MEDICAID EXPANSION FOR HOUSING PURPOSES

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If you are concerned about affordable housing and homelessness in your communities, you also should be aware of the importance of the Medicaid program to your efforts and the people you serve. Medicaid has been in the headlines as one of the programs taking some of the largest cuts in H.R.1: "One Big Beautiful Bill Act" signed by the president this summer. Over the next ten years, H.R.1 is estimated to decrease federal spending on Medicaid by a trillion dollars, and ten million more people will lose health insurance coverage. Medicaid, a health insurance program for low-income Americans, is a state and federal partnership led at the federal level by the Centers for Medicaid and Medicare Services or CMS. Each state has its own State Medicaid Agency (SMA).

Many fiscal responsibilities will be shifted to states and states will have difficult decisions to make, starting in Fiscal Year 2027. All states but Vermont are required to pass balanced budgets, so deficit spending for states is generally not allowable. With the significant decrease in federal spending in the program, advocates have an uphill battle in protecting programs (housing and services) and growing investments to address community needs. As of December 2025, 40 states and DC have expanded Medicaid to all low-income populations, and ten states, primarily in the southeast, have not expanded Medicaid. In non-expansion states, a person must prove both low income AND belonging to a category (children, elders, disabled, pregnant) that the state has chosen to cover in their Medicaid program.

This year's *Advocates' Guide* will cover a variety of ways that HR1 achieves those savings and reduces health access for low-income people. The law is large and complex, and the below analysis focuses only on the **Medicaid** aspects of the law relevant to the affordable housing industry and the people they serve. The law also reduces funding for the Medicare program, and that is not covered in this analysis. The law will have a significant impact on people with disabilities, and there are a variety of federal laws that states must follow, as they implement the HR1 but also maintain compliance to disability law. Finally, a variety of advocates from the Medicaid field have held webinars, created guides or resources for advocates and states, including National Health Care for the Homeless Council (NHCHC), National Alliance to End Homelessness (NAEH), National Health Law Program (NHLP), Justice in Aging, and of course, CSH. These resources and ongoing series can assist your efforts throughout the year.

Corporation for Supportive Housing (CSH) has summarized critical aspects of the law, is offering a regular webinar series on state implementation, and has guidance for states on how to legally implement the law with a frame of mitigating harm as much as possible.

In this section, various aspects of the law will be considered from the below perspectives.

1. Policy and timeline
2. Impact on low-income populations including those in HUD assisted housing and those experiencing homelessness
3. State efforts and how to influence those efforts to limit harms
4. Needed long term efforts to mitigate harm

I. HR1, Section 71119: Work Requirements

a. *Policy and timeline*

Section 71119 of the law requires that persons who receive Medicaid solely due to low income now must prove 80 hours of "community engagement activities" in the month prior to initially applying for or reapplying for Medicaid. Those activities can include

1. Paid employment
2. Volunteer activities
3. Higher education

There are also a number of exemptions for people who do not have to prove work activities. Exemptions from work requirements include if you are

1. Under age 19 or over age 65
2. Caring for a child under the age of 13
3. Caring for a disabled family member
4. A veteran with a disability
5. An American Indian or Alaska native
6. Enrolled in substance use treatment
7. Medically Frail- Creating this designation and how one qualifies as Medically Frail is a state choice. States must develop their own process for determining "Medical Frailty". What exemptions states ask for and are approved for remains to be determined.
8. Experiencing a short-term hardship
9. In a geographic area impacted by a federally declared disaster
10. In a geographic area with an unemployment rate that is at or above 1.5 times the national unemployment rate.

States are now setting up systems to track individual compliance with this new requirement. States have ambitious, difficult timelines to set up systems that can gather and track this information and respond accurately. Many states are looking to link state data systems that can offer this information to Medicaid, such as linking a state tax system to the Medicaid system to determine hours worked in the appropriate time period.

