MEMORANDUM

Date: May 11, 2026

To: The Honorable Chair and Members
Pima County Board of Supervisors

From: Jan Lesher
County Administrator

Re: **Federal Medicaid and Supplemental Nutrition Assistance Program (SNAP) Cuts**

Last year, upon the release of several federal policy directives and the passing of H.R.1 (known as the One Big Beautiful Bill Act – OBBA), I informed the Board of Supervisors (BOS) about the future impacts of several federal benefits programs and the impact across Pima County. In April 2025, I provided the Board with an economic impacts update and Pima County benefits impact detail pertaining to the – at the time – proposed cuts and associated impacts to Supplemental Nutrition Assistance Program (SNAP) and Medicaid (Arizona Health Care Cost Containment System – AHCCCS) across Arizona.

Included in one of the Federal Updates to the BOS, we included several statistics about Pima County specific AHCCCS[1] and SNAP[2] enrollment types, benefit recipient groups and proposed impacts to individuals and families, locally. In Pima County, slightly less than one third of Pima County residents are enrolled in AHCCCS, with roughly 30% enrolled in 'expansion group' enrollment – reflecting several expanded access to care opportunities, such as the Affordable Care Act (ACA).

The food insecurity rate in 2022 was roughly 10%, and grew to 15.1% in 2023, even prior to the proposed benefit reductions detailed in H.R.1. In 2026, Arizona eclipsed all other states in SNAP benefit losses – 450,000 Arizonans[3] between July 2025 and March 2026, and in the same year, AHCCCS enrollments dropped by over 32,000 across the state – prior to the federal cuts timelines, due to several administrative burden requirements across state agencies.

H.R.1 was passed in July 2025, and while several appropriations committees adjusted much of the proposed cuts to federal and state grant programs, the substantial modifications to critical benefits programs and redirection to the states for Medicaid and SNAP are signed into law. Notably, AHCCCS and SNAP beneficiaries will be subject to the implementation of work requirements, stricter enrollment and reenrollment timelines, retroactive coverage, and eventually state cost sharing. There are also several stipulations on provider assessments and reduced state-directed payments to providers (specific to AHCCCS), administrative error monitoring and resulting state cost burden (specific to SNAP), and redirection of oversight for several of these federal administrative criteria directives, to state agencies.

[1] Arizona Health Care Cost Containment System (AHCCCS) Population Statistics
[2] Department of Economic Security, Statistical Bulletins

Attached is a policy Memorandum and proposed *AHCCCS and SNAP Action Plan* from the Pima County Health Department on several of the critical implications of these federal policy directives, and proposals to support individuals and families across the County with maintaining their benefits.

The Action Plan details several opportunities for Pima County departments, community partners, and leadership to support enrollments and reenrollment into critical benefit programs, work, training and community engagement programs, and methods to alleviate the administrative burden that will negatively affect individuals and families across the state and in Pima County. This action plan is intended to bolster community access points and partnerships to ensure retained benefits. This plan is intended to be malleable, with regular updates to the BOS on progress, policy barriers, and community impacts.

JKL/dym

Attachment

c: Carmine DeBonis, Jr., Deputy County Administrator
Steve Holmes, Deputy County Administrator
Chad Kasmar, Deputy County Administrator
Terry Cullen, MD, MS, Public Health Director, Health Department
Daniel Sullivan, Director, Community Workforce Development
Sarah Davis, Senior Advisor, Pima County Administrator's Office

PIMA COUNTY
HEALTH DEPARTMENT

MEMORANDUM

Date: May 7, 2026

To: Jan Lesher
County Administrator

From: Theresa Cullen, MD, MS
Health Department Director

Re: PCHD Overview and Plan for Changes in SNAP and Medicaid

The purpose of this memo is to provide an overview of the upcoming changes to the Supplemental Nutrition Assistance Program (SNAP) and Medicaid and to outline the response plan to guide Pima County's coordinated response to anticipated impacts.

Summary

Federal changes enacted through H.R. 1, also known as the One Big Beautiful Bill (OBBBA), represent a significant restructuring of the Supplemental Nutrition Assistance Program (SNAP) and Medicaid, which is referred to as the Arizona Health Care Cost Containment System (AHCCCS, pronounced "access") in Arizona (and will be referred to as AHCCCS throughout this document moving forward). This legislation significantly restricts program eligibility by imposing new work-reporting requirements (which may include nonpaid/volunteer work), shortening eligibility periods, reducing eligible exemptions, and eliminating longstanding administrative flexibilities for adults ages 18–64.

These policy shifts will increase the risk of losing food and healthcare benefits; create operational strain across state and local systems; and place greater financial pressure on Pima County residents, community partners, first responders, and healthcare providers.

Arizona is seeing a substantial reduction in provision of SNAP benefits, and the AHCCCS enrollment modifications are anticipated to start in late 2026, with the most substantial eligibility and enrollment requirements starting January 2027. In Pima County just under a third of County residents are on AHCCCS. In fiscal year (FY) 2023, 13% of Pima County residents were using SNAP benefits and over 10% of households across the state were designated food insecure per the U.S. Census Bureau.

In March of 2026, the Urban Institute reported that national modeling shows H.R.1s work reporting requirements and semiannual redeterminations will reduce Medicaid expansion enrollment in 2028 by 4.9–10.1 million adults (a 27%–55% decline relative to prior law). [1]

[1] Buettgens M, Carter J, Karpman M, Kenney GM, Haley JM. Projected reductions in Medicaid expansion enrollment under OBBBA's work requirements and six-month redeterminations. Urban Institute. March 25, 2026. Accessed April 9, 2026. https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work.

Arizona's projected decline is 123,000–246,000 residents (27%–55%) depending on the strength of state mitigation efforts.

Changing work-reporting requirements and more frequent redeterminations put approximately 10,895 Pima County residents at immediate risk of losing coverage, and tens of thousands more vulnerable as these mandates take effect. In anticipation of the changes detailed in H.R.1, community agencies and organizations are planning how to respond and determine community impact on individuals and families throughout Pima County who are enrolled in these programs.

In response, Pima County Health Department is developing a plan with strategies to help residents navigate the administrative barriers created by these policy shifts. This preparation includes planning for the January 2027 rollout of semiannual AHCCCS renewals, stricter retroactive eligibility rules, expanded SNAP work reporting requirements, and new federal administrative mandates for states and individual benefit recipients. It also involves assessing how these changes will affect residents and local systems and how to mitigate these changes.

Overview of the Federal & State Policy Landscape

H.R. 1 directly reduces federal funding and imposes new administrative and eligibility requirements on enrollment for benefits, specifically SNAP and AHCCCS. These changes build on multiple federal policies that previously expanded access to food and healthcare benefits but now introduce substantial fiscal cuts, shift cost burden to states, and narrow eligibility, exemptions, timelines, and reporting requirements.

SNAP Overview

H.R. 1 substantially redirects oversight and fiscal responsibility to states. Under H.R. 1, states will be required to pay 75% of administrative costs, compared to 50% previously. States' administrative oversight requirement is determined by their payment error rate from the prior five years. Arizona's error rate has averaged roughly 10%; states with error rates below 6% will not be responsible for benefit costs.

The new model for state cost share is based on error rates above 6%. States with error rates of 6% or more will be required to contribute 5%–15% of total SNAP benefit costs, increasing by 2% error-rate increments (0–6%, 0% match; 6–8%, 5% match; 8–10%, 10% match; and over 10%, 15% match). In 2024, Arizona had an overall Payment Error Rate of 8.84%, and in FY 2028 the state can project a 10% cost share for SNAP benefits.

