Key Health Provisions in the 2025 Budget Reconciliation Bill

as of June 17, 2025

	Current Law	House-passed	Senate Finance
State Directed Payments	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. 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.	• 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. Effective Date: Upon enactment	• For grandfathered payments, reduces payments by 10 percentage points each year (starting January 1, 2027) 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 May 1, 2025.
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.	• Requires states to conduct eligibility redeterminations at least every 6 months for Medicaid expansion adults. Effective Date: For renewals scheduled on or after December 31, 2026	• Same as House-passed bill but also requires the Secretary to issue guidance within 180 days of enactment.

Provider Taxes	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).	• 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. Effective Date: Upon enactment, but states may have at most 3 fiscal years to transition existing arrangements that are no longer permissible	• Reduces the safer harbor limit for states that have adopted the ACA expansion by 0.5% annually starting in fiscal year 2027 until the safe harbor limit reaches 3.5% in FY 2031. • New limit applies to taxes on all providers except nursing facilities and intermediate care facilities.
Reasonable Opportunity Period	States must verify immigration status through the DHS SAVE system which can provide automatic real-time verification. If the SAVE system cannot verify immigration status in real time, states are required to provide Medicaid benefits to applicants during a "reasonable opportunity period" of 90 days while their immigration status is being verified, if they meet all other eligibility criteria.	• Eliminates the requirement for states to provide Medicaid coverage during a reasonable opportunity period but allows states to do so at state option. • Prohibits states from claiming federal matching funds during a reasonable opportunity period. Effective Date: October 1, 2026	• Same as House-passed bill.

Work Requirements	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.	• Requires states to condition Medicaid eligibility for individuals ages 19-64 applying for coverage or enrolled through the ACA expansion group 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). • 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. Effective Date: Not later than December 31, 2026, or earlier at state option	Same as House passed bill, except: • Caps the “look-back” for demonstrating community engagement at application to three months. • Limits exemptions to parents with children ages 14 and under (instead of all parents). • 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.

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.	• 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. Effective Date: October 1, 2028	Same as House-passed bill, except: • Permits cost sharing for non-emergency services provided in a hospital emergency department to exceed $35.
Retroactive Coverage	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.	• Limits retroactive coverage to one month prior to application for coverage. Effective Date: December 31, 2026	• 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. Effective Date: January 1, 2027

Disproportionate Share Hospital Payments (DSH)	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. 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.	• Delays the DSH reductions (of $8 billion per year) through September 30, 2028. • Extends Tennessee's DSH program through September 30, 2028. Effective Date: Upon enactment	• No provision.

Prescription Drug Pricing and Rules for Pharmacy Benefit Managers	States are not required to offer Medicaid prescription drug coverage, but all states do. States provide prescription drug benefits through either fee-for-service (FFS) Medicaid or through managed care organizations (MCOs). Under FFS, states often use the National Average Drug Acquisition Cost (NADAC) survey, which surveys pharmacies about their costs of acquiring prescription drugs, to inform their prescription drug payment rates. The survey is optional for pharmacies to complete and may overstate prescription drug costs. When MCOs provide prescription drugs, they often use Pharmacy Benefit Managers (PBMs) to administer pharmacy benefits. Some PBMs charge Medicaid MCOs for pharmacy costs that far exceed the actual costs of reimbursing pharmacies for drugs, a practice known as "spread pricing." As of 2019, only 11 states had prohibited spread pricing in MCO contracts.	• Requires all retail pharmacies and certain non-retail pharmacies to complete the NADAC survey and imposes penalties for non-completion. • Requires the Secretary of Health and Human Services to make data from the NADAC survey about prescription drug costs and pricing publicly available. • Establishes requirements for PBM payments to pharmacies and prohibits spread pricing. Requires that payments to PBMs and similar entities reflect the pharmacies' costs and an administrative fee that is fair market value. Effective Date: starting 6 months after enactment for the Drug Acquisition Cost Survey for retail pharmacies (18 months after enactment for non-retail pharmacies), 18 months after enactment for the requirements governing PBMs	• Same as House-passed bill. Effective Date: starting 9 months after enactment for the NADAC survey for retail pharmacies; other effective dates are the same as the House