H.R. 1 Medicaid Resource Guide

RCPA
REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

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Introduction

On July 4, 2025, Congress passed H. R. 1, which contains provisions to drastically change the Medicaid landscape and has the potential to remove nearly 300,000 Pennsylvanians from their healthcare coverage. RCPA has designed this H.R. 1 guide to educate providers, advocates, and stakeholders on the impacts that the resolution will have on the state's most vulnerable population.

Key H.R. 1 Medicaid Provisions

Provider Taxes: The legislation prohibits states from creating new provider taxes, which states use to finance their share of Medicaid program costs. H.R. 1 will also reduce current provider taxes from the current 6% threshold to 3.5% by requiring states to reduce any provider taxes over that threshold by 0.5% beginning in 2027.

State-Directed Payments: H.R. 1 will lower the maximum rate of state-directed payments to 100% of the equivalent Medicare published payment rate for relevant services for expansion states, which includes Pennsylvania.

Community Engagement/Work Requirements: New requirements for states to make Medicaid eligibility for adults ages 19–64 in the expansion population (or waiver population) are contingent on completing at least 80 hours per month of work or another qualified activity. This provision includes exemptions for mental health and substance use disorders, though clear definitions for those exemptions have not been released.

6-Month Eligibility Redeterminations: Beginning on January 1, 2027, Medicaid expansion enrollees will need to have their Medicaid eligibility checked every six months to maintain coverage as opposed to the current annual requirement.

Cost Sharing: There will be new cost sharing requirements for the expansion population, which will require states to charge expansion adults with incomes between 100–138% of the Federal Poverty Level cost sharing of up to $35 per service. Exemptions include primary care, mental health, and substance use disorder services, and prescription drug cost sharing is capped at low levels. There are also exemptions for CCBHCs, FQHCs, and RHCs, among other clinic types.

Retroactive Coverage: Under current law, states are required to cover Medicaid-eligible medical expenses up to 90 days before an individual applies for coverage. H.R. 1 reduces that retroactive coverage period to one month for expansion enrollees and two months for non-expansion enrollees.

Implementation Timeline

July 4, 2025

- **Replacement of Revenue Threshold Cap:** Replacement of the current 6% cap ("safe harbor threshold") for existing provider taxes with the applicable percentage of net patient revenue attributable to the taxed class as in effect on July 4, 2025.
- **Moratorium on CMS Rules:** Delays implementation of three finalized CMS rules intended to streamline enrollment processes and impose new verification requirements for enrollees.
- **Prohibition to Entities That Provide Abortion Services:** Bars Medicaid participation by certain providers of abortion services for one year.
- **Prohibition on New Provider Taxes:** States will no longer be able to establish new provider taxes or increase existing rates.

July 31, 2026

- **Comment Deadline for CMS IFR:** Comments for the Community Engagement Interim Final Rule (IFR) can be submitted, but CMS does not have to publicly address these comments in revised rules.
- **CER IFR Effective:** The rules for the community engagement requirements (CER) will be considered final.

October 1, 2026

- **Non-Citizen Eligibility Changes:** Refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, trafficking victims, and other non-citizens will no longer be considered qualified aliens for purposes of Medicaid and CHIP.
- **FMAP Reduction for Emergency Medicaid:** States will only receive the base Federal Medical Assistance Percentage (FMAP) for Emergency Medicaid Services.

January 1, 2027

- **Work Requirements Begin for Medicaid Expansion Population:** States will be required to implement community engagement requirements for Medicaid Expansion and in waivers that provide minimum essential coverage.
- **Semiannual Eligibility Renewals for Medicaid Expansion:** States will be required to redetermine eligibility for the Medicaid Expansion population every six months, which will impact approximately 750,000 Pennsylvanians.
- **Retroactive Coverage Reduction:** Retroactive coverage period for Medicaid will be reduced from three months to one month for expansion enrollees and two months for all other Medicaid applicants.

