Budget Reconciliation

June 19, 2025

Utah Department of
Health & Human
Services

Budget Reconciliation

Reminder

- Reconciliation is a **special legislative process that allows Congress to fast-track legislation related to the federal budget**
- The budget reconciliation process **can be used to make changes to the Medicaid program** and other entitlement programs, because they impact mandatory spending

Current Status

- House passed reconciliation bill on Thursday, May 22
- Senate released proposed language on June 16
- Congressional Republicans are aiming to fully pass the reconciliation bill by July 4

Specific Policy Language

- On May 22, the House passed the One Big Beautiful Bill Act in a 215 – 214 vote
  - The House-passed version of the One Big Beautiful Bill Act is linked here
- On June 16, the Senate Finance Committee released legislative text that amends the Medicaid provisions in the House-passed version of the bill.
  - The Senate Finance Committee bill text and section-by-section are linked here

What did the Senate Change?

Significant changes to the following provisions:
Provider tax provisions: freezes provider taxes at current levels in all states; in expansion states, phases down hold harmless threshold for taxes other than SNFs and ICFs from 6% to 3.5% over a specified period of years; in non-expansion states, caps hold harmless threshold at 6%
State-directed payment provisions: for non-expansion states, caps any new SDP submissions at 110% of Medicare and for expansion states, caps at 100% of Medicare; requires already approved SDPs to be reduced by 10 percentage points per year starting in 2027 until they are no greater than the above percentages of Medicare rates
Work/community engagement requirements: changes to exempt populations (requirements now apply to those caring for children ages 14 and under; new optional exemption for travel for medical care); option for CMS to extend implementation deadline to 2028; conflict of interest provision for MCOs/contractors
Retroactive Medicaid/CHIP coverage: One-month retroactive coverage limit for expansion; two months for other eligibility groups and CHIP

What did the Senate Change? (continued)

- **Added significant new provisions around health coverage for immigrants**
  - Significant new limitations on groups that have historically been eligible for regular Medicaid
  - Reduction of the 90% federal match rate to a state's regular match rate for emergency Medicaid coverage of people who would, but for their immigration status, qualify for the expansion group
- **Smaller changes to the following provisions:**
  - Federal payments to prohibited entities
  - Requirements regarding waiver of uniform tax requirement for Medicaid provider tax
  - Budget neutrality requirements
  - Biden-era regulations
  - FMAP penalty for coverage of certain non-citizens

Section 71120: Moratorium on new or increased provider taxes

- As of the effective date of the legislation, states may not implement new provider taxes or increase that tax amount on a per unit basis, rate, or tax base unless legislation or regulations providing for a new or increased tax were adopted prior to the date of enactment
  - New exception for changes made to comply with the generally redistributive requirement
- The legislation amends the thresholds for the hold harmless provision:
  - For non-expansion states: 6 percent threshold
  - **For expansion states: phases down the current 6 percent threshold to 3.5 percent over five fiscal years (5.5 percent for FY2027; 5 percent for FY2028; 4.5 percent for FY2029; 4 percent for FY2030; 3.5 percent for FY2031 and beyond)**
  - **Taxes on nursing facility and ICF services that are in effect on May 1, 2025, are exempt from the lower hold harmless threshold, as long as the tax is not modified**

Section 71121: Revising the payment limit for certain state-directed payments

- For rating periods that begin on or after the date of enactment, this section directs HHS to limit state directed payments (SDPs) from exceeding a percentage of the total published Medicare payment rate or, when no such rate is available, the payment rate under a Medicaid state plan.
    - The cap is set at 100% of Medicare for expansion states and 110% of Medicare for non-expansion states.
- **Beginning with rating periods on or after January 1, 2027, the legislation would phase down existing SDPs by 10 percentage points each year until the total rate reaches 100 percent of Medicare for expansion states** and 110 of Medicare for non-expansion states.
    - This phase-down applies to SDPs:
        - That received prior written approval from CMS or a good faith effort to receive such approval before May 1, 2025, for the rating period occurring within 180 days of the date of enactment.
        - For a rating period for which a completed preprint was submitted to the Secretary prior to the date of enactment.

