

KFF Report: Health Provisions in the 2025 Federal Budget Reconciliation Bill

This summary compares the health care provisions in the versions of the reconciliation bill passed by the Senate on 7/1/25 & by the House on 5/22/25 with current law.

Area	Current Law	House-passed Bill	Senate-passed Bill
Expansion Coverage and Financing	The Affordable Care Act expands Medicaid eligibility to non-elderly adults with incomes up to 138% FPL based on modified adjusted gross income and provides 90% federal financing for the expansion population. The Supreme Court effectively made expansion an option for states. The American Rescue Plan Act (ARPA) added a temporary financial incentive for states that newly adopt expansion. Currently, 41 states, including DC, have implemented the Medicaid expansion.	<ul style="list-style-type: none"> Eliminates the temporary incentive for states that newly adopt expansion. <p>Effective Date: January 1, 2026</p>	<ul style="list-style-type: none"> Same as House-passed bill.
Cost Sharing	States have the option to charge premiums and cost-sharing for Medicaid enrollees within limits, and certain populations and services (emergency, family planning, pregnancy and preventive) are exempt from cost-sharing. Cost-sharing is generally limited to nominal amounts but may be higher for those with income above 100% of the federal poverty level (FPL). Out-of-pocket costs cannot exceed 5% of family income. States may allow providers to deny services for enrollees for nonpayment of copayments.	<ul style="list-style-type: none"> Eliminates enrollment fees or premiums for expansion adults. Requires states to impose cost sharing of up to \$35 per service on expansion adults with incomes 100-138% FPL; explicitly exempts primary care, mental health, and substance use disorder services from cost sharing, maintains existing exemptions of certain services from cost sharing, and limits cost sharing for prescription drugs to nominal amounts. Maintains the 5% of family income cap on out-of-pocket costs. <p>Effective Date: October 1, 2028</p>	<ul style="list-style-type: none"> Same as House-passed bill, except: <ul style="list-style-type: none"> Exempts services provided by federally qualified health centers, behavioral health clinics, and rural health clinics. Provides \$15 million in implementation funding for FY 2026.

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Work Requirements	<p>Current law prohibits conditioning Medicaid eligibility on meeting a work or reporting requirement. During the first Trump administration, 13 states received approval to implement work requirements through Section 1115 waivers. Work requirement waiver approvals were either rescinded by the Biden administration or withdrawn by states, and Georgia is the only state with a Medicaid work requirement waiver in place. Several states have recently submitted new 1115 waiver requests to implement work requirements.</p>	<ul style="list-style-type: none"> • Requires states to condition Medicaid eligibility for individuals ages 19-64 applying for coverage or enrolled through the ACA expansion group (or a waiver) on working or participating in qualifying activities for at least 80 hours per month. • Mandates that states exempt certain adults, including parents of dependent children and those who are medically frail, from the requirements. • Requires states to verify that individuals applying for coverage meet requirements for 1 or more consecutive months preceding the month of application; and that individuals who are enrolled meet requirements for 1 or more months between the most recent eligibility redeterminations (at least twice per year). • Specifies that if a person is denied or disenrolled due to work requirements, they are also ineligible for subsidized Marketplace coverage. • These provisions cannot be waived including under Section 1115 authority. • Provides \$100 million in funding to states for systems development for FY 2026 and an additional \$50 to HHS to support implementation (for FY 2026). <p>Effective Date: Not later than December 31, 2026, or earlier at state option</p>	<ul style="list-style-type: none"> • Same as House-passed bill, except: <ul style="list-style-type: none"> - Caps the “look-back” for demonstrating community engagement at application to three months. - Limits exemptions to parents with children ages 13 and under (instead of all parents). - Specifies seasonal workers meet requirements if average monthly income meets specified standard. - Requires states to use data matching “where possible” to verify whether an individual meets the requirement or qualifies for an exemption (House bill only requires data matching “where possible” for verifying meeting work requirements). - Allows the Secretary to exempt states from compliance with the new requirements until no later than December 31, 2028, if the state is demonstrating a good faith effort to comply and submits progress in compliance or other barriers to compliance. - Increases funding to states for FY 2026 to \$200 million and increases HHS implementation funding for FY 2026 to \$200 million.

