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

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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, and recently revised by the House Committee on Rules on May 21, 2025.

This summary of the House Energy and Commerce Committee's reconciliation text is a section-by-section outline of the committee print for Subtitle D-Health and is reflective of both original language and official revisions to that language as of May 21, 2025.

The actual impacts of this proposed legislation are dependent on the version of the text at final passage, as well as the federal and state level implementation of the directives the text requires. Any data, statistics, or background information provided alongside certain sections of the summary are for purely contextual purposes only and are based on information that is highly subject to change.

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PART ONE: MEDICAID

Subpart A – Reducing Fraud and Improving Enrollment Process

Section 44101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs.
This section requires the Department of Health and Human Services (HHS) to delay implementation, administration, or enforcement of the final rule titled "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" until January 1, 2035.

Section 44102. Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program.
This section requires HHS to delay implementation, administration, or enforcement of the final rule titled "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" until January 1, 2035.
The final rule addressed in this section is the second part of a two-part rule that was published on April 2, 2024. This proposal would prohibit the Secretary of Health and Human Services from implementing this rule until January 1, 2035.

Section 44103. Ensuring appropriate address verification under the Medicaid and CHIP programs.
This section requires states to establish processes to regularly obtain beneficiary address information from reliable data sources, including by requiring state Medicaid programs to collect address information provided by beneficiaries to managed care entities (where applicable). In addition, this section requires HHS to establish a system to prevent individuals from being simultaneously enrolled in multiple State Medicaid programs by no later than October 1, 2029.

States would be required to submit to the system the Social Security Number of the individual enrolled under the State plan to identify when Social Security Numbers for individuals enrolled in Medicaid are identified concurrently in two or more States at the same time.

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[1].

Section 44104. Modifying certain state requirements for ensuring deceased individuals do not remain enrolled.
This section requires state Medicaid programs to check the Social Security Administration's Death Master File on at least a quarterly basis to determine whether Medicaid enrollees are deceased and to disenroll individuals who are determined to be deceased from Medicaid coverage.

Section 44105. Medicaid provider screening requirements.
This section requires states to conduct monthly checks of databases or similar systems to determine whether HHS or another state has already terminated a provider or supplier from participating in Medicaid and to also disenroll them from the state's Medicaid program.

Section 44106. Additional Medicaid provider screening requirements.
This section codifies the requirement that state Medicaid programs check, as part of the provider enrollment and re-enrollment process and on a quarterly basis thereafter, the Social Security Administration's Death Master File to determine whether providers are deceased and enrolled in the state's Medicaid program.

Section 44107. Removing good faith waiver for payment reduction related to certain erroneous excess payments under Medicaid.
This section requires HHS to reduce federal financial participation (FFP) to States for errors identified through the ratio of a State's erroneous excess payments for medical assistance, by the Office of the Inspector General, or by the Secretary are directly attributable to payments to ineligible individuals or for ineligible services.

Section 44108. Increasing frequency of eligibility redeterminations for certain individuals.
This section requires States to conduct eligibility determinations for Expansion population adults every six months. Current law currently requires such determinations to occur on every twelve months.

Mississippi is one of ten states that have not expanded Medicaid eligibility as allowed by the Affordable Care Act and would therefore continue to only conduct eligibility redeterminations on an annual basis. If Mississippi were to expand Medicaid, the Division of Medicaid would be required to redetermine the eligibility of that population once every six months beginning on October 1, 2027.

Section 44109. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.
This section establishes a ceiling of $1,000,000 for permissible home equity values for individuals when determining allowable assets for Medicaid beneficiaries that are eligible for long-term care services. This section also prohibits the use of asset disregards from being applied to waive home equity limits.

Section 44110. Prohibiting federal financial participation under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status.
This section prohibits FFP in Medicaid for individuals whose citizenship, nationality, or immigration status has not been verified, including during reasonable opportunity periods when an individual has not yet verified citizenship, nationality, or immigration status. Current law permits states to enroll individuals in coverage immediately and then provide 90-day reasonable opportunities that allow individuals to immediately begin receiving coverage and then wait up to 90 days before verifying citizenship or immigration status, all while receiving FFP during this period. This policy permits states, at the state's option, to provide coverage during a reasonable opportunity period in which an individual may not yet have provided evidence of citizenship, nationality, or immigration status, so long as the state does not request FFP until citizenship, nationality, or immigration status have been verified.

This section would not apply to Mississippi because the state does not provide Medicaid coverage to qualified aliens as defined herein or receive federal funds for the provision of such coverage[2].

