



National Alliance  
for Care at Home

# Medicaid in The News: Key Issues

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# Agenda

Background on Reconciliation



Discussion of Specific Policies



Fraud Discussions



# Background

On July 4<sup>th</sup>, President Trump signed a “reconciliation” bill into law that made significant changes to Federal spending policy

- Reconciliation is necessary to pass legislation without any Democrat votes
- Comes with significant process and content restrictions

The core of the bill is an extension and expansion of lower taxes coupled with spending reductions to offset the budgetary impacts

Medicaid reductions represent a significant portion of the legislation

- Estimated at \$990 billion over ten years
- HFS estimates the Illinois share of the cuts will be \$26 billion, but potentially as high as \$51 billion.

<https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/>

# Key Bill Provisions

Sec. 71107. Increasing frequency of eligibility redeterminations for certain individuals.

- Changes expansion redeterminations from 12 to 6 months (Native Americans/American Indians are exempt)

Sec. 71108. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.

- Would drop the limit from 1.07million (indexed to inflation) to \$1 million flat

Sec. 71111. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.

- Rule was intended to address nursing home/LTC quality; raised concerns about cost, ability to recruit workforce

Sec. 71112. Reducing State Medicaid Costs (aka Modifying retroactive coverage under the Medicaid and CHIP)

- Limit coverage from current 3-months to 1-month prior to application for ACA expansion enrollees; 2-months for everyone else

# Sec. 7115 Provider Taxes

## Nonexpansion states:

- Provider tax threshold is frozen at whatever was in place on the date of enactment of the legislation
- States would not be permitted to expand taxes to new types of providers or services, nor would they be allowed to increase any existing tax rates

## Expansion states:

- provider tax threshold is frozen
- the maximum allowable provider tax rate slowly decreases on the following schedule:
  - 5.5% for Federal fiscal year (FFY) 2028
  - 5% for FFY 2029,
  - 4.5% for FFY 2030
  - 4% for FFY 2031
  - 3.5% for FFY 2032 and beyond.
- Nursing facilities and intermediate care facilities for individuals with intellectual disabilities will not be subject to the lower threshold; taxes are frozen
- IL expects the provision to result in \$5 billion fewer federal funds over the first 5 years (ie: until 2030), growing to \$3.8B annually in 2033.

# Sec. 71116. State Directed Payments

## Nonexpansion states:

- Limited to 110 percent of the Medicare rate
- If there is no Medicare rate, then 110% of the Medicaid State plan rate

## Expansion states:

- Limited to 100 percent of the Medicare rate
- If there is no Medicare rate, the Medicaid State plan rate
- January 1, 2028: SDPs that exceed these limits must decrease by 10% each year
- Illinois expects ~3.4 billion reduction to hospitals

# Medicaid “Work Requirements”

Section 71119.. Requirement for states to establish Medicaid community engagement requirements for certain individuals

Beginning January 1, 2027, must meet 80 hours of “community engagement” via some combination of:

- Work
- School
- Volunteering

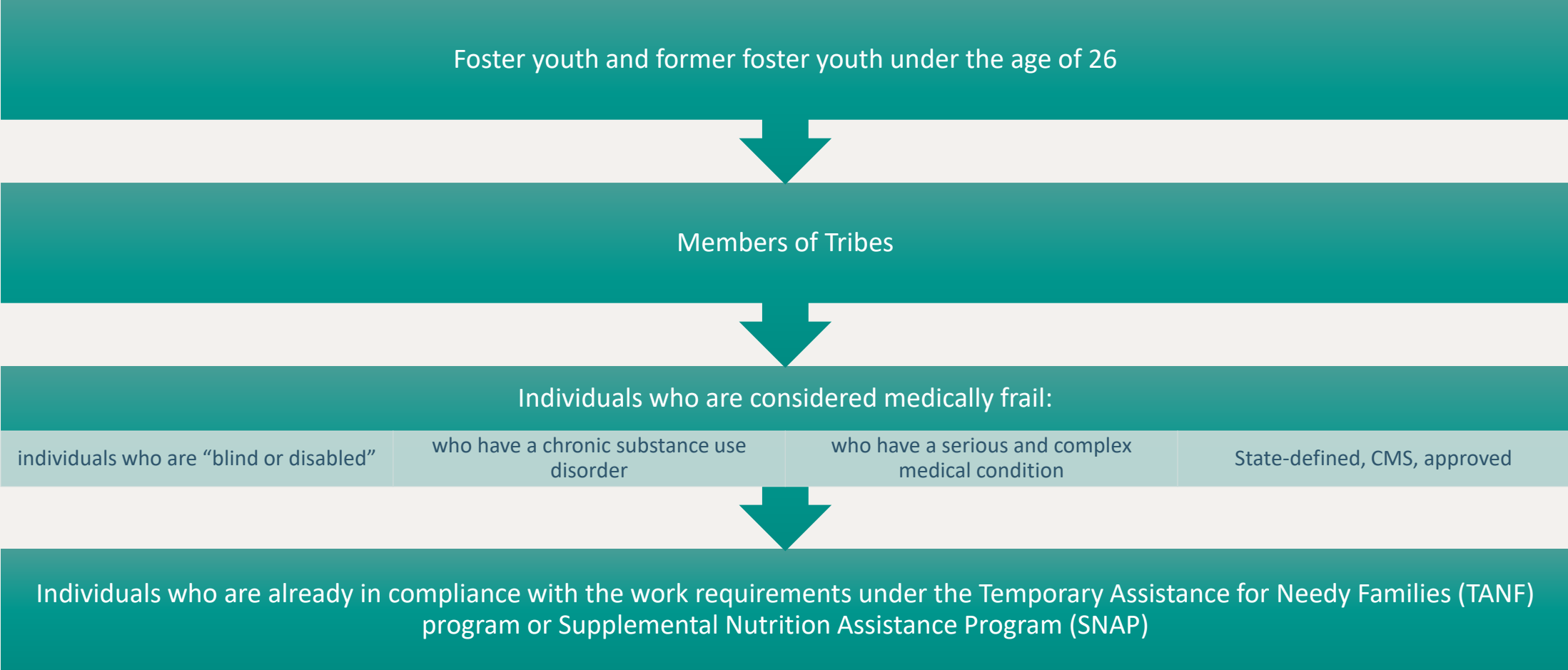
Applies to adults without disabilities age 19-64 (see exceptions on next slide)

States would verify at least for the month preceding an individual’s enrollment/renewal (could be a longer period)

“Good Faith Effort” option for states to delay until Jan 1, 2029 with CMS approval

