Medicaid-Related Provisions in the House Energy & Commerce Budget Reconciliation Bill

Updated: May 12, *2025 (5pm ET)*

References H. Con. Res. 14, FY 2025 budget resolution – House Energy & Commerce Committee Reconciliation Text (Subtitle D—Health of Title IV)

I. Key Provisions of Interest

Medicaid Expansion Redeterminations

Section: 44108, p. 16

Effective Date: October 1, 2027

- Requires individuals enrolled under Medicaid expansion to undergo eligibility redeterminations every 6 months, instead of annually

FMAP Penalty for Coverage of Undocumented Immigrants

Section: 44111, p. 25-28

Effective Date: October 1, 2027

- Enacts a 10-percentage point penalty for expansion FMAP on a quarterly basis if a state elects to provide Medicaid coverage to undocumented immigrants with state-only funds.

Preventing Spread Pricing in Medicaid

Section: 44124, p. 44-52

Effective Date: The first day of the first quarter that begins on or after the date that is 18 months after the date of enactment of this section.

- Increases the transparency of prescription drug pass-through pricing for PBMs in Medicaid.
- Requires that payments to the PBM for administrative fees be limited to fair market value and that the PBM make available to the State or HHS Secretary detailed breakdowns of costs and payments related to covered outpatient drugs and administrative fees.
- Prohibits spread pricing by PBMs or charging indirect claw backs.

Moratorium on New or Increased Provider Taxes

Section: 44132, p. 61-62

Effective Date: Takes effect on the date of enactment.

- Prohibits new provider taxes and does not allow for increases for existing provider taxes to "the amount or rate of tax imposed with respect to a class of health care items or services (or with respect to a type of provider or activity within such a class) or increases the base of the tax."

Revising the Payment Limit for Certain State Directed Payments
Section: 44133, p. 63-64)
Effective Date: Takes effect on the date of enactment.

- For SDPs that have already received written approval or submitted programs for written approval from CMS prior to enactment date, programs can remain at current size (even if above Medicare/at ACR) but are frozen at current size – cannot exceed amount already approved in outyears.
- For new SDPs that have not yet been submitted or received written approval, they must not exceed the total published Medicare payment rate.
- **Note**: There may be additional impact/limitations for assessment-funded SDPs where tax used to fund SDPs had any differential – see below.

Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax
Section: 44134, p.64-68
Effective Date: Takes effect upon the date of enactment "subject to any applicable transition period determined appropriate by the Secretary of Health and Human Services, not to exceed 3 fiscal years."

- Tax is not considered "generally redistributive" if within permissible class, tax rate imposed on Medicaid is higher or lower than any other tax group using Medicaid basis.
- This includes all differential taxes, not only MCO taxes.

Mandating 1115 Waiver Budget Neutrality
Section 44135, p. 68-69
Effective date: Takes effect on the date of enactment.

- Codifies in statute the requirement that HHS must determine an 1115 demonstration waiver is budget neutral. Requires the Secretary to determine the methodology for applying savings in extensions if applicable.

Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals
Section 44141, p. 69-89

Effective Date: *January 1, 2029. HHS must promulgate regulations implementing this section no later than July 1, 2027.*

- Requires states to implement community engagement requirements for Medicaid beneficiaries.
- Requirements are set at 80 hours per month of work, a work program, or community service, or at least part-time enrollment in an education program, as long as total engagement hours for the month add up to at least 80.
- There are exceptions for those under age 19 or over age 64; tribal members; foster and former foster youth under age 26; individuals considered medically frail; individuals already meeting SNAP or TANF work requirements; individuals released from incarceration within the past 90 days; and individuals caring for a dependent child or individual with a disability.
- States must verify compliance in the month prior to enrollment for new enrollees and in the month prior to redetermination for existing enrollees (note that another provision of this bill would require eligibility checks every six months for the expansion population). States have the option to do more frequent verification. This provision is not waivable.

Delaying DSH Reductions

Section 44303: p. 122-123

Effective Date: Takes effect on the date of enactment.

- Delays DSH reduction scheduled to take place for fiscal years 2026 through 2028, instead implementing in fiscal years 2029 through 2031. Extends funding for Tennessee's DSH program through fiscal year 2028.

Modifying Update to the Conversion Factor Under the Physician Fee Schedule Under the Medicare Program

Section 44304, p. 123-124

Effective Date: 2026 and subsequent years

- Creates a Medicare Economic Index (MEI) update formula and establishes that 75% of the MEI be used to determine percent increases in 2026 and 10% be applied in 2027 and going forward.

Modernizing and Ensuring PBM Accountability

Section 44305, p. 124-160

Effective Date: For plan years beginning on or after January 1, 2028.

- Establishes requirements for Pharmacy Benefit Managers (PBMs) within prescription drug plan (PDP) agreements, including tying compensation to bona fide

service fees and increasing transparency around cost-performance evaluations, drug manufacturer contracting, formulary placement, subsequent rebate and other price concessions.

II. Additional Provisions

ELIGIBILITY AND RESTRICTIONS ON SERVICES

Moratoria on Eligibility and Enrollment Final Rules

Section 44101 and 44102, p. 1-2

- Prohibits the implementation of the 2023 Medicare Shared Savings Program and 2024 Medicaid and CHIP Eligibility and Enrollment final rules until January 1, 2035.

