ISSUE BRIEF

Implications of Key Medicaid Provisions from the One Big Beautiful Bill Act (OBBBA) on Reentry, Health, and Public Safety

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November 2025

HARP
THE HEALTH AND REENTRY PROJECT

INTRODUCTION

On July 4, 2025, Congress enacted the One Big Beautiful Bill Act (OBBBA), a far-reaching set of changes that extends tax reductions, increases spending in areas such as immigration enforcement and defense, and substantially reduces federal funding for Medicaid and other safety net programs through specific new policy changes. The Medicaid changes, which were estimated by the Congressional Budget Office (CBO) as reducing net projected federal Medicaid and CHIP spending by $910 billion over the next decade, are significant and will have consequences for many people, organizations, and stakeholders.[1] This includes those who are implementing or affected by policies that advance continuity of care for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries who are leaving prison and jail across the country. This paper describes key aspects of the new law and assesses their implications for expanding access to health care at reentry.

KEY TERMS

For definitions of key terms used in this paper, please consult "Key Terms and Acronyms — Health and Reentry," a product HARP co-authored with The National Academy for State Health Policy (NASHP). It defines key terms and acronyms from both the corrections and health and human services sectors that are relevant to Medicaid reentry policies. Examples of terminology that may be useful include: State Medicaid Agency (SMA), Centers for Medicare and Medicaid Services (CMS), Medicaid Section 1115 Demonstration Waiver, and CHIP among others.

BACKGROUND: MEDICAID'S ROLE IN STRENGTHENING REENTRY AND PUBLIC SAFETY

HEALTH NEEDS AT THE POINT OF REENTRY

Every year, there are more than seven million releases of people from jails and nearly half a million releases of people from prisons.[2] Individuals returning to their communities from incarceration often experience significant health, and particularly behavioral health, needs high rates of mental illness, substance use disorders, and chronic conditions. The reentry period is also often marked by multiple forms of instability—gaps in housing, employment, food, and transportation—that can complicate and compound challenges in securing access to health care. People returning from incarceration are 12 times more likely to die in the first two weeks after release, and 120 times more likely to die of an overdose.[3] Timely access to Medicaid coverage and care upon release is critical. Poor health outcomes at reentry, such as overdoses or untreated conditions, are closely tied to diminished public safety and higher recidivism. A large majority of incarcerated individuals will eventually return to their communities, and public safety improves when they are supported to be healthy and prepared for successful reentry.[4]

Medicaid, which provides health care coverage for approximately 71 million Americans, is an important reentry tool to connect individuals returning to the community from incarceration with care. Jointly funded and administered by the federal government and states, Medicaid is also the nation's largest payer for both mental health and substance use disorder services. Having coverage through Medicaid is associated with reduced recidivism and criminal justice involvement.[5]

Recent Medicaid policy changes aim to build a bridge at reentry that strengthens access to and continuity of services at reentry, reducing the likelihood that people fall into gaps in care at release that are linked to poor health outcomes, including mortality, and repeat justice involvement. The specific changes being made require suspension, rather than termination, of Medicaid coverage during incarceration, authorize limited pre-release services through Medicaid Section 1115 demonstration waivers, and provide coverage of select services for youth and young adults returning to communities (*see Recent Medicaid Reforms text box*). Many of these changes also apply to CHIP.

These changes have been advanced on a bipartisan basis at the federal, state, and local levels. Many sheriffs and correctional administrators have joined with their health agency counterparts to advocate for and implement these changes. Their interest has been motivated by both health and safety concerns: improving continuity of care before and after release can reduce the risk of relapse, overdose, hospitalization, and future criminal justice involvement. In addition, Medicaid coverage and financing for targeted pre-release services brings some additional targeted resources to bear on correctional health services. This has historically been a sole responsibility of state and local governments, although jails and prisons were not originally designed, equipped, or intended to serve primarily as health care facilities.