October 1, 2027

- **Provider Tax Limit Reduction:** The provider tax limit will reduce by 0.5% each year until reaching a 3.5% cap in FY 2032. This has the potential to remove $20 billion from Pennsylvania's Medicaid program over the next 10 years.

Janaury 1, 2028

- **State-Directed Payment Limits:** Any existing state-directed payments that are not in compliance with the allowable rate (100% of the Medicare rate in Pennsylvania) are reduced by 10%.
- **SDP Proposals:** CMS has proposed to eliminate uniform increases as a permissible type of SDP for rating periods, with a limited exception for grandfathered SDPs effective January 1, 2028. They have also proposed to permit states to adopt minimum or maximum fee schedules that are no greater than the applicable payment rate limit without CMS' prior approval for rating periods beginning on or after January 1, 2028. These currently remain proposals and have not been finalized.

Pre-Implementation Communication

PA DHS has released sample communications, including a CER Initial Outreach Letter, Periodic CER Outreach Letter, CER Non-compliance Notice Application, CER Non-compliance Notice Renewal, and a CER Self-Assessment.

Aug-Sept 2026

- PA DHS will begin initial outreach for current Medicaid recipients, which will take place over four mailings.
- Clients who have shared phone numbers will also be receiving texts and automated calls.

Oct-Dec 2026

- Outreach will begin to newly eligible Medicaid recipients with monthly mailings.
- Monthly texts and automated calls will also be sent.

January 202y

- Medicaid work requirements will begin, and enrollees must show that they are meeting CERs at least one month since their last renewal date.
- 6-month renewal implementation will begin after the existing 12-month renewal due date is processed.

ODP Communications

- Most individuals enrolled in Medicaid services administered by the Office of Developmental Programs (ODP) will not be subject to community engagement requirements—though Direct Support Professionals and caregivers may be.
- ODP has released a "Keep Your Medicaid" guide for ODP participants that explains important preparation details for Medicaid renewals.

Keep Your Medicaid

A Helpful Guide for ODP Participants

Don't Miss Your Medicaid Renewal

Look for the PINK Envelope!

Participants served through the Office of Developmental Programs (ODP) MUST complete their Medicaid renewal paperwork and submit the necessary documentation to the County Assistance Office (CAO) in order to maintain healthcare coverage and continue receiving critical ODP services. The CAO has made it even easier to recognize the arrival of your benefit renewal packet. Simply watch for a large PINK envelope in the mail and submit your renewal by the due date indicated.

ODP Participants MUST maintain Medicaid coverage to receive necessary medical, behavioral and ODP services.

Submit Your Renewal

- Via COMPASS
- By mail in the return envelope, or
- In-person to your CAO.

What is Medicaid?

In Pennsylvania, Medicaid is called Medical Assistance. Medicaid provides access to essential healthcare needs and daily living support, including services provided through the Office of Developmental Programs' (ODP) Home and Community-Based Waivers and Targeted Support Management (TSM). Medicaid eligibility is determined by your local CAO.

Preparing for Medicaid Renewals

Sign up for COMPASS

- Create COMPASS account
- Download PA CompassPA app
- Sign up for text messages through COMPASS

Pay attention to communications

- Respond to the CAO information requests
- Renew ON TIME!

Address potential eligibility issues NOW

Be Aware of Your Renewal Date(s)!

Report address changes

- Customer Service Center at 1-877-395-8930 or 215-560-7226 (Philadelphia) or to your local CAO
- COMPASS or MYCOMPASS PA mobile app

Report language needs

- Customer Service Center
- Write language needs on all documents submitted to the CAO
- Ask for interpreters if necessary

Community Engagement Requirements

Community Engagement Requirements (CER) apply to non-pregnant adults ages 19–64 enrolled in Medicaid through the ACA expansion or comparable 1115 waiver coverage. Beginning January 1, 2027, enrollees must demonstrate at least 80 hours per month of qualifying community engagement activities. These include employment, job training, education, community service, or a combination. The requirements are also met if the enrollee's gross income is below $580 per month.