In addition to the administrative cost shifts, H.R. 1 builds upon the Fiscal Responsibility Act (FRA) of 2023, which expanded work reporting requirements for SNAP and TANF programs and preserved broad waiver flexibility for states. Under the FRA, able-bodied adults without dependents (ABAWD) were required to meet work reporting requirements up to age 54, with

exemptions managed by the Arizona Department of Economic Security (DES) for certain populations, including veterans, individuals experiencing homelessness, and former foster youth.[2]

AHCCCS Overview

Understanding the impacts of H.R. 1 on AHCCCS requires grounding in Arizona's Medicaid expansion history. The Proposition 204 Expansion redirected the obligation for indigent health care to the state and extended coverage to childless adults between 0%–100% of the Federal Poverty Level (FPL). A second substantive policy shift occurred with the Affordable Care Act (ACA), which expanded Medicaid and broadened coverage through the ACA Marketplaces, Basic Health Plans, and associated tax incentives.

Arizona adopted the ACA Medicaid expansion in 2014, making it an "expansion state." This extended AHCCCS eligibility to childless adults with incomes up to 138% FPL, including application of the 5% Modified Adjusted Gross Income (MAGI) disregard. Through this expansion, AHCCCS also provided coverage to adults between 100%–133% FPL, with the disregard permitting eligibility slightly above that threshold.

In Pima County, approximately 30% of residents are covered under Medicaid. Of these, an estimated 66% are enrolled in traditional Medicaid; around 26% are part of the Proposition 204 Expansion group; roughly 4% are enrolled in the ACA Expansion group; and about 4% participate in the Arizona Long Term Care System (ALTCS). Compared to the traditional Medicaid population, expansion adults experience higher rates of co-occurring medical conditions, behavioral health needs, and neurodevelopmental conditions.

AHCCCS relies heavily on federal funding, which constitutes roughly 70% of its operating budget. Arizona previously attempted to implement AHCCCS work-requirement policies, but they were never put into practice due to non-approval by the Centers for Medicare & Medicaid Services (CMS) and legal challenges in other states. As a result, Arizona has no operational experience administering AHCCCS work-reporting systems. H.R. 1 newly requires work reporting requirements, creating significant administrative and systems-management pressures for AHCCCS.

H.R. 1 imposes the most substantial changes on the ACA expansion group, including mandatory work reporting requirements (for those without exemptions), new renewal rules, and impacts on individuals who obtain coverage through the Marketplace. Its provisions narrow eligibility and enrollment pathways and have contributed to increased costs for Marketplace enrollees. Prior to H.R. 1, AHCCCS eligibility relied on annual redetermination cycles, and Medicaid work reporting requirements were not federally mandated.

[2] Work reporting requirements for Able-bodied Adult Without Dependents. Arizona Department of Economic Security. 2026. Accessed March 27, 2026. https://des.az.gov/services/basic-needs/food-assistance/nutrition-assistance/work-requirements-able-bodied-adult.

In contrast, H.R. 1 reshapes both SNAP and AHCCCS by expanding work reporting requirements mandates; narrowing exemptions; reducing administrative flexibility; and shortening timelines for reporting, verification, and eligibility processing. Together, these changes substantially increase the likelihood of benefits loss due to procedural complications rather than changes in actual need.

Eligibility and Exemption Changes under H.R.1

Changes to SNAP

H.R. 1 expands SNAP's ABAWD work requirement age range to 18–64, raising the previous upper limit of 54. It also removes Fiscal Responsibility Act exemptions for veterans, people experiencing homelessness, and former foster youth unless they qualify under another category. Arizona has implemented the newly added federal exemption for individuals identified as Indian, Urban Indian, or California Indian, definitions that align with American Indian/Alaska Native beneficiaries eligible for services under the Indian Health Care Improvement Act.

H.R. 1 also makes several changes to SNAP work requirement exemptions. Parents caring for children under 14 remain exempt, but the exemption for parents of teens ages 14–17 is eliminated. Exemptions continue for individuals under 18 or over 65; pregnant individuals; those medically certified as unfit for employment; caregivers of children under 14; and individuals identified as Indian, Urban Indian, or California Indian under the Indian Health Care Improvement Act. In addition, H.R. 1 sharply restricts geographic waivers: whereas Arizona previously qualified most counties and Tribal areas under "insufficient jobs" criteria, waivers are now limited to areas with unemployment rates above 10%. For FY 2026, only Yuma County and certain Tribal reservation areas met this threshold, and Arizona submitted a waiver request for those areas in September 2025.

Income rules are also tightened by eliminating several deductions formerly used in SNAP calculations, such as standard utility and internet costs. Eligibility is now based on gross monthly income with far fewer allowable deductions, meaning more household earnings count toward eligibility. Participants must provide verified proof of income and work or qualifying activities; self-attestation is no longer accepted, which increases the risk that otherwise eligible residents may lose their benefits.

Changes to AHCCCS

There are several mandated H.R.1 timelines for AHCCCS implementation. The earliest change occurred immediately on July 4, 2025, which was the cessation of payments to 'prohibited entities', specifically Planned Parenthood for all types of care until July 3, 2026.

In October of 2026, H.R.1 mandated the 'Immigrant Eligibility' changes for all AHCCCS or KidsCare coverage. Importantly, groups that previously had protected healthcare access such as

refugees, asylees and other humanitarian groups who were previously eligible for full AHCCCS coverage are now only qualified for emergency services. Federal Emergency Services payments will be lowered and shifted to the state.

AHCCCS eligibility and reenrollment criteria impact include several requirements for the ACA expansion group starting on January 1, 2027. H.R.1 mandates that individuals enrolled in AHCCCS that are aged 19-64, and enrolled in the ACA Medicaid expansion group, or an 1115 demonstration waiver, must engage in employment, education, work, and/or volunteer community service to maintain eligibility.

Upcoming changes to AHCCCS include eligibility redeterminations for the ACA Medicaid Expansion adults, requiring renewal every 6 months instead of annually. This will be coupled with the community engagement / work reporting requirements which will require enrollees to demonstrate participation in a qualifying activity every six months. Individuals with physical, behavioral health, developmental, or serious medical conditions (also referred to as "medically frail") may be limited in their ability to meet work-reporting requirements and qualify for an exemption.[3,4] While federal law requires states to exempt medically frail individuals from these requirements, AHCCCS has not yet finalized the specific criteria or verification processes Arizona will use. PCHD is working closely with ADHS and AHCCCS as state definitions and procedures are clarified to ensure exemptions are identified and implemented appropriately.

Several other provider-specific mandates are slated to start in 2027, including retroactive coverage and care authorizations, provider assessment changes (including but not limited to provider taxes to support coverage of the Medicaid programs, assessment reductions that stage a reduction of allowable provider assessments to 3.5% of net patient revenue), reduced stated directed payments to providers, and enhanced audits for payment error and error rates. This will eventually result in the 2028 state cost sharing for Medicaid individuals in the Proposition 204 expansion group (with income above the 100% FPL) with certain exemptions.

Experts and the Arizona Department of Economic Security (DES) note that H.R. 1 requires states and participants to complete reporting and verification steps more quickly than before, increasing the likelihood that eligible individuals lose benefits due to paperwork or documentation barriers rather than actual changes in eligibility. DES has already begun applying alternative exemptions automatically and issuing notices to households subject to the new reporting and work-requirement rules.

Tables 1 and 2 provide side-by-side comparisons of eligibility and reporting requirements before and after H.R. 1 for SNAP and AHCCCS, respectively.

