Timeline of Changes to Florida Medicaid and KidCare Due to H.R. 1

Updated January 2026

FLORIDA HEALTH JUSTICE PROJECT

BUDGET RECONCILIATION BILL PASSED BY CONGRESS (H.R. 1)

Effective in 2025

Subject	Previous Law	Change in Law
Medicare Savings Programs Rule (s. 71101)	Through Medicare Savings Programs (MSPs), Florida's Medicaid program covers certain expenses for Medicare-eligible individuals, including premiums and cost-sharing. See DCF SSI-Related Medicaid Fact Sheet at 17. The Center for Medicare and Medicaid (CMS) issued a final rule titled "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment"on September 21, 2023, which changes certain MSP enrollment processes and grants automatic MSP entitlement to qualifying Medicare beneficiaries without requiring a separate application. It also requires states to use Medicare Part D Low-Income Subsidy (LIS) information for the purposes of determining MSP eligibility.	Prohibits the Secretary of the Department of Health and Human Services (HHS) from implementing, administering, or enforcing provisions of this rule that had not yet gone into effect as of July 4, 2025. This prohibition, in effect until September 30, 2034, applies to the following provisions of the rule: • Clarifies when QMB coverage begins with respect to Medicare Part A entitlement. 42 C.F.R. § 406.21(c)(5). • Aligns Low-Income Subsidy (LIS) and MSP family size definitions and income counting rules. 42 CFR § 435.601(e). • Enforcement of existing requirement that states use Low Income Subsidy (LIS) application data as an application for an MSP. 42 C.F.R. §§ 435.4; 435.911(e). • Allows self-attestation for income and asset information, including burial funds and life insurance. 42 CFR § 435.952(e). H.R. 1 does not prohibit state implementation of these provisions; it only prohibits CMS enforcement of them. Florida implemented the change to MSP "family size" in January 2024. Effective upon enactment (July 4, 2025)
Medicaid and CHIP Eligibility and Enrollment Rule (s. 71102)	CMS issued a final rule titled "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" on April 2, 2024. The rule simplifies eligibility and enrollment processes for Medicaid, the State Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP).	Prohibits the Secretary of the Department of Health and Human Services (HHS) from implementing, administering, or enforcing provisions of this rule that had not yet gone into effect as of July 4, 2025. This prohibition, in effect until September 30, 2034, applies to the following provisions of the rule: • Aligns non-MAGI enrollment requirements with MAGI policies. 42 C.F.R. §§ 435.907(d), 435.916. • Improves coordination between Medicaid, CHIP, and other forms of coverage. 42 C.F.R. §§ 435.1200. • Imposes limitations on premiums and cost-sharing, at state option, for individuals under age 19, 20 or 21. 42 C.F.R. §§ 447.56(a)(1)(v). • Provides continued enrollment following termination. 42 C.F.R. § 457.1140(d)(4). • Improves Medicaid and CHIP processes for updated address information. 42 C.F.R. §§ 435.919, 457.3444 • Establishes requirements and timeframes for acting on changes in circumstances. 42 C.F.R. §§ 435.919, 457.344, 457.960 • Establishes timeliness requirements for agency action on applications, renewals, change in circumstances; reasonable timeframes for enrollee responses. 42 C.F.R. §§ 435.907(d), 435.912, 457.1170. • Revises state agency requirements and processes required when a state receives reliable information about a change in circumstances that may impact eligibility. 42 C.F.R. § 435.911(c). • Requires timely written notice of a denial of eligibility, a failure to make a timely eligibility determination, and a suspension or termination of enrollment. The notice must include the reasons for the determination and the right to review the determination. 42 C.F.R. § 457.1180. H.R. 1 does not prohibit state implementation of these provisions; it only prohibits CMS enforcement of them. Effective upon enactment (July 4, 2025)

