



TO: Medicaid Directors
FROM: NAMD Staff
DATE: July 9, 2025
RE: Medicaid policies in OBBBA

On July 3, Congress passed via the FY 2025 budget reconciliation process HR 1, the One Big Beautiful Bill Act (OBBBA), and on July 4, the President signed it into law. [Full text of the bill as enacted is available here.](#)

As OBBBA shifted from the House to the Senate, Medicaid policies in the bill evolved. This resource calls out notable changes from previous NAMD analyses of OBBBA in **bolded red text throughout the body of this resource and in the table of contents**. Please note that section numbers are revised from the Senate Finance version, with some policies removed entirely and others added in; we detail new and removed policies in a dedicated sections of this resource. We do not address Medicare or Marketplace policies in this analysis.

NAMD will continue to update our members-only [2025 Congressional Medicaid Proposals resource library](#) (member login required) with additional information on OBBBA policies and implementation activities going forward.

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Quick Overview of Key Changes

Significant changes in OBBBA compared to language initially released in the Senate include:

- **Provider tax provisions at Sec. 71115:**
 - Prohibits new provider taxes on provider categories not taxed as of July 4, 2025 by setting the hold harmless threshold for new taxes at zero percent.
 - Effective October 1, 2026, phases down hold harmless thresholds for provider taxes in expansion states (except for taxes for skilled nursing facilities and ICF/IDDs) to the lower of:
 - Applicable percent of net patient revenue, or
 - The applicable percent for specified fiscal years as follows:
 - For FY 2028, 5.5 percent
 - For FY 2029, 5 percent
 - For FY 2030, 4.5 percent
 - For FY 2031, 4 percent
 - For FY 2032 and beyond, 3.5 percent
- **Managed care state directed payments (SDPs) provisions at Sec. 71116:**
 - Maintains cap for any new SDP submissions at 110% of Medicare for non-expansion states and 100% of Medicare for expansion states
 - Requires already approved SDPs to be reduced by 10 percentage points per year until they are no greater than the above percentages of Medicare rates, but now starting this reduction in 2028
 - Revising how existing SDPs are grandfathered, with SDPs that are not directed to rural hospitals grandfathered if approved (or good faith effort sought) before May 1, 2025 and SDPs for rural hospitals approved (or good faith effort sought) by date of enactment being grandfathered
- **Community engagement provisions at Sec. 71119:**
 - Changes to the compliance standard to consider seasonal workers with an average monthly income over the preceding 6 months that is not less than the federal minimum wage multiplied by 80 hours to be compliant
 - Certain changes to the populations that are exempt from the requirements, notably including parents, guardians and caretaker relatives of children (requirements now apply to those caring for children age 13 and under, as opposed to Senate Finance language of 14 or under)
 - Requirement to utilize *ex parte* processes to determine if an individual is exempt from the requirement
- **New rural provider relief fund at Sec. 71401:**
 - Appropriates a total of \$50 billion available from FY 2028 – 2032

- 50% allocated across all states; 50% allocated based on rural population and facility characteristics
- Funds available for a variety of rural settings, not limited to hospitals
- One state application detailing rural transformation plan submitted by December 31, 2025, if approved, would make state eligible for all funding years
- No state match required to draw awarded funds, but funds may not be used to draw down federal match
- **New HCBS waiver option at Sec. 71121:**
 - Effective July 1, 2028, creates a new 1915(c) waiver option that does not require participants to be subject to a determination that, but for the provision of home and community-based services (HCBS), they would need nursing home or ICF/IDD level of care.
- **Removal of sections of previous Senate language (all the following policies were struck or otherwise removed):**
 - Prohibition of federal financial participation under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status
 - Expansion FMAP penalty for coverage of certain non-citizen populations with state general funds
 - Prohibition of federal match for specified gender dysphoria treatments
 - Federal ban on spread pricing in Medicaid, including requirement for managed care entities to pay at least the state plan dispensing fee to pharmacies
 - Requirements for retail and certain non-retail pharmacies to participate in the National Drug Acquisition Cost (NADAC) survey

Summary of Legislative Text

Subpart A: Reducing Fraud and Improving Enrollment Processes

- *Section 71101, Prohibition on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs:* **Delays** implementation, administration, and enforcement of CMS’s eligibility and enrollment rule pertaining to dual eligibles, titled [“Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment,”](#) **effective July 4, 2025 through September 30, 2034. Only those provisions not yet in effect are subject to this delay.**
- *Section 71102. Prohibition on implementation of rule relating to eligibility and enrollment for Medicaid and CHIP:* **Delays** implementation, administration, and enforcement of CMS’s eligibility and enrollment rule for Medicaid and CHIP (but not BHPs), titled [“Medicaid Program; Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and](#)

[Renewal Processes](#),” effective July 4, 2025 through September 30, 2034. Only those provisions not yet in effect as of July 4, 2025 are subject to this delay.

