H.R. 1 One Big Beautiful Bill Act

(OB3)

Impact to Medicaid 2025

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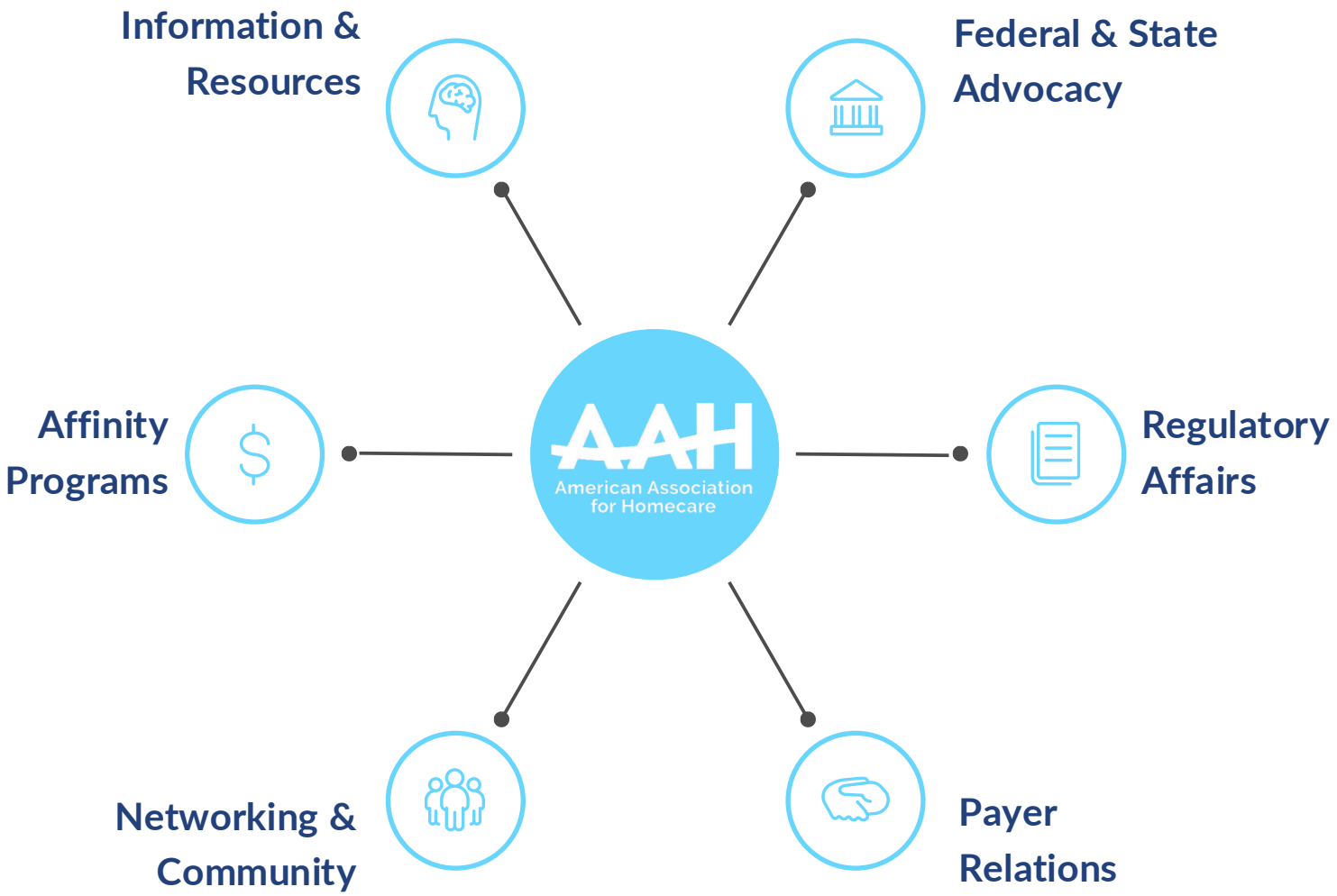

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What is OB3?

The "One Big Beautiful Bill"

- Signed into law by President Trump 7/4/25 *(Public Law 119-21)*.
- Extends and modifies several tax changes from 2017 Tax Cuts & Jobs Act that were set to expire.
- Makes significant changes and cuts to health care and other programs, many of which run by the states.

