H.R.1 Health Care Access Strategies

A Report from the H.R.1 Health Care Access Workgroup

NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Parker 25th ANNIVERSARY Family Health Center
CARING FOR FRIENDS, NEIGHBORS and COMMUNITY...

About the New Jersey Health Care Quality Institute

Mission

Improving the safety, quality, and affordability of health care for everyone.

Vision

A world where all people receive safe, equitable, and affordable health care and live their healthiest lives.

Values

To support healthy communities and individuals, the Quality Institute believes that health care should be:

- Safe and of high quality;
- Accessible and affordable;
- Equitable, respecting individual dignity; and,
- Transparent to promote accountability and quality improvement.

Parker Family Health Center

25TH ANNIVERSARY

CARING FOR FRIENDS, NEIGHBORS and COMMUNITY...

*The mission of the Parker Family Health Center is to operate a **FREE** health care facility where Monmouth County residents **without health insurance or the means to pay for medical care** can be treated with dignity and compassion.*

Over 210 volunteer medical and non-medical volunteers provide free care for over 1600 county residents in primary care and 14 specialties.

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H.R.1 Health Care Access Workgroup Purpose and Goals

The Issues

- H.R.1 brings major reductions in federal Medicaid funding
- New verification and enrollment requirements for Medicaid ACA expansion population create significant operational challenges
- Changes in federal immigration policy will further affect coverage pathways
- Expiration of ACA tax credits has increased cost of individual market premiums and furthered unaffordability of insurance
- Anticipated increase in number of uninsured people and how they will access care
- New Jersey's incoming administration must address access and financing issues that impact every community

Our Charge

- Develop consensus-based, evidence-informed strategies to ensure:
  - Individuals eligible for Medicaid can enroll and maintain coverage
  - Uninsured residents have access to essential health care services
  - State and private financing models are aligned to support a sustainable safety net for everyone

Why This Workgroup

- Builds on lessons from Medicaid unwinding and prior large-scale enrollment efforts
- Engages cross-sector leaders to craft actionable solutions for the next administration
- Ensures approaches are equitable, regionally responsive, and grounded in real operational NJ experience

Purpose of This Project

Support the incoming administration in responding to coverage and access disruptions created by H.R.1

Preserve Medicaid coverage for eligible residents

Reduce avoidable coverage loss during renewals and work requirement verification

Support residents and providers with clear communication and navigation

Ensure access to care for people who are or become uninsured or underinsured

Identify near term actions that can begin during the administrative transition alongside longer term system reforms

How This Work Was Conducted

Formation of the H.R.1 Health Care Access Workgroup with cross sector representation- over 60 people representing industry, health care, insurance, advocates, community organizations, immigrants, legislature, and state and local government. The process was guided by a multi-disciplinary steering committee.

Alignment on H.R.1 policy changes, timelines, and risks.

Three structured workgroups focused on key system challenges and strategies to mitigate impact and ensure maintenance of Medicaid and access to care.

Synthesis of all strategies to identify shared priorities and next steps.

This report and recommendations reflect consensus across policy experts, community and consumer advocates, state and county government, system leaders, health plans, and frontline providers.

The Impact of H.R.1

H.R.1 Impacts- Overview

H.R.1 introduces new enrollment and verification requirements, including increasing the frequency of verification for the adult expansion population.

County and state eligibility systems are already under operational strain.

Hospitals and safety net providers are facing an uncertain and challenging financial future.

Without early intervention, H.R.1 is expected to increase Medicaid churn and coverage loss Medicaid and lack of federal action on tax subsidies is expected to increase coverage loss in the ACA Individual Marketplace.

Coverage loss will increase uncompensated care, avoidance of care, escalation of disease progression, and higher rates of emergency department use for care.

Early coordinated action can prevent avoidable harm and reduce downstream system costs.

H.R.1 Mandatory Work Requirements and Increased Verification- ACA Expansion Population

- Currently, there are no “community engagement” or work requirements for most NJ FamilyCare applicants.
- HR 1 requires working age adults enrolled in Affordable Care Act expansion group to meet “community engagement” or work requirements - certain populations are exempt, (See subsequent slide for more detail).
- Work requirements can not be waived.
- States must implement by December 2026 (Deadline can be extended at federal discretion to 2028) but CMS has indicated that federal extensions will not be granted without strong cause.
- An estimated 300,000 individuals may lose (or fail to obtain) Medicaid coverage, mostly due to difficulty producing required documentation.
- Could result in $2.5 billion in lost federal investments in New Jersey’s healthcare system each year.
- Beyond work requirements, all individuals enrolled in the ACA expansion group will be required to reverify eligibility every six months.
- Both work requirement and increased frequency of verification will have extensive administrative burden and cost.

ACA Funding Loss in New Jersey: Immediate Financial and Coverage Impacts

The loss of enhanced Affordable Care Act (ACA) premium tax credits at the end of December 2025 will have major impacts in New Jersey:

New Jersey expects to lose more than $500 million in federal premium assistance that has made coverage more affordable for hundreds of thousands of residents. Of current enrollees, approx 450,000 will see premiums increase significantly, with 60,000+ losing federal subsidies.

