

Working with State Medicaid Agencies In Implementing H.R. 1

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About NAMD

NAMD is a professional community of leaders who provide health insurance to almost 80 million people through Medicaid and CHIP in the states, D.C. and the U.S. territories.

NAMD elevates thought leadership on policy matters, amplifies the experience and expertise of state leaders, supports programs in continuous improvement and innovation, and optimizes partnerships to help millions live their healthiest lives.

NAMD is led by a mission-focused 14-person Board of Directors representing the states of Georgia, Kentucky, Maine, New York, New Mexico, New Hampshire, North Dakota, Oregon, Texas, Virginia, Wisconsin, Iowa, the District of Columbia and the U.S. Virgin Islands.



Overview

- Medicaid in context
- OBBA Medicaid policy
- Implementation considerations
- Advice for partnering with Medicaid

Medicaid in context:

The program has experienced an intense few years

**COVID-19 Public Health
Emergency:** rapid cycle uptake
of newly eligible
people/emergency
authorities/telehealth, large
infusion of federal pandemic
funding

Post unwinding: Navigating
the change in federal
administrations and
identifying new
opportunities, experiencing
new state budget constraints,
Congressional budget
reconciliation

Post PHE: “Unwinding”
the PHE continuous
coverage requirement,
post-unwinding
managed care rate
experience, spending
down federal pandemic
funds

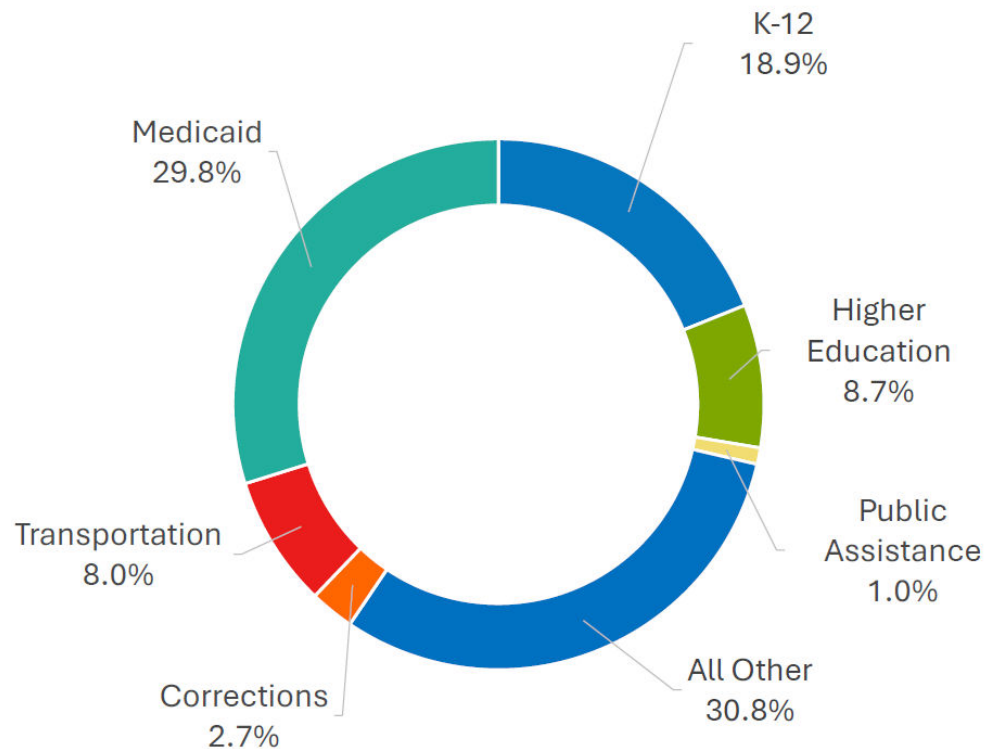
OBBBA Implementation:
planning for and executing
federal policy change
(differential impact among
states), navigating budget
constraints, program
sustainability