RECENT MEDICAID REENTRY REFORMS

Beginning with the passage of the bipartisan SUPPORT Act in 2018, a series of new policies enacted by federal and state policymakers to expand Medicaid and CHIP coverage in the period before reentry are, for the first time, providing opportunities for people to return to communities with better connections to necessary services. Some of these changes amend longstanding provisions of federal law that over Medicaid's 60 year history prohibited Medicaid from covering services when beneficiaries were incarcerated. Reforms include:

- **Medicaid Section 1115 Reentry Demonstration Waivers** are carried out under an authority through which states can depart from certain areas of federal Medicaid law, subject to the federal Centers for Medicare and Medicaid Services' (CMS) approval. Under reentry waivers, Medicaid can cover targeted pre-release services (including case management, medication assisted treatment and a supply of prescription medications upon release) for incarcerated individuals who are Medicaid beneficiaries. The coverage period, eligible populations, and other specifics of the reentry waivers vary by state. Currently, 19 states have approved waivers and eight other states and the District of Columbia have waiver proposals pending CMS' approval. The bipartisan SUPPORT Act of 2018 required CMS to issue guidance establishing the reentry waiver opportunity.
- **Youth and Young Adult Continuity of Care Policies**, which took effect nationwide this year, require states to use Medicaid to cover a narrow set of health care services before and after release and are designed to support successful reentry. These services are screenings, diagnostic care, and targeted case management. The provisions apply to a specific group of Medicaid and CHIP beneficiaries: post-adjudicated youth who are under age 21 or former foster youth up to age 26. These policies were authorized by Section 5121 of the Consolidated Appropriations Act of 2023, which also established a state option (Section 5122) to cover certain services for eligible juveniles in custody awaiting disposition of charges.[6] For more information, see HARP's issue brief on continuity of care for youth and young adults.
- **New National Policies to Suspend Medicaid Coverage,** which will take effect on January 1, 2026, require that state Medicaid programs suspend, rather than terminate, Medicaid (and CHIP) enrollment of adults over 21 during incarceration to ensure faster reactivation and improved continuity of care upon release. This provision builds on an existing requirement (also dating back to the SUPPORT Act) that states suspend, not terminate, Medicaid coverage for youth and young adults.
- **State Continuity of Care Planning Grants**, which are intended to help states develop systems and capabilities (e.g., enrollment coordination, data sharing, and system upgrades) to support incarcerated individuals' continuity of care, were awarded earlier this year. In early 2025, CMS awarded $106.5 million in grants, ranging from $1.2 million to $4.6 million per state, to 28 states.[7]

MAJOR MEDICAID PROVISIONS OF OBBBA AND THEIR IMPLICATIONS

State and local leaders who are building continuity of care at reentry will need to be active partners in navigating the significant changes that OBBBA makes to Medicaid and CHIP, many of which take effect in 2027. Additionally, the law changes certain tools that states currently use to raise revenue that supports their share of Medicaid spending.

OBBBA AND REENTRY

OBBBA does not directly alter recent policies linking Medicaid and CHIP to reentry and continuity of care. However, the law makes broad changes to Medicaid eligibility that will affect many Medicaid beneficiaries, including beneficiaries who stand to benefit from improved continuity of care as they leave correctional facilities.

SIGNIFICANT NEW ELIGIBILITY CHANGES

OBBBA makes several significant changes to longstanding Medicaid eligibility rules. These changes are expected to reduce the number of people with Medicaid coverage over time. The CBO estimated that as a result of the Medicaid provisions of OBBBA the number of uninsured will increase by 7.5 million by 2034.[8] This means that over time fewer people in the community, as well as people who are in prisons and jails, will have Medicaid coverage. In addition, because having health care coverage is associated with greater access to health care services, more people going without Medicaid coverage could increase the number of people who enter prison or jail with unaddressed health and behavioral health conditions.

