

Medicaid Access Under H.R. 1: Critical Changes

National Alliance to End Homelessness Webinar Series

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Why Medicaid Matters for People Experiencing Homelessness?

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- Medicaid is the most important source of **health coverage** available to people experiencing homelessness, especially after ACA:
 - Pre-ACA, only people experiencing homelessness who were in mandatory eligibility groups could qualify for Medicaid. Therefore, obtaining SSI/SSDI was the primary way to enroll in Medicaid.
 - After ACA, nearly all people experiencing homelessness are eligible for Medicaid in the 41 states plus DC that expanded their Medicaid programs, due to their extremely low incomes or disability status.
- Medicaid covers **medical and behavioral health care**, including street medicine and clinic services. Health Care for the Homeless Programs rely on Medicaid for nearly 40% of their revenues. Several states are covering **medical respite and recuperative care** programs.
- Many states have begun covering **housing-related services** that help beneficiaries find housing, transition into housing, and remain stably housed.

Health Policy Provisions of H.R. 1

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On July 4, the president signed the budget reconciliation legislation, H.R.1. The Congressional Budget Office estimates the law would reduce federal Medicaid spending by over \$1 trillion and cause coverage loss for 10 million people (reflects Medicaid and Marketplace provisions) over 10 years.

Medicaid/CHIP (Today's Focus)

- Imposes new eligibility and access restrictions for the ACA's Medicaid expansion population (e.g., work requirements, copayments, more frequent redeterminations).
- Constrains the ways states can finance their share of Medicaid program costs and influence provider access through payment policy.
- Restricts noncitizen coverage and family planning access in Medicaid.

ACA Marketplace*

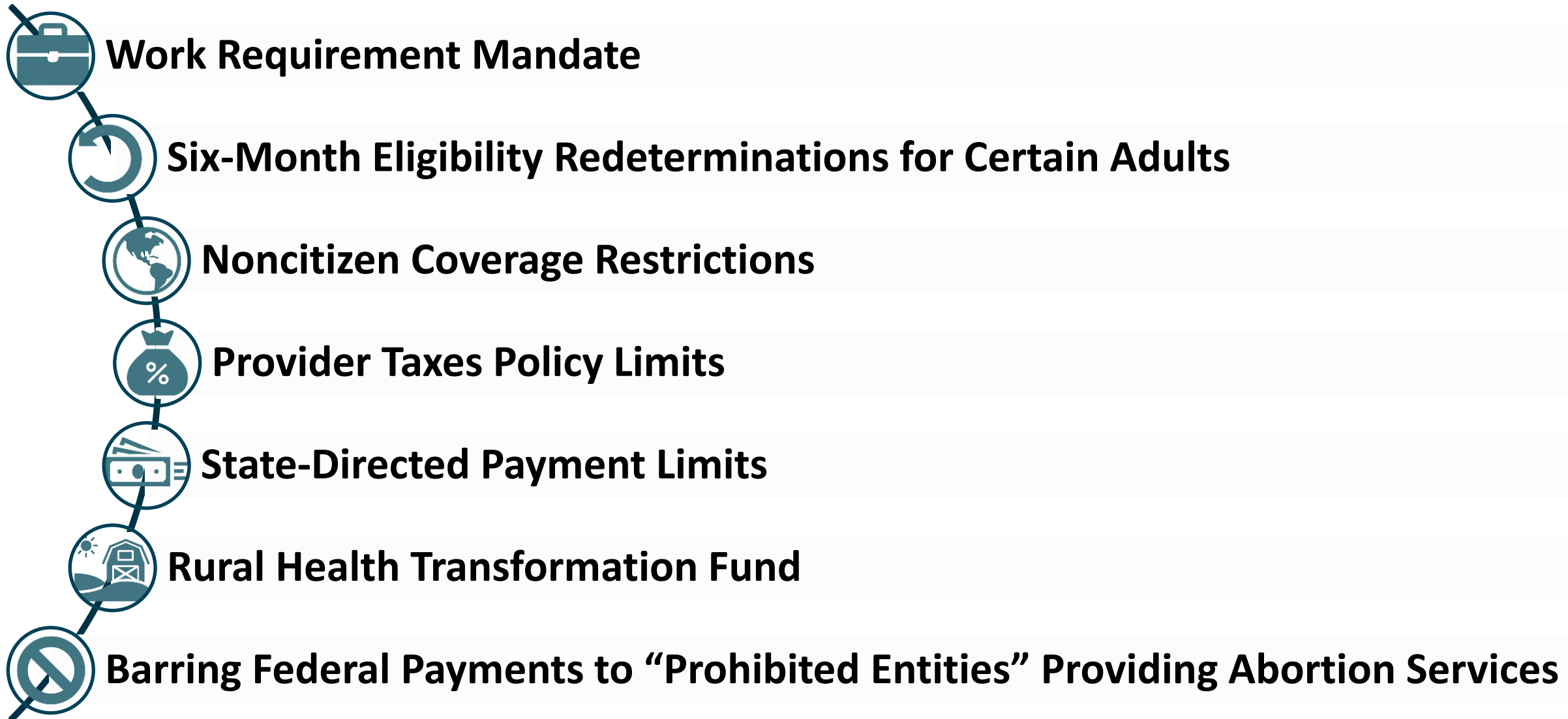
- The law enacts policies that make it harder for individuals to enroll or reenroll in subsidized coverage through Marketplaces, with most provisions effective starting in plan year 2026.