States must begin the process of requiring potential beneficiaries to prove 80 hours of community engagement in the month previous to application, by December 31, 2026, and must outreach to impacted enrollees in the fall of 2026. The law and CMS guidance are not specific regarding a path back to coverage if a person can prove compliance in the future.

b. *Impact on low-income populations including those in HUD assisted housing and those experiencing homelessness.*

Many persons in HUD assisted housing will be those needing to prove 80 hours of community engagement and will struggle to comply. Those who need housing assistance, such as those experiencing homelessness, have to navigate the same systems with limited supports. While research shows that over 90% of those receiving Medicaid through Medicaid expansion are working, complying with hastily developed state systems is often the challenge. Persons who are not able to comply with the requirements will lose Medicaid health insurance coverage. States must decide if and when a person can prove compliance, what is the 'path' back for renewed coverage. The Congressional Budget Office's last estimate was that 4.8 million people would lose health insurance coverage over the next 10 years due to this requirement alone. This requirement is also the single largest cost savings to the federal government in the Medicaid aspects of HR1.

c. *State efforts and how to influence those efforts to limit harms*

States are setting up systems to gather needed information and ensure that those who are not compliant with the new reporting requirements are dropped from Medicaid health insurance coverage. States can prioritize maintaining coverage over other priorities. Cross-sector focus groups and consulting groups, particularly those with lived expertise, are needed to weigh in on the developing process. States can allow train and even fund 'application assisters' or those who can help potential beneficiaries prove compliance with the law's requirements. These staff can be notified when information is needed and have access to a persons' online account to help ensure compliance. Research has also shown in states that have put work requirements in place already, such as Arkansas and Georgia, that difficulty navigating compliance systems was the primary reason people lost coverage. In other

words, they were working but could not navigate state systems to prove they were working.

States have some flexibility in how they implement section 71119. States are setting up these tracking systems, so the systems can be designed with ease of access for the end user in mind. States can prioritize cross sector data sharing, so that the state's Medicaid Eligibility and Enrollment data system searches all other state data systems for compliance, before requesting information from the individual. States have the ability to request waivers from CMS in regard to persons experiencing "short term hardship." Montana has requested that homelessness be defined as a short-term hardship, and as of December, 2025, CMS has not ruled yet on this interpretation of the law.

d. *Needed long term efforts to mitigate harm*

Once states have their systems in place, case managers, services coordinators and other direct services staff will need to understand the new state system, who needs to comply with these requirements and how to assist them to keep their health insurance coverage active. States will need to be reminded to offer training and support outside the traditional healthcare sector networks and leverage the homelessness and housing sector partners. Training, support, advocacy, and coaching on how to effectively interact with these new systems and help them evolve to ensure continuous coverage will be critical efforts to prepare for in 2026 and execute in 2027.

II. HR1, Section 71103: Address Verifications or Preventing Duplicate Enrollments

a. *Policy and timeline*

To end duplicate enrollments between states, state Medicaid Eligibility and Enrollment systems will be setting up processes to verify addresses of all Medicaid enrollees. What happens to beneficiaries whose addresses cannot be verified, is unclear at this time and is likely to differ state by state. The law does not require CMS to issue guidance for how states must implement this policy or how CMS will ensure state compliance. States must submit their processes to CMS for approval in 2027 and these systems must be operational by 2029.

b. *Impact on low-income populations including those in HUD assisted housing and those experiencing homelessness.*

Persons whose addresses cannot be verified may lose their Medicaid health insurance coverage. Persons who have an address where they do not reside long term, may be at special risk, including those who use post office boxes, shelters, soup kitchens, drop in centers, or other programs that offer a mailing service and a mailing/ address service to those experiencing homelessness and housing instability. Persons leaving institutional care or carceral facilities are also likely to have an unstable address and be at greater risk for losing health insurance coverage.

c. *State efforts and how to influence those efforts to limit harms*

As with work requirements, advocates can work to influence state planning efforts to limit healthcare coverage losses. The stories of housing instability of people with lived expertise will be invaluable to these efforts. States officials also need to learn addresses of where vulnerable populations receive their mail, so the validity of those addresses will not be questioned.

d. *Needed long term efforts to mitigate harm*

State efforts to verify addresses will evolve over time and advocates, communities and individual voices will all be needed to ensure those systems are not disproportionately ending health care coverage for people with unstable housing or addresses. Strategies that prioritize that goal will be developed as all the states develop their systems, and best practices evolve.