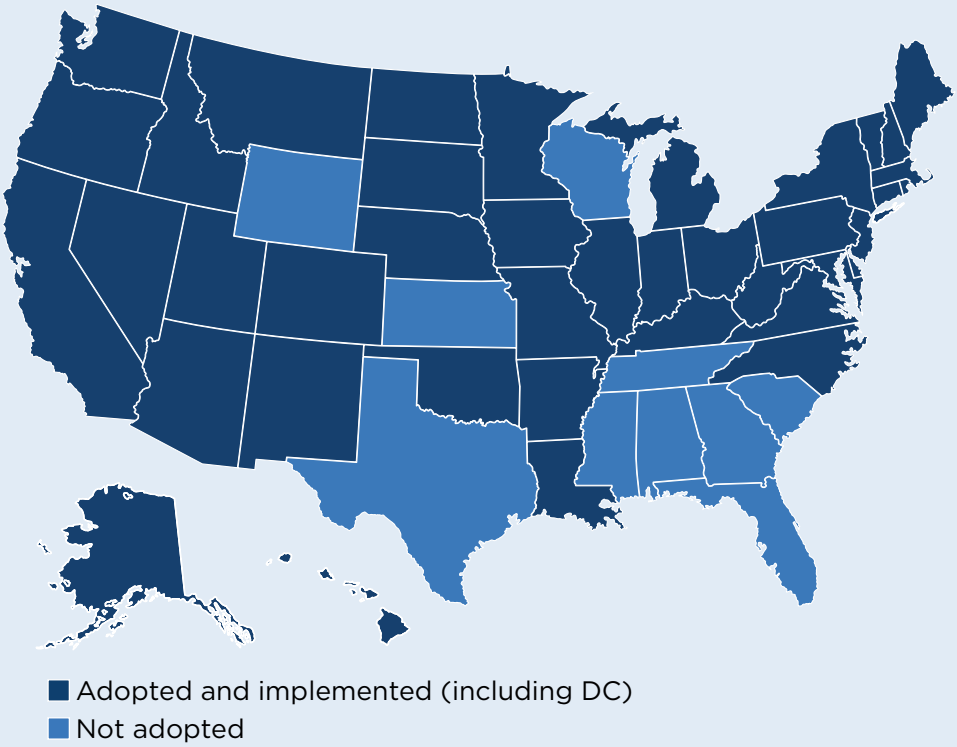
Two of the most significant provisions contained in the new law condition Medicaid eligibility on meeting new requirements that some beneficiaries work or engage in work-like activities (which the law terms “community engagement requirements” but are also colloquially referred to as “work requirements”) and requirements that will increase the frequency of Medicaid eligibility redeterminations to every six months for certain individuals.

These two changes apply only to the population of adults who qualify for Medicaid expansion, which was established by the Affordable Care Act and extended Medicaid coverage to adults with incomes below 138 percent of the poverty level.[9, 10]

BACKGROUND: WHAT IS MEDICAID EXPANSION?

Under the Affordable Care Act (ACA), Medicaid expansion allows states to extend health coverage to all adults with incomes up to 138% of the Federal Poverty Level, with the federal government paying a larger share of cost, compared to non-expansion beneficiaries. 138% of the FPL for a single adult without children is approximately $21,600 annually. Medicaid expansion significantly increased the overlap between the incarcerated population and the population eligible for Medicaid. Estimates are that in Medicaid expansion states, 80 to 90 percent of incarcerated adults are Medicaid-eligible, compared to an estimated 2% in non-expansion states.

As of this year, 41 states and DC have taken up Medicaid expansion.[11] Ten states have not adopted Medicaid expansion. Notably, the community engagement requirements and more frequent renewals apply only to the expansion population in those states, as well as to enrollees in the waiver programs in Georgia and Wisconsin, which currently provide coverage to a limited subset of the Medicaid expansion population.[12] Likewise, other Medicaid provisions in OBBBA make distinctions between requirements for expansion beneficiaries versus beneficiaries who are eligible through other Medicaid pathways (primarily children, seniors, people with disabilities, and some low-income parents.)



COMMUNITY ENGAGEMENT REQUIREMENTS

New policy: conditioning Medicaid expansion eligibility on work, education, and/or community participation activities. Historically, Medicaid eligibility for most beneficiaries, including the expansion population, has been based on income, household size, residency, and other select factors. An individual's eligibility for Medicaid coverage has not been conditioned upon that individual being employed or engaging in work-like activities. OBBBA changes this for Medicaid expansion beneficiaries by establishing national "community engagement" requirements as a condition of Medicaid eligibility.