Work

- Work in exchange for money, including self-employment, independent contracting, and employment with an organization or company.
- Work in exchange for goods or services ("in-kind" work).
- Unpaid work other than community service, including internships and opportunities to gain job experience.
- Unpaid family caregiving that does not meet other exclusionary criteria.

Community Service

- Must be completed through a structured program under a public or nonprofit organization that will provide oversight and have a process in place for tracking.
- Includes training activities and court-mandated service.
- Excludes activities that benefit one individual rather than the broader community and activities that are purely recreational in nature.

Work Programs

- Workforce Innovation and Opportunity Act programs and Trade Adjustment Assistance programs.
- Employment and Training programs from DOL or VA programs for veterans, SNAP, and other state-approved programs.
- SNAP workforce partnerships.
- Supervised job search and training programs that count as subsidiary activities (less than 40 hours).
- Unemployment insurance job search activities that must be consistent with qualifying work program requirements.

Educational Program

- Enrollment status is determined by the educational institution.
- Institution of higher education, including college, university, or community college.
- Career and technical education.
- High school and state-approved GED programs.
- Excludes independent study and self-paced online programs.
- If the program is not in person, must be a state-approved program able to monitor and document program hours.

CER Exceptions

Mandatory Exceptions: Individuals under 19, individuals receiving Medicare, mandatory Medicaid groups, and recently incarcerated individuals are mandatory exceptions from CERs. Information to verify these exceptions should be available to the State without any additional documentation from the recipient. In the case where information is not available, self-attestation may be accepted before 01/01/28. If information is not available after 01/01/28, the State may require documentation to maintain eligibility. Any eligibility notices must address if an individual meets an exception.

Specified Exclusions

- Former Foster Care
- American Indian
- Caretaker Relatives
- Veterans with 100% Disability (Temporary or Permanent)
- Meeting TANF Work Rules
- Exempt from SNAP Work Rules
- In Drug or Alcohol Program
- Pregnant or Postpartum Period
- Medically Frail

Optional Hardships

Inpatient Services

- An individual qualifies if, for the month in question, they receive inpatient hospital services, services in institutional settings, or comparable inpatient services likely to lead to inpatient care.
- The State must specify the start date, anticipated end date, and inform the individual when the exemption will end.

Disaster/Emergency Area

- This exception applies when a presidential emergency/disaster is issued, the individual resides in the area covered by the declaration, and the disaster creates barriers to completing CERs.
- The duration is at least the full "incident period" of the emergency/disaster and can be extended based on CMS approval.

High-Unemployment Area

- A State may request this hardship for any county or locality where unemployment is greater than 8% or 1.5 times the national unemployment rate, whichever threshold is lower.
- This exception applies for the month(s) when unemployment in the area meets the threshold, subject to CMS approval.

Travel for Treatment

- The hardship applies when an individual or dependent must travel outside the "community," and the purpose of the travel is to receive medically necessary treatment for a serious/complex condition that is not available within the community.
- The State must be able to verify the individual's inability to meet CERs due to the travel need.

CER Exemption Verification Fact Sheet

Medical Frailty Exemption – Qualifying Conditions

Blind or Disabled: Central vision acuity less than or equal to 20/100 in better eye with correction OR unable to engage substantial gainful activity due to a medically determinable physical or mental impairment lasting 12+ months or expected to result in death.

Substance Use Disorder (SUD): Includes individuals with an active or recovering SUD, including alcohol use disorders, opiate use disorders, and stimulant use disorders, provided the SUD significantly impairs an individual's ability to comply with CERs. Medical frailty applies whether or not an individual is in an active treatment program. Excludes individuals in "stable recovery" (more than five years).