Medicaid in context:

Programs are facing budget pressure

- States are facing [new budget pressures](#), including slowing state revenue growth and the end of federal pandemic-era funding
- Medicaid costs accounted for [nearly 30 percent of state budgets](#) in FY2024, which is the single largest budget item for states
- [Health care cost growth](#) continues to pressure Medicaid spending and squeeze out investment in other state priorities
 - National healthcare costs continue to trend upward and grow more rapidly than the rest of the economy
 - Medicare and commercial have higher cost growth trends than Medicaid (8.1% and 11.5% in 2023 respectively), but growth in Medicaid is still significant (7.9% in 2023).

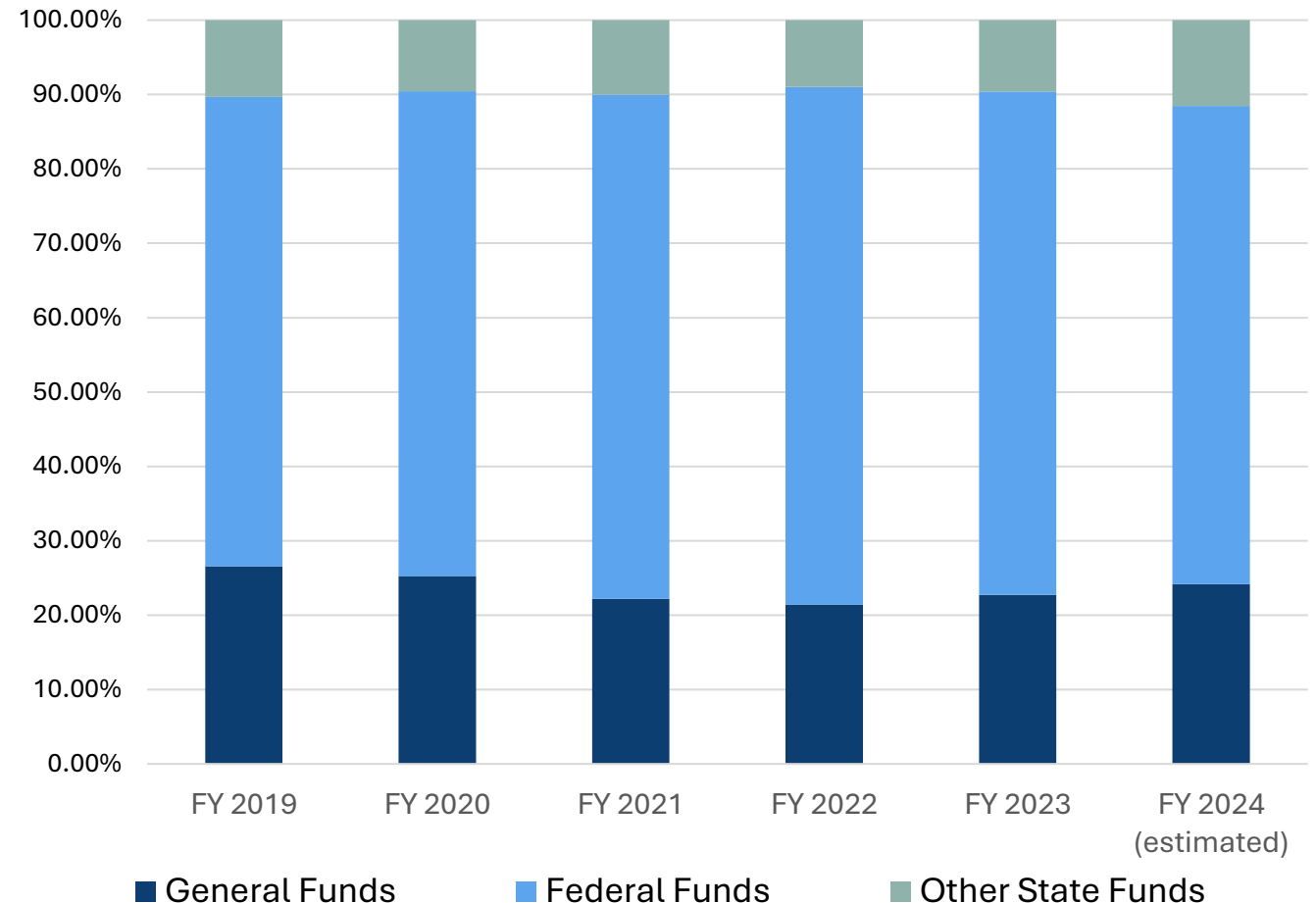
Medicaid in context: State Budget & Financing