- *Section 77103. Reducing duplicate enrollment under the Medicaid and CHIP programs:* Requires Medicaid programs to regularly obtain address information for enrolled individuals, provide specified information to HHS, and use a system that HHS is required to establish to identify and take action on duplicate enrollments in multiple Medicaid programs. Specifically:
 - Beginning no later than **January 1, 2027**, Medicaid agencies in the states and the District of Columbia must have a process in place to regularly obtain address information for enrolled individuals. This has already been their regular practice.
 - This process must include checking reliable data sources, including returned mail with a forwarding address, the National Change of Address Database, address information provided to or verified by a contracted managed care organization (MCO), and any other sources identified by the state and approved by the Secretary.
 - Newly established by this text, Medicaid agency contracts with MCOs must require MCOs to promptly transmit address information received by the MCO to the Medicaid agency beginning **January 1, 2027**.
 - Beginning no later than **October 1, 2029**, Medicaid agencies must submit to HHS each month, and at the time of determination or redetermination of eligibility, individuals’ Social Security numbers (if required to provide them at application or renewal) and any other information required by the Secretary.
 - This information will populate a system HHS must develop by **October 1, 2029** to identify instances of duplicate enrollment in multiple Medicaid programs.
 - HHS will use this system monthly to notify states when duplicate enrollment is identified. If duplicate enrollment is identified in this system, the state must verify the individual’s residency in the state. If residency cannot be verified, the state must disenroll the individual, unless the individual meets an exception designated by the Secretary.
 - HHS may waive state participation in the Public Assistance Reporting Information System (PARIS) match system once this new system is in place.
 - These requirements do not apply to the U.S. territories.
- *Section 71104. Ensuring deceased individuals do not remain enrolled:* Starting **January 1, 2028**, requires the states and the District of Columbia on at least a quarterly basis to check the Death Master File to identify if enrolled individuals are deceased. If an individual is identified as deceased on the Death Master File, then the state must treat

this information as factual, disenroll the individual, and discontinue any payments for items or services furnished after the death of the individual.

- If an individual is erroneously disenrolled based on information from the Master Death File, the individual must be reinstated to coverage retroactive to the date of disenrollment.
- States may use additional electronic data sources outside of the Death Master File to identify deceased individuals.
- These requirements do not apply to the U.S. territories.
- **Section 71105. Ensuring deceased providers do not remain enrolled:** Starting **January 1, 2028**, requires states, as part of their provider and supplier enrollment, reenrollment, and revalidation processes and at least quarterly while a provider is enrolled, to check the Death Master File to determine whether the provider or supplier is deceased.
- **Section 71106. Payment reduction related to certain erroneous excess payments under Medicaid:** This section expands the definition of “erroneous excess payment,” gives the Secretary the option to allow state-conducted audit findings to be considered in determining a state’s error rate, and puts new limits on the amounts of penalties the Secretary may waive through good faith effort. Specifically:
 - Starting **October 1, 2029**, the extent to which HHS is permitted to waive reduction of payment in situations in which a state has an improper payment finding more than the 3% error rate allowable under current statute and regulation is modified. This change will narrow the scope of potential waivers of payment reductions.
 - The definition of “erroneous excess payments” is amended to include payments made on behalf of ineligible individuals, overpayments to eligible individuals related to error, payments to an eligible person who is not eligible for particular items and services, **or payments where insufficient information is available to confirm eligibility.**
 - Payments made on behalf of individuals not eligible for FFP (i.e. certain non-citizen populations) would also be considered erroneous.
 - Any audit conducted by the Secretary count towards the 3% error rate, **and, at the Secretary’s option, audits conducted by the state.**
 - The amount that the Secretary may waive via a good faith effort may not exceed an amount equal to the erroneous excess payments described at Section 1903(u)(1)(D)(ii) of the Social Security Act, which are, as amended by this legislation, “overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility, **or payments where insufficient information is available to confirm eligibility.**”