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Eligibility Determinations	States must renew eligibility every 12 months for Medicaid enrollees whose eligibility is based on modified adjusted gross income (MAGI), including children, pregnant individuals, parents, and expansion adults, and must renew eligibility at least every 12 months for enrollees whose eligibility is based on age 65+ or disability. States are required to review eligibility within the 12-month period if they receive information about a change in a beneficiary's circumstances that may affect eligibility.	<ul style="list-style-type: none"> Requires states to conduct eligibility redeterminations at least every 6 months for Medicaid expansion adults. <p>Effective Date: For renewals scheduled on or after December 31, 2026</p>	<ul style="list-style-type: none"> Same as House-passed bill, except: <ul style="list-style-type: none"> Requires the Secretary to issue guidance within 180 days of enactment. Provides \$75 million in implementation funding for FY 2026.
Verifying Enrollee Address and Other Information	States are not required to take proactive steps to obtain updated enrollee contact information. The Eligibility and Enrollment final rule (see below) requires states to leverage reliable data sources to update enrollee address information, effective June 2025.	<ul style="list-style-type: none"> Requires states to obtain enrollee address information using reliable data sources, including the National Change of Address Database and managed care entities. Requires the Secretary to establish a system to share information with states for purposes of preventing individuals from being simultaneously enrolled in two states and requires states to submit monthly enrollee SSNs and other information to the system. Requires states to review the Master Death File at least quarterly to determine if any enrolled individuals are deceased. <p>Effective Date: January 1, 2027 for states to obtain contact information; October 1, 2029 to establish system to prevent enrollment in two states simultaneously; January 1, 2028 to review Master Death File</p>	<ul style="list-style-type: none"> Same as House-passed bill, except: <ul style="list-style-type: none"> Changes effective date of requirement to review Master Death File to January 1, 2027.

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Eligibility and Enrollment Final Rule	<p>CMS issued two separate rules, collectively referred to as the Eligibility and Enrollment final rule. The first rule reduces barriers to enrollment in Medicare Savings Programs (MSPs), which provides Medicaid coverage of Medicare premiums and cost sharing for low-income Medicare beneficiaries. The second rule streamlines application and enrollment processes in Medicaid, aligns renewal policies for all Medicaid enrollees, facilitates transitions between Medicaid, CHIP, and subsidized Marketplace coverage, and eliminates certain barriers in CHIP. Implementation deadlines for states vary across provisions but many provisions are already in effect, and for others, states are already in compliance.</p>	<ul style="list-style-type: none"> • Delays implementation of both rules until January 1, 2035. <p>Effective Date: Upon enactment</p>	<ul style="list-style-type: none"> • Prohibits the Secretary from implementing, administering, or enforcing certain provisions in both rules until October 1, 2034. <p>Effective Date: Upon enactment</p>
Retroactive Coverage	<p>Under current law, states are required to provide Medicaid coverage for qualified medical expenses incurred up to 90 days prior to the date of application for coverage.</p>	<ul style="list-style-type: none"> • Limits retroactive coverage to one month prior to application for coverage. <p>Effective Date: December 31, 2026</p>	<ul style="list-style-type: none"> • Limits retroactive coverage to one month prior to application for coverage for expansion enrollees and two months prior to application for coverage for traditional enrollees. • Provides \$15 million in implementation funding for FY 2026. <p>Effective Date: January 1, 2027</p>

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Provider Taxes	<p>States are permitted to finance the non-federal share of Medicaid spending through multiple sources, including state general funds, health care related taxes (or “provider taxes”), and local government funds. Federal rules specify provider taxes must be broad-based and uniform (i.e., states can’t limit provider taxes to only Medicaid providers) and may not hold providers “harmless” (i.e., guarantee providers receive their money back). The hold harmless requirement does not apply when tax revenues comprise 6% or less of providers' net patient revenues from treating patients (referred to as the “safe harbor” limit).</p>	<ul style="list-style-type: none"> • Prohibits states from establishing any new provider taxes or from increasing the rates of existing taxes. • Revises the conditions under which states may receive a waiver of the requirement that taxes be broad-based and uniform such that some currently permissible taxes, such as those on managed care plans, will not be permissible in future years. • Provision overlaps with a proposed rule released May 12, 2025. <p>Effective Date: Upon enactment, but states may have at most 3 fiscal years to transition existing arrangements that are no longer permissible</p>	<ul style="list-style-type: none"> • Reduces the safe harbor limit for states that have adopted the ACA expansion by 0.5% annually starting in fiscal year 2028 until the safe harbor limit reaches 3.5% in FY 2032. • New limit applies to taxes on all providers except nursing facilities and intermediate care facilities. • New limit also applies to local government taxes in expansion states. • Provides \$20 million in implementation funding for FY 2026.