Source: NASBO State Expenditure Report



Medicaid Expenditure by Source



OBBBA Medicaid policy

H.R. 1 – the One Big Beautiful Bill Act (OBBBA) **will reshape many aspects of Medicaid** over the next decade, but **it impacts states differently**

Policies generally address **three domains**:

1. Eligibility
2. Financing
3. Program integrity

Medicaid leaders shared goal: **implement OBBBA as efficiently and effectively** as possible

OBBBA Medicaid Policy Timeline



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)



July 4, 2025

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.



Dec. 31, 2025

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



Oct. 1, 2026

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



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



OBBBA affects states differently

Requirements that affect all or most states:

- Processes for duplicate enrollment and decreased members/providers
- Narrowed definition of "qualified alien" for purposes of eligibility
- New limits on retroactive eligibility*

Requirements that affect only expansion states:

- Community engagement requirements
- More frequent redeterminations (at six-month intervals)
- Phase down of the "hold harmless" threshold for provider taxes
- Cost sharing requirements**

*Note that there are different standards as between expansion and non-expansion states

**Non-expansion states that provide waiver coverage that is equivalent to minimum essential coverage (MEC) have to review the applicability of these requirements

Implementation considerations:

State budget development

- Medicaid agencies are **developing budget requests for FY2027 now** to be considered by legislatures this winter/spring
- Budgets must project funding needed to deliver Medicaid benefits and implement OBBBA provisions, **especially those effective in CY2026:**
 - Work/community engagement requirements
 - 6-month redeterminations
- Budget development **is always a difficult exercise, but doubly so this year** due to many interpretive policy questions and insufficient historical data

Budget considerations

- How will policies change the number of people covered by the program ongoing (caseloads) and the health care needs of those enrolled (acuity)?
- What will it cost to make IT systems changes and/or procure new solutions?
- Will new staff and contractors be needed (e.g., eligibility workers or call center staff)?
- How will changes in provider taxes will impact resources available to fund the state share of program costs?
- Will CMS grant any good faith deadline extensions? (early signals: extensions unlikely)

Implementation considerations:

Identifying needed state legislative authority

- **State legislatures will play a key role in OBBBA implementation** by providing Medicaid budget authority to implement the policies and amending state statute to align state law with federal law.
- **The timing of state legislative sessions is key.** Legislatures meet annually or biannually for a short window (e.g., 45 days), often in the winter/spring. Special sessions may be needed, depending on timing.
- **Medicaid agencies must identify where changes in state law are needed to align with new federal requirements.** This work is particularly challenging when states are waiting for CMS clarity and guidance on interpretive questions.

Advice for partnering with Medicaid

- ✓ **Recognize the differential impact and timing of OBBBA policies.** Non-expansion states are not as impacted by the policy changes.
- ✓ **Be sensitive to the fiscal context.** States must balance their budget, and in leaner fiscal environments, Medicaid will necessarily face pressure to find savings.
- ✓ **Acknowledge the immediate operational realities for Medicaid,** such as the need for CMS clarity, challenges in budget development, IT systems issues, and the role of the legislature.
- ✓ **Partner in offering solutions and expertise,** such as helping Medicaid communicate policy changes to members, providers, and other stakeholders.