State impacts vary based on each state's fiscal health and exposure to federal programs.

Medicaid Federal Spending Cuts

- **The Congressional Budget Office (CBO) Estimates:**

$1 Trillion Reduction in Federal Spending Over 10 Years

This is 15% of federal spending

10 Million People Will Become Uninsured Over 10 Years

10.5 Million Reduction in Medicaid Enrollment By 2034

Per 6/24/25 CBO House Letter

**CBO analysis assumption: states would replace half of the reduced federal funds with their own resources*

- **Of note: expansion states account for $526 billion of reductions**

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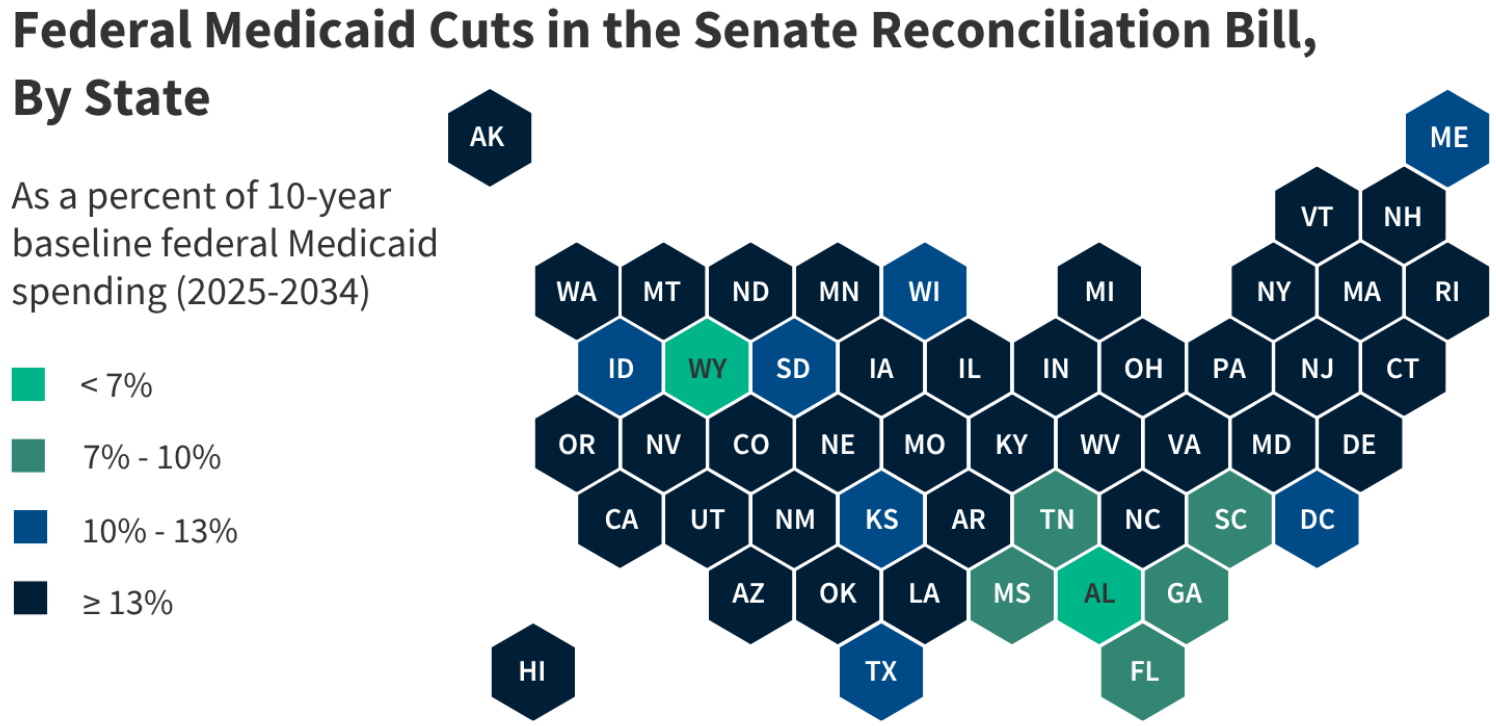
Medicaid Budget State Impact