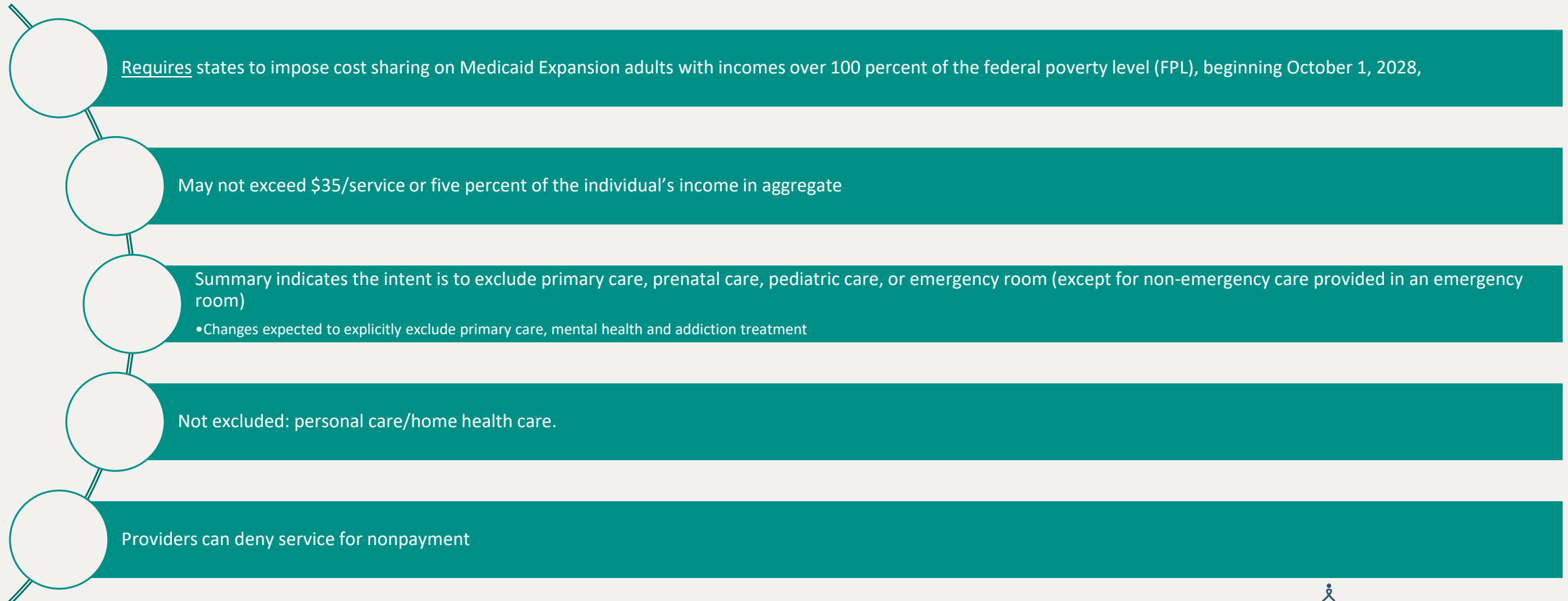
Regulation implementing the requirements is under review at the White House as of 4/1

# Exceptions to Community Engagement Requirement



# Mandatory Cost Sharing

## Section 44142. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program



## SEC. 71121. Making Certain Adjustments to Coverage of Home or Community-Based Services Under Medicaid

Allows states to create a new 1915(c) waiver, beginning July 1, 2028, that serves individuals who do not meet the institutional level of care typically required for these waivers

- Clinical eligibility for these waivers uses a needs-based criteria
- Similar to the eligibility requirements for 1915(i) state plan HCBS

State must demonstrate

- The per-capita cost will be lower than the cost of institutional care for serving these individuals,
- The waiver will not result in increased waiting times for those who meet the institutional level of care criteria

# Next Steps

States will be responsible for implementing new requirements and for balancing budgets once the cuts are implemented

Already seeing States expressing concern/reducing outlays in response

- Colorado – repeal of previously scheduled rate increases & additional proposed cuts
- Idaho – across the board reductions with more proposed
- North Carolina – ongoing debate