III. HR1, Section 71107: More Frequent Eligibility Determinations

a. *Policy and timeline*

Beginning in 2027, persons whose Medicaid eligibility is due solely to low income will also have to prove to states their continued eligibility once every 6 months. Currently most Medicaid beneficiaries only need to prove eligibility once a year. During the COVID Public Health Emergency, these 'redeterminations" were paused for 2+ years, to ensure more people had healthcare coverage during the pandemic. States have been experimenting with decreasing the number of redetermination events to increase continuous health insurance coverage for critical populations, such as children under the age of 6. Research has shown that increasing complexity and frequency of redetermination processes is a barrier to coverage and increases the ranks of the uninsured.

CMS must provide guidance to states on this process by 12/31/25 and the process begins for those applying for health insurance after January 1, 2027.

b. *Impact on low-income populations including those in HUD assisted housing and those experiencing homelessness.*

As with work requirements, many low-income persons living in HUD assisted housing, or experiencing homelessness and housing instability will now have to prove Medicaid eligibility every 6 months. In a life in which basic needs might not be met, keeping up with this process is a barrier to health insurance and good health. Support to maintain coverage such as application assisters, would help more people comply with new requirements.

c. *State efforts and how to influence those efforts to limit harms*

States set priorities and ensuring that continuous coverage for all who qualify remains a state priority will be a crucial advocates priority in 2026. Supporting those with lived expertise to influence state processes can help. State support for application assisters to help those impacted by this policy change will make a significant difference. Application assisters, with the beneficiary's permission, should receive the same notifications as the beneficiary and have the same access to online systems to support compliance with redetermination systems. Application assisters should be funded and trained in their role to ensure success. Any way a state can make the process as easy and simple as possible will mean any number of people will maintain health coverage and experience the improved health benefits that are a part of health insurance coverage.

d. *Needed long term efforts to mitigate harm*

Application assisters will need to be funded and trained over the long term. Many direct services professionals such as service coordinators, peer navigators, and case managers can be trained in this role. Agencies can set up reminder systems to ensure that residents and staff are watching and responding when the state needs new materials or information.

IV. HR1, Section 71120: Cost Sharing

a. *Policy and timeline*

Persons who qualify for Medicaid, solely due to low income and whose household income is over 100% of the Federal Poverty Level (FPL), will now have to contribute financially to their health insurance coverage. States are required to ensure that these payments are "greater than $0 and not more than $35" and are not more than 5% of the household income. States cannot require these cost sharing measures for certain services including primary care, mental health care, substance use care or the services of a Federally Qualified Health Center or FQHC. As with all Medicaid programs, states will be setting up their systems to track this

requirement and maintain compliance. Cost sharing can mean premiums, in which people pay the state regularly to maintain coverage or can be collected at the provider level.

This aspect of the law goes into effect October 1, 2028.

b. *Impact on low-income populations including those in HUD assisted housing and those experiencing homelessness.*

Even co-pays as low as $1 have been shown to decrease access to care. People with fixed and low incomes, particularly those who are rent burdened, make difficult choices in budgeting and often healthcare is a lower priority than rent and food. With less access to care, people will not receive needed services, including primary care and behavioral health services. Over the long term, continued stable tenancy can be challenged or the ability to effectively navigate housing systems will grow in difficulty. With a goal of stable housing for all, helping people make these payments can improve their health and tenancy.

c. *State efforts and how to influence those efforts to limit harms*

States will have to set up systems to collect this revenue and ensure state and provider compliance with the law. State rules around who can contribute and how they can contribute to the cost sharing requirements, will make a difference in who accesses care. How states communicate around cost sharing requirements will also impact and housing and homelessness advocates should raise their voices to make these systems as flexible and inclusive as possible.

d. *Needed long term efforts to mitigate harm*

Direct services staff that intersect with active and potential tenants, need to understand these requirements and how to help those they serve navigate them. If public or private systems are set up to help with payments, then making sure all are aware of the process for access will be helpful.