The uninsured rate in New Jersey had begun to rise again before the subsidy loss, climbing to about 7.7% overall, with over 600,000 residents uninsured, and as high as 10.8% among adults ages 19–64.

A significant uptick in uninsured and underinsured residents will directly lead to increased *uncompensated care* burdens on hospitals and clinics, especially acute care centers and emergency departments (EDs).

Access to Care for the Uninsured

- When seeking care, uninsured New Jerseyans rely on Free Clinics (NAFC), Community Health Centers (CHCs, Federally Qualified Health Centers, FQHCs) and Emergency Departments.
- New Jersey hospitals have some of the highest average ER costs in the United States, with moderate-severity ED visits billing around $3,087 per visit before insurance—well above the national average. https://www.unbiased.com/discover/banking/healthcare-costs-in-new-jersey
- As residents lose insurance or see their premiums and deductibles escalate, many may *delay care or skip preventive and routine visits* until conditions become serious. When this happens, patients disproportionately seek care through EDs, the costliest setting.
- Hospitals in New Jersey will see rising numbers of uninsured patients seeking care, particularly in EDs where patients are *legally entitled to treatment regardless of ability to pay*.
- This shift increases both overall health spending and the financial strain on hospitals forced to provide uncompensated care or incur costs higher than reimbursements.

Loss of Federal Funding & Policy Changes Impact Access

- In a policy shift - HHS's reinterpretation of Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) classified the Community Health Centers as a "federal public benefit" meaning that non-qualified aliens (e.g., undocumented immigrants) would no longer be eligible to access federally funded services through the Centers. This HHS action has been temporarily stayed in states that sued the federal government – including New Jersey.
- If upheld, HHS's PRWORA reinterpretation would prevent FQHCs from using federal funds to provide care to non-U.S. citizens or "non-qualified aliens." FQHCs would have to rely upon other private and non-federal funds to support such activity, which negatively impact their finances.
- The PRWORA reinterpretation would require FQHCs to adjust their internal processes including eligibility screening, and may create operational challenges, and overall uncertainty about serving undocumented patients. The HHS rule reinterpretation has been challenged in federal court by several states including NJ and for now has been temporarily stopped from going into effect. The situation is fluid and uncertain.

Loss of Federal Funding & Policy Changes Impact Access

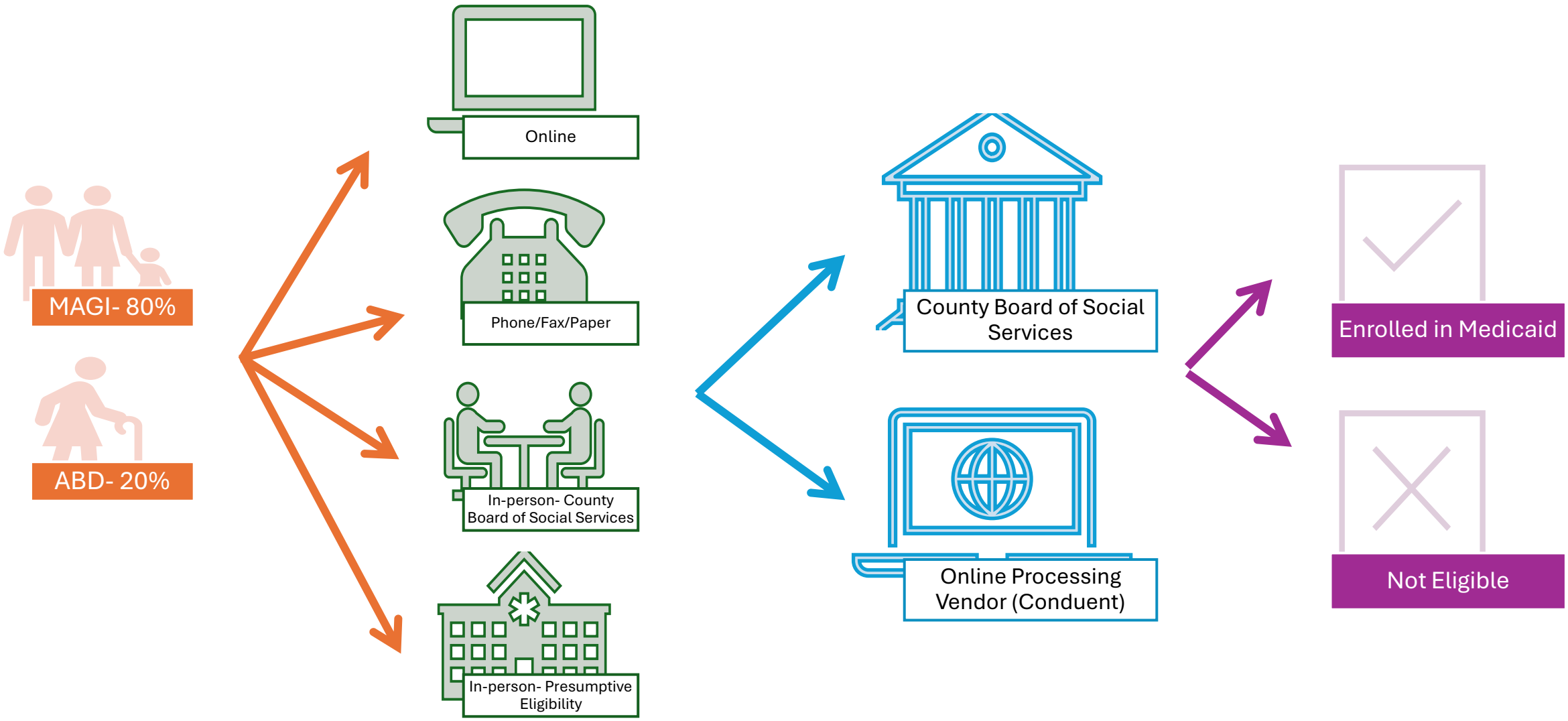
- The recission of the number of countries included as part of the Temporary Protective Status (TPS) designation which previously included El Salvador, Haiti, and Venezuela, means these New Jerseyans will lose their insurance coverage and be considered non-qualified aliens for purposes of a federal benefit.
- The loss of TPS designation will also impact medical staffing, as removal of TPS will eliminate individuals' ability to work.
- Now, DACA recipients are no longer eligible for ACA subsidies. New Jersey currently has 22,000 DACA recipients.
- H.R.1 also blocks federal Medicaid payments to Planned Parenthood, shifting the entire funding costs to the State and private funds and potentially harming access to contraception, cancer screenings, sexually transmitted infection (STI) care, and other preventive services for individuals who rely on these centers for care.
- CMS and HRSA have proposed new rules that would bar hospitals and community health centers from providing gender-affirming care to minors and prohibit the use of federal Medicaid/CHIP funding for such care, effectively eliminating Medicaid and Medicare funds for these facilities offering puberty blockers, hormone therapy, and related services to transgender youth if the rule is finalized.

