

PCG Summary of Medicaid Related Provisions – 2025 HR 1

One Big Beautiful Bill Act (OBBBA), as signed by
the President on July 4, 2025

July 7, 2025

Introduction

This document provides a summary of Medicaid-related provisions in 2025 HR 1, the “One Big Beautiful Bill Act (OBBBA),” as signed into law by President Trump on July 4, 2025. The Medicaid-related provisions were included in Title VII of the Act and are comprised of twenty-one separate sections numbered 71101 through 71121.

OBBBA includes one additional non-Medicaid provision at Section 71401 that has a significant impact on state healthcare programs – the creation of a Rural Hospital Transformation program allotting \$50 billion to states over 5 years (\$10 billion per year in each of federal fiscal years 2026 through 2030) to improve healthcare access and outcomes for rural communities.

Summary of OBBBA Medicaid Provisions

PCG’s summary of each Medicaid-related section begins on the next page of this document and includes information on the implementation dates and associated savings or cost estimates prepared for each item by the Congressional Budget Office. It also identifies implementation funding provided under the bill for each item, as appropriated to the Centers for Medicare and Medicaid (CMS) and/or to CMS for purposes of being allotted to states.

Section 71101

Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs

Directs the Secretary of Health and Human Services, through September 30, 2034, to not implement, administer or enforce the “Streamlining Medicaid, Medicare Savings Program (MSP) Eligibility Determination and Enrollment” (88 Fed. Reg. 65230) final rule, which was published on September 21, 2023. Among other things, this rule established automatic MSP eligibility to all qualifying Medicare beneficiaries without requiring a separate state application and required states to use Medicare Part D Low-Income Subsidy (LIS) information to determine MSP eligibility.

Effective Date: Upon enactment

CBO Federal Fiscal Impact Estimate: Saves \$85.3 billion cumulative, 2025-2034.

Implementation Funding Appropriated: \$1 million to HHS in FFY26, to remain available until expended

Section 71102

Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program

Directs the Secretary of Health and Human Services, through September 30, 2034, to not implement, administer or enforce the “Medicaid Program; Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes” (89 Fed. Reg. 22780) final rule, which was published on April 2, 2024. Among other things, this bill limited renewal of eligibility for Medicaid aged, blind and disabled beneficiaries to once every twelve months and provided a 90 day reconsideration period for procedural terminations.

Effective Date: Upon enactment

CBO Federal Fiscal Impact Estimate: Saves \$81.7 billion cumulative, 2025-2034.

Implementation Funding Appropriated: None

Section 71103

Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs

Requires, by October 1, 2029, for the Secretary of HHS to establish a system to be utilized by the Secretary and states to prevent an individual from being simultaneously enrolled under the State Plans (or waivers of such plans) of multiple states. This system must be able to accept Medicaid enrollee address information from states and transmit information to states that identifies when the member is also enrolled in another state.

Correspondingly, by January 1, 2027, each state’s Medicaid state plan (or state plan waiver) must provide a process to regularly obtain address information for individuals enrolled and, by October 1, 2029, a process for the state to submit this information to HHS to facilitate duplicate enrollment data matching. Each state’s Medicaid state plan, by October 1, 2029, must also provide a process to identify if the individual identified as enrolled in more than one state is currently residing in that state and a process to disenroll the individual if not.

This Section also defines the “reliable data sources” that States shall use to obtain address information for enrolled individuals, to include returned mail, the National Change of Address Database, address information obtained by the Medicaid Managed Care Organizations directly from the enrolled individual or “other data sources” approved by the Secretary. It further gives the HHS Secretary the authority to

discontinue Medicaid enrollment data matching requirements specific to the Public Assistance Reporting Information System (PARIS) by October 1, 2029.

By January 1, 2027, State contracts with Medicaid Managed Care Organizations (MCOs) must include a provision requiring the MCO to promptly transmit any address information obtained directly from the enrolled individual.

