State of Play: Status of the 2025 Budget Reconciliation Bill & Implications for Health Care in Mississippi

Supplemental Update Two: Wednesday, July 9, 2025

INTRODUCTION

House Concurrent Resolution 14 was passed by Congress on April 10, 2025. The resolution, which established the budget for Fiscal Year 2025 and set budgetary outlines for the next ten years, directed the House Energy and Commerce Committee to produce $880 Billion in savings from programs under its jurisdiction. Of the programs under the committee's jurisdiction, Medicaid accounts for 93% of total outlays for that period. The Energy and Commerce Committee held a marathon markup meeting on May 13, 2025, where they outlined specific reforms they would pursue to reach those savings and ultimately passed those proposals out of committee. Those proposals and the reconciliation texts of other committees were passed by the House Budget Committee on May 18, 2025, revised further by the House Committee on Rules manager's amendments on May 21, 2025, and ultimately passed as H.R. 1, the One Big Beautiful Bill Act (H.R. 1) on May 22, 2025.

In the United States Senate, the Committee on Finance has jurisdiction over the Medicaid program and released their legislative text for the reconciliation bill on June 16, 2025. The Senate narrowly passed their amended version of H.R. 1 with a 51-50 vote on July 1, 2025, and returned the legislation to the House of Representatives Committee on Rules for a review of the Senate's amendments. After floor debates that went well into the night and into the morning, and the longest House floor speech in the history of Congress, the House of Representatives passed the Senate amendment to H.R. 1 with a vote of 218-214 on July 3, 2025. President Donald Trump signed the bill into law on July 4, 2025.

This summary analysis includes a section-by-section outline and is reflective of language released by the Senate Committee on Finance and was included in Title VII, Subtitle B, Chapters 1, 2, 3, and 4 upon final passage on July 3, 2025[1].

The actual impacts of the provisions in this legislation will be highly dependent on the implementation and effectuation of directives the text requires at both the Federal and State level. Any data, statistics, or background information provided alongside certain sections of the summary are purely for contextual purposes only and are based on information that is currently available and believed to be accurate.

CHAPTER ONE: MEDICAID

Subchapter A – Reducing Fraud and Improving Enrollment Process

Sec. 71101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs (MSP).
This provision delays the enforcement of the rule for 10 years and would suspend requirements for states to automatically enroll certain Supplemental Security Income recipients in the Qualified Medicare Beneficiary (QMB) group, use low-income subsidy program data as an application for MSP, and to accept self-attestation for certain types of income.

Sec. 71102. Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid and CHIP.
This provision delays the enforcement of the rule for 10 years which would limit the type of data sources states can use to determine eligibility and would allow states to impose annual or lifetime limits on Children's Health Insurance Program (CHIP) benefits.

Sec. 71103. Reducing duplicate enrollment under the Medicaid and CHIP programs.
This provision was included in the original House version of the bill and requires state Medicaid programs to regularly obtain and act upon updated address information from reliable data sources, including from managed care entities by October 1, 2029. The HHS Secretary would be required to establish a system to prevent simultaneous Medicaid enrollment in multiple states. Unless exempt by the HHS Secretary, the section would require states to submit specified information on a monthly basis to CMS and to take action when a case of multiple state enrollment is identified. This provision provides $10 million to HHS for FY2026 to establish the address verification system and standards to operate the system and $20 million for FY2029 for system maintenance.

States must offer Medicaid services to individuals who qualify, even if those individuals are temporarily outside the state. However, federal law requires that if a state determines a beneficiary has established residency in another state, their eligibility in the original state must be terminated (42 CFR § 435.403(a) and (j)(3)). The Transformed Medicaid Statistical Information System (T-MSIS) and the Public Assistance Reporting Information System (PARIS) are both existing databases managed by the federal government that could be reformed or repurposed to effectuate the goals of this section[2].

Sec. 71104. Ensuring deceased individuals do not remain enrolled.
This provision requires states to review the Social Security Administration's (SSA) Death Master File (or other electronic data sources) at least quarterly to determine if any enrollees are deceased. The provision would specify processes for disenrollment of deceased enrollees and for reinstatement of coverage in the event of an error.