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[3] Spears, R. (2026, April 30). *States rush to figure out how to enforce Trump's Medicaid Work Requirements*. KFF Health News. https://kffhealthnews.org/medicaid/medicaid-work-requirements-kff-survey-state-implementation-strategies/

[4] Tolbert, J., Diana, A., Mudumala, A., Brooks, T., Yafimenka, Y., & Lin, A. (2026, April 30). *An early look at policy decisions as states get ready to implement work requirements*. KFF. https://www.kff.org/medicaid/an-early-look-at-policy-decisions-as-states-get-ready-to-implement-work-requirements/

Table 1: SNAP Eligibility & Exemptions Before vs. After H.R.1

Feature	Before H.R.1	After H.R.1
ABAWD Age Range	Required only for ages 18–54	Expanded to ages 18–64
Parental Exemption	Exempt if caring for a child under 18	Exempt only if caring for a child under 14
Veterans / Homeless / Former Foster Youth Exemption	Exempt under Fiscal Responsibility Act	Exemption removed unless qualifying under another category
Geographic Waivers	Arizona qualified most counties under "insufficient jobs"	Waivers allowed only in areas with >10% unemployment (only Yuma + select Tribal areas qualify in FY26)
Income Calculation	Standard deductions (utilities, internet, etc.) applied	Deductions removed; eligibility now based on gross income with fewer allowable deductions
Verification	Some self-attestation allowed	Self-attestation eliminated; verified proof required for income & work activities
Eligible Immigrant Groups	Refugees, asylees, parolees eligible	Restricted primarily to Lawful Permanent Residents (LPRs) and limited categories

Table 2: AHCCCS Eligibility & Reporting Requirements Before vs. After H.R.1

Feature	Before H.R.1	After H.R.1
Immigrant Eligibility	Included multiple humanitarian statuses (e.g., asylum, refugee)	Narrowed eligibility; restrictions begin Oct 1, 2026
Work Requirements	No federal mandate; required waivers (1115 Waiver)	Work/community engagement requirements mandated for expansion adults ages 19–64 by Dec 31, 2026
Work Requirement Exemptions	States allowed broad exemptions, including medical frailty and other health-related conditions.	Exemptions narrowed; medical frailty remains but requires stricter verification effective Dec 31,2026.

Redeterminations	Annual (12-month) renewal	Semiannual (every 6 months) starting Jan 1, 2027
Retroactive Coverage	Up to 3 months before application	Limited to 1 month for expansion adults; 2 months for traditional AHCCCS groups starting Jan 1, 2027
Verification	Standard verification schedule	Shorter response windows: more frequent proof-of-work requirements; increased documentation burden starting Jan 1, 2027

Community Impact of H.R.1

Both SNAP and AHCCCS programs face mounting administrative pressures that increase the likelihood of residents losing benefits due to documentation delays, technology barriers, and system backlogs. For AHCCCS, the transition from annual to semiannual redeterminations beginning in January 2027 will require significant staffing increases, updates to IT systems, and more intensive verification processes to manage rising workloads.

For SNAP, states must shoulder 75% of the program's administrative costs beginning in FY2027, including costs related to eligibility determinations, case processing, work-requirement reporting, technology systems, staffing, call centers, and customer service functions. Changes to work-verification requirements will add new burdens for participants with unstable work hours or limited access to documentation, technology, or language support.

These combined administrative and eligibility changes under H.R. 1 are expected to exacerbate food insecurity, reduce access to healthcare coverage and services, and increase economic strain for Pima County residents. The following assessment outlines current conditions, emerging trends, and community-level implications for vulnerable populations.

Current Conditions in Arizona and Pima County

Arizona's current levels of food insecurity, SNAP participation, AHCCCS enrollment, and economic stressors provide important context for assessing Pima County's vulnerability to increased administrative burden and reduced program flexibility. Recent reporting shows that more than 400,000 Arizonans, nearly 47% of all SNAP participants statewide, including about 180,000 children, have lost benefits since July 2025, the largest decline in the nation.[5] These losses reflect the combined effects of H.R. 1 implementation, administrative strain, and

[5] Santa Cruz N. Nearly half of Arizona's SNAP participants have lost benefits. ProPublica. April 8, 2026. Accessed April 8, 2026. https://www.propublica.org/article/arizona-snap-benefits-trump-legislation?utm_source=flipboard&utm_content=ProPublica%2Fmagazine%2FArizona.

significant staffing shortages at the Arizona Department of Economic Security (DES), which have contributed to case backlogs, processing delays, and reduced capacity for customer support.

Pima County is experiencing similar patterns. SNAP participation has fallen to 88,679 individuals and 37,604 households, and food insecurity has risen to 15.1% in 2023. These trends suggest that the rapid administrative losses seen in SNAP may foreshadow similar challenges for AHCCCS as new work reporting requirements and semiannual redeterminations take effect in 2026–2027.

Together, Table 3, Table 4, and Table 5 provide a snapshot of recent trends in Arizona and Pima County across SNAP participation, food insecurity, and AHCCCS enrollment.[6,7,8,9,10] The 2025–2026 reductions largely reflect post-pandemic unwinding, non-automatic renewals, and DES administrative capacity challenges, not the full effects of H.R. 1, which have not yet taken hold for AHCCCS. However, the scale and speed of these declines demonstrate how administrative strain can drive substantial loss of food and healthcare benefits, offering an early indication of the vulnerability Pima County may face as federal mandates intensify in 2026–2027.

Table 3: SNAP Participation & Food Insecurity (Arizona; Pima County)

Indicator	Arizona (Statewide)	Pima County
SNAP participation (individuals)	532,868	88,679
SNAP households	286,612	37,604
SNAP participation (children age 0–17)	204,274	28,920
Average monthly SNAP benefit (household)	$334	$309
Average monthly SNAP benefit (per person)	$180	$183

[6] DBME January 2026 Statistical Bulletin. Arizona Department of Economic Security. January 2026. Accessed March 27, 2026. https://des.az.gov/sites/default/files/dl/dbme-statistical_bulletin-1-2026.pdf.
[7] Food Insecurity Rate. Pima County Health Data. July 2, 2025. Accessed April 10, 2026. https://www.pimahealthdataportal.org/indicators/index/view?indicatorId=2107&localeId=158full-impact-of-gops-medicaid-cuts-on-people-federal-dollars-wont-be-known-for-years.
[8] AHCCCS Population Highlights March 2026. Arizona Health Care Cost Containment System. March 5, 2026. Accessed March 27, 2026. https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/PopulationHighlights03052026.pdf.
[9] AHCCCS Population By Category. Arizona Health Care Cost Containment System. March 5, 2026. Accessed March 27, 2026. https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/PopulationbyCategory03052026.pdf.
[10] AHCCCS Population By County. Arizona Health Care Cost Containment System. March 5, 2026. Accessed March 27, 2026. https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/PopulationbyCounty03052026.pdf.

Food insecurity rate	—	Increased from 10.9% (2020–2022) to 15.1% (2023)
Contributing factors	Housing instability, low wages, rising food prices, limited transportation, systemic inequities	Same, with additional impact from reduced SNAP-Ed and Emergency Food Assistance Program funding

Table 4: AHCCCS Enrollment, March 2025- March 2026

Geography	Enrollment (Mar 2025)	Enrollment (Mar 2026)	Change	% Change
Arizona	2,027,424	1,808,167	−219,257	(−11%)
Pima County	296,040	263,615	−32,425	(−11%)

Table 5: Statewide Enrollment Declines by Category, March 2025 - March 2026

Enrollment Category (Statewide)	Mar 2025	Mar 2026	Change	% Change
AHCCCS Complete Care	1,699,317	1,487,621	−211,696	−12%
Traditional Medicaid (1931 Families & Children)	211,128	175,860	−35,268	−17%
Proposition 204 (0–100% FPL)	429,144	360,440	−68,704	−16%
Adult Expansion (100–133% FPL)	65,033	54,569	−10,464	−16%
SOBRA Child	594,788	536,879	−57,909	−10%
SOBRA Pregnant	42,024	37,294	−4,730	−11%
ALTCS (Elderly & Physically Disabled + Developmental Disabilities)	72,587	75,144	+2,557	+4%

The "unwinding" of continuous coverage after the COVID-19 pandemic produced large procedural losses as members were required to re-submit paperwork, verify eligibility, and respond to notices within tight timeframes. During the public health emergency, AHCCCS members were guaranteed continuous coverage from March 2020 through March 2023, and renewals were paused. When automatic renewals ended in spring 2023, the state began processing three years' worth of delayed eligibility checks, which led to substantial procedural disenrollments as members struggled with returned mail, documentation requirements, and short response windows. H.R. 1's new semi-annual redeterminations and work-reporting requirements are expected to compound this administrative burden, requiring more frequent documentation, additional verification steps, shorter response deadlines, and more complex proof of work or exemption status.