On June 20, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that also restricts eligibility, reduces benefits, and imposes new paperwork burdens for enrollment, with most provisions taking effect in calendar year 2025 or 2026. Further, unless Congress acts, premium tax credits will expire on December 31, 2025.

*The law includes two private market provisions beyond the Marketplace: (1) allows high-deductible health plans to cover telehealth before the deductible; and (2) it makes certain direct primary care arrangements Health Savings Account-eligible.

Overview of Select Medicaid Provisions in H.R. 1

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States must condition Medicaid eligibility on compliance with work requirements for adults covered by Medicaid expansion or expansion-like coverage ages 19 to 64.

- **Implementation Date.** January 1, 2027 – though states can implement earlier via a SPA or section 1115 waiver or delay until December 31, 2028 with Secretary approval.
- **Qualifying Activities.** 80 hours per month of: work, a Supplemental Nutrition Assistance Program (SNAP)-defined work program, community service, part-time education, or a combination of these activities. Alternatively, individuals can qualify by earning at least \$580/month—or averaging that over six months for seasonal workers.
- **Exemptions.** The law outlines mandatory and short-term hardship exemptions (see Appendix). States must use ex parte data “where possible.”
- **Outreach.** States must begin enrollee outreach between June 30, 2026 and August 31, 2026, depending on how many months of compliance they require before application, and continue outreach regularly thereafter.¹
- **Compliance Checks.** States must verify compliance at both application and renewal using ex parte data—meaning individuals need to demonstrate completion of 80 hours of qualifying activities for at least one month prior to application and again once enrolled for at least one month within every six-month period. States may impose more stringent approaches.
- **Terminations.** If a person is denied or disenrolled due to work requirements, they need to file a new application to re-apply (triggering the compliance check for at least the month prior to application).

Medicaid Work Requirement Exemptions

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Required Exemptions. States *must* exempt the following individuals from work requirements for a given month if, at any point during that month, they are:

- Parents/guardians/caretaker relatives, or family caregivers of a dependent child age 13 and under or a disabled individual
- Pregnant or receiving Medicaid postpartum coverage
- Foster youth and former foster youth under the age of 26
- AI/ANs
- Veterans with a disability rated as total
- Incarcerated or recently released from incarceration within the past 90 days
- Entitled to Medicare Part A or enrolled in Medicare Part B
- Meeting Temporary Assistance for Needy Families or SNAP work compliance requirements
- Participating in a drug addiction or alcohol treatment program
- Medically frail:
 - Blind or disabled
 - Have a substance use disorder
 - Have a disabling mental disorder
 - Have a significant physical, intellectual, or developmental disability
 - Have a serious or complex medical condition

Optional Temporary Exemptions. States *may* (under procedures established by the state in accordance with the Secretary’s standards) exempt individuals for a given month if, at any point during that month, they experience a “short-term hardship” exemption, including:

- Receiving inpatient hospital care, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric care, or other services of similar acuity (including related outpatient care) determined by the Secretary*
- Living in a county impacted by a federally declared emergency or disaster
- Living in a county with a high unemployment rate (at or above the lesser of 8% or 150% of the [national unemployment rate](#), which was 4.1% as of June 2025)
- Traveling for an extended period to access medically necessary care for a serious or complex medical condition that is not available in the individual/their dependent(s)’ community*

Six-Month Eligibility Redeterminations for Certain Adults

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States must redetermine eligibility for adults enrolled through Medicaid expansion or an expansion-like section 1115 waiver once every six months.

- **Implementation Date.** December 31, 2026. Unlike work requirements, there is no option to delay. States that obtain approval to delay implementation of work requirements will have misaligned effective dates.
- **Policy Requirements.** Redeterminations for expansion and expansion-like adults must occur twice a year.

This is a major departure from previous Medicaid eligibility rules, whereby states may redetermine eligibility for expansion enrollees no more frequently than annually or unless information received by a state indicates a change in circumstances.

- **Exemptions.** The law exempts American Indian/Alaska Natives (AI/AN) from this provision. Territories are also exempt from six-month redeterminations.
- **Timeline.** CMS must issue guidance by January 5, 2026 (within six months of July 4, 2025).