Current Processes and Access Pathways

Enrollment in Medicaid- Today's Process (Simplified)

- Approximately 1.8 million individuals are enrolled in NJ FamilyCare.
- A little more than 80% are enrolled through MAGI eligibility groups.
    - MAGI (Modified Adjusted Gross Income) eligibility includes children, pregnant individuals, parents and caretaker relatives, and adults covered under the Affordable Care Act (ACA) Medicaid expansion
- The remaining less than 20% are enrolled through Aged, Blind, and Disabled (ABD) eligibility groups.
- Individuals may apply for Medicaid through several channels:
    - Online, including through the Get Covered New Jersey Marketplace, which is integrated with Medicaid eligibility screening
    - County Social Service Agencies, one in each county
    - By phone, fax or paper application
    - Presumptive eligibility, typically at hospitals or FQHCs, which provides temporary coverage while a full eligibility determination is completed
- While applicants can enter through different doors, the eligibility determination process is centralized into two operational pathways.
- Regardless of where an application begins, it is ultimately routed to one of two primary eligibility processing pathways: County Social Service Agencies or the State's eligibility vendor, Conduent, depending on the applicant's eligibility category.

Enrollment in Medicaid- Today's Process (Simplified)



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Eligibility Processing Pathways

- **County Social Service Agencies**
  - County welfare agencies in all 21 counties play a central role in eligibility determinations:
  - They are responsible for nearly all ABD cases, due to their complexity.
  - They also process a significant portion of MAGI cases, particularly those that are more complex or require additional verification.
  - Counties handle ongoing case maintenance for many beneficiaries, including renewals and changes in circumstance.
  - Each county operates its own agency, but they function within statewide eligibility rules and systems.
- **Conduent (Health Benefits Coordinator)**
  - Conduent is the State's contracted Health Benefits Coordinator and operates the **BenePath** eligibility system.
  - Conduent processes a large share of MAGI-only cases, particularly those routed through automated or streamlined pathways.
  - These cases tend to be more straightforward, income-based determinations.
  - Conduent functions as part of the State's centralized eligibility infrastructure rather than a county-based system.

