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Summary and Implementation Timeline of Medicaid Provisions Within the One Big Beautiful Bill Act (OBBBA)

Section of the OBBBA (P.L. 119-21)	Summary	Implementation Deadline	Anticipated Regulatory Action
	Eligibility Related Provisions		
Work Requirements *Section 71119* - Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals	Requires states to implement community engagement/work requirements as a condition of Medicaid eligibility for able-bodied working adults between the ages of 19-64, beginning Jan. 1, 2027 (or earlier through a section 1115 waiver). Enrollees will be required to report at least 80 hours of work or work-related activity per month as a condition of Medicaid eligibility. Mandatory exemptions exist for parents and guardians of dependent children 13 years of age or younger, pregnant and postpartum women, individuals enrolled in Medicare, "medically frail" individuals (which includes the legally blind and people with disabilities) and allows for states to define additional, optional exemptions for people experiencing "short-term hardship." **CBO estimated 10-year coverage losses:** 5.3 million individuals. **CBO estimated 10-year Medicaid spending cut:** $317.0 billion.	**January 1, 2027** (States that have made a good faith effort to implement these requirements but need more time to implement may be granted an exemption from CMS and will have until December 31, 2028, to implement)	The Secretary must issue an interim final rule on implementation by June 1, 2026. The OBBBA specifies this will not be subject to notice and comment requirements. The Secretary will also need to address and specify the process and manner in which States may apply for the exemption. The legislative text indicates a submission from states will be required, but additional details are needed.
General Eligibility	Requires states to conduct Medicaid eligibility redeterminations at least every six months, instead	**January 1, 2027**	The Secretary must issue guidance within 180 days of enactment (Dec. 31, 2025).

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Section 71107 - Eligibility Redeterminations	of annually, for Medicaid expansion adults and those enrolled under a premium assistance waiver. **CBO estimated 10-year coverage losses:** 700,000 individuals. **CBO estimated 10-year Medicaid spending cut:** $58.0 billion.		
Immigrant Eligibility *Section 71109* - Alien Medicaid Eligibility	Restricts the definition of "qualified" immigrant to include lawful permanent residents (LPRs), certain Cuban immigrants, citizens of the Freely Associated States (COFA migrants) lawfully residing in the U.S., and lawfully residing children and pregnant adults in states that cover them under CHIPRA 214. Those considered lawfully residing under CHIPRA 214 include refugees, asylees, victims of human trafficking, etc. Changes to immigrant eligibility excludes refugees, asylees, and victims of human trafficking from being covered using federal Medicaid funds if they are not otherwise eligible lawfully residing children and pregnant adults under CHIPRA. **CBO estimated 10-year Medicaid spending cut:** $6.2 billion.	**October 1, 2026**	The OBBBA did not specify specific rulemaking action or a deadline, but the agency may issue rulemaking or additional sub-regulatory guidance at its discretion.

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	The OBBBA included changes to premium tax credits (PTCs) used in the ACA marketplace. Specifically, Section 71302 changed the eligibility for PTCs for lawfully present immigrants. Lawfully present immigrants under 100 percent of the federal poverty line (FPL) that don't qualify for Medicaid (such as being in the five-year waiting period) will no longer be eligible for PTCs as of Jan. 1, 2026. The OBBBA aligns the definition of PTC-eligible non-citizens with incomes above 100% of FPL with the Medicaid definition under section 71109, beginning on Jan. 1, 2027. **CBO estimated 10-year Medicaid spending cut:** $49.5 billion.	**January 1, 2026** (for those with incomes under 100% of FPL) **January 1, 2027** (for those with incomes at or above 100% of FPL)	
Eligibility and Enrollment Final Rule *Sections 71102* – Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program	Prohibits the Secretary from implementing, administering, or enforcing certain provisions of the "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule" (89 FR 22780) until Oct. 1, 2034. The provisions of the final rule are aimed at reducing Medicaid and CHIP coverage disruptions, streamlining eligibility and enrollment processes, reducing administrative burden, and increasing enrollment and retention of those who are eligible for these programs. **CBO estimated 10-year coverage losses:** 400,000 individuals.	**July 4, 2025**	CMS could engage in additional notice and comment rulemaking to alter or remove the Final Rule prior to the end of the moratorium.