Source: KFF analysis of CBO estimates of the Senate Reconciliation Bill

Estimated impacts by state can be found at:
https://aahomecare.org/state-medicaid-and-medicaid-managed-care

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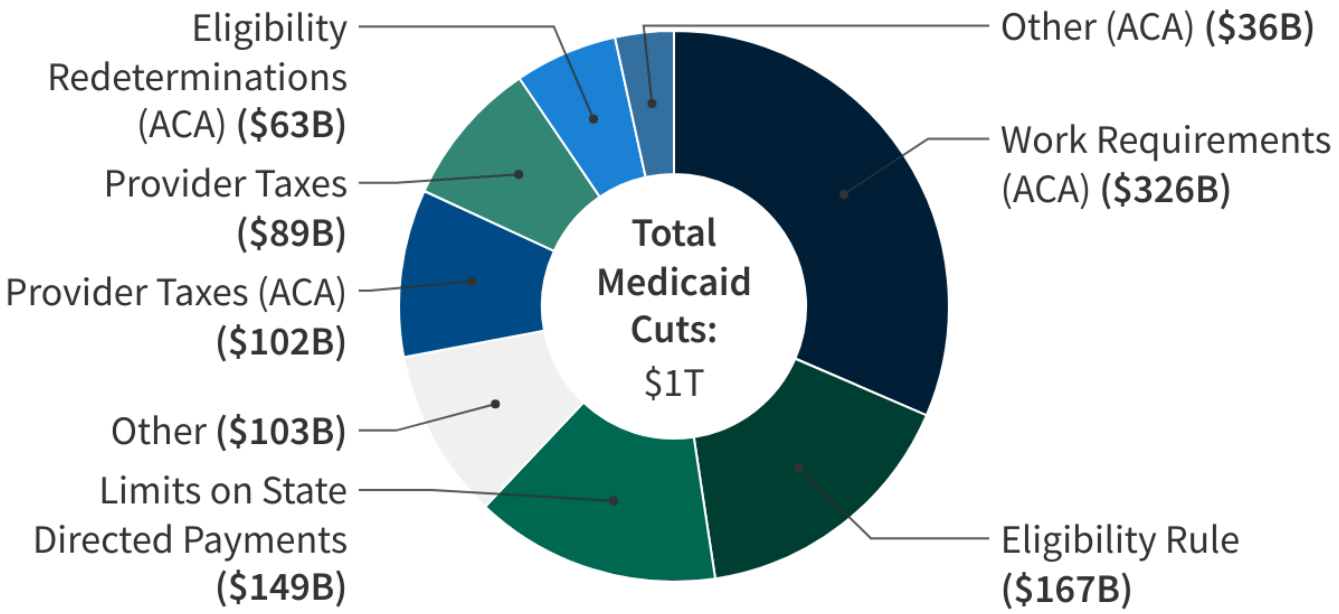
Medicaid Federal Spending Cuts-CBO Estimates

Figure 1

CBO Estimates of Federal Medicaid Cuts in the Senate Reconciliation Bill

CBO's estimated 10-year federal spending cuts, by policy



Note: See Methods in "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Senate Reconciliation Bill" for more details.

KFF

Source: KFF analysis of CBO estimates of the Senate Reconciliation Bill

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Medicaid Federal Spending Cuts

Topic	Effective Date(s)
Work Requirements	12/31/26 (flexibilities to 12/31/28)
Eligibility Changes	10/1/26 – 10/1/29
Provider Taxes	Upon Enactment – 2032
State Directed Payments	1/1/28
Elimination of 5% Incentive for Expansion	1/1/26
Cost Share	1/1/26
Limit Federal Match Emergency Medicaid	1/1/26
Rural Health Funding	2026 – 2030

