New 1915(c) Waiver Opportunity under OBBBA

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The "One Big Beautiful Bill Act" (OBBBA) includes a new waiver authority for certain people who need home and community-based services (HCBS). This fact sheet discusses this new option as well as suggesting advocacy strategies for advocates in states considering implementing a waiver under this new option.

New 1915(c) Waiver Option

Home and Community-Based Services (HCBS) waivers are authorized by § 1915(c) of the Social Security Act and provide an alternative to institutional care for people with disabilities. States use § 1915(c) waivers to provide various types of HCBS, including case management, home health, personal care, adult day health care, habilitation, rehabilitation, and respite care. In order to qualify for such services, individuals usually have to meet an "institutional level of care," which means that they would otherwise need the level of services provided in a nursing facility or an intermediate care.[1] Section 1915(c) permits states to ask CMS to "waive" certain provisions of the Medicaid statute, thus allowing states to target services to certain populations, to limit enrollment in the waiver, and to create budgetary limits.[2] While § 1915(c) waivers help ensure children and adults with disabilities can live at home in the community, many states have waivers with long waiting lists, due to a state's ability to limit enrollment.[3]

[1] 42 U.S.C. § 1396n(c).
[2] 42 U.S.C. § 1396n(c)(1); *see also* Centers for Medicare and Medicaid Services, *Home & Community-Based Services 1915(c)*, https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c (last visited November 21, 2025).
[3] Alice Burns et al., KFF, *A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024* (October 31, 2024), https://www.kff.org/medicaid/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2024/.

OBBBA creates a new kind of waiver: a "1915(c)(11) waiver," for individuals who do *not* meet an institutional level of care.[4] Waivers under this option are subject to an initial three year term, with the option for five year terms for subsequent waivers.[5] States must use "needs-based criteria" to determine eligibility for HCBS under a new waiver and must show that any new waiver under this section does not "materially increase" the average wait time for HCBS for people who need an institutional level of care.[6] In addition, a state's average per capita Medicaid expenditures for individuals covered by the waiver cannot exceed the state's average per capita Medicaid expenditures for individuals receiving institutional care under the state plan or a waiver.

Additional statutory language in the new option appears to be intended to prevent states from deducting standard employment benefits such as health care and union dues from non-agency based HCBS worker payments.[7] These payments, commonly referred to as "check off payments," are only withheld with employee consent.[8] States will be required to report, at least once a year, certain cost and utilization data.[9] States may submit 1915(c) Waivers under this new option to CMS for approval as early as July 1, 2028.

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[4] 42 U.S.C. § 1396n(c)(11).

[5] 42 U.S.C. § 1396n(c)(11)(A).

[6] 42 U.S.C. § 1396n(c)(11)(B)(ii). "Material increase" has not been further defined in this context by CMS.

[7] 42 U.S.C. § 1396n(c)(11)(C). Center for Medicaid and CHIP Services (CMCS) guidance provides that "states are prohibited from using Medicaid payments under this new waiver authority to pay third parties on behalf of an individual practitioner for benefits such as health insurance or skills training, if the practitioner belongs to a practitioner class for which Medicaid is the primary source of revenue." CMCS, "*Working Families Tax Cut" Legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) Related Provisions* 22 (Nov, 24, 2025), **https://www.medicaid.gov/federal-policy-guidance/downloads/cib11182025.pdf**.

[8] Generally, such payment arrangements are permitted under Medicaid. In 2019, the Trump administration attempted to restrict such payments, based on an interpretation of the anti-reassignment provision in Medicaid. 42 U.S.C. § 1396a(a)(32). HHS, Medicaid Program; Reassignment of Medicaid Provider Claims, 84 Fed. R. 19718 (May 6, 2019) (rescinding 42 C.F.R. § 447.10). These regulations were challenged and vacated in *Becerra v. Azar*, 501 F.Supp.3d 830 (2020). In 2022, new regulations were finalized, once again clarifying such payments are permissible. HHS, Medicaid Program; Reassignment of Medicaid Provider Claims, 87 Fed. R. 29675 (May 16, 2022).