- *Section 77107. Eligibility redeterminations:* Starting for redeterminations scheduled on or after **December 31, 2026**, requires Medicaid agencies to conduct eligibility redeterminations for adult expansion group enrollees (or those receiving minimum essential coverage through a waiver program) once every six months, a change from current law’s requirement to conduct redeterminations once every 12 months.
 - Members of Tribes are not subject to the 6-month eligibility check requirement.
 - These requirements do not apply to the U.S. territories.
 - Guidance on this provision is to be issued within 180 days of enactment of this legislation, by **December 31, 2025**
 - Congress appropriates \$75 million in FY 2026 to CMS to implement this section.
- *Section 71108. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program:* Starting **January 1, 2028**, sets a maximum home equity limit of \$1 million for purposes of determining eligibility for nursing facility services or other long-term care services. This cap, which replaces a limit that was adjusted annually, cannot be waived through asset disregards.
- *Section 71109. Alien Medicaid eligibility:* Beginning **October 1, 2026**, amends the definition of qualified alien to include only “aliens lawfully admitted for permanent residence as an immigrant as defined by sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act, excluding, among others, alien visitors, tourists, diplomats, and students who enter the United States temporarily with no intention of abandoning their residence in a foreign country”, certain Cuban and Haitian immigrants, and Compact of Free Association (COFA) migrants.
 - This narrows the definition of qualified alien from current law. Refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, trafficking victims, and certain other non-citizens would no longer be considered qualified aliens for purposes of Medicaid and CHIP.
 - Coverage of the CHIPRA 214 group and individuals covered under a CHIP Health Services Initiative are permitted under this definitional change.
 - Congress appropriates \$15 million in FY 2026 to CMS to implement this provision.
- *Section 71110. Expansion FMAP for emergency Medicaid:* Beginning **October 1, 2026**, sets FMAP for emergency Medicaid at the base FMAP for the state, regardless of eligibility category for the individual receiving emergency Medicaid.

Subpart B: Preventing Wasteful Spending

- *Section 71111. Prohibition on implementation of the final staffing rule for nursing facilities:* **Delays** implementation, administration, and enforcement of CMS’s nursing facility minimum staff ratio rule, titled “[Medicare and Medicaid Programs; Minimum](#)

[Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting,” effective July 4, 2025 through September 30, 2034.](#)

- **Only the minimum staff elements of the rule are delayed.** Elements of the rule related to compensation reporting for direct care workers and support staff at the individual facility level by Medicaid agencies remain in place.
- *Section 71112. Reducing state Medicaid costs:* For Medicaid and CHIP eligibility applications submitted **on or after January 1, 2027**, sets out retroactive coverage periods along the following lines:
 - Adult expansion population: one month
 - Other Medicaid eligibility categories: two months
 - CHIP: two monthsCongress appropriates \$10 million in FY 2026 to CMS to implement this provision.
- *Section 71113. Federal payments to prohibited entities:* For **the 1-year period following date of enactment of this legislation**, prohibits federal match for items and services provided by prohibited entities that, as of the first day of the first quarter beginning after date of enactment of this legislation:
 - Are 501(c)(3) entities under the Internal Revenue Code of 1986;
 - are essential community providers that are primarily engaged in family planning services, reproductive health, and related medical care;
 - provides for abortions other than those provided if the pregnancy is the result of an act of rape or incest or to save the life of the pregnant woman; and
 - received directly or through its affiliates as part of a nationwide health care provider network over \$800,000 in total federal and state expenditures under title XIX of the Social Security Act in FY 2023.Congress appropriates \$1 million in FY 2026 to CMS to implement this section. This section is broadly understood as being directed at Planned Parenthood.

Subpart C: Stopping Abusive Financing Practices

- *Section 71114. Sunsetting eligibility for increased FMAP for new expansion states:* Removes the temporary 5 percentage point enhanced FMAP for states that opted to expand Medicaid after March 11, 2021 that was enacted by the American Rescue Plan Act that opt to expand Medicaid after March 11, 2021. This would apply on a prospective basis; any state must begin expending funding for the expansion population prior to January 1, 2026 to receive the enhancement.
- *Section 71115. Provider taxes:* **Beginning October 1, 2026, modifies the permissible levels of provider taxes based on applicable law in effect as of May 1, 2025, described at 42 CFR 433.56(a) for taxes enacted by states or units of local government.**

- For both expansion and non-expansion states, for any provider class that did not have a tax in effect as of **July 4, 2025**, the hold harmless threshold for that provider class is set at 0 percent.
 - In effect, this policy means that states may not enact provider taxes on new provider classes after July 4, 2025 and have those taxes remain in place after October 1, 2026.
- **For non-expansion states with currently approved provider taxes, the hold harmless threshold will be the applicable percent of net patient revenue attributable to the class¹.**
- **For expansion states with currently approved provider taxes, the hold harmless threshold will be the lower of:**
 - **The applicable percent of net patient revenue attributable to the class; or**
 - **The applicable percent for specified fiscal years as follows:**
 - **For FY 2028, 5.5 percent**
 - **For FY 2029, 5 percent**
 - **For FY 2030, 4.5 percent**
 - **For FY 2031, 4 percent**
 - **For FY 2032 and beyond, 3.5 percent**
 - **Note that for nursing facilities and ICF/IDDs provider taxes in expansion states, the phase-down of the hold harmless threshold does not apply. Their cap is the applicable percent of net patient revenue.**
- These provisions do not apply to the U.S. territories.
- Congress appropriates \$20 million in FY 2026 to CMS to implement this section.
- ***Section 71116. State directed payments:* For rating periods beginning on or after date of enactment of this legislation**, requires HHS to revise federal regulations (or issue new regulations) to limit total payments made through managed care state directed payments (SDPs) to a percentage of the total published Medicare rate or, when no such rate is available, the payment rate under the Medicaid state plan.
 - SDPs are limited to:

¹ NAMD’s understanding of “applicable percent of net patient revenue attributable to the class” is that revenue amounts associated with an existing tax structure can increase as the revenue base increases. For example, if a state taxes their hospitals at 5% prior to July 4, 2025, then 5% of hospital patient revenue is the threshold going forward – even if the absolute dollar amount associated with that patient revenue increases in a future year. We recommend close review of this provision by Medicaid agency financial experts and legal counsel.