Ex Parte Renewals and Current Performance

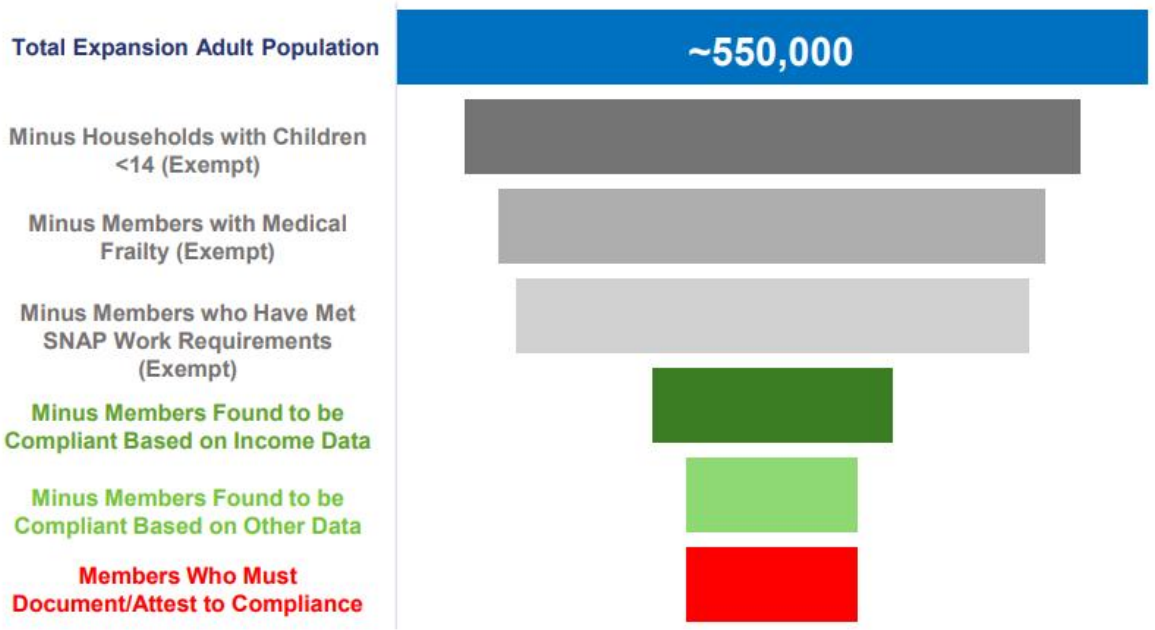
- ***"Ex parte"*** is the state process of automatically renewing a person's coverage using data it already has (like income info from SNAP or tax records) without the beneficiary filling out forms, a ***contactless*** process.
- This ensures eligible people keep coverage, reducing paperwork, and preventing unnecessary disenrollments. It is also called auto-renewal or passive renewal.
- Ex parte renewals allow Medicaid coverage to be renewed using existing data without contacting the enrollee
- Get Covered NJ, New Jersey's individual marketplace, achieves a much higher rate of *ex parte* renewals
- Medicaid *ex parte* renewal rates have increased significantly since the beginning of the unwinding, where NJ had a rate in the teens, with significant work done to increase to its present 40 to 50% range. Medicaid *ex parte* renewal rates have improved to achieve the 40 to 50 percent range, but more work remains to achieve the levels found in high-performing states
- The remaining Medicaid population is harder to reach and more likely to churn off of coverage because manual data is required
- H.R.1 work requirements will further increase churn risk
- Improving *ex parte* performance is the most effective strategy to preserve coverage

Challenges in Medicaid Enrollment- Today's Process

- New Jersey relies on multiple enrollment and eligibility technology systems for Medicaid enrollment and eligibility determination, including systems run through the counties, Conduent, and Get Covered.
- Insurance Enrollment whether for the ACA Marketplace or Medicaid is supposed to operate under a "no wrong-door approach" for enrollee.
- In practice, because there are different technology platforms and many different enrolling entities, the information provided by the member may be handed off or transferred from one entity to another, sometimes leading to delays in processing and uncertainty for the member as to where they stand in the process.
- When not verified for renewal via *ex parte*, members are required to verify information rather than transition seamlessly in a contactless manner.
- Coverage gaps can occur even when individuals remain eligible because of procedural loss of coverage and they are required to reapply.
- System fragmentation increases administrative burden and avoidable coverage loss

Work Requirements: Key Steps

1. Begin with **total expansion population** (**blue bar** at the top)
2. Identify **exempt members** using existing data sources (three **gray bars** under the blue bar)
3. Identify **compliant members** using existing data sources (two **green bars** under the gray bars)
4. Request that **remaining members** submit documentation/attestation of exemption or compliance (**red bar** at the bottom)



*Slide text and graphic: October 2025 NJ MAAC Meeting

How Free Clinics Work Today

- There are currently 5 free clinics located in Bergen, Monmouth, Ocean, Camden and Cape May counties.
- Free clinics are prohibited from charging a fee for service and provide a medical home for uninsured or underinsured New Jerseyans.
- Free clinics do not receive or rely on Federal funding.
- Free clinics rely on a small number of paid staff and a large number of volunteer medical and non-medical professionals.
- Free clinics can operate as doctor's offices or as ambulatory care centers.
- Free clinics, like Community Health Centers, are overseen by HRSA and obtain their malpractice coverage under the Federal Torts Claims Act. Free clinics partner with hospitals, FQHCs, and social service agencies to provide comprehensive, high-quality care.
- In addition to primary care, most free clinics also provide specialty care, as well as wrap-around services.

How Federally Qualified Health Centers Work Today

- There are 23 FQHCs in New Jersey that operate 138 sites throughout the state.
- FQHCs are governed by a Board of Directors, the majority of which (51%) is comprised of actual FQHC patients.
- FQHCs are required to fulfill operational and clinical guidelines established by the Health Resources and Services Administration (HRSA), US DHHS.
- FQHCs are required to adhere to strict quality standards. A majority of NJ FQHCs are NCQA or Joint Commission recognized as Patient Centered Medical Homes.
- FQHCs are open to all, regardless of a patient's ability to pay. FQHCs offer a sliding fee scale to make health care affordable for all New Jerseyans.
- NJ FQHCs serve over 620,000 patients annually. Over 53% of FQHC patients are Medicaid (1 in 6 New Jerseyans) insured and 27% are uninsured.
- Over 94% of FQHC patients are low income (at or below 200% of the FPL).
- Over 44% of FQHC patients are best served in a language other than English.
- FQHCs serve a large number of special populations comprising the homeless, seasonal farm workers, veterans, public housing residents, and school aged children.