Statewide modeling estimates that up to 171,000 Arizonans could lose AHCCCS coverage by FY2030, including approximately 144,000 (85%) due specifically to work-requirements, with additional losses expected from more frequent redeterminations.[11] These projections occur alongside substantial enrollment and renewal time lags already present in the AHCCCS system due to the 2023 unwinding of continuous coverage, staffing shortages, and large backlogs in eligibility processing. These existing administrative delays likely contributed to the enrollment declines observed in 2025–2026 prior to H.R. 1 implementation. As a result, the new semiannual redeterminations and work-reporting requirements introduced under H.R. 1 are expected to amplify these system-level bottlenecks, leading to additional coverage loss among eligible individuals who encounter barriers navigating increasingly complex reporting processes.

Affordable Care Act (ACA) Marketplace Coverage Loss and Affordability Pressures

Separate from AHCCCS changes under H.R. 1, adults who do not qualify for Medicaid are experiencing additional coverage pressures in the ACA Marketplace due to the expiration of enhanced federal subsidies. As these subsidies sunset, Marketplace premiums have risen and coverage losses have accelerated. A national survey conducted by KFF, a nonpartisan health policy research organization, found that 9% of 2025 Marketplace enrollees are now uninsured and 28% switched to a different plan, most citing unaffordable premiums as the primary reason.[12] Eight in ten returning enrollees report higher overall costs for 2026, including 51% who say their premiums, deductibles, or co-pays are "a lot higher."

These increases are driving significant financial strain on individuals. Over half (55%) of returning enrollees say they are cutting back on food or basic household spending to afford

[11] Schutsky W. In Arizona, full impact of GOP's Medicaid cuts on people, federal dollars won't be known for years. KJZZ. September 30, 2025. Accessed April 10, 2026. https://www.kjzz.org/politics/2025-09-30/in-arizona-full-impact-of-gops-medicaid-cuts-on-people-federal-dollars-wont-be-known-for-years.

[12] Lopes L, Valdes I, Sparks G, Mulugeta M, Kirzinger A. Cost concerns and coverage changes: A follow-up survey of ACA Marketplace enrollees. KFF. March 19, 2026. Accessed March 27, 2026. https://www.kff.org/public-opinion/a-follow-up-survey-of-aca-marketplace-enrollees/.

coverage, and 17% report they are not confident they will be able to afford their premiums for the full year. Among those who disenrolled, cost was the dominant factor.

These data show that the loss of federal affordability protections is pushing more adults out of ACA Marketplace coverage, especially those who do not qualify for AHCCCS but cannot afford full-priced plans. This churn, combined with rising premiums and downgraded coverage, is likely to increase local uninsured rates and place additional pressure on safety-net providers across Pima County.

Several states including New Mexico, California, Massachusetts, Vermont, and Texas have taken steps to reduce coverage losses by offering supplemental subsidies, adjusting insurer pricing rules, or establishing state-based affordability programs. Arizona has not adopted similar measures, underscoring the importance of local support strategies to reduce avoidable coverage loss.

As illustrated in Table 6, several states have implemented targeted strategies, such as supplemental subsidies, insurer guardrails, and state-funded affordability programs, to reduce Marketplace coverage losses and stabilize premiums.[12] These examples highlight policy levers Arizona could consider as affordability pressures increase.

Table 6: State Strategies to Reduce ACA Marketplace Coverage Losses

State	Strategy Used	Description
New Mexico	State-funded subsidies (full replacement)	Fully replaced expired federal ACA subsidies, preventing estimated coverage losses and increasing enrollment.
California	State supplemental subsidies	Provides additional state-funded ACA subsidies to offset loss of federal assistance.
Massachusetts	State supplemental subsidies	Offers state-funded affordability programs to compensate for loss of federal subsidies.
Vermont	State supplemental subsidies	Provides extra state subsidies to reduce premium increases.
New York	State affordability programs	Maintains affordability programs that help reduce Marketplace costs for residents.
Minnesota	State affordability programs	Operates programs to help residents afford ACA Marketplace coverage.
Texas	Pricing rules / insurer guardrails	Legislation requires insurers to price plans in ways that preserve affordable options, supporting enrollment stability.

Projected Statewide and Local Impacts

While county-specific modeling is forthcoming, statewide projections show dramatic increases in coverage losses and subsequently rising uninsured rates. These projected trends provide insights into the challenges Pima County is likely to face.

As shown in Table 7, statewide modeling projects substantial Medicaid coverage loss under H.R. 1, including large numbers of adults at risk of disenrollment due to work-reporting requirements and semiannual redeterminations.[13,14,15,16,17] These projections highlight the scale of potential impacts Arizona, and Pima County in particular, may experience as federal mandates are fully implemented.

Table 7: Projected Medicaid Impacts

Impact Area	Estimate
Subject to potential disenrollment (Arizona)	~380,000 members
Adults subject to new AHCCCS work-requirement rules (exposed population) (Arizona)	~190,000 adults statewide *(adults 19–55 in Group VIII who are not exempt)*
Projected increase in Arizona's uninsured population (10-year)	+330,000 residents (It's about 10.5% of uninsured in 2023, following national trend of 1.7 increase, projection ~12.2% in 2034
Additional statewide losses expected from semiannual redeterminations	50,000 residents
Current uninsured adults in Pima County (baseline 2024)	~120,000 adults (12%)
Pima County Immediate Coverage Loss	10,895
Pima County adults subject to H.R. 1 reporting requirements (exposed population)	~49,000 residents
Pima County residents at elevated risk of disenrollment due to work-reporting rules	~25,000 residents

[13] The Governor's FY 2027 Budget. Arizona Governor's Office of Strategic Planning and Budgeting. Accessed April 10, 2026. https://ospb.az.gov/sites/default/files/2026-01/budget-briefing-presentation-fy-2027.pdf.
[14] FY 2027 Baseline Book. The Staff of the Joint Legislative Budget Committee. January 2026. Accessed April 10, 2026. https://www.azjlbc.gov/budget/27baselinesinglefile.pdf.
[15] Health Insurance Coverage. Health & Social Well-Being. Making Action Possible for Southern Arizona. 2024. https://mapazdashboard.arizona.edu/health-social-well-being/health-insurance-coverage.
[16] Pima County Board of Supervisors. Memorandum. Potential Impact on the State of Arizona of the Federal Budget Reconciliation Bill/ One Bill, H.R. 1. September 24, 2025. Accessed April 10, 2026. https://content.civicplus.com/api/assets/9bcd1f4a-1369-4183-988c-ca4a4d2fcdd0.
[17] Pima County Board of Supervisors. Memorandum. Arizona Policy Brief – Federal Medicaid Cuts & Arizona's Economy. April 8, 2025. Accessed April 10, 2026. https://content.civicplus.com/api/assets/77c6c939-ab0e-41e5-86bb-f759db4124ea.

Pima County residents at risk due to semiannual redeterminations	~6,500 residents

Similarly, Table 8 presents recent trends and projected SNAP impacts, including significant declines in caseloads and individual participation and the proportion of closures linked to ABAWD and H.R. 1 work-requirement rules.[5,6,18,19] These patterns mirror the Medicaid projections and signal additional strain on food security across Pima County.

Table 8: Projected SNAP Impacts

Impact Area	Oct 2025	Jan 2026	Change	% Change
SNAP Caseload (households)	401,994	286,612	–115,382	–29%
SNAP Participation (individuals)	775,813	532,868	–242,945	–31%
Closures linked to ABAWD & H.R.1 rules			~50% of closures	

Public Health Implications

Loss of SNAP and AHCCCS benefits will increase food insecurity and reduce access to all medical care, including preventive services and routine care. This will worsen chronic disease management by delaying needed treatments and increasing avoidable emergency department use. Food insecurity is closely linked to poor health outcomes, including higher rates of diabetes, hypertension, obesity, and mental health conditions. Individuals who lose coverage are more likely to skip medications, delay checkups, and miss recommended screenings, leading to preventable complications and higher long-term healthcare costs. As families struggle to meet basic needs, they may prioritize housing and utilities over medical care, further destabilizing health and wellbeing.