V. HR1, Section 71109: Limits to insurance coverage for lawfully present immigrants

a. *Policy and timeline*

Historically, states have been able to access Federal Medicaid Funds for various immigration status groups, after the person has been a lawfully allowed US resident for 5 years. States may have offered health insurance coverage for other immigrant groups such as those here for less than 5 years, but that was a state-by-state decision, and only state funds could support those programs. Post HR1 enactment, states are limited in the immigration status groups that can be covered after 5 years, using federal funds. Those allowable groups are:

- Lawful Permanent Residents aka Green Card Holders
- Former residents of the Compact of Free Association nations
- Cuban and Haitian Migrants

States will be unable to access funds to support coverage for other immigrant groups beginning January 1, 2026.

b. *Impact on low-income populations including those in HUD assisted housing and those experiencing homelessness*

Anyone who falls outside the immigrant groups listed above is expected to have their health insurance coverage terminated as of January 1, 2026 unless the state steps in to cover the gap from lost federal funds. As with other barriers to care, lose of coverage is expected to lead to poorer health.

c. *State efforts and how to influence those efforts to limit harms*

The primary state option here is to continue coverage to immigrant groups, through 100% state funds. This will be a challenge in difficult state budget years, but one that would improve the health and wellbeing of these individuals.

d. *Needed long term efforts to mitigate harm*

Supporting individuals to gain access to immigration categories such as Legal Permanent Residency would help individuals regain health insurance coverage. Otherwise, only a reversal of HR1 would change these outcomes.

VI HR1, Section 71115 and 71117: Limits to state revenue generation via provider taxes

a. *Policy and timeline*

Medicaid, as a jointly financed state and federal program, requires states to generate revenue for the 'state share' of the Medicaid program. One mechanism many states have used is imposing provider taxes on the healthcare industry. HR1 limits state's use of provider taxes, setting a long-term cap and a gradual decrease in that cap over the next ten years. Many states must decrease their provider tax rates to be in compliance with the law. States that will need to cut provider tax rates in 2027 to comply with the law including Arizona, Colorado, Connecticut, Michigan, Rhode Island, Vermont and Virginia. With the expected decreases in state revenue, states are expected to develop new revenue strategies to maintain their Medicaid programs. If the states approach this work from a need to cut programs, research shows that 3 primary strategies are used, 1) States cut services offered, 2) States cut populations served or increased administrative burden so that fewer people maintain coverage, or 3) states cut what they pay providers for services. Strategic advocacy efforts are needed here.

b. *Impact on low-income populations including those in HUD assisted housing and those experiencing homelessness*

The impact on these populations depends upon how states address these new revenue shortfalls. Paying providers less means that fewer providers will accept Medicaid patients. Limiting populations or adding administrative burden means that people will lose coverage and be unable to access healthcare and other services. Limiting services means that those you serve will be in poorer health, with less access to needed services.

c. *State efforts and how to influence those efforts to limit harms*

States can also make an effort to raise revenue in other ways and not to use the strategies listed above. Experts remind us that with baby boomers now reaching retirement age, new revenue sources are needed to meet their needs. Advocates engaged in state efforts will need to partner and work strategically to ensure their priorities are met within state budgets.

d. *Needed long term efforts to mitigate harm*

Housing and homelessness advocates are advised to collaborate with their health sector partners in state-level advocacy efforts. Learning about statewide coalitions to ensure statewide continuous healthcare coverage for all, can create new coalitions that will maximize impact on state budget advocacy. Documenting any cuts, impact on the health of individuals and communities and tying that impact politically to HR1, can also, in the long-term prepare efforts to undo the law.

VII. HR1, Section 71112: Limits to Retroactive Coverage

a. *Policy and timeline*

Historically, Medicaid has paid providers for services rendered 90 days before a health insurance coverage decision was made by the state. As of January 1, 2027, states are only able to use federal funds to pay providers up to 30 days prior to the health insurance coverage decision.

b. *Impact on low-income populations including those in HUD assisted housing and those experiencing homelessness*

This new rule will also harm healthcare providers, particularly those who work with homeless populations. Those who find navigating Medicaid eligibility systems difficult

commonly only come in contact with the healthcare sector when ill, and historically, providers will sign up for coverage, while providing services. Providers who serve people who cannot navigate coverage eligibility requirements within 30 days for reasons such as identification, evaluations needed or other reasons will be providing uncompensated care.

c. *State efforts and how to influence those efforts to limit harms*

The law is clear, simple, and concrete with limited flexibility for states. The primary strategy will be to ensure an adequate provider network serving those receiving Medicaid financed services and work to ensure that providers remain fiscally sustainable despite this change.

d. *Needed long term efforts to mitigate harm*

Advocacy around the need for fiscal sustainability for providers who serve Medicaid patients is the primary strategy.