This Section also amends Title XXI of the Social Security Act to apply these same requirements to the Children’s Health Insurance Program (CHIP).

Effective Dates: As described above

CBO Federal Fiscal Impact Estimate: Saves \$17.4 billion cumulative, 2025-2034.

Implementation Funding Appropriated: \$10 million to HHS in FFY26 and an additional \$20 million to HHS in FFY29 for system maintenance, to remain available until expended

Section 71104 Ensuring Deceased Individuals Do Not Remain Enrolled

Requires states to, not less than quarterly, review the Death Master File or successor system to determine if any individuals enrolled under the State Plan (or waiver of the State Plan) are deceased. States must treat information obtained from the Death Master File as factual, disenroll identified individuals and discontinue related payments. If a disenrollment is found to have been made erroneously, states must re-enroll the individual retroactive to the date of disenrollment. This section also clarifies that states are permitted to use additional data sources to identify deceased members as long as they otherwise meet the requirements of this Section.

Effective Date: January 1, 2027

CBO Federal Fiscal Impact Estimate: Budget neutral, cumulative, 2025-2034.

Implementation Funding Appropriated: None

Section 71105 Ensuring Deceased Providers Do Not Remain Enrolled

Requires states to, not less than quarterly and, during the process of enrollment, re-enrollment or revalidation of a provider or supplier, review the Death Master File to determine if the provider or supplier is deceased.

Effective Date: January 1, 2028

CBO Federal Fiscal Impact Estimate: Budget neutral, cumulative, 2025-2034.

Implementation Funding Appropriated: None

Section 71106 Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid

Limits the authority of the Secretary of HHS to waive federal penalties imposed on states for Medicaid payment errors identified as a result of payment audits under Section 1903(u) of the Social Security Act. The amount that the Secretary may waive is now limited to the difference between the total error rate and the 3% allowable error threshold specific to 1903(u)(1)(D)(II), *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. This effectively restricts the Secretary from waiving the loss of federal financial participation to states for errors in excess of the 3% allowable threshold specific to 1903(u)(1)(D)(I), *payments under the State plan with respect to ineligible individuals and families.* Further, Section 71106 broadens the definition of eligibility related payment errors to include eligibility determinations where “insufficient information is available to confirm eligibility.”

Effective Date: Changes apply “beginning with respect to fiscal year 2030”

CBO Federal Fiscal Impact Estimate: Saves \$7.6 billion cumulative, 2025-2034.

Implementation Funding Appropriated: None

Section 71107 Eligibility Redeterminations

Requires states to conduct redeterminations of eligibility for “Medicaid Expansion” enrollees once every six months. This includes those enrolled under a Medicaid waiver who would otherwise be enrolled under the Medicaid Expansion category of eligibility. Provides an exclusion for tribal members. CMS is required to issue guidance related to the implementation of this provision within 180 days of its enactment.

Effective Date: Changes apply with respect to redeterminations “scheduled on or after the first day of the first quarter that begins after December 31, 2026.”

CBO Federal Fiscal Impact Estimate: Saves \$62.6 billion cumulative, 2025-2034

Implementation Funding Appropriated: \$75 million to CMS for FFY26, to remain available until expended

Section 71108 Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services Under the Medicaid Program

Caps at \$1 million the home equity interest that a state may permit an individual to maintain and still be eligible for Medicaid nursing home or other longer-term care services.

Effective Date: January 1, 2028

CBO Federal Fiscal Impact Estimate: Saves \$195 million cumulative, 2025-2034

Implementation Funding Appropriated: None

Section 71109 Alien Medicaid Eligibility

Restricts the categories of non-citizens who can become eligible for Medicaid after five years of US residency. The categories are now limited to legal permanent residents, certain Cuban immigrants and individuals living in the United States through a Compact of Free Association (CoFA).