- 100% of Medicare for expansion states (or states providing expansion-equivalent MEC via waiver) and states that newly expand, even if an SDP was grandfathered at a higher rate
 - 110% of Medicare for non-expansion states
- **Certain SDPs are grandfathered, including those:**
 - **that received written approval from CMS (or good faith effort to receive approval) prior to May 1, 2025 for the rating period occurring within 180 days of date of enactment (December 31, 2025);**
 - **for which a completed preprint was submitted to the Secretary prior to July 4, 2025; and**
 - **directing payments to rural hospitals, as defined in Medicare statute, including:**
 - **hospitals in a rural area or treated as being in a rural area in the Medicare program**
 - **hospitals in a rural census tract of a metropolitan statistical area**
 - **critical access hospitals**
 - **sole community hospitals**
 - **a Medicare-dependent, small rural hospital**
 - **a low-volume hospital**
 - **a rural emergency hospital**
- Beginning with the rating period on or after **January 1, 2028**, grandfathered SDPs are reduced by 10 percentage points each year until the total rate reaches 100% of Medicare for expansion states and 110% percent of Medicare for non-expansion states.
- The Medicare payment rate is defined as amounts calculated as payment for specific services developed under Medicare Part A or Part B.
- These provisions do not apply to the U.S. territories.
- **Congress appropriates \$7 million in FY 2026 to CMS to implement this section.**
- *Section 71117. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax:* Effective **the date of enactment of this legislation and with an up to 3-year transition period** determined by the Secretary, modifies the criteria HHS must consider when determining whether certain health care-related taxes are generally redistributive in nature. Specifically, a tax with any of the following conditions would not be considered generally redistributive:²

² The provider tax changes in Section 71117 substantially align with [CMS's proposed rule on provider taxes](#) formally published in the Federal Register on May 15, 2025 and is open for comment through July 14, 2025.

- If, within a permissible class, the tax rate imposed on the taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer or tax rate group explicitly defined by its relatively higher volume or percentage of Medicaid taxable units.
- If, within a permissible class, the tax rate imposed on the taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable unit.
- The tax excludes or imposes a lower tax rate on a taxpayer or tax rate group based on or defined by any description that results in the same effect as the scenarios described above, even in instances where the term “Medicaid” or similar term is not mentioned in the tax, or when a close approximation to Medicaid through other characteristics is used.
 - “Medicaid taxable units” are units used as the basis for Medicaid payment (e.g., bed days), Medicaid revenue, costs associated with the program (e.g., Medicaid claims), and other units associated with the program as determined by the Secretary.
 - “Non-Medicaid taxable units” are defined as a unit that is being taxed that is not applicable to the program under this title, including payment by non-Medicaid payers (e.g., non-Medicaid bed days), non-Medicaid revenue, costs not associated with Medicaid (e.g., non-Medicaid claims) and other units determined by the Secretary.
- A state will not violate the prohibition on new or increased provider taxes if it imposes a tax or increases a tax to comply with the requirements in this section by the effective date of this paragraph, subject to any applicable transition period determined by the Secretary.
- These provisions do not apply to the U.S. territories.
- *Section 71118. Requiring budget neutrality for Medicaid demonstration projects under section 1115:* Effective **January 1, 2027**, codifies in federal statute budget neutrality requirements for demonstration projects under section 1115 of the Social Security Act. Specifically:
 - The Secretary may only approve or renew waivers that are certified by the chief actuary of CMS. CMS’s actuary must certify that, based on expenditures for the state program in the preceding fiscal year, federal expenses are not expected to increase over the amount that federal spending would have been absent the waiver project.
 - The following are considered expenditures that would have existed without the waiver project:

- expenditures for coverage of populations and services that the state could otherwise have provided through the state plan or other Medicaid authority, including expenditures that could be made under such authority but for the provision of such services at a different site of service than authorized under the state plan or other authority.
- The Secretary must specify the methodology for accounting for savings generated under an 1115 demonstration in future approval periods.