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Subject	**Previous Law**	**Change in Law**
Federal Staffing Standards in Long-Term Care Facilities Rule (s. 71111)	In May 2024, CMS issued a final rule titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" to set minimum staffing standards for Medicare and Medicaid long-term care facilities.	Prohibits the Secretary of the Department of Health and Human Services (HHS) from implementing, administering or enforcing the rule in its entirety, including: • New definition of "hours per resident day" (HPRD) as the total number of hours worked by countable staff by the total number of residents as calculated by CMS. 42 C.F.R. § 483.5. • Minimum nurse staffing requirement of 3.48 hours per resident day. 42 C.F.R. § 483.35(b)(1). • Requirement that nursing homes have a registered nurse onsite 24 hours per day, seven (7) days per week and available to provide direct resident care. 42 C.F.R. § 483.35(c). This prohibition is in effect until September 30, 2034. Effective upon enactment (July 4, 2025) (Note: This rule had been vacated in April 2025 by the Northern District of Texas in American Health Care Ass'n v. Kennedy. HHS Secretary Kennedy initially appealed this ruling, but subsequently moved to dismiss the appeal. This dismissal was granted. Therefore, it is unlikely that this rule can be implemented even after the moratorium in this section ends in 2034.)
Prohibiting federal payments to entities that provide family planning, reproductive health and abortion services (s. 71113)	Generally, states must permit enrollees to receive services from any willing Medicaid-participating provider. See, e.g., Fla. Admin. Code R. 59G-1.050(5). Medicaid enrollees may obtain family planning services from a Medicaid participating provider of their choice. Pursuant to the Hyde Amendment, Medicaid funds may not be used for abortions, except in the cases of rape, incest, or endangerment of a woman's life.	Prohibits federal Medicaid spending for any services provided by "prohibited entities" for one year beginning on the date of enactment. "Prohibited entities" include any Section 501(c)(3) organizations that are essential community providers, as defined therein (including its affiliates, subsidiaries, successors, and clinics) that provide family planning services, reproductive health and related medical care as well as abortion services other than those allowable under the Hyde Amendment, and that received federal and state Medicaid reimbursements exceeding $800,000 million in Fiscal Year 2023. In Florida, three (3) health care providers meet the definition of "prohibited entities" and therefore may no longer receive Medicaid reimbursements for health services. See Presentation by AHCA to House Health Care Facilities & Systems Subcommittee, Oct. 8, 2025 at p. 27. Effective upon enactment (July 4, 2025). (Note: Implementation of Section 71113 of H.R. 1 was preliminarily enjoined by the U.S. District Court of Massachusetts in Planned Parenthood of America, Inc. v. Kennedy in orders dated July 21, 2025 and July 28, 2025. As of September 11, 2025, these rulings are stayed pending the federal government's appeal to the First Circuit Court of Appeals. Therefore, this section is currently in effect.)

BUDGET RECONCILIATION BILL PASSED BY CONGRESS (H.R. 1)		
Subject	**Previous Law**	**Change in Law**
Provider taxes (s. 71115)	A provider tax is a health care-related fee, assessment, or other mandatory payment for which at least 85 percent of the burden of the tax revenue falls on health care providers. 42 U.S.C. § 1396b(w)(3)(A). States are permitted to hold providers harmless, i.e., guarantee they will receive their money back, for taxes of 6% or less of providers' patient revenues. Florida uses revenues from health care provider taxes to help finance the state share of Medicaid expenditures. See, e.g., Fla. Stat. § 409.9082 (nursing home assessments); Fla. Stat. § 395.701 (hospital assessments); Fla. Stat. § 409.9083 (intermediate care facilities assessments).	Prohibits non-expansion states, including Florida, from increasing the rate of current provider taxes or increasing the base of the tax to a class or items of services that the tax did not previously apply. "Grandfathers" the 6% hold harmless limit on provider taxes applicable to nursing facilities and intermediate care facilities in effect on July 4, 2025. Reduces the "hold harmless" threshold to zero for new taxes. This provision will have no impact on Florida's existing provider taxes, but will prohibit Florida from implementing provider taxes on new provider classes. See Presentation by AHCA to House Health Care Facilities & Systems Subcommittee, Oct. 8, 2025 at p. 7. Effective upon enactment (July 4, 2025)
State Directed Payments (s. 71116)	Medicaid state directed payments are supplemental payments to providers under managed care organization contracts. See, e.g. Fla. Stat. § 409.908. The total payment rate for inpatient hospital services, outpatient hospital services, nursing facility services or qualified practitioner services at an academic medical center may not exceed the average commercial rate. 42 C.F.R. § 438.6(c)(2)(iii). This is generally higher than the Medicare payment rate.	In non-expansion states, including Florida, this section limits new provider payments to no more than 110 percent of the published Medicare payment rate (instead of the average commercial rate). This may discourage new and existing providers from accepting Medicaid patients. Grandfathers existing state direct payments approved prior to enactment (except for states that newly adopt Medicaid expansion) until January 2028. This creates a disincentive for Florida to expand Medicaid in the future. Effective upon enactment (July 4, 2025)