[9] 42 U.S.C. § 1396n(c)(11)(B)(vii) requires states to report the number of individuals who received HCBS under the new waiver option during the previous year; the cost of services provided to individuals under the new waiver option, broken down by types of service; the length of time individuals receive a service; and a comparison between the cost of services

In addition to authorizing a new type of waiver, OBBBA authorizes $100 million dollars in payments to states, for the purpose of supporting delivery of HCBS services through 1915(c) waivers or 1115 waivers, regardless of whether the state pursues a new 1915(c)(11) waiver.[10] The $100 million will be disbursed "on the basis of the proportion of the population of the State that is receiving home or community-based services as compared to all States." CMS has not issued guidance on how states will access these funds.

Opportunities for Advocacy

Due to the huge funding cuts in other parts of OBBBA, it is not clear how many states will engage with this new option. The $100 million included in this provision and allocated across 50 states and the District of Columbia cannot possibly fill the projected state-level Medicaid budget holes projected to result from OBBBA.[11] When states face federal Medicaid funding reductions, HCBS has historically been cut, not expanded.[12]

Additionally, advocates in states that actively allow for deductions for employment benefits for independent provider direct care workers may want to discourage their state from pursuing this option, because the provision appears aimed at preventing states from using "check off" payments for independent providers in order to collect union dues and other benefits customarily withheld by employers. While it is unclear how CMS will interpret this provision, it risks weakening the ability of the direct care workforce to unionize and could worsen the direct care workforce shortage in states that permit this type of arrangement.[13]

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and any comparable data for individuals who do meet an institutional level of care and are being served by another waiver.

[10] OBBBA, Pub. L. No. 119-21 (July 4, 2025), 139 Stat. 319.

[11] Rhiannon Euhus *et al.*, KFF, *Allocating CBO's Estimates of Federal Medicaid Spending Reduced Across the States: Enacted Reconciliation Package* (July 23, 2025), **https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/** (last visited Feb. 13, 2026).

[12] Jessica Schubel *et al.*, *History Repeats? Faced With Medicaid Cuts, States Reduced Support For Older Adults And Disabled People,* HEALTH AFFAIRS (Apr. 16, 2025), **https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled**.

[13] Medicaid and CHIP Payment and Access Commission (MACPAC), S*tate Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages* (March 2022), **https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf** (last visited Feb. 13, 2026)**.**

Proponents of this new option to provide HCBS to individuals who do not meet an institutional level of care hope the option will be helpful for people with behavioral health needs or individuals whose disabilities do not yet meet an institutional level of care. States already have the authority to offer HCBS to individuals who do not meet an institutional level of care under the 1915(i) state plan authority. However, many states do not do so due to cost concerns.[14] Offering HCBS through a 1915(c) waiver allows states to set caps, which may act as an incentive for states who want additional assurances they will be able to limit how many individuals they serve.[15] It may also be a particularly useful option to provide preventative HCBS services which help people avoid the need for higher levels of care.

If a state decides to pursue a 1915(c)(11) waiver, there are a number of strategies advocates can consider. In terms of waiting lists, advocates should encourage their state to track existing waiver waiting lists to ensure any new waiver does not result in adverse impacts on individuals who meet an institutional level of care and are waiting for services. While CMS has not yet issued guidance on what constitutes a "material increase," states should consider not only how long an individual waits to receive a level of care determination as well as the time from a level of care determination to approval to enroll in a waiver. In addition, advocates should urge states to annually report on the existing provider network capacity and the average wait times from when services are approved to when individuals actually begin receiving the services authorized. Advocates should also urge their states to include diverse stakeholder groups with expertise in existing HCBS programs in their planning, to ensure that any new waiver meets the needs of people with disabilities, as well as ongoing stakeholder engagement to monitor implementation of any new waiver.

[14] 42 U.S.C. § 1396n(i).
[15] States *can* limit how many people are served through a 1915(i) option however, in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment. 42 U.S.C. § 1396n(i)(1)(D)(ii).