Subpart D: Increasing Personal Accountability

- *Section 71119, Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals: Effective December 31, 2026, or earlier at state option via an 1115 demonstration*, requires Medicaid programs to establish community engagement requirements for “able-bodied adults” aged 19 to 64 who do not have dependents and who are enrolled in the adult expansion or a waiver program that is equivalent to minimum essential coverage. **HHS must issue an interim final rule implementing this requirement by June 1, 2026.**
 - These provisions do not apply to the U.S. territories.
 - **Good faith effort extension:** The Secretary may exempt a state from compliance if the state submits a request and the Secretary determines the state is demonstrating a good faith effort to comply. **This exemption cannot extend beyond December 31, 2028.** States must submit quarterly progress reports and information on barriers to full compliance to the Secretary, and the Secretary may revoke good faith extensions if states do not comply with reporting requirements or are deemed to no longer be making good faith effort towards implementation.
 - **Compliance standard:** An individual can meet the community engagement requirements during a month by working at least 80 hours, completing at least 80 hours of community service, participating in a work program for at least 80 hours, enrolling in an educational program (e.g. higher education, career and technical education) at least half time, or a combination of these activities for at least 80 hours. Individuals whose monthly income is not less than the federal minimum wage multiplied by 80 hours would also be in compliance, **as would individuals who are seasonal workers with average monthly incomes over the previous 6 months is at least 80 times the federal hourly minimum wage.**
 - OBBBA specifically cites the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938. As of July 4, 2025, the federal minimum wage is \$7.25 an hour.

- **Exempt populations:** Categorical exemptions to the community engagement apply for the following populations, which the Secretary does not have authority to add to. **States may elect not to require an individual to verify information resulting in deeming an individual exempt from the requirement.** Exemptions include:
 - pregnant women;
 - individuals under the age of 19 or over the age of 64;
 - individuals enrolled in or entitled to Medicare Part A coverage
 - individuals enrolled in Medicare Part B coverage
 - foster youth and former foster youth under the age of 26;
 - members of a Tribe;
 - veterans with rated disabilities;
 - individuals who are considered medically frail, which includes, but is not limited to individuals who are blind or disabled, who have a chronic substance use disorder, who have a disabling mental disorder, who have a physical/intellectual/developmental disability that significantly impairs one or more activity of daily living (ADL), who have a serious and complex medical condition, or who have a medical condition, as defined by the State and approved by the Secretary, as meeting the definition of medically frail;
 - individuals who are participating in an SUD or AUD treatment program **as defined in section 3(h) of the Food and Nutrition Act of 2008**, which is limited to treatment programs provided by private nonprofit organizations or publicly operated community mental health centers;
 - individuals who are already in compliance with the work requirements under the Temporary Assistance for Needy Families (TANF) program or Supplemental Nutrition Assistance Program (SNAP);
 - individuals who are a parent or caregiver of a dependent child **13 years of age and under** or an individual with a disability;
 - individuals who are incarcerated or recently released from incarceration within the past 90 days; or
 - individuals entitled to postpartum medical assistance under section 1902(e)(5) (postpartum coverage after pregnancy ends) or section 1902(e)(16) (the postpartum coverage option).
- **Hardship waivers:** At state option, short-term hardship waivers to the community engagement requirement may apply for:

- Individuals who are receiving inpatient hospital, SNF, ICF-IID, inpatient psychiatric hospital or other services of similar acuity, including outpatient care related to relating to other services specified here, as determined by the Secretary;
 - Natural disasters;
 - Counties in which the unemployment rate is greater than 8% or greater than 150% of the national average; and
 - Individuals (or their dependents) who must travel outside of their community for an extended period of time to receive medical services necessary to treat a serious or complex medical condition that are not available within their community of residence.
- **Verification:** Compliance must be verified no less frequently than for the month preceding an individual’s enrollment (**or up to three months at state option**) in Medicaid and the month preceding the individual’s eligibility redetermination.
 - Verification would occur as part of the individual’s overall eligibility determination or redetermination.
 - At state option, verification may occur more frequently than at initial eligibility determination and at redetermination.
 - Note that choosing a more frequent verification schedule will require earlier notice when the requirement takes effect, described immediately below.
- **Noticing requirements:** Beginning no later than October 1, 2026 (or, if earlier, the date that precedes December 31, 2026 by the state-selected compliance period plus 3 months), states must begin notification of applicable individuals of community engagement requirements, describing how to comply, consequences of noncompliance, and how to report changes that may initiate or end an exception to the requirement.
 - Outreach must occur by regular mail (or electronic format if chosen by the individual) and at least one additional form, such as telephone, text message, website or other electronic means, or other means determined by the Secretary.
- **Ex parte:** States must streamline and simplify processes, through standards established by the Secretary, to verify compliance or exemptions from the requirement in order to reduce burden on individuals. These processes should use reliable information available to the state, such as payroll data, and without requiring, where possible, the individual to submit additional information. This is broadly analogous to the *ex parte* renewal process.