Beginning on January 1, 2027, adults covered through Medicaid expansion between the ages of 19 and 64 must demonstrate at least 80 hours per month of qualifying community engagement activities in order to successfully obtain and keep Medicaid coverage. Qualifying activities include employment, community service, participation in a work program, or enrollment in education at least half-time. Alternatively, individuals may satisfy the requirement by earning at least the equivalent of 80 hours at the federal minimum wage (currently $580/month), with seasonal workers allowed to average income over six months.

The community engagement requirements pertain when someone applies for coverage and at renewal — and states can choose to verify compliance with the requirements more often. When a person who is eligible under Medicaid expansion applies for Medicaid coverage, he or she will be expected to have met the community engagement requirement for at least one month (or up to three consecutive months, at the option of the state) prior to enrollment. Additionally, once someone obtains Medicaid coverage, states must verify compliance with the community engagement requirement at least every six months, and may choose to do so as often as every month. States may choose to begin implementing community engagement requirements sooner than the January 1, 2027 deadline.

Certain people, including those who are incarcerated and recently released, will be exempt. Importantly, certain groups of Medicaid beneficiaries are exempt from the new requirements. The new law creates exemptions for:

- Individuals who are incarcerated or who were released from incarceration within the past three months;
- Medically frail beneficiaries, including those with disabling mental health conditions or substance use disorders;
- Participants in drug or alcohol treatment programs;
- People under 19 and over 64;
- Pregnant and postpartum individuals;
- Parents or caregivers of dependents with disabilities or children under age 13;
- Those already meeting requirements in other public assistance programs (e.g., Supplemental Nutrition Assistance Program (SNAP)/Temporary Assistance for Needy Families (TANF));
- Veterans with significant disabilities; and
- Native Americans.

In implementing these new requirements, the law requires states to use data matching processes (which in Medicaid are referred to as "ex parte") to verify compliance or exemptions where possible. Currently, states match data using a variety of data sources, such as quarterly wage databases, tax records, unemployment records, and SNAP and TANF programs, to verify eligibility. Once community engagement requirements take effect, it will be important for states to proactively match correctional data with Medicaid data to automate implementation of the correctional exemption to the greatest extent possible. This will reduce administrative burdens on correctional facilities, Medicaid agencies and beneficiaries.

Federal and state planning for implementation of these new requirements is already underway. OBBBA requires CMS to issue an interim final rule (IFR) giving states direction on implementation of these new requirements by June 1, 2026. CMS also plans to issue guidance in advance of this rulemaking process.[13] Through the IFR or other guidance, CMS is expected to provide additional information on what constitutes qualifying activities, exemption definitions, and verification processes, all of which will inform states' efforts to operationalize the community engagement requirements. Even as federal guidance is being developed, states are beginning to plan key components of implementation, including determining the information technology and data sharing systems required to collect and transmit information, process applications and exemptions, and verify compliance with the new requirements. HHS also has discretion to give states more time to implement the new requirements, up to December 31, 2028, if it determines that a state is demonstrating a good faith effort to comply with the community engagement requirements.

Historically, community engagement requirements have led to fewer people being covered. The limited history of Medicaid work requirements makes it difficult to project with precision the impact that the new national community engagement policies will have on Medicaid coverage. Although most Medicaid beneficiaries are already working, some face barriers to employment such as illness, retirement, or child care responsibilities that make it difficult for them to work or participate in work-like activities.[14] The actual coverage impacts will play out differently across states, because states will make different implementation decisions and have different policy and operational contexts. The number of people who retain or lose coverage when the community engagement requirements take effect will be a result not just of who is participating in the required activities, but of how effective states are at identifying which people must meet these new requirements, which people are meeting them, and who is exempt from them — among other factors. It will also depend on how well people applying for or renewing Medicaid coverage understand these new policies so that they can comply with them.