Disabling Mental Disorder: A mental disorder that significantly impairs an individual's ability to comply with CERs. CMS will allow states to consider certain conditions as "disabling mental disorders" based on ISMICC, DSM-5, and ICD-10 criteria. Examples may include schizophrenia, schizotypal disorders, delusional disorder, non-mood psychotic disorder, moderate or sever bipolar depression, major depressive disorder, and panic disorder.

Physical, Intellectual, or Developmental Disability: A disability that significantly impairs an individual's ability to perform one or more activities of daily living (ADL), including bathing, dressing, getting out of bed, using the toilet, and eating. Instrumental ADLs, including shopping and meal preparation, are not included in the definition. CMS directs states to consider the impact of the disability on an individual's ability to comply with CERs. Examples of conditions include muscular dystrophy, cerebral palsy, cystic fibrosis, spina bifida, impairments from injuries (spinal cord injury, brain injury, amputation), Down syndrome, Fragile X syndrome, and Prader-Willi syndrome.

Serious or Complex Medical Condition: Applies to individuals with a serious medical condition, a complex medical condition, or a medical condition that is both serious and complex. The condition does not necessarily need to be life-threatening, but it must be seriously disabling, cause significant pain or discomfort that requires major caregiver time commitment, require frequent monitoring, and/or have multi-specialty coordination. This also includes treatments with risk of serious complications. Examples include HIV/AIDS, end stage renal disease, cancer, and sickle cell disease, but the severity of the condition must be considered.

Medical Frailty Documentation and Verfication

Step 1 – Ex Parte Verification

Before permitting self-attestation, states must attempt to verify medical frailty status with ex parte reviews and screenings. These verification sources may include:

- Claims and encounter data from the previous 12-month period;
- ICD-10 codes with utilization data;
- Acuity scoring algorithms;
- Severity of condition indicators; and
- Caregiver utilization data.

Absence of claims data alone may not be used to deny eligibility.

Step 2 – Individual Documentation

Before January 1, 2028, states can accept self-attestation for individuals seeking status as a specified excluded individual as medically frail. Beginning in 2028, states may allow for this attestation only one time. At subsequent renewals, the state must require documentation of medical frailty status.

Acceptable provider documentation may come from physicians, NPs, PAs, psychologists, counselors, therapists, clinical social workers, and other credentialed practitioners.

Medical Frailty in PA

The Interim Final Rule released by CMS requires that medical frailty demands not only the presence of a particular diagnosis or condition but also requires the State to consider the extent to which the condition impairs an individual's ability to comply with community engagement requirements. PA DHS will be sorting conditions into three categories to determine their potential impact on an individual's ability to comply with CERs.

Category 1

Medically frail based on the presence of a high-risk, severe condition.

Category 2

Medically frail based on the presence of a chronic condition with additional supporting evidence of severity, complexity, treatment burden, functional impairment, or overall worse health.

Category 2 conditions will also be given severity indicators to measure the impact on fulfilling community engagement requirements. By categorizing conditions, DHS aims to create transparent expectations for consumers and stakeholders while limiting administrative burden and cost. These categories were developed to utilize data that is consistently available in administrative records, to be manageable for clinicians and analysts, and to directly identify higher-complexity care.

Severity Indicators:

- High acuity or high frequency utilization
  - Examples: SNF admission, repeat emergency care, frequent outpatient visits, high cost
- Treatment that is high risk or requires frequent monitoring
  - Examples: Dialysis, chemotherapy, radiation
- Services that directly reflect functional limitations
  - Examples: Durable medical equipment, home health services
- Risk factors for impairment or mortality
  - Examples: Polypharmacy, multiple chronic conditions, advanced age

Category 3

Medically frail based on the presence of a significant acute or temporary condition.

6-Month Renewals for Current Medicaid Recipients

H.R. 1 will require Medicaid recipients to renew every 6 months instead of the current 12-month process, beginning on January 1, 2027. In Pennsylvania, individuals enrolled in Medicaid will keep their 12-month renewal date for 2027, then begin the 6-month process after their first 2027 renewal.