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	CBO estimated 10-year Medicaid spending cut: $53.6 billion.		
Enrollee Address Verification *Section 71103* - Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs	In order to prevent duplicate beneficiary enrollment in multiple states, this provision: • Requires states to update enrollee address information using reliable data sources, including the National Change of Address Database and managed care entities. • Requires the Secretary to establish a system to share information with states to prevent individuals from being simultaneously enrolled in two states' Medicaid or CHIP programs and requires states to submit monthly enrollee SSNs and other information to the system. **CBO estimated 10-year Medicaid spending cut:** $17.4 billion.	**January 1, 2027,** for states to update data sources. **October 1, 2029,** to establish a system to prevent duplicate enrollment in two states.	CMS will need to issue rulemaking to establish a system to identify duplicated enrollment in two states as well as determine how and what information will be submitted by states into the system.
Retroactive Coverage *Section 71112* - Reducing State Medicaid Costs	Limits retroactive coverage to one month prior to application for coverage for expansion enrollees and two months prior to application for coverage for traditional enrollees. **CBO estimated 10-year Medicaid spending cut:** $4.2 billion.	**January 1, 2027**	The OBBBA did not specify specific rulemaking action or a deadline, but the agency may issue rulemaking or additional sub-regulatory guidance at its discretion.
Medicaid Financing Related Provisions			
Provider Taxes *Section 71115* – Provider Taxes	Places a moratorium on new provider taxes and freezes existing provider taxes at their current rates. Beginning in FY 2028, ACA expansion states will be subject to a lower safe harbor threshold by gradually lowering from six percent to 3.5 percent	**July 4, 2025, for prohibition on new provider taxes and freeze on existing rates.**	OBBBA did not specify rulemaking action or a deadline, but the agency may issue rulemaking or additional sub-

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	in FY 2032. Each year the safe harbor threshold will be lowered by 0.5 percent. Taxes in effect on Oct. 1, 2026, that apply to nursing facility services and intermediate care facility services are exempt from this reduction. • 5.5 percent for fiscal year 2028 • 5 percent for fiscal year 2029 • 4.5 percent for fiscal year 2030 • 4 percent for fiscal year 2031 • 3.5 percent for fiscal year 2032 **CBO estimated 10-year coverage losses:** 1.1 million individuals. **CBO estimated 10-year Medicaid spending cut:** $182.7 billion.	For ACA expansion states, the safe harbor threshold will begin gradually lowering in FY 2028 (Oct. 1, 2027).	regulatory guidance at its discretion.
Provider Taxes *Section 71117* – Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax	Revises the broad-based and uniform waiver requirements in a way that eliminates eligibility for certain taxes that were previously permissible under the waiver (ex. MCO taxes). **CBO estimated 10-year Medicaid spending cut:** $34.6 billion.	**July 4, 2025** CMS may allow up to three years to revise provider taxes in violation of the broad-based and uniform requirements.	CMS may alter and finalize proposals in the "Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule," (90 FR 20578).
State Directed Payments *Section 71116* - State Directed Payments	Prospectively caps state-directed payments at 100% of Medicare rates for ACA expansion states and 110% of Medicare rates for non-expansion states. Reduces the cap from the average commercial rate (ACR). Allows for certain SDPs to be grandfathered until Jan. 1, 2028, after which	**July 4, 2025** CMS will grandfather certain existing SDPs until January 1, 2028.	On Sept. 9, 2025, CMS issued guidance on Section 71116. The agency is expected to issue additional notice and comment rulemaking on this provision and may consider changes to