VIII. HR1, Section 71121: Home and Community Based Services (HCBS) Expansion potential

a. *Policy and timeline*

The law allows states new flexibility in designing services and eligibility categories of Home and Community Based Services (HCBS). HCBS are services that help people maintain community living and avoid costly institutional care. Beginning in July 2028, states may request waivers that have new flexibility in who they serve. Previously, states could only serve persons who needed nursing home or institutional care. Now, under the flexibility allowed in HR1, states can adapt their programs for a broader group of people, who may not meet stringent nursing home criteria.

b. *Impact on low-income populations including those in HUD assisted housing and those experiencing homelessness*

Residents of HUD assisted housing may now be able to access in home supports sooner, if their states choose and can fund new and expanded HCBS programs.

c. *State efforts and how to influence those efforts to limit harms*

Advocates can contact state Medicaid offices or local Area Agencies on Aging (AAAs) to see if their state is exploring this new services option.

d. *Needed long term efforts to mitigate harm*

Advocates should learn more about their state HCBS programs and how they can serve active and potential supportive housing residents.

Health Related Social Needs (HRSN) and Housing Related Services and Supports (HRSS)

Despite these challenges outlined above, many states are years into implementing Medicaid coverage of Housing Related Services and Supports (HRSS) and other Health Related Social Needs (HRSNs) screenings and services. Affordable housing advocates should be aware of the basics of their state's processes, so that they can leverage these new services, data and potential coalitions to achieve their goals of greater opportunities for ALL community members to thrive. States are screening Medicaid beneficiaries at time of medical care asking them if they have safe and affordable housing, access to food and other essential social needs. States will soon have screening data with these results to better document need in your communities, and advocates can use that data to support their efforts.

Persons with disabilities can benefit from supportive housing, a program model that combines affordable housing and support services in order to assist low-income persons with disabilities. Supportive housing

provides a chance for tenants to achieve affordable, stable housing to fully integrate into their communities. A 2019 CSH Needs Assessment estimates that creating an additional 1.1 million supportive housing units nationwide would address a variety of housing needs, including: homelessness, institutional placements, reentry from incarceration, and aging populations. Medicaid, as an entitlement program, is currently the only feasible program option for funding the supportive services needed to move beyond pilot programs and create supportive housing at scale.

The creation of new supportive housing generally requires three sources of funding:

1. The necessary **capital** to acquire land and build housing,
2. **Operating** subsidies to keep the housing affordable to persons with extremely low incomes, and
3. **Services** funding to assist persons with disabilities and other needs access, locate and maintain housing.

Notably, programs that use community landlords, commonly called scattered-site programs would not need capital funding, if a local landlord network will accept operating subsidies and agree to participate in a supportive housing program.

Creating or Adapting Your State's Medicaid Housing Related Services and Supports (HRSS) Benefit

For many communities, services funding can be the most challenging to access and braid with the other funding streams to create new supportive housing. In many states, advocates and state officials have worked together to leverage a state's Medicaid program to offer Housing Related Services and Supports (HRSS). HRSS commonly includes pre- and post-tenancy services. **Pre-tenancy services** help people find eligible housing and **post-tenancy services** help people maintain housing over time. For example, Massachusetts and Louisiana have been using their state's Medicaid plan for this purpose for close to two decades. The Centers for Medicare and Medicaid Services (CMS) offered guidance in 2021, noting that housing related services can be a voluntary choice of states to cover via Medicaid.

Advocates also play a role in ensuring that state choices are guided by principles of transparency and access. They can advocate for a program that serves as many people as possible while creating simple, accessible systems of access. Affordable housing and homeless services providers should also ensure that there is a clear pathway to reimbursement of their services. CSH is also tracking how and how much states are paying for these services and should release this analysis in early 2026.