For individuals receiving renewal information via mail, DHS will send the renewal packet one month before the renewal date in a pink envelope. The packet must be completed and returned to the County Assistance Office (CAO). For individuals who have opted to renew online, the process can be completed on the COMPASS website.

Below is a sample cadence for a Medicaid enrollee whose renewal would be completed in September 2026.

August 2026
Client will receive their renewal packet due in September 2026, along with outreach regarding upcoming changes to the renewal process.

September 2026
Renewal packet must be completed and returned to CAO for eligibility determinations to be made. The next renewal will be in 12 months.

August 2027
Client will receive their renewal packet that will be due in September 2027. The packet will include an outreach letter and, if applicable, a notice of non-compliance for information that could not be verified in the ex parte process.

September 2027
Continued eligibility is assessed through the renewal. During this renewal, the client must demonstrate compliance with CERs during at least one month since the last renewal (October 2026 - September 2027).

February 2028
Client will receive their renewal packet that will be due in March 2028. The packet will include an outreach letter and, if applicable, a notice of non-compliance for information that could not be verified in the ex parte process.

March 2028
Continued eligibility is assessed through the renewal. Client must demonstrate compliance with CERs during at least one month since last renewal (October 2027 - March 2028). 6-month renewals will continue.

6-Month Renewals for New Medicaid Recipients

Medicaid eligibility requirements for new applicants will also change beginning January 1, 2027. In addition to meeting normal eligibility criteria, applicants will have to demonstrate that they are meeting community engagement requirements in the month prior to their application. If the applicant is eligible, they will be subject to 6-month renewals.

Below is a sample cadence for an individual applying for Medicaid in January 2027.

December 2026
Applicant will have to meet CERs through work, volunteering, education, or a work program in the month prior to applying for Medicaid.

January 2027
Applicant will submit their Medicaid application with proper documentation to prove that CERs were met in the month prior to applying.

June 2027
Six months after their application is approved, individuals will receive their first renewal packet, which will include an outreach letter and a notice of non-compliance if information cannot be verified through the ex-parte process.

July 2027
Continued eligibility is assessed through the renewal. During this renewal, enrollees must demonstrate compliance with CERs during at least one month since their last renewal. 6-month renewals will continue on the same cycle.

Where to Complete Renewals

- **Online:** Complete your renewal online in COMPASS.
- **By Mail:** Complete and return your renewal forms by mailing them back in the provided envelope. Look out for the pink envelope that contains the renewal packet!
- **In Person:** Complete and submit your renewal in person at any local county assistance office (CAO).
- **On the Phone:** Call 1-866-550-4355 to talk to a customer service representative.

Provider Readiness

Fraud, Waste, and Abuse

In Spring of 2026, the House Committee on Energy and Commerce sent ten states letters that identified them as "high risk" for Medicaid fraud, including Pennsylvania. The State was required to respond to this letter, though the response has not been publicly released. CMS has also required Pennsylvania to submit a plan on a process to revalidate "high risk" providers, which DHS plans to submit in June.

Recommendations for Providers

With such significant changes coming to the Medicaid program, providers can take the following steps to minimize negative impacts:

- Ensure patient contact information is up-to-date.
- Monitor eligibility by incorporating related questions into office and clinical practices.
- Collect data now to establish a baseline and continue to collect data once changes are implemented to measure the impact of the policy changes on clients, programs, and the workforce.

Implementation Challenges

- **State Challenges:** Final guidance for CERs was released on June 1, 2026, leaving states with only seven months to ensure that their beneficiary communication, workforce, and technological infrastructure are prepared for the January 1, 2027, implementation of semi-annual redeterminations and community engagement requirements.
- **Provider Challenges:** Providers will also see an increase in administrative burden, as they may need to serve as the source of documentation for medical frailty and will also be crucial in aiding beneficiaries with eligibility status.
- **Beneficiary Challenges:** Beneficiaries will have to navigate the new, complicated landscape of eligibility changes.