Sec. 71105. Ensuring deceased providers do not remain enrolled.
This provision codifies the requirement for states to check the SSA's Death Master File during a provider or supplier's enrollment and reenrollment and would add a new requirement for states to check the file not less than quarterly.

Sec. 71106. Payment reduction related to certain erroneous excess payments under Medicaid.
For states with erroneous excess Medicaid payments over the allowable error rate of 3 percent, the HHS Secretary is required to reduce federal Medicaid payments by the amount that exceeds the threshold. However, the HHS Secretary may waive this reduction in federal payments if the state is unable to reach the allowable rate despite a good faith effort. This provision reduces the amount of erroneous excess payments that the Secretary may waive and expands the definition of erroneous excess payments to include items and services furnished to individuals who are not eligible for federal reimbursement in Medicaid.

Sec. 71107. Eligibility redeterminations.
Beginning January 1, 2027, states will be required to conduct eligibility redeterminations once every 6 months for individuals enrolled through the Affordable Care Act's (ACA) Medicaid expansion.

Sec. 71108. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.
Generally, an individual may be excluded from eligibility for Medicaid-covered long-term services and supports (LTSS) if the individual's equity in a home exceeds a state-determined limit. These state-determined limits typically must fall within a minimum and a maximum amount indexed to inflation. As of 2025, the home equity limit minimum is $730,000 and the maximum is $1,097,000.11. This provision caps the home equity limit maximum at $1,000,000 regardless of inflation indexing, except for certain homes on agricultural lots. The section also prohibits states from excluding certain income or assets when determining an individual's eligibility for Medicaid-covered LTSS without applying home equity limits. Additionally, it requires the application of home equity limits for the purposes of determining eligibility for Medicaid-covered LTSS for modified adjusted gross income (MAGI)-excepted enrollees.

Sec. 71109. Alien Medicaid eligibility.
The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) has provided certain non-citizens, referred to as qualified aliens, access to public benefits. Qualified aliens were defined as: (1) lawful permanent residents (LPRs); (2) refugees; (3) aliens granted parole for at least one year; (4) aliens granted asylum or related relief; (5) certain abused spouses and children; (6) certain victims of trafficking; (7) Cuban- Haitian entrants; and (8) Citizens of the Freely Associated States (COFA migrants) residing in states and territories. Qualified aliens are only eligible for Medicaid after the first five years of U.S. residency. This provision amends the definition of qualified aliens to only include the following:

Sec. 71109, continued:

- Lawful Permanent Residents (LPRs);
- Certain Cuban immigrants; and
- Citizens of the Freely Associated States (CoFA migrants) lawfully residing in the United States.

The original House version would have lowered the ACA Medicaid expansion match rate from 90% to 80% for states covering individuals who aren't "qualified aliens." However, that provision was deemed in violation of the Byrd Rule by the Senate Parliamentarian, so the amendment to the definition of "Qualified Alien" was made instead.
This section would not apply to Mississippi because the state has not expanded Medicaid and therefore does not receive the expansion match rate of 90%. However, if the state were to expand Medicaid, this section still may not apply as the state does not provide Medicaid coverage to qualified aliens defined herein[3].

Sec. 71110. Expansion FMAP for emergency Medicaid.
Unlawfully present aliens that would otherwise be eligible for Medicaid expansion if not for their immigration status have been able to qualify for the enhanced ACA expansion FMAP of 90 percent. This provision equalizes the FMAP for otherwise ineligible aliens receiving emergency Medicaid, ensuring that they do not receive a higher FMAP than the traditional Medicaid population.

Subchapter B – Preventing Wasteful Spending

Sec. 71111. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.
This provision delays the enforcement of the rule for 10 years. The rule would have established minimum staffing standards for long-term care facilities and the Medicaid Institutional Payment Transparency Reporting system

Sec. 71112. Reducing state Medicaid costs.
This provision limits retroactive coverage to the month preceding enrollment for ACA Medicaid expansion beneficiaries, and two months preceding enrollment for the traditional Medicaid beneficiaries.