Effective Date: October 1, 2026

CBO Federal Fiscal Impact Estimate: Saves \$6.3 billion cumulative, 2025-2034

Implementation Funding Appropriated: \$15 million to CMS for FFY26, to remain available until expended

Section 71110
Expansion FMAP for Emergency Medicaid

Limits the federal share for services provided under the Emergency Medicaid benefit authorized under Section 1903(v)(2) to the state's standard FMAP rate, even when services are provided to a non-qualified alien who would otherwise be eligible under the Medicaid Expansion category of eligibility if not for their alien status.

Effective Date: October 1, 2026

CBO Federal Fiscal Impact Estimate: Saves \$28.7 billion cumulative, 2025-2034

Implementation Funding Appropriated: \$1 million to CMS for FFY26, to remain available until expended

Section 71111
Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities Under the Medicare and Medicaid Programs

Directs the Secretary of Health and Human Services, through September 30, 2034, to not implement, administer or enforce the "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" (89 Fed. Reg. 40876) final rule, which was published on May 10, 2024. Among other things, this bill established minimum staffing standards for nursing facilities and required states to report on the percentage of total homecare provider payments that were paid to direct care staff.

Effective Date: Upon Enactment

CBO Federal Fiscal Impact Estimate: Saves \$23.1 billion cumulative, 2025-2034.

Implementation Funding Appropriated: None

Section 71112
Reducing State Medicaid Costs

Reduces the period of retroactive Medicaid eligibility to one month preceding the month of application for Medicaid Expansion applicants and two months for all other Medicaid and CHIP applicants. Current law allows three months of retroactive eligibility.

Effective Date: Applies to applications received on or after the first day of the first quarter that begins after December 31, 2026

CBO Federal Fiscal Impact Estimate: Saves \$4.2 billion cumulative, 2025-2034.

Implementation Funding Appropriated: \$10 million to CMS in FFY26, to remain available until expended

Section 71113
Federal Payments to Prohibited Entities

For one year following the date of enactment of this bill, prohibits Medicaid payments for services provided by tax-exempt essential community providers that deliver family planning and abortion services, other than those allowable under the Hyde Amendment, and that received federal and state Medicaid reimbursements exceeding \$800,000 in 2023.

Effective Date: Upon Enactment

CBO Federal Fiscal Impact Estimate: Saves \$44 million during its one year of enactment

Implementation Funding Appropriated: \$1 million to CMS for FFY26, to remain available until expended

Section 71114 Sunsetting Increased FMAP Incentive

Eliminates a financial incentive that was authorized under the American Rescue Plan Act for non-Medicaid expansion states to expand Medicaid. The incentive provided a five percent increase to the state's standard FMAP rate for eight calendar quarters.

Effective Date: January 1, 2026

CBO Federal Fiscal Impact Estimate: Saves \$13.6 billion cumulative, 2025-2034

Implementation Funding Appropriated: None

Section 71115 Provider Taxes

For Medicaid expansion states, OBBBA establishes a new provider tax "safe harbor" cap, which is the lower of a state's existing tax rate for that provider class or the rate identified in a five-year phase down schedule established in the bill. A "safe harbor" is the maximum net patient revenue tax rate under which providers in the class are permitted to be held harmless by the fiscal impact of the tax. The phase down schedule begins in federal fiscal year 2028 and reduces the safe harbor from 6 percent to 3.5 percent of net patient revenue over five years (0.5% per year) through federal fiscal year 2032. Existing state provider taxes on nursing homes and intermediate care facilities are exempted from the five year phase down and may continue at currently approved rates indefinitely. Non-expansion states are permitted to maintain their existing safe harbor percentages for applicable provider classes as of the date of enactment of this bill. For both expansion and non-expansion states, for any class of providers for which a provider tax has not been enacted as of the date of enactment of this bill, the safe harbor is 0%, effectively meaning that a new provider tax that holds providers harmless may not be implemented.

Effective Date: October 1, 2026, however, provisions effective after this date apply back to the date of enactment of the bill.