Over the last several years, two states (Arkansas and Georgia) have implemented similar requirements to varying and limited degrees, using Medicaid 1115 demonstration waivers. While Arkansas' approach was in place for a short time, thousands of people lost health coverage, including some people who were in compliance or should have been exempt. These coverage losses were primarily due to challenges in reporting work status or documenting eligibility for an exemption. This loss of coverage was associated with care delays, medication lapses, and medical debt for many individuals.[15] New Hampshire planned to implement work requirements, but paused implementation when large numbers of people did not meet requirements and were at risk of losing coverage.[16] Georgia, which implemented work

requirements as part of a modest expansion of Medicaid, has experienced high bureaucratic complexity and administrative costs, with relatively small gains in enrollment.[17] Based in part on the limited experience of these states, the CBO, the nonpartisan federal agency charged with estimating the impact of federal legislation, estimated that community engagement requirements in OBBBA will lead to 5.3 million fewer Medicaid enrollees by 2034, comprising the largest share of Medicaid coverage reductions.[18] CBO does not expect that Medicaid community engagement requirements will meaningfully result in an increase in employment.[19]

Implementation of community engagement requirements is likely to be challenging for states, despite some federal implementation support. Implementing new community engagement requirements poses multiple overlapping issues for states to address, including: developing new policies and procedures; training and hiring staff; educating beneficiaries and providers about new requirements; updating IT and data systems to verify individuals' eligibility, community engagement compliance, or exemption status; and making choices about whether to take up state options like frequency of verifying compliance.

Determining compliance with (or exemption from) the new requirements requires linking real-time data across systems that verify income, employment, Medicaid eligibility, and involvement in other systems, including corrections. Ensuring that IT systems are linked and operate in a way that automates as much of the process as possible, while also making sure people are not inadvertently falling through the cracks, takes a high level of coordination, adequate staffing, and technology. Currently, state eligibility systems have mixed performance when it comes to automating eligibility determinations and renewals.[20]

Interfacing with correctional systems could pose a challenge because of the wide variation across jurisdictions in the structure and functionality of IT systems, with many jurisdictions, like many state Medicaid programs utilizing legacy manual systems. However, new requirements that states suspend rather than terminate eligibility for incarcerated Medicaid beneficiaries could be leveraged to operationalize the correctional exemption. For example, when a state suspends a person's Medicaid coverage upon incarceration, it could also activate the correctional exemption. When a person is released, along with reinstating coverage, the state could begin activation of the three-month post release exemption period.

Implementation of community engagement requirements will occur at a time that some states face budgetary constraints. OBBBA provides $200 million to states and $200 million in fiscal year 2026 to HHS for implementation of these new requirements. Within the Medicaid context, this is a significant federal investment in implementation support. Additionally, federal matching funds will be available to support systems implementation. However, anecdotal context from recent state experiences suggests that implementation will be costly for states and that even these federal resources may not be sufficient to cover those costs. The Government Accountability Office (GAO) found that Georgia spent $54.2 million on administrative costs of implementing its work requirement between 2021 and the first quarter of 2025.[21] In a separate 2019 analysis, five states provided GAO with their estimates for the administrative cost of implementing a work requirement, and those estimates ranged from $10 million to more than $250 million per state.[22] OBBBA provides additional implementation resources for other provisions of the new law, but does not provide specific resources for states to put in place services such as work supports that can help people meet new requirements.

Potential implications for reentry and public safety. Medicaid plays several roles in supporting public safety. As the largest payer of behavioral health services, Medicaid undergirds the community-based mental health and substance use treatment infrastructure that is often critical to keeping people out of prison and jail. Reduced enrollment in Medicaid will diminish access to these and other services. Opportunities to bolster deflection and diversion efforts, such as crisis response, could be diminished, placing additional strain on local law enforcement as well as state budgets.