Because Mississippi has not expanded Medicaid, the retroactive period would be reduced from three to two months. This reduced time frame will potentially limit hospitals' ability to obtain reimbursement for services provided, even if the patient was determined to be eligible during the dates of service. The new limits for retroactive coverage would apply to medical assistance, child-health assistance, and pregnancy-related assistance when an individual's eligibility is based on an application made on or after January 1, 2027.

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Sec. 71112. Reducing state Medicaid costs.
This provision limits retroactive coverage to the month preceding enrollment for ACA Medicaid expansion beneficiaries, and two months preceding enrollment for the traditional Medicaid beneficiaries.

Sec. 71113. Federal payments to prohibited entities.
In general, Medicaid enrollees have been able to obtain family planning services from a participating provider of their choice. Medicaid is subject to the Hyde Amendment, which prohibits the use of federal funds for abortions, except in the cases of rape, incest, or endangerment of a woman's life. This provision prohibits states from receiving federal matching funds for services rendered by providers who provide abortions and received more than $800,000 in Medicaid payments in 2023. The original Senate language established this prohibition for a period of ten years but was reduced to the one-year period beginning on the date of enactment.

While there are no providers in Mississippi that offer abortion services, this provision more broadly applies to essential, non-profit providers that are primarily engaged in family planning services, reproductive healthcare, and related care.

Subchapter C – Stopping Abusive Finance Practices

Sec. 71114. Sunsetting increased FMAP incentive.
Similar to the original House bill, this section repeals the temporary five percent enhanced FMAP provided by the American Rescue Plan Act for states that opt to expand Medicaid. This provision would apply prospectively, not affecting states currently receiving an enhanced federal match under this authority.

The American Rescue Plan Act (ARPA) offered an incentive for states to expand Medicaid by providing an additional 5% to the state's traditional FMAP for two years after the expansion. In Mississippi, this incentive would have temporarily boosted the state's FMAP to around 83% and yielded more than $600 million in additional funding to the state over two years. This provision eliminates the ARPA incentive for states that have not expanded Medicaid by January 1, 2026, meaning that Mississippi will be ineligible for this incentive if the state were to expand Medicaid in the future. While expanding Medicaid in Mississippi would change much of the program's financing, in April 2024 the Hilltop Institute estimated that, even without the ARPA incentive, expanding Medicaid would yield approximately $80 million in savings to the state annually[4].

Sec. 71115. Provider taxes.
This provision prohibits states from increasing the rate of current provider taxes or increasing the base of the tax to a class or items of services that the tax did not previously apply. Beginning in 2027, the hold harmless threshold in expansion states for provider classes other than nursing or intermediate care facilities will be reduced by 0.5 percent annually until the maximum hold harmless threshold reaches 3.5 percent by the end of FY 2032.

Similar to original House language, this provision freezes existing provider taxes as of the date of enactment and prohibits the imposition of any new provider taxes after enactment by reducing the "hold harmless threshold" from 6% to 0% for both expansion and non-expansion states. The Senate went further by phasing in a reduction to the hold harmless threshold for states that have expanded Medicaid or opt to in the future.
While Mississippi's provider tax for inpatient and outpatient hospital services is already at the legal limit of 6% and the law freezes the current tax rates, the provision prevents the state from increasing the other provider tax rates. Additionally, if Mississippi opted to expand Medicaid in the future, the hold harmless threshold for the hospital provider tax would be gradually reduced to 3.5%. Initial projections implicate that at the rate of 3.5%, the loss of funding for the Mississippi Hospital Access Program would be greater than $10 billon over a ten-year period[5].

Sec. 71116. State directed payments.
Medicaid state directed payments (SDPs) are supplemental payments to providers under managed care organization contracts. Previously, the total payment rate for inpatient hospital services, outpatient hospital services, nursing facility services or qualified practitioner services at an academic medical center could not exceed the average commercial rate.

This provision directs the HHS Secretary to revise the payment limit for SDPs. For states that have implemented ACA Medicaid expansion, the current payment limit would be reduced from the average commercial rate to 100 percent of the Medicare payment rate. In non-expansion states, the payment limit is to be reduced to 110 percent of the Medicare payment rate. SDPs that were approved or in the process for approval by May 1, 2025, and SDPs for rural hospitals can be grandfathered in at the higher rate, but will be reduced by 10 percent annually until the allowable Medicare-related payment limit is achieved. The bill provides $7 million to HHS each year through FY 2033 for implementation.

