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Medicaid Provisions in P.L. 119-21

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Issue

This report provides a general overview of changes to Medicaid under P.L. 119-21 (also known as the One Big, Beautiful Bill Act (OBBBA) or the Working Families Tax Cut legislation). The Office of Legislative Research is not authorized to provide legal opinions and this report should not be considered one.

Summary

P.L. 119-21 includes several provisions affecting Medicaid, which is administered at the federal level by the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) and at the state level in Connecticut by the Department of Social Services (DSS). Some of these provisions have already nominally gone into effect, including various rule delays (§§ 71101, 71102, & 71111), a prohibition on Medicaid payments to certain family planning providers (§ 71113), elimination of an incentive to expand Medicaid eligibility (§ 71114), new limits on state-directed payments in managed care delivery systems (§ 71116), and certain provider tax requirements (§ 71117).

Starting October 1, 2026, the act ends Medicaid eligibility for certain immigrants (§ 71109), reduces federal matching funds for certain emergency expenses (§ 71110), and restricts provider taxes (§ 71115).

Several other provisions take effect in 2027, including requirements for states to collect certain information on enrollee addresses (§ 71103), check death-related data (§ 71104), make more frequent eligibility determinations (§ 71107), limit retroactive eligibility (§ 71112), and establish work or community engagement requirements for certain Medicaid enrollees (§ 71119). Other

provisions that take effect in 2027 include additional provider tax requirements (§ 71115) and a requirement that CMS's actuary certify that demonstration waivers are budget neutral before CMS approves them (§ 71118).

Other provisions take effect in 2028 or later, such as those restricting CMS's ability to waive penalties for states with excess payments (§ 71106), lowering the limit on home equity excluded from assets when determining eligibility for long-term care services (§ 71108), setting cost-sharing requirements for certain Medicaid enrollees (§ 71120), and creating a new option for home- and community-based services waivers (§ 71121). CMS provides a table with key dates for the act's provisions in its informational bulletin (see Appendix A, pp. 26 & 27).

This report does not discuss the Rural Health Transformation Program, also established under the act. For more information on that program, see CMS and DSS websites.

Provisions Currently in Effect or Partially in Effect

Rule Delays

In 2023, CMS published a rule that principally made changes to the Medicare Savings Program (MSP), which is a Medicaid program that helps with cost-sharing for low-income Medicare enrollees. P.L. 119-21 delays until federal FY 35 provisions that (1) specify when certain people enrolled in Medicare hospital services may qualify for MSP, (2) require states to use Social Security data to enroll people in MSP, and (3) align the definition of family size under MSP with the Low-Income Subsidy (LIS) definition (§ 71101). (LIS is a separate but related benefit under Medicare.) For more details on delayed provisions, see CMS policy guidance, Appendix E (p. 33). According to CMS (p. 4), the agency will revert to regulations in place as of November 16, 2023, for sections of the regulation that are subject to the delay.

P.L. 119-21 similarly delays to federal FY 35 provisions in a 2024 rule that (1) allow state Medicaid programs to verify someone's citizenship and identity through certain systems without additional proof of identity, (2) align certain Medicaid enrollment processes for those whose eligibility is not based on income with those that are based on income, and (3) set additional timelines for Medicaid eligibility terminations (§ 71102). For more information on delayed provisions, see CMS policy guidance, Appendix F (p. 35). According to CMS (p. 5), the agency will revert to regulations in place as of June 2, 2024, for sections of the regulation that are subject to the delay.

Later that year, CMS published another rule that, among other things, (1) sets minimum staffing standards for nurses in Medicaid and Medicare long-term care facilities, requiring a nurse to be onsite at all times and requiring at least 3.48 total nurse staffing hours per resident per day, and

(2) requires state Medicaid programs to report on payments to direct care workers and support staff for nursing facilities and intermediate care facilities for people with intellectual disabilities. Implementation dates under the rule ranged from June 21, 2024, to May 10, 2029. P.L. 119-21 delays both the staffing standards and the reporting requirements until federal FY 35 (§ 71111). According to CMS (p. 12), rules in effect before May 10, 2024, will continue to be enforced.

Family Planning Providers

P.L. 119-21 prohibits federal Medicaid payments for one year to nonprofit health care providers that serve predominantly low-income, medically underserved people if the provider:

1. primarily furnishes family planning services, reproductive health, and related care;
2. offers abortions in cases other than rape, incest, or a woman's life-threatening condition; and
3. received federal and state Medicaid payments totaling over $800,000 in federal FY 23 (§ 71113).