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<p>Disproportionate Share Hospital Payments (DSH)</p>	<p>Medicaid provides DSH payments to hospitals that serve a disproportionate percentage of low-income, uninsured and Medicaid patients. The payments can be used to cover unpaid costs of care for people who are uninsured and to supplement Medicaid payment rates that often do not fully cover provider costs. DSH payments totaled over \$17 billion in federal FY 2023. Federal DSH spending is capped for each state and facility, but within those limits states have considerable discretion in determining the amount of DSH payments to each DSH hospital.</p> <p>The Affordable Care Act (ACA) called for a reduction in federal DSH allotments starting in FY 2014 based on the anticipated reduction in uninsured rates stemming from the ACA implementation, but the cuts have been delayed several times and are currently delayed through September 30, 2025.</p>	<ul style="list-style-type: none"> • Delays the DSH reductions (of \$8 billion per year) through September 30, 2028. • Extends Tennessee’s DSH program through September 30, 2028. <p>Effective Date: Upon enactment</p>	<ul style="list-style-type: none"> • No provision.

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State Directed Payments	<p>States are generally not permitted to direct how managed care organizations (MCOs) pay their providers. However, subject to CMS approval, states may use “state directed payments” (SDPs) to require MCOs to pay providers certain rates, make uniform rate increases (that are like fee-for-service supplemental payments), or to use certain payment methods.</p> <p>A 2024 rule on access to care in Medicaid managed care codified that the upper limit for SDPs is the average commercial rate for hospitals and nursing facilities, which is generally higher than the Medicare payment ceiling used for other Medicaid fee-for-service supplemental payments.</p>	<ul style="list-style-type: none"> • Directs HHS to revise state directed payment regulations to cap the total payment rate for inpatient hospital and nursing facility services at 100% of the total published Medicare payment rate for states that have adopted the Medicaid expansion and at 110% of the total published Medicare payment rate for states that have not adopted the expansion. • Grandfathers state directed payments approved prior to the legislation’s enactment; for states that newly adopt the expansion after enactment, the cap at 100% of the Medicare payment rate applies at the time coverage is implemented even for payments that had prior approval. <p>Effective Date: Upon enactment</p>	<ul style="list-style-type: none"> • For grandfathered payments, reduces payments by 10 percentage points each year (starting January 1, 2028) until they reach the allowable Medicare-related payment limit (which are the same as the House limits). • Specifies that in the absence of published Medicare payment rates, the limit is set at the Medicaid fee-for-service payment rate. • Specifies that the grandfathering clause only applies to payments submitted prior to enactment of the bill for rural hospitals and prior to May 1, 2025 for all other providers.
Section 1115 Demonstration Waiver Budget Neutrality	<p>Under long-standing policy and practice, Section 1115 demonstration waivers must be “budget neutral” to the federal government over the course of the waiver. Federal costs under an 1115 waiver may not exceed what they would have been for that state without the waiver. Typically, budget neutrality calculations are determined on a per enrollee basis—so, per enrollee spending over the course of the waiver (usually 5 years) cannot exceed the projected per enrollee spending calculated in the “without-waiver baseline.”</p> <p>Budget neutrality calculations and the use of “savings” when expenditures decrease on account of the waiver are negotiated between states and CMS and the Office of Management and Budget).</p>	<ul style="list-style-type: none"> • Requires the HHS Secretary to certify 1115 demonstration waivers are not expected to result in an increase in expenditures compared to expenditures without the waiver and to specify a methodology for applying any budget neutrality “savings” in a waiver extension period. <p>Effective Date: Upon enactment</p>	<ul style="list-style-type: none"> • Specifies the Chief Actuary for CMS (rather than the HHS Secretary) must certify 1115 waivers are not expected to result in an increase in federal expenditures compared to federal expenditures without the waiver. • Provides \$5 million in implementation funding for each of FY 2026 and FY 2027. <p>Effective Date: January 1, 2027</p>