The Mississippi Hospital Access Program (MHAP) has provided supplemental payments to hospitals since 2016. In 2023, CMS approved Governor Reeves' reforms to the program to increase reimbursement rates to near the average commercial rate (ACR), which are much higher than traditional Medicaid or Medicare reimbursements[6]. These reforms increased total annual MHAP payments from $500 million-$600 million, to more than $1.5 billion[7].

Sec. 71116, continued:

The original bill would have grandfathered in Mississippi's use of the ACR in MHAP payments and would have only required a change to the program if the state expanded Medicaid. Later, the House Rules Committee manager's amendments changed this provision, however, so that states with a Medicaid Expansion would be limited to only 100% of the Medicare rate, but states that had not expanded would be allowed up to 110% of the Medicare rate. The Senate language that has become law included those changes to the original provision and went further by establishing a process to gradually reduce all SDPs across the country to their respective Medicare rate.

Mississippi will have to work to reformulate its SDPs to be at 110% of the Medicare rate. If the state were to expand Medicaid, it would need to be reduced to 100% and, to be in compliance with Section 71115, the safe harbor threshold would gradually be reduced from 6% to 3.5%.

Sec. 71117. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.

For states to draw down federal Medicaid matching funds, provider taxes have been required to be both broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers), and the HHS Secretary has had the authority to waive the broad-based and uniform requirements if the net impact of the tax is "generally redistributive" and the amount of the tax is not directly correlated to Medicaid payments.

This provision limits the definition of "generally redistributive" and what qualifies for a waiver of the uniform requirement. A tax would only be considered as such if the tax rate is lower for providers with a lower volume or percentage of Medicaid taxable units or if the tax rate on Medicaid taxable units is higher than the tax rate imposed on non-Medicaid taxable units.

Sec. 71118. Requiring budget neutrality for Medicaid demonstration projects under Section 1115.

Section 1115 of the Social Security Act provides HHS with broad authority to waive federal Medicaid requirements to allow states to make budget-neutral changes to their Medicaid programs. Current law has allowed for waivers to be approved that result in spending that is higher than what states would have spent in the absence of a demonstration. This section codifies and strengthens budget neutrality requirements for demonstration projects under section 1115 of the Social Security Act. CMS's Chief Actuary would be required to certify that the total federal expenditures do not exceed what would otherwise have been spent under Medicaid absent the demonstration project. The HHS Secretary would also be required to develop methodologies for applying savings generated under a project to allowable expenditures in a project's extension.

Subchapter D – Increasing Personal Accountability

Sec. 71119. Requirement for States to establish Medicaid community engagement requirements for certain individuals.
This provision requires certain specified nonpregnant, nondisabled, childless adults, aged 19 through 64, to complete a minimum of 80 hours of qualifying community engagement activities prior to initial application or a renewal as a condition of Medicaid eligibility.

Exempted Individuals:

- Veterans with total disability;
- Individuals who are medically frail or otherwise have special medical needs ;
- Individuals who are blind, have a substance use disorder, a disabling mental disorder, a physical or intellectual disability, or a serious or complex medical condition;
- Parents, guardians, and caretaker relatives of children aged 13 or under or a disabled individual;
- Individuals who are Indians, Urban Indians, California Indians, and other Indians who are eligible for the Indian Health Service; or
- Individuals who are inmates in a public institution or who were inmates in a public institution at any point during the three-month period prior to the month where compliance with community engagement activities is being verified.

Good Cause Exemptions: States are permitted to exempt "applicable individuals" from the community engagement requirements for short-term hardships. Short-term hardships would be defined as for all or part of the month that the requesting individual:

- Receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services or other services of similar acuity (including outpatient care), as determined by the HHS Secretary;
- Resides in an area where there is declared an emergency or disaster by the President
- Lives in areas with an unemployment rate that is at or above the lesser of 8 percent or 1.5 times the national unemployment rate; or
- Must travel outside of their community for an extended period of time to receive medical services not available within their community of residence.