This section has been subject to several legal challenges. Twenty-two states, including Connecticut, have sued HHS, arguing, among other things, that the provision violates constitutional freedom of speech protections and is ambiguous (*State of California* v. *U.S. Department of Health and Human Services*, No. 1:25-cv-12118). Separately, Planned Parenthood has sued, arguing, among other things, that the provision is an unconstitutional bill of attainder (i.e. legislation that punishes a person or group without due process) (*Planned Parenthood Federation of America* v. *Kennedy*, No. 1:25-cv-11913).

Expansion Incentive

The federal Affordable Care Act required states to expand Medicaid coverage to low-income, non-pregnant, non-disabled adults (the Medicaid expansion population, HUSKY D in Connecticut) and provides an enhanced federal matching rate ("FMAP") for this purpose. A subsequent U.S. Supreme Court decision made this expansion optional (*National Federation of Independent Business* v. *Sebelius*, 567 U.S. 519 (2012)). As a result, 40 states, including Connecticut, have adopted the Medicaid expansion, while 10 states have not.

The federal American Rescue Plan Act (P.L. 117-2 (2021)), § 9814, gave an additional 5% FMAP increase for eight quarters to states that newly granted eligibility to this group.

P.L. 119-21 requires any state that did not expand before March 11, 2021, to do so by January 1, 2026, in order to receive the 5% increase to the federal matching rate, effectively sunsetting this

incentive to expand eligibility (§ 71114). This provision will not directly affect Connecticut, which was among the first states to implement the expansion.

State-Directed Payments in Managed Care Programs

Under existing federal regulations, states that use managed care to deliver Medicaid services have an option to direct payments to providers under certain circumstances ("state-directed payments," 42 C.F.R. § 438.6(c)). States use this option for various purposes, including setting minimum or maximum fee schedules for certain providers, establishing value-based payment arrangements, or making large additional payments to providers (similar to supplemental payments used in fee-for-service Medicaid). (For background information on state-directed payments, see this October 2024 Medicaid and CHIP Payment and Access Commission (MACPAC) Issue Brief and CMS's website).

P.L. 119-21 directs CMS to revise these regulations to limit certain state-directed payments to the Medicare rate (or, for states that do not cover the Medicaid expansion population, 110% of the Medicare rate), rather than the average commercial rate (§ 71116). In September 2025, CMS published preliminary guidance on this provision. In February 2026, that letter was rescinded and CMS published an updated letter.

This provision does not explicitly affect Connecticut's Medicaid program, as the state does not use managed care and therefore does not use state-directed payments. However, the federal Office of Management and Budget rule page for the proposed regulation that would implement this provision states in its abstract that the regulation also "proposes to set a limit for certain targeted Medicaid practitioner payments in Medicaid fee-for-service." The proposed regulation is not yet published.

Provider Taxes

Federal law allows states to provide supplemental Medicaid payments to certain institutional providers (e.g., hospitals). Like other Medicaid payments, these supplemental payments are matched by the federal government at rates that vary by state (i.e. the FMAP, see above). States may also fund these payments through taxes on the same providers, but certain restrictions apply. For example, taxes must be broad-based and uniform (unless a waiver is approved) and taxpayers cannot be held harmless. If requirements for a uniform tax are waived, the tax must be generally redistributive in nature and the tax amount cannot be correlated to Medicaid payments.

Prior law generally limited certain provider taxes to 6% of net patient service revenues. P.L. 119-21 sets new limits on provider taxes, starting for federal FY 27. Among other things, for states that have expanded Medicaid, such as Connecticut, P.L. 119-21 caps the provider tax at the lower of its current rate or a specified rate set in the act that decreases from federal FY 28 to FY 32 (§ 71115).

CMS states (p. 15) "Effectively, this provision prohibits states from increasing the revenue a health care-related tax can generate in almost all instances and generally prohibits states from establishing new provider taxes."

P.L 119-21 also codifies a proposed rule that CMS describes (p. 16) as closing a loophole related to statistical tests used to determine whether a proposed tax is redistributive in nature (§ 71117). The act allows CMS to grant a transition period of up to three years for states to come into compliance with these provisions. In November 2025, CMS published preliminary guidance. In February 2026, the agency published a rule.