- States must establish due process procedures for individuals prior to denying coverage or disenrolling individuals from coverage. This includes notices, a 30-calendar-day period (during which coverage remains available) to demonstrate compliance or that an exemption condition is met, assessment of eligibility on other bases, notice of disenrollment, and fair hearing rights.
- **Non-waivable:** The community engagement requirement may not be waived via an 1115 demonstration waiver.
- **Interactions with other federal requirements:** An individual who would be otherwise eligible for coverage except for failure to meet the community engagement requirement would be deemed to be eligible for minimum essential coverage. This has implications for the availability of advance premium tax credits for marketplace coverage for such individuals.
 - OBBBA specifies that a state will not be treated as not providing Medicaid to all individuals described in 1902(a)(10)(A)(i)(VIII) (the Medicaid expansion group) or as not expending amounts for all individuals under the state plan solely because an individual is determined ineligible due to not meeting the community engagement requirement.
- **Conflict of interest prohibition:** States cannot use a Medicaid managed care entity or other contractor to determine beneficiary compliance with the community engagement requirement, unless the contractor has no direct or indirect financial relationship with any Medicaid managed care entity or other specified entity that is contractually responsible for providing/arranging coverage of medical assistance for Medicaid members.
- **Implementation funding:**
 - **\$100 million** in grant funding is appropriated in FY 2026 for state implementation, to be allocated by the ratio of individuals subject to community engagement in the state compared to the total number of individuals subject to the requirement nationwide.
 - **\$100 million** in grant funding is appropriated in FY 2026 for state implementation, to be allocated evenly among states.
 - **\$200 million** is appropriated to CMS in FY 2026 for overall implementation efforts.
- *Section 71120. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program:* Effective **October 1, 2028**, requires mandatory cost sharing for individuals with incomes above 100% of the federal poverty level enrolled in the adult expansion group (or a waiver providing minimum essential coverage). Cost sharing must be an amount greater than \$0, may not exceed \$35 per service (a

reduction of the \$100 per service limit in current law), and may not exceed 5% of the individual's family income as applied on a quarterly or monthly basis at state option.

- Prohibitions on cost sharing for services under current law remain in place, including primary care, prenatal care, pediatric care, and emergency room care (except for non-emergency care provided in an emergency room).
 - **Additionally, cost sharing may not be imposed on primary care services, mental health care services, SUD services, or services provided by a Federally Qualified Health Center or rural health clinic.**
- Current cost sharing limits on prescription drugs would remain in place (for people at or below 150% FPL, maximum \$4 for preferred drugs and \$8 for non-preferred drugs; for people above 150% FPL, maximum \$4 for preferred drugs and up to 20% of drug's Medicaid cost for non-preferred drugs).
- States may permit providers to require payment of cost sharing obligations as a condition for provision of care. A provider may reduce or waive cost sharing on a case-by-case basis.
- This section does not apply to the U.S. territories.

Congress appropriates \$15 million in FY 2026 to CMS for implementation of this section.

Subchapter E: Expanding Access to Care

- *Section 71121. Making certain adjustments to coverage of home or community-based services under Medicaid:* Effective **July 1, 2028**, creates a new 1915(c) waiver option that does not require participants to be subject to a determination that, but for the provision of home and community-based services (HCBS), they would need nursing home or ICF/IDD level of care.
 - Conditions for use of this waiver include:
 - All other 1915(c) waivers operated by the state must meet all statutory requirements.
 - The state must demonstrate that approval of the standalone waiver will not increase average wait time to receive HCBS under any other approved waiver.
 - The state must establish needs-based criteria for eligibility for the standalone waiver.
 - The state must establish more stringent needs-based criteria to determine whether an individual meets level of care requirements than are typically required.

- The state must attest to the cost neutrality of the standalone waiver as compared to the average per capita cost of individuals receiving institutional care.
 - The state must agree to submit annual reports detailing 1) cost of services provided under the standalone waiver, broken out by service type; 2) by service type, the duration of those services; 3) a comparison of these two data points with equivalent data on other 1915(c) waivers; and 4) the total number of participants during the preceding year.
- States may not make any payments under this waiver to a third party on behalf of an individual practitioner for benefits such as health insurance, skills training, and other benefits customary for employees.
- Congress appropriates \$50 million in implementation funding in FY 2026 for CMS for this section.
 - Congress appropriates \$100 million in implementation funding for states, to be made on the basis of the proportion of the population of the state that is eligible for 1915(c) HCBS.

Rural Health Transformation Program

A newly added Section 71401 modifies Section 2105 of the Social Security Act establishes a \$50 billion grant program (\$10 billion per fiscal year for FY 2026 – 2030) for HHS to make payments to the 50 states.