Medicaid benefit programs often evolve in important details over time. States typically develop amendments to services, as persons served, providers, advocates, and family members provide feedback on which aspects of the program are working and which aspects are not. Advocates should know there is **always** the potential for change in the program. State or Managed Care rates for providers may also change over time, if providers can provide documentation that proves the cost of delivering care exceeds the rate of reimbursement. State may choose to pay providers through one of the three most common payment mechanisms:

- 15-minute increments
- Per diem (a daily rate)
- Per Member, Per Month (PMPM)

Out of these methods, PMPM rates provide the lowest administrative burden for providers. On the other hand 15-minute increment payments are the most burdensome for direct care workers and agencies to document and bill.

Align the Benefit with Affordable Housing in Your Community at the Systems Level

HRSS will only create new supportive housing if persons in need can access these services AND the affordable housing needed to create supportive housing. Structural connections need to be in place at the systems level between these new HRSS and the affordable housing options in communities. Since approximately only 1 in 4 persons who qualify for housing assistance receive that assistance, communities will have to be develop cross sector referral systems between these new housing related services and affordable housing opportunities in communities. Waivers in Arizona, California, and Oregon can offer short-term housing options of either Medical Respite (called Recuperative Care by Medicaid) or six months of housing assistance. These programs can be bridges to long-term affordable housing opportunities in communities, but only **if** that affordable housing exists and is linked systemically to these Medicaid-funded housing options. Aligning these systems should occur at the government or system level. To align housing and services, communities need to establish a a **cross-sector referral system** between housing and services. Equity needs to be centered in the process of creating such a referral system. In an ideal, equitable system, individuals are referred to housing options in a community, including short-term housing options. There should be no gap between these shorter-term settings and when individuals enter permanent, affordable housing options.

For systems to come together to create a cross-sector referral system, both sectors need to be aligned on serving the same population with similar goals. If the housing sector is prioritizing persons experiencing chronic homelessness or those over age 65, who is the health sector prioritizing? Data matching between systems can help determine a priority population and create a list of people who meet all eligibility criteria and can be engaged for these housing opportunities. Without alignment on populations served, a state or community risks leaving groups without services and serving no one effectively.

Next Steps for Advocates

LEARN: WHERE IS MY STATE MEDICAID PLAN, REGARDING HOUSING RELATED SERVICES AND SUPPORTS (HRSS)?

Use the CSH interactive map to determine if your state offers these services and to whom. If your state does not offer these services, advocate to have these services covered by your state's Medicaid plan. Likewise, get involved and raise issues with your state legislators or Medicaid offices around populations served, linkages to long-term affordable housing, and how can your state can make Medicaid enrollment simpler and easier. Organize housing and homeless services providers around the challenges that make it difficult to operate efficiently, and advocate to eliminate or reduce those barriers. If your state is not a Medicaid expansion state, support and join the state coalition working on that issue.

NETWORK

Who are the healthcare partners in your state that are advocating for continuous healthcare coverage for all and implementing either HRSS or Health Related Social Needs (HRSN) programs? What are they learning and finding about those needs in your communities? How are they addressing those needs and resource gaps? Are they authentic partners with community members and social services organizations that are already on the ground and addressing those needs? As a growing number of health care partners recognize the need for affordable housing, you have an opportunity to build a network and coalition of new healthcare partners.

RESEARCH

If your state has a HRS benefit, who is accessing the benefit and what is the impact on health outcomes? Is the benefit reducing health costs and helping people thrive in communities? If so, tell that story! What reports do your state already have about the benefit that need to be promoted in order to gain broader support or effect change? Does your benefit have significant administrative barriers that hinder progress? How can those barriers be eliminated or reduced?

ORGANIZE

If your state does not have a benefit, organize those who would benefit to tell their story about why expanding access to housing is so important to your community. If your state does have a benefit, but the benefit is inaccessible, communicate the impact this fact has on community members. If your state is doing well, tell that story to demonstrate impact and maintain support for the program.

CONCLUSION

For 2026, state Medicaid programs will be revising budgets and adapting for managing a program with billions less in federal funding. Mitigating harm by actively engaging with your state and state coalitions should be a priority for 2026 advocacy efforts. As more healthcare providers are screening for homelessness and housing instability as part of Health-Related Social Needs (HRSNs) efforts, this data can be used to move towards a better understanding of the resource gaps in our communities. Affordable housing advocates can find powerful new partners in their work. The voices of people with lived expertise (PLE) of institutionalization and housing instability must be centered in these evolving efforts. This advocacy work is essential to ensure full community integration, an end to homelessness, and making sure that everyone in need has access to affordable and supportive housing in communities of their choice.