The Connecticut Hospital Association and the state are currently subject to a settlement agreement that limits hospital provider taxes and sets requirements for certain other Medicaid payments to hospitals. The agreement's provisions apply through June 30, 2026. OLR Report 2019-R-0330 describes the settlement and the conflict that led to it.

Provisions Starting in 2026

Immigrant Eligibility

Under prior law, many categories of lawful immigrants were eligible for Medicaid, including refugees, asylees, petitioners under the Violence Against Women Act, and others. Starting in federal FY 2027, P.L. 119-21 limits Medicaid and Children's Health Insurance Program (CHIP) eligibility for noncitizens to U.S. residents who are:

1. lawful permanent residents,
2. Cuban-Haitian entrants, or
3. Compact of Free Association migrants (§ 71109).

This section does not affect (1) emergency Medicaid services provided to people regardless of immigration status or (2) optional services states provide to certain lawfully residing children and pregnant women. Nor does it directly affect coverage provided through solely state funded health programs (e.g., State HUSKY in Connecticut), though more people may be eligible for these programs to the extent they are now ineligible for Medicaid.

Reduced FMAP for Emergency Medicaid Services

Federal law sets a formula to establish each state's Federal Medical Assistance Percentage (FMAP), which is the federal government's share of most Medicaid expenditures. Under this formula, the FMAP is higher in states with lower per capita incomes and lower in states with higher per capita

incomes, compared to the national average, but must be at least 50%. Ten states, including Connecticut, had FMAPs set at the federal minimum (50%) for federal FY 25. There are several exceptions to the regular FMAP rate for certain services, costs, or populations. For example, under the federal Affordable Care Act (ACA), states' costs to provide Medicaid services to the Medicaid expansion population (HUSKY D in Connecticut) receive an enhanced FMAP of 90%.

Federal law requires Medicaid programs to cover emergency services for people who would be eligible for Medicaid but for their immigration status (42 U.S.C. § 1396b(v)). Currently, services provided to those who would be eligible for the Medicaid expansion coverage group but for their immigration status are reimbursed at the enhanced FMAP under the ACA. Beginning in federal FY 27, P.L. 119-21 limits the FMAP for emergency services provided to this group to the state's regular FMAP (50% in Connecticut), rather than the enhanced 90% FMAP under the ACA (§ 71110).

Provisions Starting in 2027

Enrollee Address Information

P.L. 119-21 requires CMS to establish a centralized system for states to check whether people are simultaneously enrolled in Medicaid or CHIP in multiple states. States must (1) regularly get Medicaid and CHIP enrollee addresses from specified authorized sources starting in 2027 and (2) report enrollee Social Security numbers to CMS's system monthly starting in 2030. CMS must report to states at least monthly on anyone enrolled in multiple states so that states may take appropriate action (§ 71103). According to guidance from CMS (p. 5), address sources include mail returned by the U.S. Postal Service, the U.S. Postal Services National Change of Address Database, certain managed care entities, and other data sources identified by the state and approved by CMS.

Existing federal law requires states to participate in the Public Assistance Reporting Information System (PARIS) as a condition for receiving Medicaid funds for automated data systems (42 U.S.C. 1396b(r), CMS SMDL #10-009). According to CMS (p. 6), the act's new provision does not eliminate this existing requirement, but, beginning October 1, 2029, CMS may determine that a state is not required to participate in PARIS to comply.

Death Status

P.L. 119-21 requires state Medicaid programs to check the Social Security Administration's (SSA) Death Master File (DMF) to determine whether Medicaid enrollees and providers are deceased (§§ 71104 & 71105). The SSA receives death record information from various sources, including relatives of deceased people, funeral directors, financial institutions, and local, state, and federal

government agencies. SSA uses this information to create its DMF, where it maintains data for deceased individuals (e.g., names, Social Security numbers, dates of birth and death).

A December 2025 report from the U.S. Department of Health and Human Services Office of Inspector General describes millions in payments to managed care organizations (MCOs) on behalf of deceased Medicaid enrollees since 2016. The report found no such payments in Connecticut (which does not use MCOs in its Medicaid program). Among other things, the report recommends CMS work with state Medicaid agencies to ensure this OBBBA provision is properly implemented.