- DC and the territories are not eligible for payments under this program.
- States must submit by **December 31, 2025** an application detailing their plans for rural health transformation, certify that funds will not be used as state share of Medicaid, and any other information the Secretary may require in order to be eligible for funding.
 - HHS must approve or deny received applications by this date.
 - This is a one-time application process. States will not need to reapply in each fiscal year to receive funds; one approved application allows for funding in each fiscal year from FY 2026 – 2030.
 - States do not need to provide match to draw awarded funds.
- Half of each fiscal year’s funding shall be distributed evenly among applicants, and half based on considerations including percentage of the state’s population living in a rural area, proportion of rural health facilities in the state compared to the nation, the situation of hospitals in the state, and other factors the Secretary deems appropriate.
 - Rural health facilities are not limited to hospitals. Rural health clinics, FQHCs, CMHCs, CCBHCs, and rural opioid treatment programs will also be considered.
- States must carry out at least three of the following activities with awarded funds:
 - Promote evidence-based interventions to improve prevention and chronic disease management

- Provide payments to health care providers for the provision of health care items or services
- Promote consumer-facing, technology-driven solutions for the prevention and management of chronic diseases
- Provide training and TA for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, AI, etc.
- Recruiting and retaining clinical workforce talent to rural areas
- Providing TA, software, and hardware for significant information technology advances
- Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines
- Supporting access to OUD, SUD, and mental health services.
- Developing projects that support innovative models of care, including VBP and APMs
- Additional uses, as designated by the Secretary.

Congress appropriates \$200 million in FY 2025 for CMS to implement this grant program.

Provisions Struck by the Senate Parliamentarian

Several provisions in initial Senate language were struck by the Senate parliamentarian as not complying with the Senate’s reconciliation rules. These sections are:

- *Previous Section 71109. Prohibiting federal financial participation under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status:* Effective **October 1, 2026**, makes the 90-day reasonable opportunity period during which individuals have been able to receive medical assistance while verifying their citizenship or immigration status optional for states as opposed to mandatory.
 - Federal match would not be allowed unless a state both:
 - chooses to offer the reasonable opportunity period; and
 - only claims federal match for individuals whose citizenship or immigration status is ultimately verified by the end of the 90-day reasonable opportunity period.
- *Previous Section 71111. Expansion FMAP for certain states providing payments for health care furnished to certain individuals:* Effective for calendar quarters beginning on or after **October 1, 2027**, sets the adult expansion federal match to 80% in a given quarter for any state that, in that quarter, provides any form of financial assistance in whole or in part under Medicaid or another state-established program to or on behalf of an alien

who is not a qualified alien and is not a child or pregnant woman who is lawfully residing in the United States and receiving medical assistance pursuant to section 1903(v)(4) to purchase health insurance coverage, or provides comprehensive health benefits coverage to these same individuals, unless otherwise required by federal law.

- *Previous Section 71115. Ensuring accurate payments to pharmacies under Medicaid:* Beginning **the first day of the first quarter nine months after enactment of this legislation for retail community pharmacies and the first day of the first quarter 18 months after enactment for applicable non-retail pharmacies**, HHS would be required to administer a national survey of drug prices to determine the national average drug acquisition costs (NADAC) of covered outpatient drugs. HHS may use a vendor, and the vendor must update HHS on survey results on a monthly basis.
- *Previous Section 71116. Spread pricing in Medicaid:* Requires that all contracts between states and managed care entities, other specified entities, or pharmacy benefit managers (PBMs) that have an effective date **on or after 18 months after enactment of this legislation** and that require coverage of covered outpatient drugs to include a transparent pass-through pricing model.
 - The contracted entity's payment for covered outpatient drugs must be limited to ingredient cost and a professional dispensing fee that is not less than what the state would pay under the state plan, i.e. at least equivalent to the state FFS professional dispensing fee. This payment must be passed through in its entirety to the pharmacy or provider dispensing the drug, unless federal or state law and regulation responding to instances of fraud, waste, and abuse applies.
- *Previous Section 71117. Prohibiting federal Medicaid and CHIP funding for certain items and services:* Prohibits federal match in Medicaid and CHIP for specified gender transition procedures provided to any individuals when such procedures are performed for the purpose of intentionally changing the body of such an individual to no longer correspond to the individual's sex, as that term is defined in this section. **No effective date is specified in the statutory language.**

Initial House Provisions Not Included in Final Bill

OBBBA legislative text drops several provisions from the House-passed version of the bill.

Provisions that were removed include:

- **Section 44105: Medicaid provider screening requirements.** This provision would have required states to conduct monthly checks of databases and similar systems to determine whether HHS or another state has already terminated a provider or supplier from participating in the Medicaid program.
- **Section 44201: Addressing waste, fraud, and abuse in the ACA exchanges.** This provision would have created new eligibility and income verification processes for

Exchange enrollees; rolled back income-based special enrollment periods; created reenrollment guardrails for enrollees in zero-dollar premium health plans; prohibited gender transition services from being included as an essential health benefit (EHB); and amended the definition of “lawfully present” for the purposes of qualified health plan enrollment. Some provisions in this section were brought into *Chapter 3 – Health Tax* in the Senate Finance Committee text.