Source: 2024 Uniform Data System, US Department of Health and Human Services.

How Federally Qualified Health Centers Work Today

- New Jersey's Federally Qualified health Centers (FQHCs), also known as community health centers, provide high quality, primary and preventive health, dental and behavioral health services to the medically underserved populations in New Jersey.

- FQHCs provide continuity of care that is sustained throughout a patient's lifetime, from birth to old age and this care is not disrupted if the patient's insurance status changes.

- While FQHCs are established under a federal statute and follow federal guidelines, they have formalized collaborations with the State and Local Health Departments that allow them to provide an extensive healthcare safety net for all patients regardless of their insurance status.

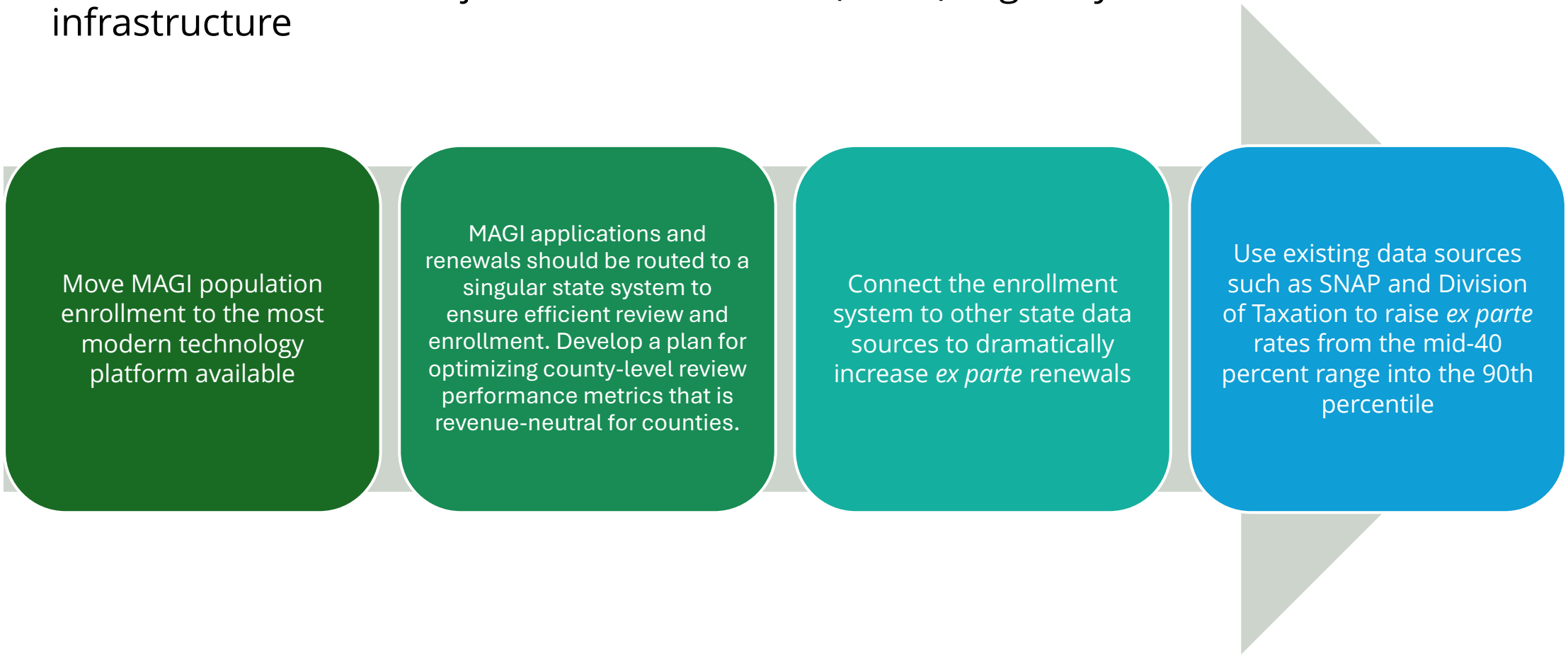
- FQHCs partner with hospitals, local providers, and other social service agencies to provide comprehensive, high quality primary care to a wide variety of patients including the Homeless, public housing residents, veterans, seasonal farm workers and school-aged children. A few examples of these partnerships include ambulatory care services at hospitals reducing cost of care; providing residency, and preceptorship opportunities to promote workforce solutions; and conducting mass testing and vaccination clinics to address public health emergencies and seasonal needs.