FAQ

Do we know what diagnoses qualify as a Serious Mental Illness?

CMS released their Interim Final Guidance on June 1, 2026, which included a description of what is constituted as a "disabling mental disorder," where states are instructed to consider whether or not the mental disorder significantly impairs an individual's ability to comply with the community engagement requirements. Instead of narrowly defining what is considered a disabling mental disorder, CMS is encouraging states to use criteria from the ISMICC, DSM-5, and ICD-10. CMS provided examples of disorders that may be considered for the medical frailty exemption, including:

- Schizophrenia and schizotypal disorder;
- Moderate or severe bipolar depression;
- Major depressive disorder;
- Delusional disorder and non-mood psychotic disorders; and
- Panic disorder.

CMS states this is not an exhaustive list, only examples for states to consider.

What is the timeline for PA's Rural Health Transformation Program fund release?

The Rural Health Transformation Program is a $50 billion initiative to expand and improve healthcare in rural areas, with $10 billion allocated every year between 2026 - 2030. The funding opportunities will be released throughout the duration of the 5-year grant. The first year allocation of $193 million must be obligated to a program by October 31, 2026. PA DHS has continued to release funding opportunities throughout the summer. Find more information about the PA Rural Health Transformation Program.

Will refugees with one or two exceptions but without green cards still qualify for Medicaid?

Individuals without a green card will no longer qualify for Medicaid, even if they meet criteria for exemptions. Beginning October 1, 2026, federal financial participation (FFP) for full scope Medicaid and CHIP will only be available for the following narrow groups of non-citizens as a federal baseline: Lawful Permanent Residents, Cuban and Haitian entrants, and Compact of Free Association migrants.

Which behavioral health services will be impacted by the state-directed payment caps? Are CCBHCs, FQHCs, and RHCs included?

While H.R. 1 statutory text excluded CCBHCs, FQHCs, and RHCs, CMS guidance from May 2026 extends the caps more broadly. RCPA will continue to update this FAQ as information is released.

Is there still an opportunity for states to delay implementation for two years?

There was information stipulated in H.R. 1 that a delay could be requested if the state was making a "good faith effort" towards implementation, but that would have to be reviewed by CMS. In discussions with DHS, it does not seem that requesting a waiver or delay will be a viable strategic option.

Will outreach letters be sent in people's native languages?

On May 11, 2026, DHS released a number of documents for public review, which included drafted communications to Medicaid expansion enrollees. DHS will be sending letters in different languages, but it is still unclear which languages will be included and if it will include every enrollee's native language.

With the anticipated termination of Medicaid coverage for immigrants and refugees, what is Pennsylvania's plan for providing medical care for the families who depend on MA to stabilize and become self-sufficient?

RCPA has requested additional information from the Office of Income Maintenance and will update this FAQ accordingly.

There are many parents in the expansion population. How are we including information on children's eligibility for adults who may be parents? Are other state agencies engaged?

While we still do not have full clarity on the impacts of children's coverage, we do know that updates to the eligibility platforms, like COMPASS, are being made. RCPA will continue to update this FAQ as information becomes available.

Do you have a question?

This FAQ will be updated as the State and Federal governments release more information. Please forward any questions to esharp@paproviders.org.

Resources

National Council for Mental Wellbeing

- H.R. 1 Hub
- H.R. 1 Implementation Journey Map

Academy of Health Information Professionals

- Medicaid Community Engagement Requirements Toolkit for States

Inseparable

- A State Guide to Using Data for Community Engagement Determinations
- Medicaid, Mental Health, and H.R. 1: A Guide for State Agencies and Policymakers

Pennsylvania Department of Human Services

- Federal Changes to Benefits Programs
- H.R. 1 Implementation: Medical Frailty
- Improving Rural Health in Pennsylvania

Sellers Dorsey

- Community Engagement Requirement Interim Final Rule Summary

This document will continue to be updated as new information from CMS and DHS is released.