CBO Federal Fiscal Impact Estimate: Saves \$191.2 billion cumulative, 2025-2034

Implementation Funding Appropriated: \$20 million for CMS for FFY26, which continues to be available until fully expended.

Section 71116 State Directed Payments

This provision reduces the cap on supplemental payments to certain provider types that states direct their Medicaid managed care organizations to make. The current cap is the average commercial rates paid to the provider for the applicable services. This bill reduces the cap to "100% of the specified total published Medicare payment rate" for states that have expanded Medicaid and 110% of the Medicare payment rate for non-expansion states. States that currently maintain state directed payment amounts that are higher than this new cap must reduce those payments by 10 percent per year beginning January 1, 2028, until they come into compliance. Current non-expansion states that prospectively elect to expand Medicaid in their state in the future will be subject to the "100% of Medicare" cap.

Effective Date: Assumed to be the publish date of the revised regulation that enacts this change

CBO Federal Fiscal Impact Estimate: Saves \$149.4 billion cumulative, 2025-2034

Implementation Funding Appropriated: \$7 million for CMS for each of federal fiscal years 2026-2033, which continues to be available until fully expended.

Section 7117

Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax

This provision narrows the authority of the Secretary of HHS to waive requirements that provider taxes must be broad based (applied to all providers in the provider class) and uniform (applied at the same rate to all providers in the provider class). Currently, the Secretary may waive these requirements if the tax is determined to be “generally redistributive.” This change specifies that a provider tax shall not be considered generally redistributive if the tax rate is lower for providers with a lower volume or percentage of Medicaid taxable units or the tax rate on Medicaid taxable units is higher than the tax rate imposed on non-Medicaid taxable units.

Effective Date: Upon enactment, except that a transition period of up to three fiscal years is permitted at the discretion of the Secretary of HHS

CBO Federal Fiscal Impact Estimate: Saves \$34.6 billion cumulative, 2025-2034

Implementation Funding Appropriated: None

Section 7118

Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115

Strengthen Medicaid demonstration waiver budget neutrality requirements by requiring the CMS Chief Actuary to independently certify that expenditures under the waiver will not be higher than expenditures the state would have made under the State Plan in the absence of an approved waiver. The language in the bill appears to tie approval of waiver renewals to the actuary’s certification that the waiver was budget neutral in the preceding period. The bill also appears to permit the Secretary of HHS to identify a methodology under which states may get credit for savings achieved by the waiver in the preceding approval period that may be applied to future approval periods.

Effective Date: January 1, 2027

CBO Federal Fiscal Impact Estimate: Saves \$3.3 billion cumulative, 2025-2034

Implementation Funding Appropriated: \$5 million for each of fiscal years 2026 and 2027 to CMS, to remain available until expended

Section 7119

Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals

This provision establishes a community engagement requirement as a condition of eligibility for Medicaid expansion population enrollees (or Medicaid waiver enrollees who would otherwise be eligible under the Medicaid expansion) aged 19-64 who are not pregnant and not eligible for Medicare. Within this population, the bill exempts tribal members, parents of children 13 years of age and under and individuals who meet the definition of “medically frail” from the requirement.

Individuals subject to this requirement who are newly applying for Medicaid must show compliance for at least one month, and, at the discretion of a state, up to three consecutive months preceding their month of application. Individuals already enrolled must show compliance for one or more months (specified by the state) in the period between their most recent eligibility determination and their next scheduled redetermination.

Ways that an individual can demonstrate compliance with the community engagement requirement in a month include: working not less than 80 hours, completing not less than 80 hours of community service, being enrolled in an educational program at least half time, or any combination of work, community service and education of not less than 80 hours. Further, an individual can demonstrate compliance if they have a monthly income that is not less than 80 times the federal minimum hourly wage or has averaged 80 x the federal minimum hourly wage per month over the past six months.