Section 44111. Reducing expansion FMAP for certain states providing payments for health care furnished to certain individuals.
This section reduces by ten percent the Federal Medical Assistance Percentage (FMAP) for Medicaid Expansion States who use their Medicaid infrastructure to provide health care coverage for illegal immigrants under Medicaid or another state-based program.

This section proposes reducing federal Medicaid funds to states that use their own money to cover undocumented immigrants. A recent change made in the House Committee on Rules expands the penalty to states that offer coverage to lawfully residing children and pregnant people under Medicaid or CHIP. Specifically, it would lower the ACA Medicaid expansion match rate from 90% to 80% for states covering individuals who aren't "qualified aliens" – a limited group of lawfully present immigrants. 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].

Subpart B – Preventing Wasteful Spending

Section 44121. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.
This section requires HHS to delay implementation, administration, or enforcement of the final rule titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" until January 1, 2035.

The final rule addressed in this section was published on May 10, 2024. This proposal would prohibit the Secretary of Health and Human Services from implementing this rule until January 1, 2035.

Section 44122. Modifying retroactive coverage under the Medicaid and CHIP programs.
This section limits retroactive coverage in Medicaid to one month prior to an individual's application date. Current law provides retroactive coverage for up to three months before an individual's application date.

The proposed limit of one month for retroactive coverage would apply to medical assistance, child-health assistance, and pregnancy-related assistance when an individual's eligibility for such assistance is based on an application made on or after October 1, 2026.

Section 44123. Ensuring accurate payments to pharmacies under Medicaid.
This section requires participation by retail and applicable non-retail pharmacies in the National Average Drug Acquisition Cost (NADAC) survey. The NADAC survey measures pharmacy acquisition costs and is often used in the Medicaid program to inform reimbursement to pharmacies.

Section 44124. Preventing the use of abusive spread pricing in Medicaid.
This section bans "spread pricing" in the Medicaid program, which occurs when pharmacy benefit managers retain a portion of the amount paid to them (a "spread") for prescription drugs.

Section 44125. Prohibiting federal Medicaid and CHIP funding for gender transition procedures for minors.
This section prohibits FFP for specified gender transition procedures to individuals under the age of 18.

Section 44126. Federal payments to prohibited entities.
This section prohibits Medicaid funds to be paid to providers that are nonprofit organizations, that are essential community providers that are primarily engaged in family planning services or reproductive services, provide for abortions other than for Hyde Amendment exceptions, and which received $1,000,000 or more (to either the provider or the provider's affiliates) in payments from Medicaid payments in 2024.

Subpart C – Stopping Abusive Financing Practices

Section 44131. Sunsetting eligibility for increased FMAP for new expansion states.
This section sunsets the temporary five percent enhanced FMAP afforded to states under the American Rescue Plan Act 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 proposal would eliminate the ARPA incentive for states that had not expanded Medicaid by January 1, 2026, meaning that Mississippi would be ineligible for this incentive if the state were to expand Medicaid in the future. However, in April 2024, the Hilltop Institute estimated that, even without the ARPA incentive, expanding Medicaid would still yield approximately $80 million in savings to the state annually[4].

Section 44132. Moratorium on new or increased provider taxes.
This section freezes, at current rates, states' provider taxes in effect as of the date of enactment of this legislation and prohibits states from establishing new provider taxes.

While this proposal prohibits any increases to provider taxes after the enactment of this legislation, Mississippi's provider taxes are already at or near the legal limits. This proposal would lock in Mississippi's current provider tax rates[5].

Section 44133. Revising the payment limit for certain state directed payments.
This section directs HHS to revise current regulations to limit state directed payments for services furnished on or after the enactment of this legislation from exceeding the total published Medicare payment rate. This section would not affect total payment rates for state directed payments approved prior to this legislation's enactment.

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]. While this proposal would limit such payments to the published Medicare rates, Mississippi's use of the ACR in MHAP payments would be grandfathered in and be unaffected by this proposal.

Section 44134. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.

This section modifies the criteria HHS must consider when determining whether certain health care-related taxes are generally redistributive. Under this section, a tax would not be considered generally redistributive if, within a permissible class, the tax rate imposed on the taxpayer or tax rate group explicitly defined by its relatively lower volume or percentage of Medicaid taxable units is lower than the tax rate imposed on any other taxpayer or tax rate group explicitly defined by its relatively higher volume or percentage of Medicaid taxable units. The tax would also not be considered generally redistributive if, within a permissible class, the tax rate imposed on any taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable unit.

If a State has a health care-related tax waiver that meets at least one of these criteria as of the date of enactment of this legislation, the waiver must be modified to comply with these requirements. This section provides a transition period for non-compliant programs, after which a State whose health care-related taxes do not adhere to all federal requirements would be penalized by the sum of those revenues received by State.