BUDGET RECONCILIATION BILL PASSED BY CONGRESS (H.R. 1)		
Subject	**Previous Law**	**Change in Law**
Rural Health Transformation Program Fund (s. 71401)	None	Appropriates $50 billion for distribution to states selected over fiscal years 2026-2030 ($10 billion per year) for improvements in health care to rural residents. CMS issued a Notice of Funding Opportunity regarding this program on Sept. 15, 2025. After soliciting input from providers, AHCA announced that it submitted the state's application on November 4, 2025. AHCA has not publicly released its submitted application. An abstract by CMS of Florida's application states the project will serve 1.2 million Floridians across 31 counties "by addressing provider shortages, technological fragmentation, and unsustainable reimbursement structures." On December 29, 2025, CMS announced awards to all 50 states for FY2026. Florida is to be awarded $209,938,195.

Effective in 2026		
Subject	**Previous Law**	**Change in Law**
Sunsetting of Increased Federal Funding for Medicaid Expansion (s. 71114)	In addition to the 90% federal matching funds available under the Affordable Care Act (ACA) for the expansion population, the American Rescue Plan Act provides qualifying states (defined as non-expansion states as of March 2021), which includes Florida, with a five (5) percent increase to their regular FMAP for eight quarters after a state expands Medicaid. Florida's FMAP rate for 2025 is 57.22%. See KFF'S Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier	Eliminates the five (5) percentage-point increase to the regular FMAP rate for states implementing the ACA Medicaid expansion after March 2021. This eliminates a portion of the supplemental federal funding previously offered to those states which have not yet expanded Medicaid, including Florida. This creates a disincentive for Florida to expand Medicaid in the future. Effective Jan. 2026.

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Subject	**Previous Law**	**Change in Law**
Immigrant Eligibility for Medicaid & KidCare (s. 71109)	"Qualified aliens" can receive Medicaid and KidCare in Florida after five years of U.S. residency. These include: adult lawful permanent residents (LPRs) admitted after August 22, 1996; aliens paroled for at least one year; certain battered spouses and children; and conditional entrants. The following "qualified aliens" can currently enroll in Medicaid and KidCare with no five-year waiting period: refugees; asylees; those with deportation withheld; veterans or active-duty military and their spouses/children; American Indians born in Canada; Cuban or Haitian entrants; Amerasian immigrants; trafficking victims; and individuals living in the U.S. through a Compact of Free Association (CoFA). See 8 U.S.C. § 1641; see also Fla. Stat. §§ 409.902(2), 414.095(3); Fla. Admin. Code Ann. R. 65A-1.705; 65A-1.701(58); ESS Program Policy Manual 1440.0104 through 1440.0113. States have the option to allow enrollment in Medicaid and CHIP for lawfully residing immigrant children and pregnant women. 42 U.S.C. § 1396b(v)(4)a) (the "ICHIA" option). Florida has selected this option for children, but not pregnant women. Thus, Florida allows Medicaid and KidCare enrollment for lawfully present non-citizen children under 19 with no five-year wait. See Fla. Stat. § 409.811(16); Fla. Stat. § 409.904(8). Undocumented immigrants cannot receive Medicaid or KidCare. See Fla. Stat. § 409.902(2)(b); Fla. Admin. Code R. 59G-1.050(4).	Amends the definition of "qualified aliens" eligible for Medicaid and KidCare to include only: (1) LPRs (after 5-year bar); (2) Cuban and Haitian entrants; and (3) individuals living in the United States through a Compact of Free Association (CoFA). H.R. 1 did not alter the ICHIA option; therefore Florida can continue to cover lawfully present non-citizen children with no 5-year bar. The state retains the option to offer this coverage to pregnant women, as a majority of states have done. Effective Oct. 2026

