Budget Reconciliation: Highlights from H.R. 1, the *One Big Beautiful Bill Act*

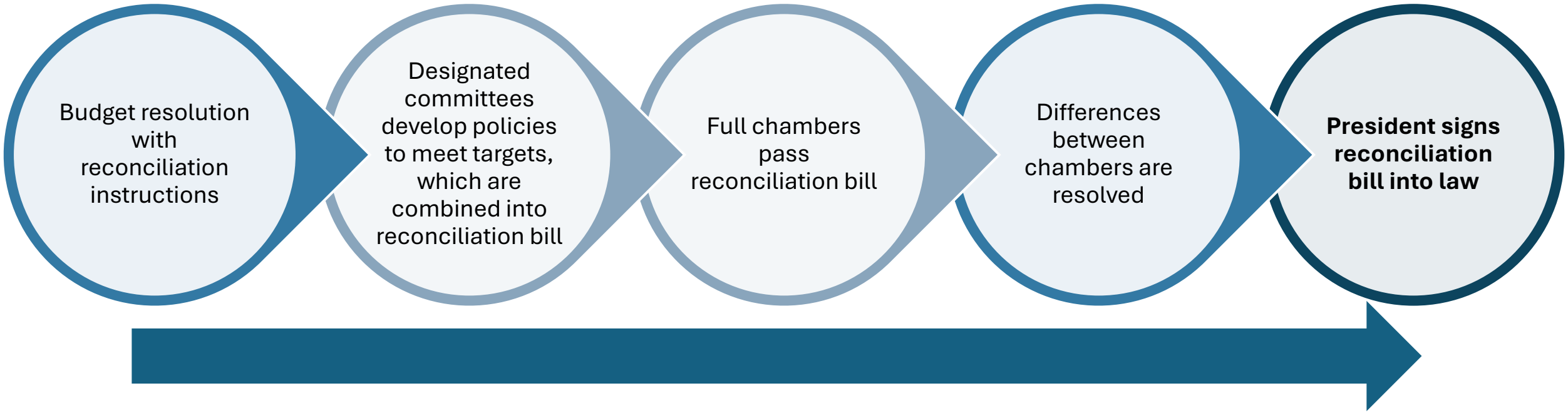
Joint Association Presentation: July 8, 2025

ADVANCING STATES

NASDDDS
National Association of State Directors of Developmental Disabilities Services

NASHIA

Budget Reconciliation: Overview



One Big Beautiful Bill Act (OBBBA): Timeline

May 22, 2025

The House passed the One Big Beautiful Bill Act (link)

July 1, 2025

The Senate passed an amended version of the One Big Beautiful Bill Act (link)

The legislation then went back to the House, since the House and Senate must pass the same version of the legislation for it to be signed into law.

July 3, 2025

The House passed the amended version of the One Big Beautiful Bill Act and the President signed it into law (link)

Read the final bill text here.

New HCBS Waiver Option

Section 71171: Making certain adjustments to coverage of HCBS under Medicaid

Permits the State to establish a standalone 1915(c) waiver that does not require participants to meet a nursing facility or ICF/IID level of care.

- All other 1915(c) waivers in 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 stand-alone 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:
    - Cost of services provided under the waiver and duration of services, broken out by service type;
    - Comparison of these two data points with equivalent data on other 1915(c) waivers; and
    - The total number of participants during the preceding year.

Effective July 1, 2028

Community Engagement/Work Requirements

Section 71119: Requirement for States to establish Medicaid community engagement requirements for certain individuals

- **Application:** Applies to adults 19 - 64 eligible for/enrolled in the expansion group and adults 19 – 64 eligible for/enrolled in waivers that provide MEC
- **Exceptions:**
  - Mandatory exclusions for children, adults 65+, individuals considered "medically frail," and parents/caregivers of children 13 and under or dependents with a disability, among others
  - Optional short-term hardship waivers, including a new hardship waiver for individuals receiving out-of-community medical care for serious or complex conditions.

Implementation date: Beginning not later than the first day of the first quarter that begins after December 31, 2026; allows the state to request a good-faith effort determination to delay implementation until up to December 31, 2028.

Community Engagement/Work Requirements *(cont.)*

Section 71119: Requirement for States to establish Medicaid community engagement requirements for certain individuals

- **Compliance standard:** An individual meets the requirement by engaging in any combination of the following activities for at least 80 hours per month:
  - Working;
  - Completing community service;
  - Participating in a work program; or
  - Participating in an educational program at least half-time.
- The individual has a monthly income that is not less than the federal minimum wage per hour, multiplied by 80 hours.
- If the individual is a seasonal worker, they have an average monthly income over the preceding 6 months that is not less than the federal minimum wage, multiplied by 80 hours.

- **Compliance verification:** Requires the State to verify compliance with work requirements at application and during regularly scheduled eligibility determinations (i.e., every 6 months). The State must use ex parte processes to verify an individual's compliance with the work requirements or qualification for an exception.

Community Engagement/Work Requirements *(cont.)*

Section 71119: Requirement for States to establish Medicaid community engagement requirements for certain individuals

- **Procedural requirements:** The State must:
  - Conduct advance outreach to individuals to make them aware of the requirements through mail and one or more additional means;
  - Establish due process procedures;
  - Provide individuals who are not compliant with 30 days to demonstrate compliance or exempted status, and provide coverage during these 30 days; and
  - Follow typical disenrollment requirements (assess eligibility on other bases, notice, fair hearings).