Qualifying Activities: Requires "qualifying individuals" to meet one or more of the qualifying activities for a combined total of at least 80 hours per month. Qualifying activities include:

- Employed and working;
- Participation in community service;
- Participation in a work program;
- Enrollment in an education program; or
- To have a monthly income no less than the applicable minimum wage requirement, multiplied by 80 hours, or an average monthly income over the preceding six months that is no less than the minimum wage requirement multiplied by 80 hours.

Consequences for Not Meeting the Community Engagement Requirement: The provision stipulates that failure to meet the community engagement requirement will result in denial of eligibility or disenrollment for noncompliance.

State Procedures for Noncompliance: The provision requires states to establish processes and use reliable information available to the states (e.g., payroll data) without requiring, where possible, the applicable individual to submit additional information. The state will be required to provide notice of noncompliance. Within 30 days from the date the notice is received, the enrollee must demonstrate either compliance with the requirement or that the individual does not meet the definition of applicable individual. During the 30-day period, medical assistance for the individual shall be maintained. After 30 days, if the noncompliance has not been resolved, the state must provide timely and adequate written notice (as specified) and deny or terminate eligibility within 30 days.

Outreach and Enrollee Education Requirements: The provision requires states to notify individuals subject to the Medicaid community engagement requirements at least three months before the requirement becomes effective and periodically thereafter by mail, electronic format, and one or more additional methods, including telephone, text message, website or other available electronic means. Enrollee education shall include information on who is impacted, who is exempt, how to comply, how to report compliance and consequences for noncompliance.

Sec. 71120. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program.

This provision requires Medicaid expansion enrollees earning more than 100% of FPL to pay cost-sharing amounts that are greater than $0 but do not exceed $35 per service. Cost sharing requirements would not apply to primary, prenatal, pediatric, mental health, or substance abuse services, or to emergency room care or services provided by Federally Qualified Health Centers (FQHCs), Certified Community Behavioral Health Clinics (CCBHCs) or Rural Health Clinics. The law does apply these requirements to non-emergency services provided in an emergency room, and allows for the cost sharing of those services to exceed $35.

States that have expanded Medicaid would be required to implement cost sharing requirements on certain individuals in an amount greater than $0.00 but no more than $35.00 and would permit state Medicaid providers to require these payments to be made as a condition for the provision of care.

These cost sharing requirements would not apply to any Mississippi Medicaid beneficiaries, unless the state were to expand Medicaid in the future.

Subchapter E – Expanding Access to Care

Sec. 71121. Making certain adjustments to coverage of home or community-based services under Medicaid.
This provision provides states with the option to pursue a standalone waiver under section 1915(c) and expand access to home and community-based services. For FY 2026, the bill appropriates $50 million to HHS for federal implementation and, for FY 2027, appropriates $100 million for making payments to states delivering home or community-based services.

CHAPTER TWO – MEDICARE

Subchapter A – Strengthening Eligibility Requirements

Sec. 71201. Limiting Medicare coverage of certain individuals.
This provision limits non-citizen eligibility for Medicare to the following three groups:

- Lawful permanent residents (LPRs);
- Certain Cuban immigrants; and
- Citizens of the Freely Associated States (CoFA migrants) lawfully residing in the United States.

Subchapter B – Improving Services for Seniors

Sec. 71202. Temporary payment increases under the Medicare physician fee schedule to account for exceptional circumstances.
This provision provides a rate update to the Physician Fee Schedule of 2.5%. The rate update is only for calendar year 2026 and provides no adjustment for calendar year 2025. The CBO projects this will increase federal spending by $1.9 billion over ten years.

Sec. 71203. Expanding and clarifying the exclusion for orphan drugs under the Drug Price Negotiation Program.
This section modifies provisions of the Inflation Reduction Act to exclude orphan drugs under the Drug Price Negotiation Program. The CBO projects this will increase federal spending by $4.9 billion over ten years.