BUDGET RECONCILIATION BILL PASSED BY CONGRESS (H.R. 1)

Effective in 2027

Subject	Previous Law	Change in Law
Duplicate Enrollments (s. 71103)	Medicaid regulations require states to regularly obtain and act on updated address information from reliable data sources, including USPS returned mail with a forwarding address, the USPS NCOA database, address information from Medicaid managed care entities, and other HHS Secretary-approved data sources. 42 C.F.R. §§ 435.919(f), 457.344(f). Currently, AHCA contracts with Allied Health Services to process returned mail and monitor the National Change of Address Database. Presentation by AHCA to House Health Care Facilities & Systems Subcommittee, Oct. 8, 2025 at p. 14.	Requires each State's plan to provide for a process to regularly obtain address information for enrollees from reliable data sources identified in the statute to prevent simultaneous enrollment in multiple states. AHCA will need to amend its MCO contracts to require them to transmit enrollee address information. Effective Jan. 2027
Deceased Enrollees (s. 71104)	CMS guidance identifies data sources to match Medicaid enrollment and payment against information on deceased individuals and suggests states conduct monthly data reviews.	States must conduct screenings, at least once per quarter , to identify deceased enrolled beneficiaries using the Social Security Death Master File. The state must disenroll deceased enrollees, and reinstate any such enrollees who it subsequently determines were disenrolled in error. According to Florida's Medicaid Director, AHCA is currently establishing a process to use the Death Master File to determine if enrollees are deceased. See Presentation by AHCA to House Health Care Facilities & Systems Subcommittee, Oct. 8, 2025 at p. 16. Effective Jan. 2027
Retroactive Medicaid & KidCare Coverage (s. 71112)	States are required to cover Medicaid benefits retroactively for the three (3) months prior to enrollment. Pursuant to federal waiver, Florida only provides up to three (3) months of retroactive Medicaid coverage to pregnant people and children under age 21. See Fla. Stat. § 409.904(12); see also Fla. Admin. Code Rule 65A-1.702(8). Florida does not currently provide retroactive KidCare coverage.	Reduces the permissible length of retroactive Medicaid coverage in non-expansion states, including Florida, from three (3) months to two (2) months. In Florida, this will only affect pregnant people and children under age 21. Also limits permissible coverage in state Children's Health Insurance Programs (CHIP) to two (2) months. This will impact Florida if it elects to provide retroactive coverage to KidCare enrollees. Effective Jan. 2027

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BUDGET RECONCILIATION BILL PASSED BY CONGRESS (H.R. 1)		
Subject	**Previous Law**	**Change in Law**
Budget Neutrality Requirement for Waivers (s. 71118)	The Secretary may waive Medicaid requirements and/or provide expenditure authority for expenditures that do not otherwise qualify for federal reimbursement in order for states to conduct experimental, pilot, or demonstration projects that, in the judgment of the HHS Secretary, are likely to assist in promoting the objectives of the Medicaid program. 42 U.S.C. § 1315.	The HHS Secretary may not approve a 1115 waiver, renewal, or amendment unless the CMS Actuary certifies that it would not increase federal expenditures compared to the amount that such expenditures would otherwise be in the absence of the project. AHCA anticipates that this will introduce additional delays to approval of any 1115 waivers. See Presentation by AHCA to House Health Care Facilities & Systems Subcommittee, Oct. 8, 2025 at p. 29. Effective Jan. 2027
Effective in 2028		
Subject	**Previous Law**	**Change in Law**
Deceased Providers (s. 71105)	Medicaid regulations require states to check the Social Security Death Master File to determine whether providers are deceased. 45 C.F.R. § 455.436(b).	States must conduct screenings against Social Security Death Master File at enrollment/reenrollment and at least once per quarter during the period that a provider or supplier is enrolled to determine if an enrolled provider or supplier is deceased. According to Florida's Medicaid Director, Florida is already in compliance with this provision. See Presentation by AHCA to House Health Care Facilities & Systems Subcommittee, Oct. 8, 2025 at p. 17. Effective Jan. 2028
Home Equity Limit for Long-Term Care (s. 71108)	States set home equity limits as part of the financial eligibility determination for long-term care Medicaid, which must fall within a minimum and maximum indexed to inflation. See 42 U.S.C. § 1396p(f). The current limits in the Updated 2025 SSI and Spousal Impoverishment Standards are a minimum of $730,000 and a maximum of $1,097,000. The limits are adjusted annually for inflation. In Florida, the current home equity limit is $730,000. Florida does not exclude property zoned for agriculture. See Fla. Admin. Code R. 65A-1.712(5)	Caps the home equity limit at $1 million, regardless of inflation, excluding homes on certain agricultural lots. Florida is not required to make any changes based upon this law, but could decide whether to increase the home equity limit and establish a limit for land zoned as agricultural. See Presentation by AHCA to House Health Care Facilities & Systems Subcommittee, Oct. 8, 2025 at p. 19. Effective Jan. 2028