For More Information

H.R.1 - 119th Congress (2025-2026): One Big Beautiful Bill Act | Congress.gov | Library of Congress (https://www.congress.gov/bill/119th-congress/house-bill/1)

Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline | Congressional Budget Office (https://www.cbo.gov/publication/61570)

Medicaid and CHIP program names in your state | HealthCare.gov

Late State Budgets (https://tr.ee/fkl1qL)

Status of State Medicaid Expansion Decisions | KFF (https://tr.ee/DKEBh3)H.R.1: What It Means for Medicare Beneficiaries - California Health Advocates

2025 Medicaid Guide (https://www.bazelon.org/wp-content/uploads/2025/12/2025-Medicaid-Guide.pdf)

One Big Beautiful Bill Act: State-Level Advocacy Actions for the HCH Community - National Health Care for the Homeless Council (https://tr.ee/3kVMUH)

Medicaid Access Under H.R. 1: Critical Changes - National Alliance to End Homelessness (https://tr.ee/lx9ITx)

Prepare. Enforce. Protect: Medicaid + ACA Defense - National Health Law Program (https://healthlaw.org/prepare/)

H.R. 1 and State Budget Impacts - Updates for Aging and Disability Advocates - Justice in Aging (https://tr.ee/jYNvOM)

State Solutions to Ensure Continuous Medicaid Coverage for Eligible Individuals - Corporation for Supportive Housing (https://tr.ee/fSj5GT)

H.R.1 Reshapes Medicaid: What Housing Providers Need to Know Now - Corporation for Supportive Housing (https://tr.ee/a9Dni4)

State Solutions to Ensure Continuous Medicaid Coverage for Eligible Individuals - Corporation for Supportive Housing (https://tr.ee/0QZPLe)

State Requirements to Establish Medicaid Community Engagement Requirements

Medically-frail-Advocacy-IMPROVE-FINAL.pdf (https://tr.ee/qACMzY)

SHVS_Work-Requirements-State-Considerations-When-Defining-Medical-Frailty_10.23.2025.pdf (https://tr.ee/SWyzB6)

State Requirements to Establish Medicaid Community Engagement Requirements (https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf)

Understanding the Intersection of Medicaid and Work: An Update | KFF (https://tr.ee/XKMOw1)

How Medicaid cuts could lead to loss of coverage for millions | Harvard T.H. Chan School of Public Health (https://tr.ee/bf3RPd)

Pathways to Coverage: Looking Back Two Years and Into the Future - Georgia Budget and Policy Institute (https://gbpi.org/pathways-to-coverage-looking-back-two-years-and-into-the-future/)

mt-he-lvhd-prtnrsp-pndg-help-aplctn-pa.pdf (https://tr.ee/SA9mqO)

Understanding Medicaid redetermination and eligibility requirements (https://www.healthinsurance.org/medicaid-redetermination/)

Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage | KFF (https://tr.ee/3sVL23)

How H.R.1 Impacts Coverage for Non-Citizens (https://shvs.org/how-h-r-1-impacts-coverage-for-non-citizens/)

COFA SHO Letter (https://www.medicaid.gov/federal-policy-guidance/downloads/sho21005.pdf)

CMS Issues New Guidance on H.R. 1's Restrictions on State Use of Provider Taxes to Finance Medicaid – Center For Children and Families (https://tr.ee/uwHXFM)

History Repeats? Faced With Medicaid Cuts, States Reduced Support For Older Adults And Disabled People | Health Affairs (https://tr.ee/CHrsHE)

A Balanced Budget Amendment Doesn't Change the Math | Center on Budget and Policy Priorities (https://tr.ee/fVD8Lo)

CSH Summary of Medicaid State Actions - Spring 2025.pdf (https://tr.ee/mQQeyG)

https://www.csh.org/supportive-housing-101/data/#Need (https://www.csh.org/csh-solutions/data/#Need)

Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov; https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf)

https://tr.ee/utVLVS

https://tr.ee/ulwxU2

https://www.dhcs.ca.gov/calaim

https://tr.ee/ODXSGS

Medicaid Update 2025 | Tableau Public (https://tr.ee/TKlo1g)