Section 44135. Requiring budget neutrality for Medicaid demonstration projects under section 1115.

This section provides budget neutrality requirements for demonstration projects under section 1115 of the Social Security Act. HHS would be required to certify that the total expenditures for FFP do not exceed what would otherwise have been spent under Title XIX absent the demonstration project. HHS must also develop methodologies for applying savings generated under a project as allowable costs to be spent in a project's extension.

Subpart D – Increasing Personal Accountability

Section 44141. Requirement for states to establish Medicaid community engagement requirements for certain individuals.

This section requires states to establish community engagement requirements for able- bodied adults without dependents. An individual can meet the community engagement requirements during a month by working at least 80 hours, completing at least 80 hours of community service, participating in a work program for at least 80 hours, enrolling in an educational program for at least 80 hours, or a combination of these activities for at least 80 hours.

The requirements of this section would not apply to the following individuals: pregnant women, individuals under the age of 19 or over the age of 64, foster youth and former foster youth under the age of 26, members of a Tribes, individuals who are considered medically frail (which includes, but is not limited to, individuals who are blind or disabled, who have a chronic substance use disorder, who have a serious and complex medical condition, or who have a condition, as defined by the State and approved by the Secretary, as meeting the definition of medically frail), individuals who are already in compliance with the work requirements under the Temporary Assistance for Needy Families (TANF) program or Supplemental Nutrition Assistance Program (SNAP), individuals who are a parent or caregiver of a dependent child or an individual with a disability, or are incarcerated or recently released from incarceration within the past 90 days. This section also provides short-term hardship waivers for natural disasters and for counties where the unemployment rate is greater than eight percent or greater than 150 percent of the national average.

Compliance with community engagement requirements would be verified by states no less frequently than for the month preceding an individual's enrollment in Medicaid and in a month preceding the individual's eligibility redetermination and verified as part of an individual's overall eligibility determination or redetermination. States would be required to provide regular, advanced notice and outreach to make individuals aware of the requirements, would be required to streamline and simplify processes to verify compliance to reduce burdens on individuals, and to establish due process procedures for individuals before denying coverage or removing individuals from coverage.

In Mississippi, Medicaid coverage other than limited benefit plans such as family planning is not available to adults without dependents. Therefore, this provision would have minimal impacts on the state's Medicaid population. If the state were to expand Medicaid eligibility, more individuals considered to be able-bodied adults would enroll and be subject to these requirements. The requirements, as well as exceptions to those requirements, proposed in this legislation are largely in line with a work and community engagement requirement that was proposed by the Mississippi Legislature in House Bill 1725 during the 2024 Regular Session[8]. Additionally, this federal proposal would provide exceptions to these requirements on an individual, month-by-month basis for short-term hardship events. Such events would include a month in which an individual receives certain inpatient services, or if the individual resides in a county where an emergency or disaster is declared, or in a county with an unemployment rate that is at or above the lesser of 8% or 1.5 times the national unemployment rate.

Section 44142. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program.

This section requires states to impose cost sharing on Medicaid Expansion adults with incomes over 100 percent of the federal poverty level (FPL). This cost-sharing may not exceed $35 per service—rather than the current $100 per service limit. Cost sharing may not exceed five percent of the individual's income, which is the current out-of-pocket limit for Medicaid beneficiaries.

This section would not permit cost-sharing on primary care, prenatal care, pediatric care, or emergency room care (except for non-emergency care provided in an emergency room).

Under this proposal, states 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 proposed cost sharing requirements would not apply to any Mississippi Medicaid beneficiaries, unless the state were to expand Medicaid in the future. The original proposal would not have allowed cost sharing to be applied to the services listed above, but a recent change made by the House Committee on Rules expanded those prohibitions to include mental health care and substance use disorder services.

PART TWO: AFFORDABLE CARE ACT

Section 44201. Addressing waste, fraud, and abuse in the ACA exchanges.
This section would institute eligibility and income verification processes for Patient Protection and Affordable Care Act (ACA) enrollees. In addition, it would roll back income- based special enrollment periods in the federally-facilitated and state ACA exchanges. This section would also make technical changes to health plans offered via the ACA exchanges. It would institute ACA reenrollment guardrails for enrollees in zero-dollar premium health plans. Additionally, this section would prohibit gender transition procedures from being included as an essential health benefit (EHB), and it would amend the definition of "lawfully present" for the purposes of qualified health plan enrollment. This section would also permit issuers to require enrollees to satisfy debt for past-due premiums as a prerequisite for effectuating new health coverage. The provisions within this section would take effect for plan years beginning on or after January 1, 2026.