For people leaving incarceration, coverage instability is especially risky because people often face complex health care needs and significant barriers to access to care, making continuity of coverage particularly critical for successful reentry. While the exemption from community engagement requirements for those who were recently incarcerated offers an important acknowledgement of the need for continuity of care, it is time-limited: lasting three months post-release, after which individuals must demonstrate community engagement activity or eligibility for a different exemption. However, individuals returning to the community often face limited opportunities and additional barriers to employment that last beyond three months, exceeding the exemption period and risking loss of essential benefits. For example, one study from North Carolina found that fewer than 40% of people released from state prison were able to find work within a full year of their release.[23]

REDUCED MEDICAID COVERAGE: IMPLICATIONS FOR CORRECTIONS

Reduced Medicaid coverage overall will reduce the number of people entering correctional settings with active Medicaid coverage, meaning prisons and jails may face increased costs for things like inpatient hospitalizations When a person is incarcerated, Medicaid can pay for the cost of inpatient hospitalization if a person who is incarcerated requires a hospital stay of more than 24 hours. This has historically been a significant source of health care financing to prisons and jails.[24] In addition, correctional settings may experience increased administrative responsibilities by, for example, having to facilitate more and more frequent eligibility determinations for incarcerated populations.

MORE FREQUENT ELIGIBILITY RENEWALS

New policy: people will have to demonstrate their eligibility for Medicaid twice a year, instead of once a year. Beginning on January 1, 2027, OBBBA requires state Medicaid programs to move from conducting annual eligibility renewals for expansion adults to conducting them at least every six months. States may terminate coverage if individuals do not verify eligibility during renewal, regardless of whether their underlying circumstances have changed.

PROJECTED IMPACT

The CBO estimates that this policy will increase the number of uninsured by 700,000 by 2034.[25] Experience from earlier redetermination changes shows that many coverage losses stem not from ineligibility but from procedural failures: lost mail, unsubmitted forms, or inability to produce timely documentation. These are referred to as "procedural disenrollments." As with community engagement requirements, the policy change is likely to add capacity demands to states (who will need to handle the workload associated with processing redeterminations for expansion adults more frequently) and will increase the frequency with which individuals must undertake the process of coverage renewal. Increased renewals will likely amplify "churn"—short periods of disenrollment on the part of people who remain eligible followed by reenrollment—which disrupts care continuity for individuals and can increase costs and administrative burden for entities that serve Medicaid beneficiaries.[26]

Potential implications for reentry and public safety. People leaving incarceration are vulnerable to procedural disenrollment. This can be for several reasons. Unstable addresses increase the likelihood that renewal notices will be missed and the lack of consistent phone or internet access makes it harder to respond to renewal requirements. Maintaining health coverage is only one of multiple high priority needs for individuals newly released from custody, alongside securing stable housing and employment, amongst other needs. Renewing coverage more frequently will make it harder for people who are working to meet these other needs to maintain coverage, creating coverage lapses among some people who would but for completing renewal paperwork remain eligible for Medicaid.

OTHER ELIGIBILITY AND COST-SHARING CHANGES

OBBBA also includes several additional changes that affect Medicaid eligibility, and may have implications for corrections and people returning to communities. These include:

- **Address verification and documentation to prevent duplicate enrollment.** Beginning in 2027, states must regularly obtain enrollees' address information for verification purposes. Many people returning from incarceration move frequently, live temporarily with relatives, experience homelessness, or do not have permanent addresses for other reasons. These circumstances heighten the likelihood of incorrect addresses being flagged. If an incorrect address is used for renewals when a state is unable to reach the beneficiary, it could potentially trigger disenrollment. In 2029, states will need to begin submitting monthly enrollee data—including Social Security numbers, addresses, and other identifiers—to federal systems, with the goal of reducing duplicate enrollment across state lines.
- **Retroactive coverage period shortened.** Today, Medicaid allows a "look back" period of 90 days to retroactively cover medical expenses incurred in the three months prior to a person's Medicaid enrollment. OBBBA shortens that period to 30 days for adults covered by Medicaid expansion, and 60 days for other beneficiaries. For someone with immediate health needs whose Medicaid application takes more than 30 (or 60) days to process, Medicaid will not be able to cover services delivered prior to the 30 (or 60) day retroactive period.