Medicaid Federal Spending Cuts

How and When Most Significant Medicaid Expenditure Cuts Hit State Budgets

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Work Requirements			$13.1	$19	$39.8	$46.3	$48.4	$50.7	$53.1	$55.6
Provider Tax Freeze & Wind Down		$2.8	$4.7	$7.6	$12.3	$18.6	$26.7	$34.1	$39.3	$45
State Directed Payments Freeze & Wind Down		$5.5	$7.5	$9.3	$13.3	$16.6	$19.6	$22.8	$25.9	$29
Six Month Redeterminations			$5.1	$7.1	$7.5	$7.8	$8.2	$8.6	$9	$9.4
Requirements on Waiver of Uniform Tax		$3.2	$3.4	$3.5	$3.7	$3.8	$4	$4.2	$4.3	$4.5
Reducing the Emergency Medicaid FMAP			$2.5	$3.2	$3.3	$3.5	$3.7	$3.9	$4.1	$4.4
Proportion of Key Provision Cuts Hitting State Budgets	**0%**	**1.4%**	**4.6%**	**6.3%**	**10.1%**	**12.2%**	**14%**	**15.7%**	**17.1%**	**18.7%**

HR 1 will cut $1.02 trillion from federal Medicaid spending to states. However, these six provisions make up more than $792 billion of those enacted cuts.
Source: Estimated Budgetary Effects of An Amendment in the Nature of a Substitute to H.R. 1. (June 28, 2025). Congressional Budget Office.

https://s3.amazonaws.com/multistate.us/production/resources/rjRPFfJIMIU2l0xjm/attachment/State%20Impacts%20of%20OBBBA%20Report%20(July%2022,%202025)%20-%20final%20(2).pdf

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Medicaid Cuts | Work Requirements

$326 Billion – Work Requirements for Expansion Population

- ***80 hours/mo work and/or community engagement*** for expansion population
- ***3-month lookback period*** demonstrating engagement
- ***Limits parental exemption to children 13/younger*** instead of all parents
- ***Criteria for seasonal workers to meet requirements*** if average monthly income meets set standard
- ***Requires states to use data matching for verifying*** if requirement/exemption is met (where possible)

Effective 12/31/26; Secretary may exempt states from compliance until 12/31/28 if good faith effort to comply

Medicaid Cuts | Eligibility & Enrollment Changes

$167 Billion – Change in Eligibility Rules

Secretary Required to:

- ***Establish system to share info with states*** to eliminate duplicate enrollments – effective 10/1/29

States Required to:

- ***Submit monthly enrollee SSNs*** – effective 10/1/29
- ***Obtain enrollee address info*** using reliable data sources – effective 1/1/27
- ***Review Master Death File quarterly*** –effective 1/1/27

Restricts definition of qualified immigrants for purposes of Medicaid/CHIP eligibility – effective 10/1/26

- *"Lawful permanent residents (LPR), certain Cuban & Haitian immigrants, citizens of the Freely Associated States (COFA migrants) residing in the US, and Lawfully residing children & pregnant adults in states that cover them under the Immigrant Children's Health Improvement (ICHIA) option"*

Medicaid Cuts | Eligibility & Enrollment Changes (cont.)

Delays implementation of Eligibility & Enrollment Final Rule, which:

- ***Reduced enrollment barriers for MSP***, providing Medicaid coverage of Medicare premiums & cost sharing for low income
- ***Streamlined application & enrollment policies*** for all Medicaid enrollees
- ***Facilitated transactions*** between Medicaid, CHIP, & Marketplace coverage

Changes eligibility redetermination frequency for Medicaid expansion population ($63 billion)

- *Eligibility determinations at least every 6 mo*
- *Effective for renewals scheduled on/after 12/31/26*
- *Secretary must issue guidance within 180 days of enactment*

Limits retroactive coverage – Effective 1/1/27

- *One month prior to application for expansion enrollees*
- *Two months prior for traditional enrollees*

$191 Billion – Change in Provider Tax Rules

- ***Establishes moratorium on provider taxes for expansion states;*** they cannot create new ones, increase current ones, or keep certain existing ones at current levels.
  - Currently, states charge provider taxes, then receive federal match on tax revenue
  - OB3 revises conditions of taxes to be broad based & uniform; some will no longer be allowed in future (ex. taxes on MCO plans)
- ***Lowers the Safe Harbor Limit for expansion* states,** starting in FY 2028
  - Currently, Safe Harbor Limit rule allows provider tax to automatically pass federal approval if tax doesn't exceed 6% of provider's net patient revenue.
  - OB3 lowers the limit starting FY 2028 where the 6% cap drops by 0.5% annually til reaches 3.5% in 2032.
  - New Safe Harbor Limit exempts nursing facilities & intermediate care facilities.
  - Effective date upon enactment, but states have up to 3 years to transition existing arrangements.
  - The new limit also applies to local government taxes in expansion states.

