: • DPC fees do not exceed $150/$300 monthly (individual/more than one person); • DPC offers "primary care services" (defined to specifically exclude services that require general anesthesia, Rx (except vaccines), lab services not administered in ambulatory primary setting).	N/A	Secretary of the Treasury must issue regs or guidance in consultation with **Secretary** regarding list of excluded services.

Table 4. Protecting Rural Hospitals and Providers

Section	Title	Applicability Date	Summary/Relevant Language	Implementation Funding	New HHS/CMS Authority
71401	Rural Health Transformation Program	**Ending NLT 12/31/25**: Application submission period. **Administrator of CMS** specifies start date **NLT 12/31/25**: **Administrator of CMS** shall approve or deny applications for funding **Annually FY26-FY2030:** Funding allotted to states by **Administrator of CMS**	Establishes $50 billion fund allotted by **Administrator of CMS** to States for purposes of carrying out specified health-related activities, including: • promoting evidence-based interventions to improve prevention and chronic disease management, • providing payments to health care providers for the provision of health care items or services as specified by the **Administrator of CMS**, • promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases, • providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals; • recruiting and retaining rural health workforce that commit to at least 5 years of service;	Implementation funding to **Administrator of CMS:** - $200 mil. For FY25 Funding to be distributed to States by **Administrator of CMS** : - $10 bil. for each of FY 2026-2030 ($50 bil. total)	In addition to the significant discretion with respect to the application for and distribution of funding described in the funding column, the **Administrator of CMS** shall implement the fund by program instruction or other forms of program guidance.

			• TA, software, and hardware for significant IT advances designed to improve efficiency, enhance cybersecurity, and improve patient health outcomes; • assisting rural communities to right-size their health care delivery systems; • supporting access to MH/SUD treatment, • developing innovative models of care that include value-based purchasing and alternative payment models; and • additional uses designed to promote sustainably access to high quality rural health care services as determined by the **Administrator of CMS.**		