# What about the Medicaid Access Rule?

Delay/repeal not included in Reconciliation due to Congressional rules

Rulemaking becomes likely avenue for changes

OMB request for information regarding deregulatory actions

Presidential order – repeal 10 regulations for every new rule

# Fraud Oversight and Investigations

CMS has focused on program integrity as a top priority

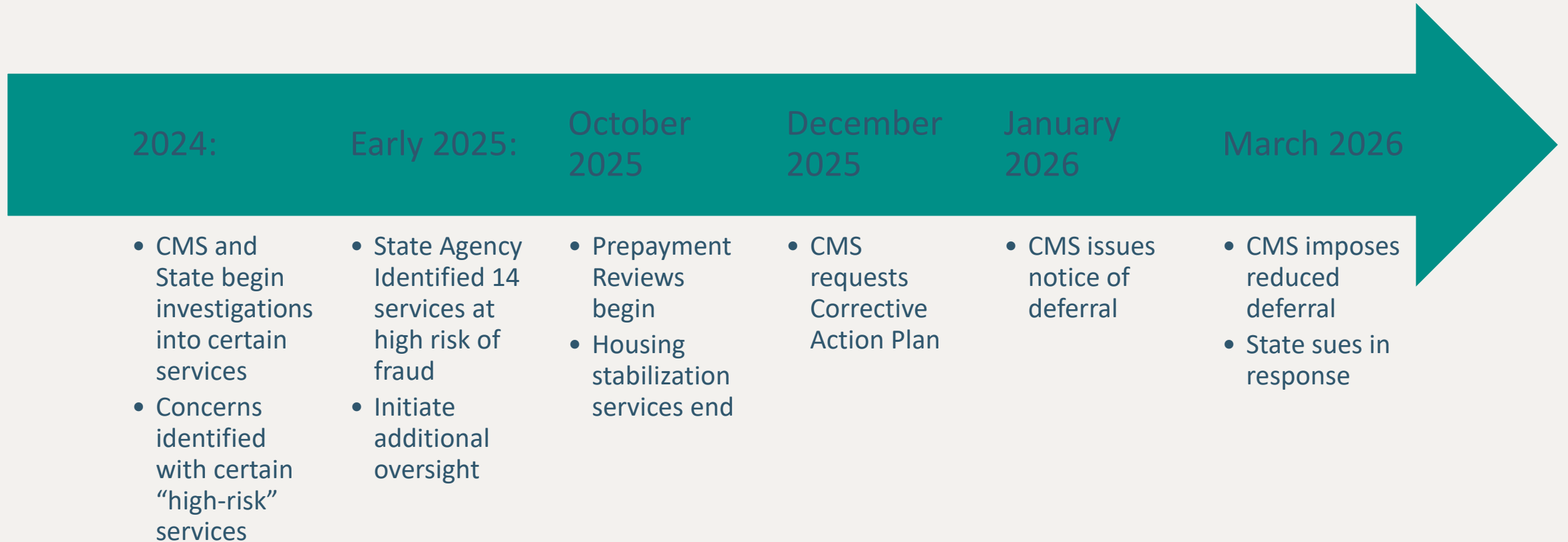
- Includes care at home services in both Medicare and Medicaid

Immediate actions are occurring in Minnesota, California, Maine, New York, and Florida

- Other states will likely be included in the future

Understanding the context can help prepare and protect your business

# Timeline in Minnesota



# Issue in Minnesota

State Medicaid Agency Identified 14 At-Risk Services

- Services found to be “at risk” of fraud
- Not necessarily indicating substantiated fraud

State Medicaid Agency initiated prepayment reviews of 14 services

- Led to claims (even ‘clean’ claims) held to the Federal maximum timeframe

CMS asserted insufficient action

- Required corrective action plan by Dec. 31
- CAP rejected by CMS, triggering ‘deferral’

# 14 Identified Services

Adult companion services.	Adult day services.
Adult rehabilitative mental health services.	Assertive community treatment.
Community First Services and Supports (CFSS)/ personal care assistance (PCA).	Early Intensive Developmental and Behavioral Intervention (EIDBI) services.
Housing Stabilization Services.	Individualized home supports.
Integrated community supports.	Intensive residential treatment services.
Night supervision services.	Nonemergency medical transportation services.
Peer recovery services.	Recuperative care services

# Congressional Activity

## Information Gathering

- Multiple letters sent requesting information from Minnesota regarding payments made and program integrity efforts
- Also sent to CA, CO, MA, ME, NE, NY, OR, PA, VT, and WA.

## House Oversight hearings

- Subcommittee on Oversight & Investigations in the Energy & Commerce Committee (jurisdiction over Medicaid) – multiple hearings into issues

# Considerations for Providers



Audits and payment reviews likely to increase

Potential risk for payment delays/disallowances

Ensuring compliance will be crucial

- Improper payments are often treated similarly to fraud, even if not the same

Potential Activities: (1) internal reviews of authorizations, documentation, all proper paperwork and coding  
(2) Review and ensure corporate compliance plan is updated  
(3) Training staff on procedures and requirements



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# Questions?



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Thank you!