What are "Provider Taxes"?

- ***State-imposed fees on health care providers*** (ex. hospitals, nursing homes)
- ***Revenue used to draw additional federal Medicaid funds***
- ***Often results in increased Medicaid payments to taxed providers.***

State Example:

- State creates provider tax on hospitals and nursing homes
- State takes taxed revenue & turns into payments to taxed provider
- Provider payments draw federal match dollars (FMAP)
- Tax could generate billions in extra federal Medicaid dollars
- Helps fund higher provider payments & Medicaid expansion
- New Safe Harbor Limit exempts nursing facilities & intermediate care facilities.

Medicaid Cuts | State Directed Payments

$149 Billion – Change in State Directed Payments (Revising Payment Limit)

- ***MCO Cap payment rate for inpatient hospital and nursing facilities***
  - ***Expansion States:*** 100% of Medicare published rates *OR* Medicaid FFS limit if Medicare rate unavailable for expansion states
  - ***Non-Expansion States:*** 110% of Medicare published rates *OR* Medicaid FFS limit if Medicare rate unavailable for expansion states
- ***Reduces payments by 10 percentage points annually*** starting 1/1/28 until reach 100% of Medicare rates
- ***Grandfathers state directed payments***
  - Rural hospitals with approval prior to enactment
  - All other providers with approval prior to 5/1/25

Medicaid Cuts | Medicaid Federal Spending Cuts

- ***Eliminates 5% temporary incentive*** for states that did not adopt expansion – Effective 1/1/26
  - (WY, WI, KS, TX, MS, TN, AL, GA, SC, FL)
- ***Cost sharing requirement*** (up to $35/service with exceptions) – Effective 10/1/28
  - Only applies to adults in expansion states
  - Maintains 5% family income cap on out-of-pocket expenses
  - Exempts primary care, mental health substance use disorder, & services provided by federally qualified health centers, behavioral health clinics, and rural health clinics.
  - DME is **NOT** exempt.
- ***Limits federal matching payments for Emergency Medicaid*** for individuals who would be otherwise eligible for expansion coverage (except for immigration status) to the state's regular FMAP – Effective 1/1/26

Medicaid Cuts | Medicaid Federal Spending Cuts (cont.)

- ***Specifies Chief Actuary for CMS to certify 1115 waivers*** that aren't expected to result in increase in federal expenditures (previously HHS Secretary) – Effective 1/1/27
- ***Requires HHS to reduce FMAP to states for improper payment error rates*** related to payments made for ineligible individuals & overpayments for eligible individuals – Effective FY 2030
  - Expands improper payments definition to include payments where insufficient info avail to confirm eligibility
  - Previously waived recoupments for states below 3% error rate
- ***Prohibits implementation of minimum staffing level requirements*** for LTC facilities until 10/1/34 by the HHS Secretary, previously passed in 2024 Final Rule

Medicaid Cuts | Other Medicaid Changes

- ***CMS monthly Medicaid enrollee immigration status check*** – Effective now
  - CMS sends states monthly reports identifying Medicaid enrollees whose citizenship/immigration status cannot be verified via federal databases.
  - States to review flagged cases, requires documentation, or modify coverage as necessary.
- ***CMS Issues Guidance on Continuous Eligibility & Workforce Initiatives*** – Effective 1/1/28
  - CMS doesn't anticipate approving new or extending existing state proposals allowing for expanded continuous Medicaid eligibility beyond what is required/available under Medicaid/CHIP statutes.
  - CMS doesn't anticipate approving new state proposals for workforce initiatives or extending existing ones. Current demonstrations may run their course.
  - **States must conduct checks at provider enrollment/re-enrollment and on quarterly basis of SSA Death Master File.**

Medicaid Rural Health Funding

$50 billion in grants to states for newly established rural health transformation program – Effective FY 2026-2030