States must also deem an individual to have met the community engagement requirement in a month if the individual was under the age of 19 or eligible for Medicare for part of the month or was an inmate of a public institution at any point during the three months preceding the month. States may, at their option, elect to offer a “short term hardship” exemption to an individual who, during the month, had an inpatient stay at a healthcare facility, must travel outside of their community for an extended period of time to treat a complex medical condition, resides in a county in which an emergency or disaster declaration exists or which has an unemployment rate of at least the lesser of 8% or 1.5 times the national unemployment rate.

For enrolled individuals, states must determine the individual’s compliance with the community engagement requirement once every six months when eligibility is redetermined, but states may elect to determine compliance more frequently. In verifying community engagement compliance, states are required to adopt “ex parte” procedures and use reliable third-party data to minimize the need for enrolled individuals to submit additional information.

The bill establishes procedures that states must follow in the event an individual is found to be non-compliant with the community engagement requirement. This includes procedures for member notification that provides the member with 30 days to show that they have been compliant with the requirement. This bill also specifies procedures for disenrollment, fair hearings and re-enrollment, as well as outreach standards to prospectively inform and educate members about the implementation of community engagement requirements.

The bill specifies that a state will not become ineligible for the enhanced Medicaid expansion FMAP for disenrolling individuals who do not comply with the community engagement requirement. It further specifies that states may not waive the community engagement requirement. The HHS Secretary is permitted under the bill to grant short term good faith exemptions to states facing significant barriers or challenges to implementing the community engagement requirements. Such an exemption must expire not later than December 31, 2028. States must not use Medicaid managed care organizations or contractors with a direct or indirect financial relationship with Medicaid managed care organizations to determine beneficiary compliance with community engagement requirements.

Effective Date: “Not later than the first day of the first quarter that begins after December 31, 2026, or, at the option of the State under a waiver or demonstration project under section 1115 or the State plan, such earlier date as the State may specify”

CBO Federal Fiscal Impact Estimate: Saves \$325.8 billion cumulative, 2025-2034

Implementation Funding Appropriated: \$200 million in implementation grants to states for FFY26, to remain available until expended and another \$200 million to CMS in FFY26 to remain available until expended.

Section 71120
Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program

This provision prohibits states from imposing enrollment fees or premiums on Medicaid expansion program benefits under the State Plan. However, it also requires states to impose cost sharing on certain services for Medicaid expansion enrollees who have incomes 100-138% of the federal poverty level (FPL). Cost sharing shall not exceed \$35 per service and cannot cumulatively exceed 5% of an individual's income during the benefit period. Services that must be exempted from this requirement include primary care, mental health and substance use disorder services as well as services provided by federally qualified health centers (FQHCs), behavioral health clinics and rural health clinics.

Effective Date: October 1, 2028

CBO Federal Fiscal Impact Estimate: Saves \$7.5 billion cumulative, 2025-2034

Implementation Funding Appropriated: \$15 million for CMS for FFY26, to remain available until expended

Section 71121
Making Certain Adjustments to Coverage of Home or Community Based Services Under Medicaid Home and Community Based Services

This provision permits states to establish Medicaid home and community based services (HCBS) waivers under Section 1915(c) of the Social Security Act for populations that do not require an institutional level of care. Previously, these waivers have been limited to individuals requiring an institutional level of care. States electing to pursue such a waiver must establish need-based criteria for eligibility, must ensure that the creation of the new waiver does not increase wait list times for other state HCBS waivers and must demonstrate that per capita spending does not exceed that of state HCBS waivers for individuals needing an institutional level of care.

Effective Date: July 1, 2028

CBO Federal Fiscal Impact Estimate: Costs \$6.6 billion cumulative, 2025-2034

Implementation Funding Appropriated: \$50 million for CMS for FFY26, to remain available until expended, and an additional \$100 million for FFY27 to be distributed to states to support their delivery of HCBS programs, to also remain available until expended.