As described by CMS (p. 7), existing regulations require states to check the DMF when enrolling, reenrolling, or revalidating enrollment of a provider in their Medicaid or CHIP program (42 CFR §§ 455.436 & 457.990(b)).

Eligibility Redeterminations

By law, state Medicaid agencies must determine whether applicants are eligible for Medicaid by verifying certain information, including the applicant's income, household size, and age, among other things. Once someone enrolls in Medicaid, the state Medicaid agency must periodically redetermine eligibility to verify that the enrollee remains eligible.

P.L. 119-21 requires states to redetermine eligibility every six months for the Medicaid expansion population (HUSKY D in Connecticut), beginning with the first quarter after December 31, 2026 (§ 71107).

Retroactive Coverage

Prior law required Medicaid coverage to begin retroactively up to three months before an application is filed, so long as the beneficiary would have been eligible for Medicaid when the services were received. Typical examples of cases when retroactive eligibility is used include an uninsured person experiencing a major health event or a person being discharged from a hospital to a long-term care facility when he or she has not yet applied for Medicaid.

Starting in 2027, P.L. 119-21 limits retroactive eligibility to (1) one month before filing for the Medicaid expansion population (HUSKY D in Connecticut) and (2) two months before filing for all other Medicaid enrollees (§ 71112). The act also limits CHIP retroactive coverage to two months before filing.

In practice, many states have already implemented shorter periods for retroactive eligibility for certain populations, using Section 1115 demonstration waivers to waive the three-month

requirement, as described in this 2019 MACPAC issue brief. Connecticut does not have one of these waivers and currently uses the three-month time period.

Work Requirements

Beginning in 2027 (or earlier at the state's option), P.L. 119-21 requires states to require that people in the Medicaid expansion population (HUSKY D in Connecticut) meet certain work or community service requirements (§ 71119). Specifically, the act requires Medicaid expansion enrollees to do one of the following, on a monthly basis:

1. work at least 80 hours,
2. complete at least 80 hours of community service,
3. participate in a work program for at least 80 hours,
4. be enrolled at least half-time in an educational program,
5. engage in any combination of the above activities for 80 hours, or
6. have monthly income equal to at least minimum wage earnings for 80 hours of work.

Medicaid applicants must demonstrate compliance with these requirements for one to three months (as determined by the state) consecutively and immediately before applying for Medicaid benefits. People already enrolled must demonstrate compliance for one month (or more, as determined by the state) during the period between their last eligibility determination and their next scheduled eligibility determination. States must verify compliance when determining or redetermining Medicaid eligibility, or more frequently at the state's option.

The act exempts certain people from these requirements (e.g., people with serious medical conditions and people with dependent children under age 14). It also allows states to provide an exception to people experiencing short-term hardships (e.g., hospitalization).

P.L. 119-21 allows CMS to exempt a state from fully implementing these requirements until December 31, 2028, at a state's request, so long as the state demonstrates good efforts to comply with these requirements and provides a detailed timeline for implementation. According to CMS (pp. 18-20), the agency will award $200 million in grants for federal FY 26 for states to establish systems needed to implement these provisions. CMS issued guidance on this provision on December 8, 2025.

Connecticut does not currently impose work or community service requirements as a condition of Medicaid eligibility and, historically, CMS did not allow states to do so. However, in 2018, CMS published guidance inviting states to apply for waivers to "test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries…"

That year, legislators in Connecticut debated a bill to impose work requirements in Medicaid and the Supplemental Nutrition Assistance Program (SB 270 (2018)). The Human Services Committee held a public hearing but took no further action on the bill.

CMS subsequently approved waivers in several states, but pending litigation or the COVID-19 pandemic prompted most to halt their implementation. In 2021, CMS reversed course again, rescinding its approval for most of these waivers. OLR Report 2023-R-0280 provides more information on 1115 waivers for work requirements during this period.

Budget Neutrality for Medicaid Demonstration Waivers

Section 1115 of the Social Security Act (42 U.S.C. § 1315) allows HHS to waive federal requirements in public assistance programs, including Medicaid, for states seeking to test new approaches while maintaining federal funding.

P.L. 119-21 requires that such demonstration projects be budget neutral, generally conforming to practice (see CMS guidance from 2018). According to CMS (p. 17), the CMS Office of the Actuary does not currently play a role in making this determination. Beginning January 1, 2027, the act prohibits CMS from approving an 1115 waiver or waiver amendment unless the CMS Chief Actuary certifies that the project will not increase federal expenditures (§ 71118).