- **New cost-sharing requirements.** Historically, Medicaid limited the amount that beneficiaries must pay in co-pays and other costs to obtain services. OBBBA requires cost-sharing of up to $35 per item or service for Medicaid expansion adults with incomes between 100%–138% of the federal poverty level starting in October 2028. Primary care, mental health, substance use disorder services, and services furnished by federally qualified health centers are exempt from the new cost-sharing requirements. States can allow providers to require payment of any cost sharing prior to providing services, potentially leading to denial of services in instances where an individual is unable to pay.[27] Denying services for nonpayment has historically been prohibited in Medicaid, which serves a low-income population.
- **Immigrant eligibility restrictions.** Historically, lawfully present immigrants have been able to obtain Medicaid coverage five years after obtaining qualified status, with certain exceptions allowing coverage sooner. OBBBA would eliminate eligibility for coverage for some lawfully present immigrants, including refugees, those seeking asylum, and victims of domestic violence and sex trafficking even after the five-year waiting period.
- **Moratorium on CMS enrollment simplifications.** OBBBA delays implementation for ten years of certain provisions in eligibility rules promulgated in 2024 that streamlined Medicaid application and renewal policies. Some provisions in the rules, including those that had already taken effect, were excluded from the implementation delay.

OTHER RELEVANT MEDICAID CHANGES UNDER OBBBA

OBBBA also makes other major Medicaid changes, including how states may finance their portion of Medicaid spending. While these changes do not directly address policies affecting continuity of care for people who are incarcerated, they are still important to be aware of. One set of changes limits state use of provider taxes, which are taxes on health care providers that many states use to finance part of their share of Medicaid. Medicaid is financed jointly by the states and federal government with the federal government matching state spending at a rate that varies by state, and by some populations and services. OBBBA phases down allowable tax thresholds in Medicaid expansion states and bars new provider taxes and prohibits increases in existing provider tax rates in all states.[28] A separate set of changes affects state directed payments, which are supplemental payments that managed care plans make to some types of providers to provide rate increases or advance specific Medicaid goals.[29] The law sets specific upper limits on state directed payments for expansion and non-expansion states.[30]

State Medicaid programs, governors, and state legislatures will make decisions about how to address these complex financing changes starting this year, at a time when some states may face additional budgetary constraints. About half the states are projecting lower general fund spending in recommended budgets for 2026 compared to 2025, although state fiscal circumstances vary state to state.[31] In addition, states will be facing fiscal effects from other provisions of OBBBA, such as new requirements that states finance part of the Supplemental Nutrition Assistance Program[32]. In most states, Medicaid is both the largest source of federal funding and one of the largest state expenditures, which means that overall budget pressures, as well as the new Medicaid financing changes, may prompt additional budgetary changes to Medicaid. Such changes could include provider rate reductions or reductions in benefits, and could have ripple effects for other parts of state budgets, including correctional and public safety budgets.

An additional financing change is relevant to states, especially those that have Medicaid 1115 demonstration waivers, as the vast majority of states do. OBBBA codifies into law the longstanding policy requirement that all Medicaid Section 1115 demonstration waivers, including but not limited to reentry waivers, be "budget neutral," meaning a state may not spend more federal resources than it would have in the absence of a waiver. It requires federal actuaries at the Centers for Medicare & Medicaid Services certify that a waiver meets this requirement, which establishes a significant new and rigorous federal budget neutrality review process as a condition of waiver approval.