BUDGET RECONCILIATION BILL PASSED BY CONGRESS (H.R. 1)		
Subject	**Previous Law**	**Change in Law**
State Directed Payments (s. 71116)	Please see above for a description of the portions of Section 71116 that became effective upon enactment.	Beginning January 1, 2028, non-expansion states must reduce state directed payments by 10 percent per year until they are no more than 110% of the Medicare payment rate. Existing state direct payments approved or requested prior to enactment are grandfathered (except for states that newly adopt Medicaid expansion) until January 2028. According to Florida's Medicaid Director, Florida currently has four (4) state directed payment programs over the 110% Medicare limit. See Presentation by AHCA to House Health Care Budget Subcommittee, Dec. 2, 2025, p. 6. The largest of these programs is the Hospital Directed Payment Program (HDPP), which currently generates $3.3 billion per year for 280 hospitals. Prior to the enactment of H.R. 1, Florida requested CMS approval to raise funding of this program to the average commercial rate, which would yield $7.8 billion in SFY 2025-2026. If this increase is approved, even with the required reductions beginning in 2028, Florida will enjoy increased funding from this program through SFY 2034-35. Thereafter, the program's annual funding will be approximately $1 billion more than the current level. (pp. 7,10,11). Effective Jan. 2028
Home or Community-Based Waivers (s. 71121)	Within broad Federal guidelines, States can develop home and community-based services (HCBS) waivers to meet the needs of people who prefer to receive long-term care services and supports in their home or the community, rather than in an institutional setting. Florida operates two (2) primary HCBS waivers: • Long-Term Care Waiver - serves individuals over 18 who are disabled or aged and require nursing facility level of care. • Developmental Disabilities Individual Budgeting Waiver - serves individuals with intellectual and developmental disabilities through an individual budgeting model. Florida operates three (3) additional waivers, with limited participation: • Model Waiver - serves children with degenerative spinocerebellar disease (5 enrollees; capacity of 15) • Familial Dysautonomia Waiver - serves participants with Familial Dysautonomia (6 enrollees) • Intellectual and Developmental Disabilities Comprehensive Managed Care Program Waiver - serves persons with developmental disabilities through a managed care delivery model (364 enrollees as of March 15, 2025 according to this legislative analysis	Creates a new type of 1915(c) waiver that does not require a determination that an individual needs institutional level of care. States would be required to establish a needs based criteria subject to approval by the Secretary. Effective July 2028

BUDGET RECONCILIATION BILL PASSED BY CONGRESS (H.R. 1)

Effective in 2029

Subject	Previous Law	Change in Law
Duplicate Enrollments (s. 71103)	Please see above for a description of the portions of Section 71103 that are effective in January 2027.	Requires the HHS Secretary to establish a system to prevent simultaneous enrollment in more than one state Medicaid program. States must submit SSN and other information determined necessary by the Secretary at least once per month. Effective Oct. 2029
Payment Reduction for Erroneous Excess Payments (s. 71106)	For states with erroneous excess Medicaid payments over the allowable error rate of 3%, the HHS Secretary is required to reduce federal Medicaid payments by the amount that exceeds the 3% threshold. However, the HHS Secretary may waive this reduction to federal payments if the state is unable to reach the allowable rate despite a "good" faith effort.	Reduces the amount of erroneous excess payments that the Secretary can waive under the "good faith waiver." Effective Oct. 2029