- **Used for payments to rural health providers and other purposes**
- **Distributes 50% of payments equally across states with approved applications**
  - States must apply including detailed plan by 11/5/25
  - Awardees announced by 12/31/25
- **Remaining funds distributed by CMS based on:**
  - States' rural populations that live in MSA
  - % of rural health facilities nationwide that are in a state
  - Situation of hospitals that serve a disproportionate number of low-income patients with special needs
- **Funding use includes** promoting care interventions, paying for health care services, expanding rural health workforce, and providing technical or operational assistance aimed at system transformation

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Medicaid Rural Health Funding

5 Strategic Goals – Grounded in Statutorily Approved Use of Funds

- ***Make American Healthy Again*** **–** support rural health innovations & new access points to promote preventative health & address root causes of diseases
- ***Sustainable Access*** **–** help rural providers become long-term access points for care by improving efficiency & sustainability
- ***Workforce Development*** – attract and retain a highly skilled health care workforce by strengthening recruitment and retention of health care providers in rural communities
- ***Innovative Care*** – spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements
- ***Tech Innovation*** – foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients

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State Specific Impacts

As of 10/22/25, all but two states (NC and PA) have enacted budgets covering FY 2026, using a variety of tools to manage OB3 pressure in budgets, including general cost reduction and efficiency measures such as:

- ***Special legislative sessions:*** CO and NM reconvened to address emerging gaps
- ***Hiring freezes:*** AK, CO, MD, MA, NH, and WA implemented, which could complicate OB3 preparation efforts
- ***Pausing/ending planned programs & benefit coverage:*** OR – juvenile justice Medicaid re-entry program; NC – not covering new weight-loss drugs
- ***Medicaid provider rate updates:*** CO – rolled back planned 1.2% rate increase; ID – decreasing all rates by 4%; TX – implemented significant rate cuts; NC – decreasing DME rates by 3%
- ***Coalitions & advisory groups:*** RI – convening groups charged with analyzing how federal cuts may affect state programs and advising legislature on feasible responses to changed landscape

https://www.healthmanagement.com/insights/weekly-roundup/october-22-2025/

Operational Strategies

Verify Eligibility Benefits

Strengthen operational processes to include verifications with every product shipment and monthly claim validation.

Financial Forecasting

Strengthen financial forecasting and scenario planning to anticipate revenue changes and risks. Understand your organization's collection policy for uninsured patients.

Technology Adoption

Expand telehealth, remote monitoring, and automation to boost efficiency and reduce costs.

Policy Monitoring Importance

Tracking Medicaid changes regionally helps suppliers adapt to diverse patient demographics effectively.

Advocacy Engagement

Engaging in payer relations and legislative advocacy empowers suppliers to influence supportive healthcare policies. Have key resources ready to go.

Industry Partnerships

Collaborating with associations like AAHomecare and your state/regional association provides coordinated advocacy and resource access.

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MEDICAID STATE OUTLOOK

AAHomecare State Scan: Threats from the "Big Beautiful Bill"

41 expansion states account for $526 billion in cuts. 42 states have cuts of federal funds above 10%.

NC, ID, and CO announced cuts to fee schedules; TX is in the process of making cuts. **AAHomecare is working in 34 states.**

Tier 1 States (10)

18-21% cuts of federal funds

CA, IL, LA, MN, NV, NH, NJ, NY, VA, plus TX planning additional cuts

6 have lobbyist(s)

9 have work currently happening

1 has NO work happening

NH (TBD HOMES)

Tier 2 States (32)

10-17% cuts of federal funds

AK, AZ, AR, CO, CT, DE, DC, HI, ID, IN, IA, KS, ME, MD, MA, MI, MO, MT, NE, NM, NC, ND, OH, OK, OR, PA, RI, SD, UT, VT, WA, WV

13 have lobbyist(s)

18 have work currently happening

13 have NO work happening

AZ, DE, DC, HI, ID, KS, MD, MO, MT, NE, NM, ND, SD

Tier 3 States (9)

<10% cuts of federal funds

AL, FL, GA, KY, MS SC, TN, WI, WY

4 have lobbyist(s)