Although school meal program changes are not part of H.R. 1, concurrent restrictions, such as reduced eligibility for the Community Eligibility Provision (CEP), will further increase food insecurity and undermine children's health and learning.[20] CEP allows high-poverty schools to provide free meals to all students without burdensome applications, reducing stigma and

[18] Beck M. Arizona Numbers Show Massive Decline in SNAP Enrollment. ABC 15 Arizona. Updated March 3, 2026. Accessed March 27, 2026. https://www.abc15.com/news/state/arizona-numbers-show-massive-decline-in-snap-enrollment.
[19] DBME October 2025 Statistical Bulletin. Arizona Department of Economic Security. October 2025. Accessed March 27, 2026. https://des.az.gov/sites/default/files/dl/dbme-statistical_bulletin-10-2025.pdf.
[20] 2025 Budget Stakes: Proposals Would Reduce Children's Access to School Meals and Other Food Assistance. Center on Budget and Policy Priorities Policy Brief. March 12, 2025. Accessed March 27, 2026. https://www.cbpp.org/sites/default/files/1-31-25fa-brief.pdf.

ensuring reliable access to nutritious breakfasts and lunches. When schools lose CEP eligibility, fewer children receive healthy meals and families face higher grocery costs.[21]

Research shows that universal school meals improve children's diet quality, food security, and academic performance, while disruptions to these programs reverse these gains and widen disparities for low-income and rural students.[22] These findings demonstrate why reductions in any nutrition supports, whether through SNAP, Medicaid-related administrative loss, or separate school meal changes, have disproportionate impacts on low-income families, rural communities, children, people with disabilities, and communities of color. While CEP changes occur outside H.R. 1, the combined effect of SNAP cuts, Medicaid churn, and reduced access to school meals further increases food insecurity and limits children's access to reliable nutrition, which is essential for healthy growth, school attendance, and academic success.

As more families lose automatic eligibility for food and medical assistance, local healthcare systems and safety-net providers will face higher uncompensated care costs, greater emergency department use, and increased demand for limited public health services. Without proactive planning and strong cross-sector collaboration, these policy changes threaten to reverse progress in chronic disease management, maternal and child health, and preventive care.[20] As such, these setbacks are anticipated to place additional pressure on county resources and community partners.

Equity Considerations

In 2020, the Pima County Board of Supervisors declared racial and ethnic health inequities and income a public health crisis.[23] This affirms PCHD's responsibility to address the social and economic conditions that shape health outcomes. SNAP and AHCCCS are core programs that reduce income inequality and improve access to food and healthcare.

The impacts of expanded work reporting requirements and increased administrative oversight will not be experienced equally. Enrollment and renewal depend on reliable documentation, stable employment, consistent internet and phone access, digital literacy, and timely reporting with the assumption that resources will be evenly distributed across communities. Residents with limited broadband access, unstable housing, language barriers, low digital literacy, or inconsistent employment are at a higher risk of losing benefits even when they remain eligible. More frequent redetermination increases the likelihood of procedural disenrollment, where individuals lose coverage due to paperwork barriers rather than actual changes in eligibility.

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[21] School Meals Support Children's Health and Learning. Community Eligibility Provision Fact Sheets. Food Research & Action Center and the Center on Budget and Policy Priorities. March 2025. Accessed March 27, 2026. https://frac.org/wp-content/uploads/Community-Eligibility-Provision-Fact-Sheets_AZ3.pdf.

[22] Reed L, Lott ME, Story M. From Policy to Plate: Implications of 2025 U.S. Federal Policy Changes on School Meals. *Nutrients*. 2025;17(23):3696. doi: 10.3390/nu17233696. Accessed March 27, 2026.

[23] Pima County Board of Supervisors. Resolution No. 2020-92: A Resolution of the Pima County Board of Supervisors Declaring Racial and Ethnic Health Inequities and Income Inequality in Pima County to Be a Public Health Crisis. December 1, 2020. Accessed March 27, 2026. https://content.civicplus.com/api/assets/41157de4-256c-4522-a2a1-5eb8b5d87ccd.

Individuals managing chronic conditions, behavioral health needs, or functional limitations may be especially vulnerable when documentation requirements become harder to meet. Without intentional protections, such as equity-focused policies and procedures that lessen the disproportionate burdens created by systemic inequities, these structural changes are likely to widen existing disparities in food security, uninsurance, chronic disease management, and preventable hospital use. They may also undermine ongoing equity-focused initiatives designed to address population-specific disparities.

Equity implications are also being monitored for other population-specific groups, including Tribal health communities, gender--based disparities, older adults, veterans, individuals experiencing homelessness, former foster youth, parents of teens, and immigrant and refugee communities. Additional- considerations include disparities related to race, ethnicity, and socioeconomic status, which further shape residents' vulnerability to administrative burden, benefit loss, and barriers to care. Aligned with Pima County Board of Supervisors Resolution 2020-92[23] and the Health Department's mission, PCHD will monitor emerging disparities using disaggregated data and community feedback to prevent widening inequities and support affected populations.

Community Assets

Pima County residents benefit from a strong network of community-based resources that support access to food, healthcare, and social services. Rural areas rely on trusted local hubs, such as farmers markets, community gardens, libraries, and community centers. These areas function as reliable entry points for food distribution, health information, and partner outreach. Many of these sites are supported by volunteer-driven community anchors, including local nonprofits and community-based organizations, which provide not only food assistance but also skill building, wellness activities, and other programs that help households move toward long term stability.

The county also has an established referral and navigation infrastructure that connects residents to essential services. Food banks, Federally Qualified Health Centers (FQHCs), mobile clinics, Community Health Workers (CHWs), and AHCCCS assister agencies work together to provide coordinated outreach and enrollment support for both SNAP and AHCCCS. Within this system, SNAP access is already a notable strength: food banks, FQHCs, and CHW networks play a central and effective role in helping residents apply for, understand, and maintain their benefits.

Community Gaps

Despite strong assets, many communities face significant barriers that may worsen under expanded work reporting requirements and administrative changes. Persistent food access and affordability challenges continue. For example, food insecurity affects 15% of Pima County

residents (2023), a rate higher than the 2024 national household average of 13.7%.[24] At the same time, Pima County's Food Environment Index score of 7.6 which is an indicator reflecting both food insecurity and access to nearby grocery stores.[25] This signals substantial barriers to obtaining affordable, healthy food. These challenges are especially pronounced in rural and high poverty neighborhoods, including USDA- designated food deserts, and they contribute to ongoing disparities in nutrition and economic -stability.[26]

SNAP access gaps further complicate these conditions. Residents face barriers in applying for and maintaining SNAP, including transportation challenges in rural areas and digital or language barriers in urban neighborhoods. Increasing administrative complexity raises the risk of benefit loss under new reporting requirements.

Service and outreach gaps also persist. Many communities lack culturally and linguistically appropriate services, integrated referral systems, and reliable navigation support, which limits residents' ability to connect with SNAP, AHCCCS, and other safety net programs.

These challenges are compounded by high social and economic vulnerability. Pima County's elevated Social Vulnerability Index (SVI) of 0.89 reflects widespread economic insecurity, concentrated poverty, and significant transportation and housing burdens.[27] These pressures heighten the risk of benefit loss and reduce residents' capacity to meet SNAP and AHCCCS requirements.

Finally, healthcare provider shortages in both rural areas and pockets of urban neighborhoods limit access to preventive and ongoing care. These shortages compound vulnerability for households already experiencing food insecurity and instability in their benefits.

Next Steps to Mitigate Potential Impacts

The changes described above demand streamlined verification processes, shared understanding of and broad use of allowable exemptions, simplified documentation, improved data sharing, and strong community support networks. Understanding this rapidly shifting policy landscape is critical to determine those most at risk and why and to take coordinated action to protect food security, health insurance coverage, and healthcare access.

The Pima County Health Department recommends a coordinated, cross-sector approach grounded in the core functions of public health: policy development, assessment, and assurance.