CHAPTER THREE – HEALTH TAX

Subchapter A – Improving Eligibility Criteria

Sec. 71301. Permitting premium tax credits only for certain individuals.
Eligible individuals have been able to receive a premium tax credit (PTC) to subsidize the cost associated with enrolling in specified health plans offered through health insurance exchanges. U.S. citizens, U.S. nationals or lawfully present individuals have been able to qualify for the PTC. This provision limits eligibility for the PTC to the following eligible aliens: lawful permanent residents, certain Cuban immigrants, and CoFA migrants lawfully residing in the United States.

Sec. 71302. Disallowing premium tax credit during periods of Medicaid ineligibility due to alien status.
This provision disallows undocumented immigrants who report incomes below 100% of FPL and are in their five-year Medicaid waiting period from receiving the PTCs to purchase health insurance on the marketplaces.

Subchapter B – Preventing Waste, Fraud, and Abuse

Sec. 71303. Requiring verification of eligibility for premium tax credit.
This provision requires verification of specific insurance application information in order for an enrollee to qualify for the PTC. Such information includes household income, any immigration status, any health coverage status or eligibility for coverage, place of residence, family size and other information that may be necessary to conduct verification. This also prohibits automatic reenrollment for enrollees that receive the PTC by requiring them to actively prove their eligibility for the PTC each year.

While the Senate language that was passed into law is less restrictive than what was originally proposed by the House, this provision still requires much more thorough eligibility and income verifications for an individual's initial enrollment in a qualified health plan. Even though this provision has no direct impacts on federal funding for Medicaid to the state, additional investments may be necessary from the state in order to establish or enhance administrative processes to effectuate these requirements. Additionally, the more strenuous eligibility and income verifications that would be required of the population enrolled in these plans could make it more difficult to enroll or reenroll and could potentially lead to significant loss of coverage or, at minimum, lapses in coverage.

Sec. 71304. Disallowing premium tax credit in case of certain coverage enrolled in during special enrollment period.
Starting with plan years beginning January 1, 2026, this provision would disallow the PTC for individuals who enrolled in an exchange plan during an income-based special enrollment period that is not connected to a change in other circumstances.

Sec. 71305. Eliminating limitation on recapture of advance payment of premium tax credit.
This provision removes the repayment limits for excess advanced PTCs, requiring taxpayers to repay the full amount of any excess. Individuals with estimated annual income at or above 100 percent of FPL that received an advanced PTC, but whose actual income is less than 100 percent of FPL, would not be required to return excess payments unless the Secretary determines the individual provided incorrect information intentionally or with "reckless disregard for the facts."

To reenroll, an individual will be required to prove they filed an income tax return for the prior tax year and reconcile any Advance Premium Tax Credit on said returns.

Subchapter C – Enhancing Choice for Patients

Sec. 71306. Permanent extension of safe harbor for absence of deductible for telehealth services.
This provides a safe harbor to allow telehealth services to be provided before the deductible has been met for individuals with high-deductible health plans.

Sec. 71307. Allowance of bronze and catastrophic plans in connection with health savings accounts.
Allows Bronze and Catastrophic Plans to contribute to Health Savings Accounts (HSAs).

Sec. 71308: Treatment of direct primary care service arrangements.
Allows individuals with high-deductible health plans to enroll in direct primary care service arrangements and to use their HSA for payment.

CHAPTER FOUR – PROTECTING RURAL HOSPITALS AND PROVIDERS

Sec. 71401. Rural Health Transformation Program.
Creates a rural stabilization fund with $50 billion, to be paid out as $10 billion annually from FY 2026 through 2030. States will need to submit a one-time application to CMS to be eligible for an allotment of these funds during a submission period specified by CMS (with an application and decision date no later than Dec. 31, 2025). Of the $50 billion in funding, 50% of the funds for each fiscal year will be equally distributed among all the states with an approved application. Forty percent of the funds for each fiscal year will be distributed in a method determined by CMS. CMS will consider the following as its distribution method:

- the percentage of the state population located in rural geographies,
- the proportion of rural health facilities in the state relative to the nation, and
- any other factors deemed appropriate by CMS.

Not more than 10% of the amount allocated to the states can be used for administrative expenses. Separately, the legislation appropriates $200 million to the CMS administrator for FY 2025 to implement these provisions.

References

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