7 have work currently happening

2 have NO work happening

WI, WY (TBD MAMES)

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Medicaid Federal Funding Scan - Prioritization

Medicaid Departments

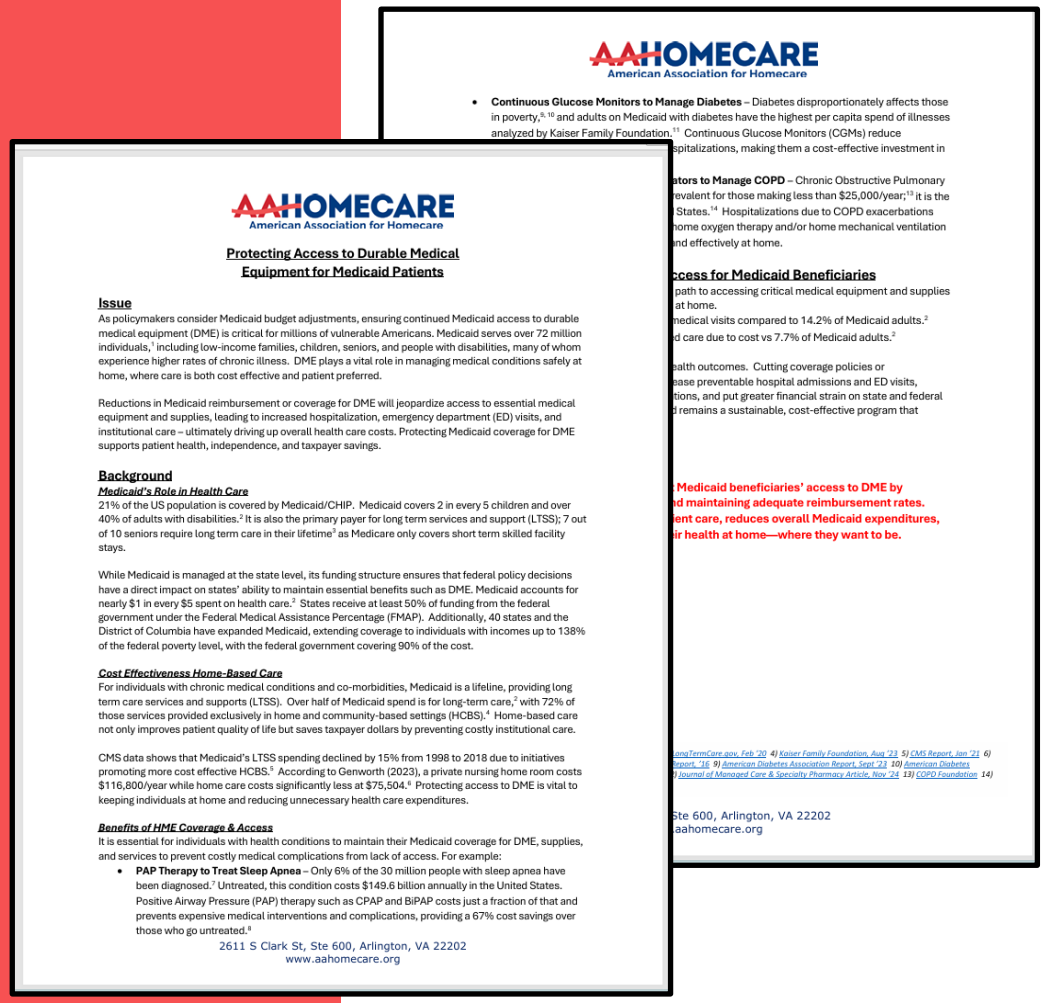
White Paper
Meetings
Eliminate/Minimize Rate Reductions
Administrative Cost Reduction
Rate Floor-Regulatory

State Legislature

Rate Floor-Legislature

Medicaid MCO Plans

Industry Talking Points



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Protecting Access to Durable Medical Equipment for Medicaid Patients

Issue

As policymakers consider Medicaid budget adjustments, ensuring continued Medicaid access to durable medical equipment (DME) is critical for millions of vulnerable Americans. Medicaid serves over 72 million individuals,[1] including low-income families, children, seniors, and people with disabilities, many of whom experience higher rates of chronic illness. DME plays a vital role in managing medical conditions safely at home, where care is both cost effective and patient preferred.