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[24] Food insecurity remained high in 2024, administration ends data collection before snap cuts push it higher. Center on Budget and Policy Priorities. January 22, 2026. Accessed April 10, 2026. https://www.cbpp.org/blog/food-insecurity-remained-high-in-2024-administration-ends-data-collection-before-snap-cuts.
[25] Blomme C, Roubal A, Givens M, Johnson S, Brown L. Arizona. 2020 County Health Rankings Report . Accessed April 10, 2026. https://www.countyhealthrankings.org/sites/default/files/media/document/CHR2020_AZ_v2.pdf.
[26] Tong D, Buechler S, Bao Y. A Comprehensive Food Access Analysis in Tucson. A Comprehensive Food Access Analysis in Tucson | MAP AZ Dashboard. February 25, 2016. Accessed April 10, 2026. https://mapazdashboard.arizona.edu/article/comprehensive-food-access-analysis-tucson.
[27] Social Vulnerability Index. Pima County Health Data. Updated June 26, 2025. Accessed March 27, 2026. https://www.pimahealthdataportal.org/indicators/index/view?indicatorId=9375&localeId=158.

PCHD's role in this approach is to convene partners and align efforts across systems, such as outreach, enrollment assistance, data monitoring, policy coordination, and workforce-related supports in partnership with Pima County Community other County Departments to enable residents to navigate new requirements as federal policy mandates evolve.

The 2026-2027 proposed Action Plan presents a unified countywide set of actions to guide our coordinated response. The strategies proposed herein strive to mitigate harm to residents, support community partners, and strengthen the systems people rely on to maintain stable nutrition assistance and healthcare coverage.

To accomplish this, PCHD proposes a framework guided by three overarching goals:

1. Preserve Access to Healthcare Coverage
2. Reduce Food Insecurity and Maintain Access to Nutrition
3. Prevent Future Gaps in Food Security and Healthcare Access

These three goals provide a clear path forward for mitigating the impacts of H.R. 1 so that Pima County is prepared for anticipated operational and community level challenges. This Action Plan builds on existing County and City directives and strategic frameworks, including the Prosperity Initiative (particularly Policy 4: Increase Health Coverage and Reduce Medical Debt; Policy 12: Improve Financial Capability; and Policy 10: Prioritize Workforce Development for Underserved Populations), the Community Health Needs Assessment (CHNA), the Community Health Improvement Plan (CHIP) 2025–2027 Priority Area on Access to Care, and the PCHD 2026–2030 Strategic Plan.

To meet these goals, PCHD recommends activities with coordinated cross-functional work, guided by a centralized implementation structure, ongoing community, multi-jurisdiction, and partner engagement, and routine performance monitoring. Progress will be assessed through quarterly data reviews, ongoing monitoring of navigation and enrollment assistance outcomes, and continuous evaluation of end user experiences. These mechanisms ensure the County remains effective, equitable, and responsive to emerging needs.

Recognizing that policy conditions and operational requirements related to SNAP and AHCCCS will continue to evolve, this Action Plan is intentionally structured as an iterative public health planning tool. Continuous assessment and adaptation are expected as new state guidance is released and as community-level impacts become clearer. Detailed roles, responsibilities, and task assignments will be developed in alignment with resource availability, partner engagement, and shared implementation needs to ensure that all activities remain feasible, equitable, and grounded in local capacity.

To support implementation, PCHD proposes the establishment of a *SNAP and AHCCCS Response Workgroup* to serve as the central coordinating body for this action plan. The

Workgroup will guide implementation across all goal areas, ensuring efforts remain aligned, data-informed, and equity-centered. The workgroup will serve to:

- Review quarterly data on SNAP and AHCCCS enrollment and churn *(*the cycle in which eligible members lose coverage due to procedural issues and then re-enroll shortly afterward*)*,
- Coordinate countywide and community partner activities, provide guidance on culturally and linguistically appropriate outreach strategies, and
- Identify opportunities for volunteer and/or work hours to meet proposed eligibility requirements.
- Share policy updates and frontline challenges, and regularly brief senior leadership on risks and resource needs.

Please find the full 2026-2027 Action Plan attached.

Attachment

c: Steve Holmes, Deputy County Administrator
Sarah Davis, Senior Advisor, County Administration

Pima County Response to SNAP and Medicaid Changes

2026-2027 Action Plan

Introduction:

Pima County faces significant and rapidly approaching federal changes to SNAP and Medicaid/AHCCCS that will tighten eligibility, expand work reporting requirements, and increase administrative burden which puts thousands of residents at risk of losing essential food and healthcare benefits. These shifts will strain local systems already supporting families with economic and health vulnerabilities, making coordinated countywide action critical to prevent avoidable coverage loss and rising food insecurity. Proactive planning will help residents navigate new timelines, more complex reporting processes, and stricter verification requirements, while strengthening the navigation, data sharing, and outreach systems that connect communities to vital services.

This action plan outlines the goals, strategies, and tactics guiding Pima County's coordinated response from March 2026 through June 2027, the period in which the most significant phases of H.R. 1 will take effect. The framework aligns with federal implementation timelines (see Appendix A) and is organized around three overarching goals:

1. **Preserve Access to Healthcare Coverage**
2. **Reduce Food Insecurity and Maintain Access to Nutrition**
3. **Prevent Future Gaps in Food Security and Healthcare Access**

These efforts are integrated with established Countywide frameworks, including the Prosperity Initiative, Healthy Pima Indicators, the Community Health Improvement Plan (CHIP), and the PCHD 2026–2030 Strategic Plan, ensuring that short-term actions taken in response to H.R. 1 reinforce long-term strategies to expand access to care, strengthen community health, and improve economic stability. Strategies under each goal draw on the core functions of public health (policy development, assessment, and assurance) and will be advanced through a cross-sector implementation structure led by PCHD.

A proposed Response Workgroup will include County departments, healthcare systems, community organizations, and state and local jurisdiction partners to ensure an equitable, unified response and quickly integrate emerging information. Detailed roles, responsibilities, and resource allocations will be further developed in subsequent phases. The Workgroup will utilize geography, language needs, disability indicators, and other social determinants of health data to identify where administrative burdens and benefit losses are most concentrated. Ongoing assessment, community feedback, and emerging policy direction will guide continuous refinement of strategies, timelines, and operational approaches.

Goal 1: Preserve Access to Healthcare Coverage

AHCCCS coverage continuity is at risk as new work-reporting requirements, shorter redetermination cycles, and tighter documentation rules increase the likelihood of residents losing coverage for procedural reasons rather than changes in eligibility. This goal focuses on identifying where coverage loss is occurring, tracking administrative barriers that prevent residents from completing renewals, and monitoring indicators such as disenrollment trends, application delays, and increased demand for navigation support. PCHD will reduce these barriers by providing direct enrollment and renewal assistance, including support through Health-e-Arizona Plus (HEAplus), the State's online portal used to apply for and manage AHCCCS, SNAP, and other public benefits. Through coordinated policy recommendations, expanded navigation services, and collaboration with AHCCCS, DES, health plans, healthcare providers, and community partners, PCHD will help residents understand changing requirements and remain connected to healthcare coverage.