Address Verification and Preventing Duplicate Enrollment

Section 44103, p. 2-9

Effective Date: October 1, 2029

- Requires states to establish a system such that individuals who are applying for or are already enrolled in coverage are reviewed to ensure that they do not have Medicaid in another state. This information will be sent to HHS by the state once a month. The text also identifies what are considered reliable data sources for addresses and requires that beginning January 1, 2027, MCO/PIHP contracts include terms that specify the entity transmit address information to the state

Deceased Beneficiary and Provider Removal

Section 44104 and 44106, p. 10-12 and 14

Effective Date: January 1, 2028

- On a quarterly basis, the state must review the SSA Death Master File to disenroll deceased members. The same applies to Medicaid providers.

Monthly Provider Screening

Section 44105, p. 12-13

Effective Date: January 1, 2028

- On a monthly basis, as a part of provider enrollment, reenrollment, and revalidation, the state must check any database or system to ensure that the HHS Secretary has not terminated their participation in the program.

Eliminating Good Faith Waivers

Section 44107, p. 14-16

Effective Date: Fiscal Year 2030

- Prevents HHS from waiving reductions in FFP for state payment errors based on "good faith" claims.

Home Equity Limit Revisions for LTC
Section 44109, p. 17-19
Effective Date: January 1, 2028

- Establishes a $1M cap on home equity for individuals applying for long-term care under Medicaid. There is an exception for homes that are zoned on a lot for agricultural use. Prohibits asset disregards from waiving this limit.

Changes to Reasonable Opportunity Period Coverage
Section 44110, p. 19-25
Effective Date: October 1, 2026

- Prohibits federal match funding for healthcare coverage to individuals under the "reasonable opportunity" period unless their citizenship/nationality or immigration status is verified. It also makes coverage during this period optional for states to provide.

Moratorium on Implementation of Rule Relating to Staffing Standards for Long-term Care Facilities under the Medicare and Medicaid Programs
Section 44121, p. 28-29
Effective Date: Takes effect on the date of enactment.

- Delays implementation and enforcement of "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" until January 1, 2035.

Prohibiting Federal Medicaid and CHIP Funding for Gender Transition Procedures for Minors
Section 44125, p. 53-58
Effective Date: TBA

- Prohibits the usage of Medicaid and CHIP Funding for gender-affirming surgeries, puberty blockers and hormone replacement therapies for transgender individuals under the age of 18.

Federal Payments to Prohibited Entities
Section 44126, p. 58-61
Effective Date: Takes effect on the date of enactment.

- Institutes a 10-year federal funding ban to community non-profit entities that provide reproductive health services receiving $1M a year, if they provide abortions in cases other than health, rape, or incest.

MEDICAID FINANCING PROVISIONS

Ensuring Accurate Payments to Pharmacies Under Medicaid
Section 44123, p.31-44
Effective Date: TBA

- Institutes a survey of retail community pharmacy drug prices and non-retail pharmacy prices for the determination of national average drug acquisition cost benchmarks.
- Requires vendors to update prices on a monthly basis and includes all relevant information.
- Pharmacies that refuse to participate or fail to provide price data will face a civil fine of up to $100K per violation.

Sunsetting Increased Medicaid Expansion FMAP Incentive
Section 44131, p. 61
Effective Date: January 1, 2026

- Removes the additional 5% FMAP incentive for states to expand Medicaid.

MANDATES TO INCREASE PERSONAL RESPONSIBILITY

Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program
Section 44142, p. 89-93
Effective Date: October 1, 2028

- Requires cost-sharing for Medicaid expansion adults whose income exceeds 100 percent FPL, which cannot exceed $35 per service and five percent of the enrollee's income. Does not apply to primary, pediatric, prenatal care, or emergency room care.

OTHER HEALTHCARE PROVISIONS

Addressing Fraud, Waste, and Abuse in the ACA Exchanges
Section 44201, p. 93-116

Effective Date: Effective for plan years beginning on or after January 1, 2026.

- Eliminates special enrollment period (SEP) eligibility for income-based reasons and standardizes SEP rules across exchanges. Sets nationwide open enrollment window of November 1–December 15. Requires stricter documentation for SEP eligibility. Permits issuers to require consumers to repay past-due premiums before issuing new coverage.

- Requires that gender transition services cannot be deemed "essential health benefits" for Qualified Health Plans. Restricts QHP eligibility by modifying the federal definition of immigration status under the ACA to exclude DACA recipients.

Expanding and Clarifying Exclusion for Orphan Drugs Under the Drug Price Negotiation Program

Section 44301, p. 117-118

Effective Date: Beginning on or after January 1, 2028

- Makes changes to Optimizing Research Progress Hope and New (ORPHAN) Cures Act, with regards to allowing drugs that treat one or more rare diseases of conditions to be included within the exemption.

Streamlined Enrollment Process for Eligible Out-of-State Providers Under Medicaid and CHIP

Section 44302, p. 118-122

Effective Date: Four years after the date of enactment.

- Requires states to establish a streamlined process to enroll out-of-state pediatric providers.