799 9th St. NW
Suite 210
Washington, D.C. 20001

T (202) 354-2600
vizientinc.com

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Vizient Office of Public Policy and Government Relations

Summary: One Big Beautiful Bill

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NOTE: *This is an updated Summary Based on the CBO Score Released on July 21, 2025*

On July 4, 2025, President Trump signed the *One Big Beautiful Bill*[1] *(OBBB)* into law. The OBBB extends the tax cuts from the 2017 *Tax Cuts and Jobs Act*, which were set to expire at the end of 2025. However, as a way to help offset some of the cost of these extensions, the law includes an estimated $1.06 trillion in healthcare spending cuts over the next decade. The bulk of these cuts are to the Medicaid program via policy changes outlined below, including to the provider tax safe harbor, caps on state directed payments, enhanced eligibility requirements and work requirements for able-bodied adults, among other changes. Further, the Congressional Budget Office (CBO) estimates that by 2034, approximately 10 million Americans will have lost health coverage. Below is a summary of several of the provisions that will have an impact on hospitals and health systems.

Medicaid Eligibility Changes

- Requires states to implement community engagement/work requirements as a condition of Medicaid eligibility for able-bodied working adults (between the ages of 19-64). Enrollees would be required to report at least 80 hours of work or work-related activity per month, with the look-back period for demonstrating compliance capped at 3 months. Individuals exempted include parents and caregivers with dependent children 13 and younger, pregnant and postpartum women, the elderly and people with disabilities. States are allowed to define optional "short- term hardship" exemptions, and there is an additional "short-term hardship" exemption for individuals needing to travel for extended periods to seek care not available in their communities.
  - **Effective December 31, 2026** – though, states are allowed to delay implementation of work requirements for up to two years (through December 31, 2028) if they obtain approval from the Secretary of HHS and demonstrate a good faith effort to come into compliance. Alternatively, states can implement work requirements earlier than January 1, 2027. **(CBO estimates this will save $325.6B)**
- States must redetermine Medicaid eligibility every six months (as opposed to annually) for ACA expansion adults (certain individuals are exempted). The Secretary of HHS must publish guidance related to the implementation of this requirement by December 31, 2025. **(effective January 1, 2027; estimated to save $62.5B)**
- All 50 states and the District of Columbia are required to take action to prevent individuals from being simultaneously enrolled in Medicaid and CHIP programs in multiple states. States will be required to disenroll individuals who no longer reside in the state, unless an exception applies.
  - States must establish a process for regularly obtaining enrollees' address information. **(effective January 1, 2027)**
  - States must begin submitting enrollee data monthly to a new federal system designed to detect and prevent duplicate enrollment. **(effective October 1, 2029; estimated to save $17.4B)**
- Restricts the definition of "qualified" immigrant to include lawful permanent residents (LPRs), certain immigrants with Cuban or Haitian entrant status, citizens of the Freely Associated States (COFA migrants) lawfully residing in the U.S. and lawfully residing children and pregnant adults in states that cover them. **(effective October 1, 2026; estimated to save $6.2B)**

[1] The final legislative text includes the official title of "An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14" but the law is commonly referred to as the *One Big Beautiful Bill*.

Medicaid Financing Changes

- Freezes provider taxes at the levels in effect prior to May 1, 2025 and prohibits the adoption of new provider taxes. In ACA expansion states, the safe harbor threshold will be reduced by 0.5% each year for five years beginning **October 1, 2027** – from 6% to 3.5%. Nursing facility services and intermediate care facilities are exempt from these reductions. **(estimated to save $191.1B)**
  - Additionally, the law limits states' ability to obtain waivers for tax structures that would impose varying rates on providers within the same, specified class. **(effective upon enactment, with a transition period of up to three years as determined by the Secretary of HHS; estimated to save $34.6B)**
- State directed payments (SDPs) will have a maximum of 100 percent of Medicare rates for Medicaid expansion states and 110 percent for non-expansion states. Certain payments will be grandfathered: those that received written approval from the Secretary of HHS before May 1, 2025, or made a "good faith effort" to receive such approval; rural hospital payments occurring within 180 days of enactment that received written approval from the Secretary of HHS or made a good faith effort; and states that submitted a completed preprint to the Secretary prior to the date of enactment. "Rural hospital" is defined to include: hospitals located in or treated as being located in a rural area; hospitals located in a rural census tract of a metropolitan statistical area; critical access hospitals; sole community hospitals; Medicare-dependent, small rural hospitals; low-volume hospitals; and rural emergency hospitals. Grandfathered SDPs will decrease by ten percent each year, beginning on January 1, 2028, until the allowable maximum is reached. **(estimated to save $149.4B)**
- Prohibits states from receiving any more than their traditional FMAP for emergency medical care furnished to undocumented immigrants. **(effective October 1, 2026; estimated to save $28.2B)**
- Sunsets an incentive from the American Rescue Plan Act to encourage non-expansion states to expand Medicaid. **(effective January 1, 2026; estimated to save $13.6B)**
- Increased penalties on states for excessive, erroneous payments under Medicaid, specifically where insufficient information is available to confirm eligibility, as well as limiting the HHS Secretary's authority to grant "good faith" waivers. **(effective FY 2030; estimated to save $7.6B)**
- Requires cost sharing for Medicaid expansion beneficiaries earning over 100 percent of the federal poverty level, not to exceed $35 per service with a cap on out-of-pocket expenses of 5% of a family's income. Exceptions to this requirement include primary care services; mental health services; substance use disorder services; services provided at federally qualified health centers, certified community behavioral health clinics or rural health clinics; or most services currently exempted from cost sharing under statute. **(effective October 1, 2028; estimated to save $7.4B)**
- Limits retroactive coverage for non-expansion Medicaid beneficiaries from three months to two months and the ACA expansion population from three months to one month. **(effective January 1, 2027; estimated to save $4.2B)**
- Requires all 1115 demonstration projects to be budget neutral, including renewals. **(effective January 1, 2027; estimated to save $3.2B)**