Section 71124: Work/community engagement requirements for expansion adults

- **As of December 31, 2026, states would be required to establish work/community engagement requirements for certain individuals as a condition of Medicaid eligibility**
  - **Extension:** The HHS Secretary can exempt a state from compliance if the state demonstrates a good faith effort. This exemption cannot be extended beyond December 31, 2028.
  - **Applicable individuals:** Applies to adults 19 - 64 eligible for/enrolled in the expansion group and adults 19 – 64 eligible for/enrolled in waivers that provide MEC
  - **Mandatory exceptions and optional hardship waivers:** Mandatory exceptions for specified individuals (pregnant women, foster and former foster youth, Indians/Urban Indians, veterans with rated disabilities, medically frail, AUD/SUD treatment, meet work requirements for TANF/SNAP, parents/caregivers of a dependent child 14 years of age and under or an individual with a disability; incarcerated individuals; individuals who are entitled to postpartum coverage) and optional short-term hardship waivers, including a new hardship waiver for individuals receiving out-of-state medical care for serious or complex conditions
  - States have the option to not require information from members verifying that they meet an exemption.

Section 71124: Work/community engagement requirements for expansion adults (continued)

- **Compliance standard:** Individuals meet the requirement by working at least 80 hours per month or completing other qualifying activities (80 hours of community service or work program, at least half-time enrollment in an educational program, or a combination of these activities for 80 hours; monthly income that is at least 80 times the federal hourly minimum wage)
- **Earlier implementation via an 1115 waiver:** States may, under an 1115 waiver, specify an earlier start date. The Senate makes changing to the outreach requirements to account for this potential earlier start date.
- **Verification:** States required to verify at application (must meet requirement for at least the preceding month) and ongoing (must meet requirement for at least one month during eligibility window)
- **Ex parte:** States required to use existing data sources to attempt to verify compliance (ex parte)
- **Procedural requirements:** States are required to: conduct advance outreach to members to make them aware of the requirements through mail and one or more additional means; establish due process procedures; provide members who are not compliant with 30 days to demonstrate compliance or exempted status, and provide coverage during these 30 days; follow typical disenrollment requirements (assess eligibility on other bases, notice, fair hearings).
- **Prohibition on waivers:** A state cannot waive this provision under an 1115 waiver.

Section 71124: Work/community engagement requirements for expansion adults (continued)

- **Interaction with other provisions:** For purposes of APTC eligibility, an individual should be determined to be eligible for minimum essential coverage if they would have been eligible for Medicaid but did not meet the work requirement. A state shall not be treated as not providing medical assistance to all expansion group individuals solely because an individual is determined ineligible due to not meeting the community engagement requirement.
- **Funding:** This provision would provide:
  - $100 million in grants to states and the District of Columbia, allocated based on the proportion of impacted individuals residing in the state.
  - $100 million in grants to states and the District of Columbia, distributed equally.
- Prohibition on conflicts on interest: States cannot use an MCO or other contractor to determine beneficiary compliance with the community engagement requirement, unless the contractor has no direct or indirect financial relationship with any entity that is contractually responsible for providing/arranging coverage of medical assistance for Medicaid members.
- Interim final rulemaking: HHS must promulgate an interim final rule for purposes of implementing this requirement by June 1, 2026.

New provisions related to immigrant coverage

- **Section 71110: Amended definition of "qualified alien":** As of October 1, 2026, the bill would amend the definition of qualified alien to only include lawful permanent residents, certain Cuban immigrants, and Compact of Free Association (COFA) migrants. Refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, trafficking victims, and other non-citizens would no longer be considered qualified aliens for purposes of Medicaid and CHIP.
  - Other provisions of the bill would mirror this language for Medicare and Marketplace coverage.
- **Section 71112: Expansion FMAP for emergency Medicaid:** Beginning October 1, 2026, sets FMAP for emergency Medicaid at the base FMAP for the state, regardless of eligibility category for the enrollee.

Section 71114: Limits on retroactive Medicaid/CHIP coverage

- For individuals who apply on or after January 1, 2027, would limit retroactive Medicaid/CHIP coverage as follows:
  - Adult expansion population: one month
  - Other Medicaid eligibility categories: two months
  - CHIP: two months

Other eligibility changes

- **Section 71107:** As December 31, 2026, would require states to conduct eligibility redeterminations for expansion adults every six months, as opposed to annually. Tribal members would be exempt from this requirement.
- **Section 77103:** Requires HHS to establish new system to identify duplicate enrollment by October 1, 2029. Requires states to establish standardized processes to update enrollee addresses using data from managed care plans, the National Change of Address Database, and returned mail by January 1, 2027.
- **Section 71104:** As of January 1, 2028, requires states to verify enrollee eligibility against the SSA Death Master File on a quarterly basis.
- **Section 71108:** As of October 1, 2028, would establish new lower cap of $1,000,000 on home equity for LTSS members that is not waivable via asset disregards.