- **Section 44301: Expanding and clarifying the exclusion for orphan drugs under the drug price negotiation program.** This section would have made technical corrections to current law by permitting product sponsors to have one or more orphan drug indication in order to be exempt from the Drug Price Negotiation Program in statute.
- **Section 44302: Streamlined enrollment process for eligible out-of-state providers under Medicaid and CHIP.** This section would have required states to establish a process through which qualifying pediatric out-of-state providers could enroll as participating providers without undergoing additional screening requirements.
- **Section 44303: Delaying DSH reductions.** This section would have delayed the Medicaid Disproportionate Share Hospital (DSH) reductions, currently \$8 billion reductions per year that are set to take effect for fiscal years 2026 through 2028, to instead take effect for fiscal years 2029 through 2031. This section also extended funding for Tennessee’s DSH program, which is set to expire at the end of this fiscal year, through fiscal year 2028.

Table A: Implementation Deadlines and Effective Dates

Policy	Implementation Deadline/Effective Date
Prohibition on implementation of eligibility rules not already in effect and nursing facility minimum staffing requirement (Secs. 71101, 71102, and 71111)	July 4, 2025
Prohibition on Medicaid funds from being paid to certain abortion providers (i.e., Planned Parenthood) for a 1-year period (Sec. 71113)	July 4, 2025
Any provider taxes established for new provider categories (i.e. those not previously taxed) on or after this date will have their hold harmless thresholds set at zero percent on October 1, 2026 (Sec. 71115)	July 4, 2025
Directs HHS to limit SDPs to 100% of the Medicare payment rate for expansion states and 110% of the Medicare rate for non-expansion states (or at the Medicaid state plan rate if no Medicare rate is available); grandfathers SDPs approved as of May 1, 2025 (except rural hospital SDPs, which are grandfathered as of date of enactment) and submitted SDPs, which are gradually reduced to the relevant cap (Sec. 71116)	For rating periods beginning on or after July 4, 2025
Modifies methodology for determining whether taxes are redistributive (Sec. 71117)	July 4, 2025, with transition period of up to three years provided at the Secretary's discretion
Deadline for state applications to rural health transformation grant program (Sec. 71401)	December 31, 2025
Sunsets temporary 5 percentage point enhanced FMAP for states that newly expand Medicaid (Sec. 71114)	January 1, 2026
Amended definitions of qualified aliens for purposes of Medicaid and CHIP (Sec. 71109)	October 1, 2026

Emergency Medicaid FMAP set at base FMAP calculation, regardless of eligibility category for the individual receiving services (Sec. 71110)	October 1, 2026
Requirement that Medicaid agencies conduct redeterminations of eligibility every six months for expansion adults (Sec. 77107)	December 31, 2026
Establishment of work requirements for expansion adults (Sec. 71119)	December 31, 2026 (with up to two-year good faith effort extension option available)
Requirement that states develop processes to obtain address information from enrollees (Sec. 71103)	January 1, 2027
Requirement that HHS certify budget neutrality for 1115 demonstration projects through the CMS Office of the Actuary and specify the methodology for accounting for savings generated under an 1115 demonstration in future approval periods (Sec. 71118)	January 1, 2027
Limits retroactive coverage period from three months to one month for expansion populations, two months for non-expansion populations, and two months for CHIP (Sec. 71114)	For Medicaid or CHIP applications submitted on or after January 1, 2027
Requirement that states check the Death Master File on at least a quarterly basis to identify if enrollees are deceased (Sec. 71104)	January 1, 2028
Requirement that states, as part of their provider enrollment processes and at least quarterly thereafter, check the Death Master File to determine if a provider or supplier is deceased (Sec. 71105)	January 1, 2028
Sets a maximum home equity limit of \$1 million for purposes of determining eligibility for long-term care services (Sec. 71108)	January 1, 2028
New 1915(c) waiver that does not require participants to be subject to a determination that, but for the provision of home and community-based services (HCBS), they would need nursing home or ICF/IDD level of care (Sec. 71121)	July 1, 2028
Requirement to implement cost-sharing for expansion adults with incomes >100% FPL (Sec. 71120)	October 1, 2028

Requirement that HHS develop a system to identify duplicate enrollment in multiple Medicaid programs (Sec. 71103)	October 1, 2029
Amended definitions of erroneous excess payments, capping of good faith waiver for payment reductions related to error rates identified in HHS audits, and ability to incorporate state-conducted audits into error rate calculations (Sec. 71106)	October 1, 2029