Strategy 1.1: Support Streamlined AHCCCS Redetermination Processes at the State Level

Tactic	Metrics	Timeline of Metrics
1.1.1 Develop a plan, led by the response workgroup, to inform the State's adoption of all allowable federal flexibilities that impact new AHCCCS policy changes.	Completion of plan	By August 2026
1.1.2 Evaluate policies and inform recommendations on safeguarding Medicaid coverage continuity and county health infrastructure.	Research conducted Policy briefs written	Ongoing

Strategy 1.2: Analyze AHCCCS Disenrollment Trends and Identify High-Risk Populations

Tactic	Metrics	Timeline of Metrics
1.2.1 Create quarterly monitoring and reporting systems to track AHCCCS disenrollment trends.	Quarterly report Identified trends	By December 2026

Strategy 1.3: Provide Navigation and Renewal Assistance for AHCCCS Enrollees

Tactic	Metrics	Timeline of Metrics
1.3.1 Provide ongoing, scheduled Health-e-Arizona Plus application assistance at PCHD clinics, with Enrollment Assistors supporting residents in completing AHCCCS, SNAP, and other benefit applications.	Number of participants assisted with application assistance	By June 2026 Ongoing
1.3.2 Provide AHCCCS renewal reminders during Clinical Services and WIC visits.	Number of renewal reminders (flyer, virtual communications, etc.) distributed Renewal process established	By April 2026 Ongoing
1.3.3 Identify and distribute multilingual, health-literacy-appropriate materials that clearly explain Marketplace transitions, eligibility pathways, coverage options, premium changes, affordability resources, and forthcoming reporting requirements.	Number of materials identified Distribution to at least 25 partners **Materials align with 2.3.1 for consistency*	By October 2026 Ongoing
1.3.4 Partner with Organizations that provide services through AHCCCS reimbursement in Pima County to develop appropriate ways to mitigate the impact of the AHCCCS changes.	Number of partner sites engaged	By December 2026 Ongoing

Strategy 1.4: Reduce ACA Marketplace Coverage Loss and Support Seamless Transitions from AHCCCS

Tactic	Metrics	Timeline of Metrics
1.4.1 Monitor approaches used in other states to reduce ACA Marketplace coverage losses (e.g., state-funded affordability programs, state-based exchanges, or insurer pricing strategies) to inform local planning and response.	One Annual policy landscape summary produced	First report by July 2026 Annually thereafter
1.4.2 Conduct a landscape analysis to identify Statewide and Pima County specific assistor organizations/programs that offer support residents losing AHCCCS coverage.	Completion of landscape analysis Completion of a community outreach and engagement plan with identified partners	August 2026 September 2026

Goal 2: Reduce Food Insecurity and Maintain Access to Nutrition

Food insecurity in Pima County is rising as federal SNAP changes narrow eligibility and increase the administrative burden placed on residents and local systems. This goal focuses on identifying the residents and communities most at risk of losing nutrition benefits, monitoring trends in food insecurity and SNAP participation, and documenting emerging administrative barriers. PCHD will address these challenges by strengthening outreach, navigation, and referral systems; coordinating with WIC, the Non-Communicable Disease Office, Clinical Services, Healthy Pima, and community partners; and expanding multilingual, culturally responsive supports that help households maintain stable access to food resources. Through targeted assistance, routine data monitoring, and cross-sector collaboration, PCHD will help residents understand changing requirements and stay connected to nutrition programs during and after the implementation of H.R. 1.

Strategy 2.1: Advocate for local and state flexibility in SNAP eligibility requirements

Tactic	Metrics	Timeline of Metrics
2.1.1 Through quarterly surveys of Women, Infants, and Children Program (WIC) staff, identify recurring barriers reported by WIC participants to inform actions that support their continued participation.	WIC participation rates Number of actionable recommendations generated from identified barriers through surveys	Quarterly beginning July 2026
2.1.2 Continue WIC outreach with community partners, health care providers, and at community events to support enrollment.	Number of New WIC enrollees	Quarterly beginning April 2026
2.1.3 Use the WIC texting platform to engage families and implement the caseload management plan.	Number of WIC participation retention and continued participation	Reporting twice/year starting October 2026

Strategy 2.2: Monitor Food Insecurity Trends and SNAP Participation Rates

Tactic	Metrics	Timeline of Metrics
2.2.1 Create quarterly monitoring and reporting systems to track SNAP disenrollment trends.	Documented changes in administrative or eligibility procedures Changes in enrollment numbers	Quarterly beginning in July 2026

Strategy 2.3: Expand Outreach and Enrollment Assistance for SNAP Alternatives and Emergency Food Programs

Tactic	Metrics	Timeline of Metrics
2.3.1 Identify and distribute multilingual, health-literacy-appropriate materials explaining SNAP eligibility, work-reporting rules, exemptions, documentation requirements, and key deadlines.	Number of materials identified Distribution to at least 25 partners **Materials align with 1.3.3 for consistency	By August 2026 Ongoing
2.3.2 Train PCHD Staff to assist residents with SNAP navigation, food resources, WIC referrals, and follow-up, using the PCHD Referral Form.	At least 75% successful linkages of all engagements Referral outcomes reviewed and reported quarterly	Quarterly beginning September 2026
2.3.3 Train community-based providers and clinical staff to integrate produce prescription referrals, which link eligible patients to Prescription for Health, a 12-weekprogram offering culturally relevant nutrition education and incentives such as grocery gift cards and seeds to support residents at risk of food insecurity and chronic disease.	Number of partners trained	By July 2026 Ongoing
2.3.4 Implement patient food insecurity screening in PCHD clinics (using the SDOH screening form); and refer all identified patients to community partner agencies.	Number/ Percentage of patient screening Number/ Percentage of referrals for food-insecure patients	By August 2026

Goal 3: Prevent Future Gaps in Food Security and Healthcare Access

Federal SNAP and Medicaid changes will have long-term effects on access to food and healthcare, requiring proactive planning and sustained cross-sector readiness. This goal focuses on using emerging data to identify future gaps, developing policy recommendations that strengthen eligibility pathways and reduce procedural loss, and preparing County and community partners for rising administrative burden and increased uninsured rates. Through coordinated planning with community organizations, healthcare partners, FQHCs, libraries, CHWs, and rural partners, PCHD will build long-term system capacity, improve communication and outreach infrastructure, and advance policy and operational strategies that ensure residents can maintain stable food and healthcare access as federal rules continue to evolve.

Strategy 3.1: Advance Immediate, Medium-Term, and Long-Term Policy Solutions to Strengthen System Readiness

Tactic	Metrics	Timeline of Metrics
3.1.1 Inform policy recommendations that may be used to expand SNAP eligibility waivers.	Completion of policy recommendations Submitted to County Administration	By August 2026
3.1.2 Provide input to the state definition of "medical frailty" that explicitly covers behavioral health conditions, chronic disease, functional limitations, and substance use disorders to reduce inappropriate placement into work-requirement groups.	Completion of Policy Brief to include input on state definition Submitted to County Administration	Ongoing
3.1.3 Inform recommendations to ADHS, AHCCCS, and DES to reduce procedural disenrollment through the following strategies: • Adoption of all optional federal exemptions under H.R.1, including allowable hardship, geography, and population-based flexibilities. • Permitting self-attestation for allowable eligibility factors and work-requirement reporting elements. • Simplifying documentation standards, reducing duplicative reporting, and expanding acceptable proof options for households with unstable employment or limited technology access.	Completion of policy recommendations Submitted to County Administration	Ongoing

Strategy 3.2: Connect Clients to Food Assistance, Healthcare Resources, Work and Volunteer Opportunities, and Social Support Services

Tactic	Metrics	Timeline of Metrics
3.2.1 Identify, develop, and coordinate additional County and volunteer opportunities to meet anticipated work-reporting requirements, ensuring accessible, appropriate, and scalable placement options for affected residents.	Number of new opportunities (slots) created Volunteer opportunities utilization rate	By September 2026 Ongoing
3.2.2 Convene cross-sector readiness planning sessions (e.g. to prepare for increased uninsured rates, higher administrative burden, and emerging community needs).	Number of planning sessions held Actions implemented as a result of those sessions	By August 2026
3.2.3 Develop and implement Pima County-wide communication plan that, in alignment with AHCCCS documentation, explains the re-enrollment process, common eligibility barriers, and the distinction between procedural disenrollment and fraud.	Plan Completed Distribution metrics	By August 2026

Strategy 3.3: Prepare for Long-Term System Readiness Through Planning and Infrastructure Development

Tactic	Metrics	Timeline of Metrics
3.3.1 Assess feasibility for a comprehensive multisource data dashboard that integrates SNAP and Medicaid disenrollment trends, Marketplace transitions, provider strain, CHW encounters, and navigation outcomes.	Completion of feasibility assessment Dashboard design proposal	By December 2026
3.3.2 Identify data sources, partnerships, and technical requirements needed to support a long-term integrated data-sharing infrastructure.	Completed landscape scan Documentation of required data-sharing agreements	By August 2027
3.3.3 Develop a phased implementation roadmap for future system-readiness activities aligned with County-wide and Healthy Pima frameworks.	Completion of roadmap Milestones established for post-2026 implementation	By September 2027

Barriers and Mitigation

PCHD's response plan is shaped by legal, fiscal, operational, data, and community constraints. Although these limitations create real challenges, the Health Department has incorporated strategies throughout this plan that help reduce their impact on residents and systems.