Changes to FMAP related to immigration status

- **Section 71109:** Beginning October 1, 2026, prohibits FMAP for individuals whose immigration status has not yet been verified, including during reasonable opportunity periods
  - Would remove current requirement to provide coverage during the reasonable opportunity period
  - States could, at state option, provide coverage during a reasonable opportunity period, so long as they do not request FMAP until immigration status has been verified.
- **Section 71111:** Beginning October 1, 2027, reduces expansion FMAP by 10 percentage points for states that provide either 1) any form of financial assistance established by the state for purchasing of health insurance coverage funded through the state general fund; or 2) any form of comprehensive health benefits coverage, funded through the state general fund, to an immigrant who is not a qualified alien and is not a child or pregnant woman receiving CHIPRA 214 coverage or otherwise lawfully residing in the United States.

Policy	Effective Date/ Implementation Deadline
Prohibition on implementation of eligibility rules and minimum nurse staffing requirement (Secs. 71101, 71102, 71113)	Date of enactment
Prohibition on Medicaid funds from being paid to certain abortion providers (i.e., Planned Parenthood) for a 10-year period (Sec. 71118)	Date of enactment
Freeze on provider taxes in effect at time of enactment, prohibition on establishment of new provider taxes, and start of reduction to 3.5% threshold for expansion states (Sec. 71120)	Date of enactment
Requirement that HHS certify budget neutrality for 1115 demonstration projects and specify the methodology for accounting for savings generated under an 1115 demonstration in future approval periods (Sec. 71123)	Date of enactment
Directs HHS to limit SDPs to 100% of the Medicare payment rate for expansion states and 110% of the Medicare rate for non-expansion states (or at the Medicaid state plan rate if no Medicare rate is available); grandfathers in already approved SDPs and submitted SDPs which are gradually reduced to the relevant cap (Sec. 71121)	For rating periods beginning on or after the date of enactment
Modifies methodology for determining whether taxes are redistributive (Sec. 71122)	Date of enactment, with transition period of up to three years provided at the Secretary's discretion

Policy	Effective Date/ Implementation Deadline
Requirement that retail and specified non-retail pharmacies participate in the National Average Drug Acquisition Cost survey (Sec. 71115)	First day of the first quarter nine months after enactment for retail pharmacies and the first day of the first quarter eighteen months after enactment for applicable non-retail pharmacies
Prohibition on FMAP for individuals whose citizenship, nationality, or immigration status has not yet been verified (Sec. 71109)	October 1, 2026
Amended definitions of qualified aliens for purposes of Medicaid and CHIP (Sec. 71110)	October 1, 2026
Emergency Medicaid FMAP set at base FMAP calculation, regardless of eligibility category for the individual receiving services (Sec. 71112)	October 1, 2026
Requirement that Medicaid agencies conduct redeterminations of eligibility every six months for expansion adults (Sec. 77107)	December 31, 2026
Establishment of work requirements for expansion adults (Sec. 71124)	December 31, 2026 (with up to two-year good faith effort extension option available)
Requirement that states develop processes to obtain address information from enrollees (Sec. 71103)	January 1, 2027

Policy	Effective Date/ Implementation Deadline
Limits retroactive coverage period from three months to one month for expansion populations, two months for non-expansion populations, and two months for CHIP (Sec. 71114)	For Medicaid or CHIP applications submitted on or after January 1, 2027
Reduces expansion FMAP by 10 percentage points for states that provide financial assistance or comprehensive health benefits coverage to "an alien who is not a qualified alien or otherwise lawfully resident in the US." CHIPRA 214 coverage and other coverage required by federal statute does not trigger this penalty (Sec. 71111)	October 1, 2027
Prohibition on spread pricing in Medicaid; includes requirement that MCO dispensing fees be not less than FFS dispensing fees (Sec. 71116)	Applies to all contracts between states and MCOs, other specified entities, or PBMs that have an effective date on or after 18 months after enactment
Requirement that states check the Death Master File on at least a quarterly basis to identify if enrollees are deceased (Sec. 71104)	January 1, 2028
Requirement that states, as part of their provider enrollment processes and at least quarterly thereafter, check the Death Master File to determine if a provider or supplier is deceased (Sec. 71105)	January 1, 2028

Policy	Effective Date/ Implementation Deadline
Sets a maximum home equity limit of $1 million for purposes of determining eligibility for long-term care services (Sec. 71108)	January 1, 2028
Requirement to implement cost-sharing for expansion adults with incomes >100% FPL (Sec. 71125)	October 1, 2028
Requirement that HHS develop a system to identify duplicate enrollment in multiple Medicaid programs (Sec. 71103)	October 1, 2029
Removal of good faith waiver for payment reductions related to PERM and MEQC error rates and other HHS findings (Sec. 71106)	October 1, 2029
Prohibition on FMAP for specified gender dysphoria services for individuals under the age of 18 (Sec. 44125)	Effective date not specified