Reductions in Medicaid reimbursement or coverage for DME will jeopardize access to essential medical equipment and supplies, leading to increased hospitalization, emergency department (ED) visits, and institutional care – ultimately driving up overall health care costs. Protecting Medicaid coverage for DME supports patient health, independence, and taxpayer savings.

Background

Medicaid's Role in Health Care

21% of the US population is covered by Medicaid/CHIP. Medicaid covers 2 in every 5 children and over 40% of adults with disabilities.[2] It is also the primary payer for long term services and support (LTSS); 7 out of 10 seniors require long term care in their lifetime[3] as Medicare only covers short term skilled facility stays.

While Medicaid is managed at the state level, its funding structure ensures that federal policy decisions have a direct impact on states' ability to maintain essential benefits such as DME. Medicaid accounts for nearly $1 in every $5 spent on health care.[2] States receive at least 50% of funding from the federal government under the Federal Medical Assistance Percentage (FMAP). Additionally, 40 states and the District of Columbia have expanded Medicaid, extending coverage to individuals with incomes up to 138% of the federal poverty level, with the federal government covering 90% of the cost.

Cost Effectiveness Home-Based Care

For individuals with chronic medical conditions and co-morbidities, Medicaid is a lifeline, providing long term care services and supports (LTSS). Over half of Medicaid spend is for long-term care,[2] with 72% of those services provided exclusively in home and community-based settings (HCBS).[4] Home-based care not only improves patient quality of life but saves taxpayer dollars by preventing costly institutional care.

CMS data shows that Medicaid's LTSS spending declined by 15% from 1998 to 2018 due to initiatives promoting more cost effective HCBS.[5] According to Genworth (2023), a private nursing home room costs $116,800/year while home care costs significantly less at $75,504.[6] Protecting access to DME is vital to keeping individuals at home and reducing unnecessary health care expenditures.

Benefits of HME Coverage & Access

It is essential for individuals with health conditions to maintain their Medicaid coverage for DME, supplies, and services to prevent costly medical complications from lack of access. For example:

- **PAP Therapy to Treat Sleep Apnea** – Only 6% of the 30 million people with sleep apnea have been diagnosed.[7] Untreated, this condition costs $149.6 billion annually in the United States. Positive Airway Pressure (PAP) therapy such as CPAP and BiPAP costs just a fraction of that and prevents expensive medical interventions and complications, providing a 67% cost savings over those who go untreated.[8]

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- **Continuous Glucose Monitors to Manage Diabetes** – Diabetes disproportionately affects those in poverty,[9, 10] and adults on Medicaid with diabetes have the highest per capita spend of illnesses analyzed by Kaiser Family Foundation.[11] Continuous Glucose Monitors (CGMs) reduce
spitalizations, making them a cost-effective investment in

ators to Manage COPD – Chronic Obstructive Pulmonary
evalent for those making less than $25,000/year;[13] it is the
States.[14] Hospitalizations due to COPD exacerbations
ome oxygen therapy and/or home mechanical ventilation
nd effectively at home.

cess for Medicaid Beneficiaries

path to accessing critical medical equipment and supplies
at home.
medical visits compared to 14.2% of Medicaid adults.[2]
d care due to cost vs 7.7% of Medicaid adults.[2]

alth outcomes. Cutting coverage policies or
ease preventable hospital admissions and ED visits,
tions, and put greater financial strain on state and federal
remains a sustainable, cost-effective program that

Medicaid beneficiaries' access to DME by
d maintaining adequate reimbursement rates.
ent care, reduces overall Medicaid expenditures,
ir health at home—where they want to be.

LongTermCare.gov, Feb '20 4) Kaiser Family Foundation, Aug '23 5) CMS Report, Jan '21 6) Report, '16 9) American Diabetes Association Report, Sept '23 10) American Diabetes Journal of Managed Care & Specialty Pharmacy Article, Nov '24 13) COPD Foundation 14)

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- To join, contact Michael Nicol, Senior Director of Membership Services: michaeln@aahomecare.org or 410-299-7100.

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THANK YOU!

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