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	grandfathered SDPs will be reduced by 10 percentage points per year until the total payment rate is equal to 100 percent of the Medicare rate for ACA expansion states or 110 percent of the Medicare rate for non-ACA expansion states. Specifies that in the absence of published Medicare payment rates for specific services, the limit is set at the Medicaid fee-for-service payment rate. **CBO estimated 10-year coverage losses:** Estimates no impact on number of uninsured. **CBO estimated 10-year Medicaid spending cut:** $149.4 billion		SDPs for other services beyond the four services (inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center) mandated by section 71116.
Section 1115 Demonstration Waiver Budget Neutrality *Section 71118* - Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115	Specifies the Chief Actuary for CMS must certify 1115 waivers are not expected to result in an increase in federal expenditures compared to federal expenditures without the waiver. **CBO estimated 10-year Medicaid spending cut:** $3.2 billion.	**January 1, 2027**	CMS will utilize greater scrutiny when evaluating Section 1115 waiver applications from states. CMS may issue additional guidance on whether they plan to apply savings achieved by a demonstration project in one year towards calculating the budget neutrality in future approval periods.
Cost Sharing *Section 71120* - Modifying Cost Sharing Requirements for Certain Expansion Individuals	States will be required to implement cost-sharing for Medicaid expansion enrollees with incomes greater than 100 percent of the federal poverty level (FPL). Cost-sharing requirements are not to exceed $35 per service on expansion adults with incomes 100-138 percent FPL and there are exceptions for	**October 1, 2028**	CMS may issue guidance to states on what is allowed when imposing cost sharing or similar charges for certain care, items and services for Medicaid beneficiaries who have an

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Under the Medicaid Program	certain types of care (e.g., primary care). Maintains a cap on out-of-pocket expenses equal to 5 percent of family income. Exempts services provided by federally qualified health centers, behavioral health clinics, and rural health clinics. **CBO estimated 10-year Medicaid spending cut:** $7.4 billion.		income that exceeds the federal poverty level.
Federal Medical Assistance Percentage (FMAP) for Emergency Medicaid *Section 71110* - Expansion FMAP for Emergency Medicaid	Establishes that states cannot receive any more than their traditional FMAP for federal matching funds received for emergency medical care furnished to immigrants who would otherwise be eligible for expansion coverage except for their immigration status. On the effective date, states will see their FMAP cut to the traditional rate for emergency services rendered to non-citizens who would otherwise be eligible for Medicaid under ACA expansion if not for their immigration status (and would therefore qualify for a 90 percent matching rate under ACA expansion). **CBO estimated 10-year Medicaid spending cut:** $28.2 billion.	**October 1, 2026**	CMS has issued additional guidance related to funding of emergency Medicaid. It is possible the agency may pursue additional related rulemaking.
Federal Medical Assistance Percentage (FMAP) *Section 71114* - Sunsetting Increased FMAP Incentive	The American Rescue Plan Act offers a 5 percent FMAP bonus for eight quarters for any states that newly adopts Medicaid expansion. The OBBBA sunsets this bonus. **CBO estimated 10-year Medicaid spending cut:** $13.6 billion.	**January 1, 2026**	The OBBBA did not specify specific rulemaking action or a deadline, but the agency may issue rulemaking or additional sub-regulatory guidance at its discretion.

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Long-Term Care Facility Staffing Requirements. *Section 71111-* Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities Under the Medicare and Medicaid Programs	This section imposes a ten year moratorium (until Sept. 30, 2034) on the implementation, administration, or enforcement of the final rule issued by CMS on May 10, 2024, titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" (89 FR 40876). This rule establishes minimum staffing standards for nursing homes participating in Medicare and Medicaid. **CBO estimated 10-year Medicaid spending cut:** $23.1 billion.	**July 4, 2025**	CMS could engage in additional notice and comment rulemaking to alter or remove the final rule prior to the end of the moratorium.
Rural Health Transformation Program			
Rural Health Transformation Program *Section 71401*	Provides $10 billion for each of fiscal years (FYs) 2026, 2027, 2028, 2029, and 2030 ($50 billion total) to support a "Rural Health Transformation Program." Distributes 50 percent of payments equally across states with approved applications; the remaining funds will be distributed by CMS based at least in part on states' rural populations that live in metropolitan statistical areas, the percent of rural health facilities nationwide that are located in a state, and the situation of hospitals that serve a disproportionate number of low-income patients with special needs. Uses of funds include promoting care interventions, paying for health care services, expanding the rural health workforce, and providing technical or operational assistance aimed at system transformation.	**January 1, 2026** (the program will run through 2031).	On Sept. 15, 2025, CMS issued a Notice of Funding Opportunity. Applications are due Nov. 5, 2025.