Medicare Changes

- Limits Medicare eligibility for non-citizens to lawful permanent residents and certain individuals from Cuba and Haiti; and COFA migrants lawfully residing in the U.S. Individuals who are not eligible will be terminated from coverage within **18 months after enactment of the bill (December 4, 2026)**. **(estimated to save $5.1B)**
- Temporarily increases the Medicare physician fee schedule by 2.5 percent for services furnished **between January 1, 2026 and January 1, 2027.**

ACA Tax Credit Changes

- Narrows premium tax credit eligibility to lawful permanent residents, COFA migrants and Cuban and Haitian entrants. **(effective January 1, 2027; estimated to save $69.8B)**
- Prohibits lawfully present immigrants from receiving tax credits during any period in which they are ineligible for Medicaid due to their immigration status. **(effective January 1, 2026; estimated to save $49.5B)**
- Enhances eligibility verification requirements to receive advanced premium tax credits or cost sharing reductions to include income, immigration status, residency and family size, as opposed to the current attestation model. **(effective January 1, 2028; estimated to save $36.9B)**
- Tightens special enrollment periods eliminating exception for individuals making below 150 percent of the federal poverty line. **(effective January 1, 2026; estimated to save $39.5B)**
- Requires tax credit recipients to repay all overpayments in full, as opposed to the current capped amounts. **(effective January 1, 2026; estimated to save $17.3B)**

Biden-Era Rule Delays

- A moratorium on implementation of a final rule relating to eligibility and enrollment in Medicare Savings Programs published by the Centers for Medicare & Medicaid Services (CMS) on September 21, 2023 (titled "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" (88 Fed. Reg. 65230)). **(delayed until September 30, 2034; estimated to save $66B)**
- A moratorium on implementation of a rule relating to eligibility enrollment for Medicaid, CHIP, and the Basic Health Program published by CMS on April 2, 2024 (titled "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" (89 Fed. Reg. 22780)). **(delayed until September 30, 2034; estimated to save $55.9B)**
- Delays implementation, enforcement and administration of a final rule relating to staffing standards for long-term care (LTC) facilities published by CMS on May 10, 2024 and titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" (89 Fed. Reg. 40876). The final rule would have instituted minimum staffing standards for LTC facilities and reporting requirements for states receiving Medicaid payments for the compensation of direct care workers and support staff at certain institutions. **(delayed until September 30, 2034; estimated to save $23.1B)**

Rural Health Transformation Program

- Creates a Rural Health Transformation Program, funded at $10 billion a year for fiscal years 2026-2030 (for a total cost of **$50B**), to aid rural hospitals. To receive funding, states must submit a detailed rural health transformation plan to:
  - Improve access to hospitals, other providers and health care items and services to rural residents of a state;
  - Improve health outcomes of rural residents;
  - Prioritize the use of new and emerging technologies that can help prevent and manage chronic disease;
  - Encourage strategic partnerships between rural hospitals and other providers to increase quality and financial stability;
  - Enhance economic opportunities for health care clinicians through enhanced recruitment and training;
  - Prioritize data and technology to help furnish care as close to patients as possible;
  - Outline strategies to manage solvency and operating issues for rural hospitals; and
  - Identify specific causes driving the accelerating rate for stand-alone rural hospitals to close, convert or reduce services.
- States must certify that no funds will be used for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure or any other expenditure to finance the non-Federal share of expenditures.
- Half of the available funds will be distributed evenly among all states with an approved application. The remaining funds will be allocated to states at the discretion of CMS – considering factors such as:
  - The percent of a state's population that resides in a rural census tract;
  - The proportion of rural health facilities in the states relative to the number of rural health facilities nationwide;
  - The "situation of hospitals in the state";
  - Any other factors deemed appropriate by the CMS Administrator.
- The CMS Administrator must approve or deny states' applications no later than **December 31, 2025**.