OBBBA Medicaid Policy Timeline

NAMD National Association of Medicaid Directors

July 4, 2025

Restriction on Funding to Certain Family Planning Providers (Sec. 71113)

- Temporarily restricts federal funding for one year to certain 501(c)(3) providers that offer abortions, primarily deliver reproductive health services, and received at least $800,000 in Medicaid payments in FY 2023, among other characteristics.
- Effective: July 4, 2025 (for 1 year)

Provider Tax Provisions (Sec. 71115)

- Prohibits new provider taxes on previously untaxed provider classes, caps overall tax rates at levels in place on date of enactment, and phases down hold harmless thresholds in expansion states, excluding Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDDs).
- Effective: Taxes will be capped as they were structured on July 4, 2025. Cap goes into effect on October 1, 2026. Expansion state phase down begins in FY 2028.

State Directed Payment Limits (Sec. 71116)

- Caps state directed payments in managed care programs at 100% of Medicare rates in expansion states and 110% of Medicare rates in non-expansion states. Grandfathered payments must be reduced by 10 percentage points per year starting in 2028.
- Effective: For rating periods beginning on or after July 4, 2025

Dec. 31, 2025

Rural Health Fund (Sec. 71401)

- Establishes a $50 billion grant program (FY2026–2030) for states to improve rural health care delivery. States must implement at least three eligible activities; CMS must make award decisions by December 31, 2025.
- Award Decision Deadline: Dec 31, 2025
- Funding Period: FY 2026–2030

Oct. 1, 2026

Eligibility Changes for Immigrants (Sec. 71109)

- Limits Medicaid and CHIP eligibility to lawful permanent residents, certain Cuban and Haitian entrants, and individuals from the Compacts of Free Association nations. Excludes refugees, asylees, and other humanitarian groups.
- Effective: Oct 1, 2026

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Dec. 31, 2026

Work/Community Engagement Requirements (Sec. 71119)

- States must require certain expansion adults to complete 80 hours per month of work, education, or community service as a condition of eligibility. Applies to individuals ages 19–64, with limited exemptions and must be verified through ex parte processes.
- Effective: Dec 31, 2026; HHS must issue rule by June 1, 2026; States may request a good faith effort extension through Dec 31, 2028.

6-Month Redeterminations (Sec. 77107)

- Requires Medicaid eligibility redeterminations every six months for adult expansion enrollees or those receiving Minimum Essential Coverage (MEC) through a waiver. Current 12-month requirement remains for all other populations.
- Effective: Dec 31, 2026; CMS guidance due by Dec 31, 2025

Jan. 1, 2027

Retroactive Coverage Limits (Sec. 71112)

- Reduces retroactive coverage in Medicaid from up to three months to one month for expansion adults and two months for all other groups.
- Effective: for applications submitted on or after Jan 1, 2027

July 1, 2028

HCBS Waiver Option (Sec. 71121)

- Creates a new 1915(c) waiver that allows states to offer Home and Community-Based Services (HCBS) without requiring institutional level of care. States must meet cost neutrality and reporting standards.
- Effective: July 1, 2028

Oct. 1, 2028

Cost Sharing for Expansion Adults (Sec. 71120)

- Requires states to implement cost-sharing on expansion adults with income above 100% Federal Poverty Level. Caps charges at $35 per service and 5% of income; excludes key services like primary care, behavioral health, and those provided in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Certified Community Behavioral Health Clinics (CCBHCs).
- Effective: Oct 1, 2028

This timeline does not include all Medicaid-related provisions from OBBBA.