IMPLEMENTATION TIMELINE

Policy	Step	Deadline	Section of the Law
Community Engagement Requirements	CMS to release interim final rule	June 1, 2026	Section 71119
Community Engagement Requirements	States to begin implementation	January 1, 2027	Section 71119
Eligibility Redeterminations	CMS to finalize regulatory guidance	End of 2025 (no later than 180 days after date of enactment)	Section 71107
Eligibility Redeterminations	States to begin implementation	January 1, 2027	Section 71107
Address Verification	States to set up process to regularly obtain address information for all individuals enrolled in Medicaid	January 1, 2027	Section 71103
Address Verification	States to abide by information submission requirement	October 1, 2029	Section 71103
Retroactive Coverage	States to begin implementation	January 1, 2027	Section 71112
Cost-Sharing Requirements	States to begin implementation	October 1, 2028	Section 71120
Immigrant Eligibility	States to begin implementation	October 1, 2026	Section 71109
Moratorium on CMS Enrollment Simplifications	States to begin implementation	July 4, 2025 (date of enactment)	Sections 71101 and 71102
Provider Taxes	Prohibition on new or increased taxes	July 4, 2025 (date of enactment)	Section 71115
Provider Taxes	Phasedown of safe harbor threshold	October 1, 2027	Section 71115
State Directed Payments	States to begin implementation	July 4, 2025 (date of enactment)	Section 71116
State Directed Payments	Phasedown of grandfathered payments	October 1, 2028	Section 71116
Codification of Budget Neutrality in Section 1115 Waivers	Effective	January 1, 2027	Section 71118

CONCLUSION

OBBBA's changes to Medicaid are estimated to reduce net federal spending on Medicaid by $910 billion over the next decade, the largest federal funding reduction that Congress has made to Medicaid. The legislation leaves intact recent policy gains linking Medicaid to reentry. However, significant new eligibility changes affect beneficiaries who are enrolled through Medicaid expansion, which could have implications for implementation of Medicaid reentry policies. In particular, requirements that condition Medicaid eligibility on community engagement and require more frequent coverage renewals and regular address verification have been projected to reduce the number of people who have Medicaid coverage over the next decade. They will also increase administrative complexity. This complexity is a challenge for state Medicaid programs to tackle as they implement these unprecedented new policies.

Medicaid agencies, corrections and public safety agencies that are working to strengthen continuity of care at reentry have an opportunity to continue to advance these policies as they operationalize OBBBA's exemption from community engagement requirements that applies when Medicaid beneficiaries are incarcerated and in the immediate post-release period, as well as broader exemptions. Continuing to strengthen data sharing across corrections and Medicaid will be key to implementing these exemptions. Additionally, strengthening opportunities to connect people to employment and other community engagement activities as they return can help people maintain Medicaid eligibility, minimizing gaps in coverage and facilitating continuity in health and behavioral health care. Strong partnerships between Medicaid agencies and correctional partners that prioritize continued progress ensuring access to care at release as an overall OBBBA implementation priority will be key to achieving continuity of care as these new policies are implemented.

CONNECT WITH HARP

HARP will provide additional analysis and technical assistance to states as implementation of the community engagement requirements, among others, continue to rapidly progress. To stay informed, we invite you to join our email list, follow us on LinkedIn, and visit our website for the latest updates and insights.

ENDNOTES

1. Congressional Budget Office (2025). *Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline*. Congressional Budget Office. https://www.cbo.gov/publication/61570
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   Volger, J. (2020). *Access to healthcare and Criminal Behavior: Evidence from the ACA Medicaid Expansions*. Journal of Policy Analysis and Management. https://onlinelibrary.wiley.com/doi/abs/10.1002/pam.22239.
6. In implementation guidance, CMS interpreted the requirement for pre-release service provision as applying subject to a state determination of feasibility. It also stated that federal requirements can be met by facilities that provide the necessary services but do not bill Medicaid.

   Centers for Medicare and Medicaid Services. (2024). *SHO #24-006, Provision of Medicaid and CHIP Services to Incarcerated Youth - FAQs.* Centers for Medicare and Medicaid Services. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24006.pdf
7. Centers for Medicare and Medicaid Services. (2022). *State Planning Grants to Promote Continuity of Care for Medicaid & CHIP Beneficiaries Following Incarceration.* Centers for Medicare and Medicaid Services. https://www.medicaid.gov/medicaid/benefits/reentry-services-for-incarcerated-individuals/state-planning-grants-promote-continuity-of-care-for-medicaid-chip-beneficiaries-following-incarceration#

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   The CBO estimate of the total coverage loss in the law is 10 million individuals, and that the remaining 2.5 million individual coverage loss is attributable to changes the law made to Marketplace coverage.

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