Rule Recissions

Sections 71101, 71102, and 71111: Moratorium on regulations

Prohibits CMS from implementing or enforcing the following regulations through September 30, 2034:

- Eligibility and enrollment rules
- Minimum staffing standards in the long-term care (LTC) facility staffing rule (at 42 CFR 483.5 and 483.35)
  - ***Note:*** The requirement for the State to report on payment transparency in LTC facilities (at 42 CFR 442.43) is not included in the moratorium.

Provider Taxes

Section 71115: Moratorium on new or increased provider taxes (p. 613)

- Freezes provider taxes at current levels for both expansion and non-expansion states.
  - ***As of the effective date of the legislation***

- Amends the hold harmless "safe harbor" threshold, currently set at 6%.
  - In expansion states, reduces hold harmless threshold for expansion states by 0.5% every year beginning in 2028 until it reaches 3.5%:
    - 5.5% for FY 2028;
    - 5% for FY 2029;
    - 4.5% for FY 2030;
    - 4% for FY 2031;
    - 3.5% for FY 2032 and beyond.
  - In non-expansion states, caps hold harmless threshold at 6%.
  - Taxes on NF and ICF services that are in effect on May 1, 2025 are exempt from the lower hold harmless threshold, as long as the tax is not modified.

Eligibility Verifications

Section 71103 (p. 584): Reducing duplicate enrollment under the Medicaid and CHIP programs

- Requires the State to establish standardized processes to update enrollee addresses using data from managed care plans, the National Change of Address Database, and returned mail by January 1, 2027.
- Requires HHS to establish new system to identify duplicate enrollment by October 1, 2029.

Section 71104 (p. 592): Ensuring deceased individuals do not remain enrolled

- Requires the State to verify enrollee eligibility against the SSA Death Master File on a quarterly basis, as of January 1, 2028.

Section 71107 (p. 597): Eligibility redeterminations

- Requires the State to conduct eligibility redeterminations for expansion adults every six months (includes exemption for tribal members).

Section 71108 (p. 599): Revising home equity limit for determining eligibility for long-term care services

- Establishes a lower cap of $1,000,000 on home equity for LTSS recipients that is not waivable through asset disregards.

State-directed Payments

Section 71116: State directed payments

- For non-expansion states, caps any new state-directed payment (SDP) submissions at 110% of Medicare rate.
- For expansion states, caps any new SDP submissions at 100% of Medicare rate.
- Requires already approved SDPs to be reduced by 10% per year starting in 2028 until they are no greater than the above caps.
  - This phase down applies to grandfathered SDPs, which are those:
    - That received prior approval from CMS or a good faith effort to receive approval before May 1, 2025.
    - For which a completed preprint was submitted prior to date of enactment of the OBBBA; and
    - For rural hospitals approved by date of enactment of the OBBBA for the rating period occurring within 180 days of the date of enactment.

Section 1115 Budget Neutrality

Section 71118: Requiring budget neutrality for Section 1115 Demonstrations (p. 625)

- Effective the date of enactment, requires HHS to certify budget neutrality for Section 1115 demonstration projects.
- The Secretary may only approve or renew waivers when the chief actuary of CMS certifies that the waiver project, based on expenditures for the state program in the preceding fiscal year, is not expected to increase federal expenditures compared to the amount that such expenditures would otherwise be without the waiver project.
- The following are considered expenditures that would have existed without the waiver project: expenditures for the coverage of populations and services that the state could otherwise have provided through the state plan or other authority under title XIX, 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.

Retroactive coverage

Section 71112: Reducing state Medicaid costs

For individuals who apply for Medicaid on or after January 1, 2027, limits retroactive coverage as follows:

- For adult expansion population: 1 month
- For other Medicaid eligibility categories: 2 months
- For CHIP: 2 months

Coverage for Immigrants

Section 71109: Alien Medicaid Eligibility

- Amends the definition of "qualified alien" to only include an alien lawfully admitted for permanent residence, excluding alien visitors, tourists, diplomats, and students who enter the U.S. temporarily, certain Cuban and Haitian immigrants, and Compact of Free Association (COFA) migrants.
  - No longer considered qualified aliens for purposes of Medicaid and CHIP: refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, trafficking victims, and other non-citizens.
  - Effective October 1, 2026

Section 1110: Expansion FMAP for Emergency Medicaid (p. 604)

- Sets FMAP for emergency Medicaid at the base FMAP for the state, regardless of eligibility category for the enrollee.
- Effective October 1, 2026

Rural Health

Section 71401: Rural Health Transformation Program

- Creates a rural health transformation fund with the amount of $10 billion each year from FY26 to FY30.

- **Eligibility:** Only the 50 states (not DC or territories) are eligible.
  - States must submit applications to HHS during an application period that ends not later than December 31, 2025, that includes a detailed rural health transformation plan, a certification that none of the funds finance state share of Medicaid, and other information.
- **Allocation of funds:**
  - 50% of funds for each fiscal year will be distributed equally among states with approved applications.
  - 50% of funds will be allotted based on the percentage of the population that is rural, the proportion of rural health facilities in the state relative to the number of rural health facilities nationwide, and the situation of hospitals.

Rural Health *(cont.)*

Section 71401: Rural Health Transformation Program

- **Funds can be used to:**
  - 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.
  - Recruit and retain 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
  - Support 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