Enrollment Systems and Technology

Priority Actions

Enrollment Systems and Technology: Priority Actions to Protect Coverage Under H.R.1

- Modernize Modified Adjusted Gross Income (MAGI) eligibility enrollment infrastructure



Enrollment Systems and Technology: Priority Actions to Protect Coverage Under H.R.1

- Existing state procurement laws significantly slow technology procurement processes and are not reflective of the complexity of the product and contract needs. ***These actions will need to be addressed as an immediate priority.***

Verify emergency procurement process and permission of exceptions in the case of emergency to determine allowances.	Address Antiquated Medicaid Technology and Procurement Barriers	Assess whether H.R.1-related risks justify emergency contracting or expedited rulemaking	Consider expanding or modifying existing state vendor contracts	Explore accelerated procurement options

Enrollment Systems and Technology: Priority Actions to Protect Coverage Under H.R.1

- Ensure modernized and integrated technology solutions.

Get Covered NJ is NJ's most modern insurance platform

Integrating MAGI Medicaid eligibility into Get Covered NJ would allow NJ to connect to additional data sources, like SNAP, Division of Taxation, and commercial data verification tools.

These integrations could increase Medicaid's *ex parte* renewal rate from the current 40 to 50 percent range to 70 to 80 percent, consistent with other states that use their state-based marketplaces for MAGI Medicaid determinations.

As a near-term solution, Medicaid could use the Get Covered NJ application portal for all MAGI Medicaid and CHIP applicants and leverage Get Covered NJ's *ex parte* and verification tools at renewal.

Get Covered NJ would then transfer enrollee information, including completed work requirement data, back to Medicaid to finalize eligibility determinations.

Enrollment Systems and Technology: Priority Actions to Protect Coverage Under H.R.1

- Design H.R.1 Work Requirement Verification Strategically

H.R.1 work requirements are assessed using income, not hours worked

The threshold is 80 hours at the federal minimum wage

This equates to approximately $580 per month in AGI

Verification systems should be designed around income testing rather than hourly tracking

Outreach and Enrollment Assistance

Priority Actions

Outreach and Enrollment Assistance: Supporting Members to Enroll and Stay Enrolled

- Develop clear, coordinated public communications

Develop plain-language explanations of Medicaid, including eligibility, how and where to enroll, how to get assistance, and renewal timelines

Implement layered communications on H.R.1 and Medicaid, including broad public awareness and direct outreach to individuals who are enrolled or eligible

Ensure all messaging is consistent, multilingual, culturally responsive, and written at an appropriate literacy level, with tailored materials for providers, MCOs, and community-based organizations

Create and implement a comprehensive, multi-year communications plan in partnership with community-based organizations

Outreach and Enrollment Assistance
Supporting Members to Enroll and Stay Enrolled

- Improve transparency in enrollment status

Enable members, Medicaid vendors, MCOs, navigators, and enrollment organizations to see real-time enrollment status of an application

Provide visibility into where an individual is in the enrollment process, through a self-serve system

Share renewal dates, application status, expected timelines, and missing information with providers and navigators

Add additional information (*e.g.*, renewal dates) to the 834 file sent by the state to MCOs so they can notify members and support reenrollment

Ensure that members are enrolled in the appropriate Medicaid program, including determining dual eligibility with Medicare.

Outreach and Enrollment Assistance
Supporting Members to Enroll and Stay Enrolled

- **Enable provider-based enrollment support and expand navigator access and capacity**

Create a central portal that allows health care providers to view member renewal status

Allow providers to identify missing documentation or upcoming renewal deadlines

Use provider touchpoints to reinforce enrollment and renewal messaging

Ensure members have access to culturally responsive navigators

Recognize that not all members can enroll or renew online

Provide in-person and phone-based assistance in addition to online tools

Outreach and Enrollment Assistance: Supporting Members to Enroll and Stay Enrolled

- Navigation, retention, and appeals support

Increase funding to recruit, train, and retain navigators to support enrollment and renewal

Expand trusted, community-based navigation supports, targeted to populations at highest risk of disenrollment

Resource and fund organizations to assist with verification, appeals, and denials, ensuring continuity of support throughout the process

Outreach and Enrollment Assistance
Supporting Members to Enroll and Stay Enrolled

- Subject matter expertise and centralized member support

Fund and coordinate organizations serving all 21 counties, with resources allocated based on demographic and enrollment risk data

Deploy subject matter experts to provide real-time guidance on complex eligibility and enrollment issues, supporting each county

Establish a centralized, responsive resource hub accessible via app and call center

Ensure the hub supports multiple languages and literacy levels and is designed around member demographics and geography

Access to Care for the Uninsured

Priority Actions

Access to Care: Steps to Increase Access and De-Escalate Emergency Department Use

- FQHCs and hospital clinics provide alternative options for care but rely on federal funding.
- Free clinics, including satellite locations of existing free clinics, provide a solution, as free clinics do not rely on federal funding. This solution requires consideration of the following priorities.

Identify geographic areas of need

Partner with

Hospital systems and provider systems

Build Staffing Model

Funding

Communications

Access to Care: Steps to Increase Access and De-Escalate Emergency Department Use

- Geographic Areas of Need and Shared Spaces

Over 10% of residents live below 150% of the Federal Poverty Level in 12 of New Jersey's 21 counties

Look to hospitals, Federally Qualified Health Centers (FQHCs), county health departments, and to provide shared space as well as some services. Regional Health Hubs may be able to provide data support.