Provisions Not Applicable to Florida

Subject	Explanation
Semi-Annual Eligibility Redeterminations (s. 71107)	Currently, states must redetermine Medicaid eligibility annually or upon an enrollee's change in circumstances. This provision requires states to conduct eligibility redeterminations every six (6) months for individuals enrolled through Medicaid expansion. Florida has not expanded Medicaid, so this provision will have no impact in Florida unless and until the state expands Medicaid and has individuals enrolled through Medicaid expansion. Effective Jan. 2027
FMAP for Emergency Medicaid (s. 71110)	Some states provide state-based Medicaid to immigrants who are not "qualified aliens." This provision reduces the federal share of funding for Emergency Medicaid for the expansion population in these states from 90% to 80%. Because Florida has not expanded Medicaid, this provision will have no impact in Florida unless and until the state expands Medicaid. Effective Oct. 2026
Cap on Provider Taxes (s. 71115)	Caps provider taxes for states that have expanded Medicaid at 5.5% in FY 2028, stepping down to 3.5% in 2032. Because Florida has not expanded Medicaid, this provision will have no impact in Florida unless and until the state expands Medicaid. Effective beginning Sept. 2027

Provisions Not Applicable to Florida	
Subject	**Explanation**
Requirements for Waivers of Uniform Provider Tax Requirements (s. 71117)	Currently, state Medicaid waivers regarding provider taxes must not be "generally redistributive," between Medicaid and non-Medicaid revenues. This provision provides stricter definitions regarding when a provider tax is "generally redistributive," for example, it prohibits a higher tax rate to be applied to higher volume Medicaid providers than lower volume Medicaid providers. This provision does not impact Florida because Florida's waiver pertaining to provider taxes on skilled nursing facilities already complies with the requirements of this section. See Presentation by AHCA to House Health Care Facilities & Systems Subcommittee, Oct. 8, 2025 at p. 8. Effective upon enactment (July 4, 2025)
Community Engagement Requirements for Medicaid Expansion Enrollees (s. 71119)	Currently, Medicaid enrollees are not subject to work reporting requirements. This provision requires individuals enrolled through Medicaid expansion to complete and report a minimum of 80 hours of qualifying "community engagement" activities (including work, a work program, community service, or an education program) for one or more months prior to applying for Medicaid and one or more months as a condition of continued Medicaid coverage. Because Florida has not expanded Medicaid, this provision will have no impact in Florida unless and until the state expands Medicaid. Effective Jan. 2027
Cost Sharing Requirements for Expansion Population (s. 71120)	States currently have the option to charge premiums and cost-sharing for Medicaid enrollees, although certain populations are exempt from cost-sharing. This provision requires states that have expanded Medicaid to impose cost sharing on Medicaid expansion enrollees with family income above 100% FPL. Because Florida has not expanded Medicaid, this provision will have no impact in Florida unless and until the state expands Medicaid. Effective Oct. 2028

Sources:

Center on Budget & Policy Priorities, Medicaid Eligibility and Enrollment Rules Lay Framework for Program Improvements States Can Still Adopt, Despite Moratorium (Sept. 24, 2025)

Congressional Research Service, Health Coverage Provisions in One Big Beautiful Bill Act (H.R. 1) (June 13, 2025)

Georgetown Center for Children & Families, Medicaid, CHIP, and Affordable Care Act Marketplace Cuts and Other Health Provisions in the Budget Reconciliation Law, Explained (Updated Aug. 11, 2025)

Justice in Aging, Final Rule to Streamline Enrollment in Medicare Savings Programs (Oct. 30, 2025)

KFF, Health Provisions in the 2025 Federal Budget Reconciliation Bill (updated July 8, 2025)

National Health Law Program, Budget Reconciliation Act Implementation Dates For Select Medicaid & Health Provisions (Aug. 13, 2025)