Connecticut currently has two 1115 waivers: (1) Connecticut Substance Use Disorder Demonstration and (2) Covered Connecticut. The state has also submitted an amendment, currently pending, to the Substance Use Disorder Demonstration to implement a reentry initiative, described in this OLR report.

Provisions Starting in 2028 or Later

Restrictions on Good Faith Waivers for Payment Reductions

Under existing law, CMS must reduce federal Medicaid payments if a state Medicaid program has an eligibility-related error rate over 3%. In certain cases, CMS can waive this penalty if the state is

unable to remedy the high error rate despite a good faith effort. Beginning in federal FY 2030, P.L. 119-21 sets new restrictions on CMS's authority to issue these "good faith" waivers (§ 71106).

Home Equity Limits for Long-Term Care

Applicants for long-term care services under Medicaid must typically have assets below certain amounts. These asset limits exclude certain types of assets, including the person's home, provided that in most cases, the person's home equity does not exceed a limit set by states within federal standards, adjusted annually for inflation. For federal FY 25, home equity limits set by states must be between $730,000 and $1,097,000 and Connecticut set the limit at the maximum allowable.

P.L. 119-21 caps the home equity limit at $1 million, regardless of inflation, beginning in 2028 (§ 71108). According to CMS (p. 9), the limit does not apply to homes on land zoned for agricultural use.

Cost Sharing

Beginning in federal FY 29, P.L. 119-21 requires states to institute cost sharing requirements for people (1) in the Medicaid expansion population (HUSKY D in Connecticut) and (2) with income above 100% of the federal poverty limit ($26,650 per year for a family of three in 2025) (§ 71120). The act limits cost sharing to $35 per item or service and total cost sharing for all people in a family cannot exceed 5% of the family's income. Under the act, states may allow providers to refuse service to those who do not pay.

Under the act, cost sharing requirements do not apply to:

1. services for which cost sharing is already prohibited (e.g., emergency services);
2. primary care, mental health, or substance use disorder services;
3. services provided by federally qualified health centers, certified community behavioral health clinics, or rural health clinics.

Additionally, according to CMS (pp. 20 & 21), existing cost sharing exemptions for American Indians and Alaska Natives are not changed by the act and continue to apply.

While the act's cost sharing requirement for states is new, existing federal law allows states to implement cost sharing and premiums under Medicaid within certain limits, as described in this 2017 MACPAC fact sheet.

Connecticut has not implemented a cost sharing requirement for these Medicaid enrollees. The state has implemented cost sharing requirements in other medical assistance programs (e.g., MedConnect, HUSKY B, and the Connecticut Home Care Program for Elders).

Waivers for Home- and Community-Based Care

Home- and community-based waivers allow states to provide Medicaid long-term care services in a home or community setting rather than an institution. States design their waiver programs and submit them to CMS for approval. These waivers are also called "1915(c)" waivers because they are authorized under section 1915(c) of the federal Social Security Act. They generally allow states to waive certain Medicaid requirements including, for example, placing limits (or caps) on the number of people enrolled under the waiver. Certain requirements apply, including that people enrolled through the waiver meet an institutional level of care requirement, meaning that without the services, they would require institutional care in a facility (e.g., a nursing home).

P.L. 119-21 creates a new waiver option for states, beginning July 1, 2028, that allows them to provide home- and community-based services without an institutional level of care determination (§ 71121). As described by CMS (pp. 21 & 22), the act sets conditions for approval, including that the waiver will not delay services for people who meet institutional level of care requirements under other existing 1915(c) waivers.

Connecticut currently has several 1915(c) waivers that provide home- and community-based services to various populations, including people with Autism Spectrum Disorder and developmental disabilities.

Resources

CMS, "Section 71115 and 71117 of Working Families Tax Cuts Legislation on Provider Taxes," November 14, 2025.

CMS, "Section 71116 of Working Families Tax Cuts Legislation on State Directed Payments," February 2, 2026.

CMS, "'Working Families Tax Cut' Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions," November 18, 2025.

National Association of Medicaid Directors, "OBBBA Medicaid Policy Timeline," August 12, 2025.

Office of the State Comptroller, “Special Examination on H.R. 1: One Big Beautiful Bill Act,” July 2025.

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