Identify where more free clinics (which charge no fees), or community health centers (which utilize a sliding fee scale) are needed, focusing on sites where people already go for care.

Access to Care: Steps to Increase Access and De-Escalate Emergency Department Use

- Fostering Hospital Buy-in And Partnership

Strengthen hospital participation in this effort to meet increased demand for uninsured care

Increase collaboration in a competitive space – recognizing potential challenges as organizations that previously competed for resources now need to work together

Look to hospitals to provide diagnostics and specialty care including reproductive health, LGBTQ, and dental care

Access to Care: Steps to Increase Access and De-Escalate Emergency Department Use

- Staffing

Expand paid and volunteer clinical staffing pipelines using hospitals, medical associations, nursing students, medical trainees, CHWs, dentists, and dental hygienists, and County Medical Reserve Corp volunteers

Consider incentives such as tuition waiver programs and loan repayment plans for residents, dental, medical students who commit to primary care in New Jersey

Provide financial incentives for medical professionals working in hospitals to volunteer their time in satellite clinics

Consider utilization of technological innovations like Clinic in a Box

Access to Care: Steps to Increase Access and De-Escalate Emergency Department Use

- Funding: Secure sustainable funding for clinics, diagnostics, and outreach.

State appropriations

In-kind and/or direct financial funding from hospitals, provider networks/systems

Private funding

County funding

Braided funding

Access to Care: Steps to Increase Access and De-Escalate Emergency Department Use

- Communications: Develop coordinated and culturally literate communications to alleviate the burdens on emergency departments

Communicate and coordinate with community, care providers, FQHCs, free clinics, to alleviate demands on emergency departments

Alert hospitals of satellite sites and other available options to treat non emergent cases

Coordinate with State, County, and local government departments regarding available medical and dental care options

Access to Care: Sustainability

Create Turnkey Operational Models to be implemented throughout the state

Format cost modeling / budgeting templates to be shared throughout the state

Research transportation solutions for ensuring patient access to care

Look for state, county, and local advocacy promoting alternative care to emergency rooms

Outstanding Questions and Data Needs

Outstanding Questions and Data Needs

These questions identify additional data, financial modeling, and policy design work is needed

They are intended to guide priorities for the next phase of H.R.1 implementation planning

Focus areas include enrollment and verification, access expansion capacity, coverage gaps, and long-term systems design

Medicaid Enrollment and Work Verification

What lessons can New Jersey apply from the ACA rollout, Cover All Kids, COVID vaccine outreach, and the Medicaid Unwinding related to engagement, education, enrollment workflows, partnerships, and communications?

How should New Jersey define “medical frailty,” including timing and flexibility, and should the State develop a definition now using other programs and ICD-10 codes? What would modeling show about how many people would qualify and the impact on *ex parte* rates?

For the high unemployment area exemption, how many areas would qualify and how many people would be covered? What are potential downsides, including implementation complexity or unintended coverage gaps?

How can the NJ Department of Labor NJ CARE Program and its CBO network supporting TANF and SNAP enrollees be used to support enrollment outreach and work verification processes?

Access to Care

What are the projected costs for clinics and community providers absorbing increased patient loads, including staffing, space, supplies, and uncompensated care?
How will detained individuals reliably access medication continuity and necessary clinical care?
What strategies best support TPS holders who are critical health care workers, including enrollment stabilization and workforce retention?
How much funding remains unclaimed across federal, state, and county sources that could support access expansions?
How will specialty care including pediatric, dental, reproductive health care and LGBTQ care be incorporated into expanded access pathways, including coverage, referral networks, and provider capacity?
How many uninsured individuals currently rely on hospitals for long-term care, and what alternatives exist to reduce avoidable hospital dependence?
Should New Jersey deploy grant funding to help medical and dental providers serving uninsured patients absorb high supply and operating costs?
How will oral health be incorporated into overall health access strategies, including integration with primary care and referral capacity?

Data Sources Needed to Inform the Work

DOBI commercial market enrollment
DOBI Exchange enrollment and plan design trends, including metallic tier and cost sharing
DHS measures of Medicaid enrollment
Census Bureau annual health insurance coverage estimates
NJ hospital charity care amounts by hospital
NJ hospital community benefit levels by hospital
Number of county employees working on Medicaid eligibility determinations
Eligibility determination turnaround time by county
Eligibility determination turnaround time for Conduent
Percentage of *ex parte* renewals