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Nursing Home Staffing Final Rule	<p>A 2024 Biden-administration final rule requires long-term care facilities (LTC) to meet minimum staffing levels (including a 24/7 RN on-site and a minimum of 3.48 total nurse staffing hours per resident day (HPRD)), requires state Medicaid agencies to report the share of Medicaid payments for institutional LTC that are spent on worker compensation, and provides funding for people to enter careers in nursing homes.</p> <p>On April 7, the US District Court for Northern Texas ruled to overturn the minimum staffing requirements, and it is expected that the Administration will not appeal that decision.</p>	<ul style="list-style-type: none"> Prohibits the Secretary of Health and Human Services from implementing, administering, or enforcing the final rule. <p>Effective Date: Upon enactment</p>	<ul style="list-style-type: none"> Prohibits the Secretary of Health and Human Services from implementing, administering, or enforcing the minimum staffing levels required by the final rule until October 1, 2034.
Home and Community Based Services (HCBS)	<p>States are required to cover nursing facility care under Medicaid, but nearly all home care (HCBS) is optional. Nearly all states provide home care through “1915(c) waivers,” which limit services to people who require an institutional level of care. Because those services are optional, states may limit the amount of care people may have receive and the number of people receiving services. Most states have waiting lists because the number of people seeking services exceeds the amount of care available.</p>	<ul style="list-style-type: none"> No provision. 	<ul style="list-style-type: none"> Allows states to establish 1915(c) HCBS waivers for people who do not need an institutional level of care. Includes requirements for states’ waiver submissions that include a demonstration that the new waiver will not increase the average amount of time that people who need an institutional level of care will wait for services. Includes \$50 million in FY 2026 and \$100 million in FY 2027 for implementation. <p>Effective Date: New waivers may not be approved until July 1, 2028</p>

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Rural Health Funding	<ul style="list-style-type: none"> • No provision. 	<ul style="list-style-type: none"> • No provision. 	<ul style="list-style-type: none"> • Establishes a rural health transformation program that will provide \$50 billion in grants to states between fiscal years 2026 and 2030, to be used for payments to rural health care providers and other purposes. • Distributes 40% of payments equally across states with approved applications; the remaining funds will be distributed by CMS based at least in part on states' rural populations that live in metropolitan statistical areas, the percent of rural health facilities nationwide that are located in a state, and the situation of hospitals that serve a disproportionate number of low-income patients with special needs. • Uses of funds include promoting care interventions, paying for health care services, expanding the rural health workforce, and providing technical or operational assistance aimed at system transformation. <p>Effective Date: Upon enactment but funding is first available in fiscal year 2026</p>
Free Choice of Provider	<p>States must generally allow beneficiaries to obtain Medicaid services from any provider that is qualified and willing to furnish services. Managed care organizations (MCOs) may restrict enrollees to providers in the MCO's network, except that such plans cannot restrict free choice of family planning providers.</p>	<ul style="list-style-type: none"> • Prohibits Medicaid funds to be paid to providers that are nonprofit organizations, essential community providers primarily engaged in family planning services or reproductive services, provide for abortions outside of the Hyde exceptions and received \$1,000,000 or more in payments from Medicaid in 2024; this would affect Planned Parenthood and other Medicaid essential community providers. <p>Effective Date: Upon enactment for 10 years</p>	<ul style="list-style-type: none"> • Same as House-passed bill, except: <ul style="list-style-type: none"> – Prohibits payments to providers that meet specified criteria and received \$800,000 or more in payments from Medicaid in 2023. – Provides \$1 million in implementation funding for FY 2026. – Changes effective date to upon enactment for one year.

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Medicaid Provider Screening Requirements	<p>Provider screening and enrollment is required for all providers in Medicaid fee-for-service or managed care networks. Additionally, the ACA requires states to terminate provider participation in Medicaid if the provider was terminated under Medicare or another state program. CMS has multiple tools to assist states with provider screening and enrollment compliance, including leveraging Medicare data.</p>	<ul style="list-style-type: none"> • Requires states to conduct checks at enrollment, reenrollment, and on a monthly basis to determine whether HHS has terminated a provider or supplier from Medicare or another state has terminated a provider or supplier from participating in Medicaid or CHIP. • Requires states to conduct quarterly checks (in addition to at provider enrollment or reenrollment) of the Social Security Administration's Death Master File to determine whether providers enrolled in Medicaid are deceased. <p>Effective Date: January 1, 2028</p>	<ul style="list-style-type: none"> • Same as House-passed bill.

Citation: Health Provisions in the 2025 Federal Budget Reconciliation Bill, (KFF, 07/02/2025)
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