Legal Authority & Preemption

Federal and state law govern program eligibility, work-reporting requirements, and documentation standards. The plan focuses on targeted policy advocacy, developing data-driven briefs, and elevating local impacts to AHCCCS, DES, and state lawmakers to influence implementation where possible.

Additionally, complex policy changes increase the risk of confusion and misinformation. The plan includes a rapid-response communications strategy, multilingual materials, and coordinated messaging across clinics, CHWs, and partners to ensure residents receive accurate, accessible information.

Resource Constraints

The plan emphasizes cross-training, shared responsibilities across County departments, health department divisions, and partnerships with FQHCs, CBOs, libraries, and health systems. Key activities are concentrated during high-impact periods between August 2026 and March 2027 to maximize efficiency.

PCHD staffing limitations restrict how quickly new activities can be expanded. The plan coordinates staffing through the SNAP & Medicaid Response Workgroup and distributes navigation, renewal support, and outreach across staff including CS, WIC, and NCDO to extend capacity where possible.

Partners face their own staffing and resource constraints. Although participation may vary, the plan stabilizes collaboration through Healthy Pima structures, predictable cross-sector coordination, and shared communication tools that reduce partner burden and support consistent implementation.

Data Limitations

Key datasets are released quarterly or biannually and do not fully capture procedural loss, documentation barriers, or digital access challenges. Although data lag is a constraint, the plan supplements state and federal data with primary sources (including CHW encounters, SDOH screenings, enrollment events, and partner feedback) and merges them into quarterly monitoring reports and a multi-source dashboard to guide timely adjustments.

Health Insurance Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), Title 42 of the Code of Federal Regulations Part 2 (42 CFR Part 2), and system incompatibilities limit real-time data exchange. Although these restrictions narrow analytic capabilities, the plan addresses this by pursuing active collaboration with partners, relying on aggregated or de-identified data, and embedding renewal reminders directly into clinical and WIC workflows to reduce reliance on cross-system data transfer.

Structural & Community Barriers

Residents may experience challenges such as limited transportation, unstable housing, language barriers, and low digital literacy. The plan helps to mitigate these impacts by using mobile services, CHW navigation, which focuses on connecting residents with community resources, education, and follow-up support; benefits enrollment assistance, which provides direct help completing and submitting applications for programs like SNAP and AHCCCS; culturally and linguistically responsive outreach, and geographically tailored rural strategies.

Rural communities face higher vulnerability due to limited broadband, long travel distances, and provider shortages. Although these structural limits persist, the plan strengthens rural access through CHW deployment, library and FQHC partnerships, rural hubs, and targeted monitoring of high-SVI areas.

Many residents face barriers in completing online reporting and renewals. The plan counters digital inequities by expanding in-person and mobile enrollment assistance, offering multilingual and low-literacy materials, and working with libraries and rural partners to increase access to devices, internet, and digital support.

Monitoring & Evaluation

Effective monitoring and evaluation will ensure that Pima County's response to H.R. 1 remains data-driven, equitable, and responsive to emerging needs. This framework establishes clear goals, metrics, timelines, governance structures, and reporting processes to track progress across all three goals of the action plan.

Response Workgroup

The Response Workgroup will serve as the central coordinating body for implementation, monitoring, and continuous improvement. The Workgroup will function as an action-driving entity that aligns efforts across County systems, ensures data-informed decision-making, and maintains an equity-centered approach.

The Workgroup is anticipated to include representatives from key PCHD divisions and programs, including Epidemiology, Office of Policy Equity and Engagement, Community Outreach Prevention and Education, Non-Communicable Disease Office, Clinical Services, WIC/ programs, Communications, Community Health Workers, and County departments, state-level organizations, local jurisdictions, and community partners. The Workgroup will meet monthly, with additional meetings convened as major policy changes arise.

Core Responsibilities include:

- Review quarterly data on SNAP and AHCCCS enrollment, churn, service utilization, and disparities across populations and geographies.
- Coordinate with County departments and external partners to maintain a cohesive, countywide response.
- Provide guidance on culturally and linguistically appropriate outreach strategies that effectively reach the most impacted populations.

- Serve as a central hub for sharing policy updates, operational impacts, and frontline challenges.
- Provide regular updates to senior leadership and key stakeholders on key decisions, risks, and resource needs.

Reporting Framework

To ensure accountability and continuous improvement, PCHD will launch a formal evaluation phase beginning January 2027. A standardized reporting process will be established in 2026 to support this work. This reporting structure will include:

- Quarterly internal reports summarizing key metrics, trends, and operational issues.
- Biannual summary briefs synthesizing major findings, emerging challenges, and recommended adaptations.
- Annual public-facing reports providing high-level trends, major impacts on access to food and healthcare, and progress toward plan goals.
- This reporting framework ensures that Pima County remains responsive as federal requirements evolve and that long-term strategies are grounded in local data, operational experience, and community feedback. Regular review and information-sharing will further support alignment across divisions, strengthen cross-sector coordination, and guide adjustments to outreach, navigation, and policy recommendations.

Appendix A

Implementation Timelines for H.R. 1

SNAP Implementation Timeline

Federal Fiscal Year 2026	
Oct. 1, 2025	SNAP-Ed funding eliminated; remaining FFY25 funds may continue to be used.
Nov. 1, 2025	End of the 120-day grace period for implementing new provisions; after this date, implementation errors count toward the state's FFY26 payment error rate.
June 2026	FFY25 payment error rates released (covering Oct. 1, 2024–Sept. 30, 2025).
Federal Fiscal Year 2027	
Oct. 1, 2026	75% administrative cost shares take effect. Planned benefit increases tied to Thrifty Food Plan revisions would have taken effect.
June 2027	FFY26 payment error rates released.
Federal Fiscal Year 2028	
Oct. 1, 2027	First year of the benefit cost shift, based on FFY25 or FFY26 payment error rates, unless the state qualifies for an exemption (PER ≥13.34%).
June 2028	FFY27 payment error rates released.
Federal Fiscal Year 2029	
Oct. 1, 2028	Second year of benefit cost shift, based on FFY26 payment error rates, unless exempt.
June 2029	FFY28 payment error rates released.
Federal Fiscal Year 2030	
Oct. 1, 2029	Benefit cost shift applies to all states based on FFY27 payment error rates; no exemptions allowed.

Medicaid (AHCCCS) Implementation Timeline

Federal Fiscal Year 2026	
Jan. 1, 2026	HHS must issue final rules for implementing Medicaid work reporting requirements.
Oct. 1, 2026	Narrower definition of "qualified immigrants" for Medicaid/CHIP eligibility takes effect. Federal Match for Emergency Medicaid is reduced to the state's standard FMAP for individuals who would otherwise qualify for immigration status.
Dec. 31, 2026	States must implement work requirements for more Medicaid enrollees ages 18-64 (with exceptions).
Jan. 1, 2027	Semiannual eligibility redeterminations required for Medicaid expansion adults. States must obtain updated address information and check the Death Master File quarterly.

	Retroactive coverage limited to: 1 month for expansion adults 2 months for traditional Medicaid populations CMS must verify that Section 1115 waivers do not increase federal expenditures.
2027-2034 Financing and Program Changes	
Oct. 1, 2027	Provider tax rate in expansion states decreases 0.5% each year until reaching 3.5% in FY2032.
Oct. 1, 2028	States may not charge enrollment fees or premiums to the expansion population; cost-sharing is required for some services (with exceptions).
Oct. 1, 2029	States must prevent dual enrollment across states Stricter limits on allowable erroneous payments to hospitals/providers; HHS may broaden definitions or thresholds.
Sep. 30, 2034	Moratorium on Medicaid Eligibility and Enrollment Final Rules expires. Moratorium on Skilled Nursing Facility staffing ratio rules expires.