Appendix

Appendix- Background References

Resource	Type	Summary
Summary of Public Health Impacts – OBBB	Summary	Summarizes anticipated population-level health impacts of OBBBA.
MAAC Meeting Presentation 10-30-25 and Video	Slide deck and presentation	Overview of work requirements under H.R.1 and outlines New Jersey's planned implementation framework for work requirements including system updates, automatic renewal, and cross-agency coordination needs.
MAAC Meeting Presentation 07-17-25 and Video	Slide deck and presentation	Outlines federal Medicaid changes including work requirements, eligibility checks, reduced retroactive and immigrant eligibility, major limits on provider taxes and state-directed payments, and large federal funding cuts and their impact for New Jersey
Implementation Dates for Health Provisions	Reference chart	Shows timing of H.R.1/OBBB implementation changes affecting both pathways.
Provisions on Immigrants' Access to Public Benefits in the Final Reconciliation Package	Fact sheet	Outlines the major changes that significantly restrict immigrant eligibility for federal public benefits such as SNAP, Medicaid/CHIP, Marketplace subsidies and Medicare, along with key implementation timelines.
Provider Tax Provisions- Overview of CMS Guidance Issued Nov 2025	Explainer	Summarizes CMS's new federal guidance explaining how states must comply with upcoming restrictions on Medicaid provider taxes, including limits on new or expanded taxes and required phase-outs of existing arrangements.
KFF: The Impact of H.R. 1 on Two Medicaid Eligibility Rules	Explainer	Clear explanation of how H.R.1 changes Medicaid eligibility and verification processes.
KFF – Medicaid & Children's Health: 5 Issues to Watch	Explainer	Highlights emerging impacts on children under new rules.
Overview of the One Big Beautiful Bill Act's Medicaid Provisions- Menges Group July 2025	Slide Deck	Outlines a phased implementation of OBBBA's major Medicaid reforms, ranging from immediate financing and eligibility constraints (July 2025), through rural health funding and immigrant eligibility changes (2025–26), to work requirements, semi-annual renewals, and provider tax/direct payment reductions (2027–2030).
H.R.1 Resources for States	Toolkits and Explainers	Comprehensive set of explainers, policy briefs, toolkits, and timelines that review health care impacts of H.R.1.
H.R.1 Comprehensive Overview	Slide Deck	Overview of all major OBBBA health care changes related to health care and financing, including Medicaid, immigrant, and ACA impact.
Impact of ACA Subsidy Loss	Brief	Overview of impact of loss of federal subsidies on ACA

Appendix- Background References

Resource	Type	Summary
Sticker Shock: Big Increase in Individual Market Premiums	News article	Summarizes expected premium spikes that may increase uninsurance.
Average ER Visit Cost	Consumer reference	Provides average national ER visit cost, highlighting gaps in coverage.
TFAH – Blueprint for Strengthening Public Health (2024)	National report	Outlines public health infrastructure needs, relevant to safety-net planning.
NJ Health Insurance Premium Spike – 175%	News video	Highlights expected significant increases in premiums if subsidies end.
Medicaid cuts will further strain free and charitable health clinics – NAFC & Project HOPE	News article	Explains how Medicaid cuts will severely increase pressure on free clinics and FQHCs.
Charity Care – NJ Hospital Care Payment Assistance Program	State website	Describes NJ's core hospital-based financial assistance program supporting uninsured residents.
NJ hospitals lose court battle challenging charity care	News article	NJ Supreme Court ruling upholding charity care requirements despite inadequate reimbursement.
Plainfield Rescues Neighborhood Health Center	Local news	Demonstrates the financial fragility of community clinics under funding stress.
NJ Medical School Clinics Overview	Summary	Review of current public clinics operated by state medical schools
NJ Free Clinics- with care statistics	Summary	Detailed review of NJ free clinic operations, services, and statistics.
National Association of Free and Charitable Clinics 2025 Data Report	Slide Deck	Overview of data from more than 1,400 free and charitable clinics and pharmacies from 2024.
Oral Health Access Data and Secret Shopper Report	Report	Overview of Medicaid access and ghost network for children's oral health care in NJ

Appendix- Background References

Resource	Type	Summary
Are states ready for H.R.1 and Medicaid work reporting?	Policy brief	Reviews state operational readiness for work verification.
CMS to roll out new income verification app	News brief	Outlines new verification app infrastructure CMS will offer for testing.
CMS to issue OBBB redetermination rule	News brief	Previews upcoming timeline for CMS policy rule for redeterminations.
CMS highlights *ex parte* use for work requirements	News brief	Reinforces CMS's push for *ex parte* processing.
Interventions To Automate Medicaid Renewals Reduce Procedural Denials and Increase Coverage	Article	Study evaluating efforts in four U.S. states to expand automated ("*ex parte*") Medicaid renewal systems. Findings include that interventions significantly reduced procedural eligibility denials and increased coverage retention for eligible beneficiaries.
Making Medicaid Work Better: Lessons from States on Implementing Ex Parte Renewals	Research Brief	Report examining how eight states used automated "*ex parte*" renewal processes to maintain Medicaid coverage with fewer eligibility interruptions, highlights major implementation challenges (like data systems and culture change), and offers actionable lessons for achieving high rates of automated renewals.
Are states ready for H.R.1 and Medicaid work reporting?	Policy brief	Reviews state operational readiness for work verification.
CMS to roll out new income verification app	News brief	Outlines new verification app infrastructure CMS will offer for testing.
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Thank you to the H.R.1 Steering Committee

This work was guided and supported by the H.R.1 Workgroup Steering Committee:

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