For plan years beginning on or after January 1, 2026, this proposal would prohibit special enrollment periods from being based on income or federal poverty level (FPL) and would only allow for them in the case of a change in circumstances or other specified event.

The proposal would also require much more thorough eligibility and income verifications for an individual's initial enrollment in a qualified health plan. In order 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.

Among these proposals and other technical reforms to qualified health plans, this section would also permit insurers to require complete payment of any past due premiums as a condition for coverage.

PART THREE: IMPROVING AMERICAN'S ACCESS TO CARE

Section 44301. Expanding and clarifying the exclusion for orphan drugs under the drug price negotiation program.
This section makes technical corrections to current law by permitting product sponsors to have one or more orphan drug indication in order to be exempt from the Drug Price Negotiation Program in statute. Current law limits exemptions from the Drug Price Negotiation Program to one rare disease indication. This section also revises the start of the timeline in which a manufacturer would be eligible for negotiation until an orphan drug receives its first non-orphan indication.

Section 44302. Streamlined enrollment process for eligible out-of-state providers under Medicaid and CHIP.
For purposes of improving access to necessary out-of-state care for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP), this section requires states to establish a process through which qualifying pediatric out-of-state providers may enroll as participating providers without undergoing additional screening requirements.

This proposal would require states to establish a process to streamline out-of-state pediatricians' enrollment as a provider under the state's Medicaid program, and to provide payment to those providers under the State plan.

Section 44303. Delaying DSH reductions.
This section delays the Medicaid Disproportionate Share Hospital (DSH) reductions, currently $8 billion reductions per year that are set to take effect for fiscal years 2026 through 2028, to instead take effect for fiscal years 2029 through 2031. This section also extends funding for Tennessee's DSH program, which is set to expire at the end of this fiscal year, through fiscal year 2028.

Section 44304. Modifying update to the conversion factor under the physician fee schedule under the Medicare program.
This section amends current law by replacing the split physician fee schedule conversion factor set to take effect on January 1, 2026, with a new single conversion factor based on a percentage of medical inflation, or the Medicare Economic Index (MEI).

This proposal would replace the Advance Alternative Payment (APM) Conversion Factor with the Medicare Economic Index and is in line with recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the sustainability of the Medicare Physician Payment System. According to MedPAC, MEI is meant to track the weighted cost trends of clinicians' practices and is likely a more predictable, stable conversion factor on which the fee schedules can be based upon[9]. The proposed update to this single conversion factor for 2026 would be set at 75% of the estimated percentage increase in the MEI for the year, and at 10% for 2027 and each subsequent year.

Section 44305. Modernizing and ensuring PBM accountability.
This section requires Pharmacy Benefit Managers (PBMs) in Medicare Part D to transparently share information relating to business practices with Medicare Part D Prescription Drug Plan Sponsors, including information relating to formulary decisions and prescription drug coverage that benefits affiliated pharmacies. The policy also prohibits PBM compensation based on a drug's list price, limiting compensation to fair market bona-fide service fees. Lastly, the legislation requires the Centers for Medicare and Medicaid Services to define "reasonable and relevant" contracting terms for the purposes of enforcing Medicare Part D's "any willing pharmacy" requirements.

References

1. Office of Inspector General. (2022, September 19). Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States. Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services. https://oig.hhs.gov/reports/all/2022/nearly-all-states-made-capitation-payments-for-beneficiaries-who-were-concurrently-enrolled-in-a-medicaid-managed-care-program-in-two-states/
2. Grusin, S., & McKee, C. (2024, August 8). Medicaid coverage for immigrants. National Health Law Program. https://healthlaw.org/resource/medicaid-coverage-for-immigrants/
3. Ibid.
4. Henderson, M. (2024). Mississippi medicaid expansion policy option analysis. The Hilltop Institute.
5. Burns, A., Hinton, E., Williams, E., & Rudowitz, R. (2025, March 26). 5 key facts about medicaid and provider taxes | KFF. KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/
6. Mississippi Division of Medicaid. (2023, September 22). Governor Reeves proposes nearly $700 million in additional hospital funding through Medicaid - Mississippi Division of Medicaid. https://medicaid.ms.gov/governor-reeves-proposes-nearly-700-million-in-additional-hospital-funding-through-medicaid/
7. Mississippi Division of Medicaid. (2019, November 12). Value-Based Incentives - Mississippi Division of Medicaid. https://medicaid.ms.gov/value-based-incentives/
8. H.B. 1725, 2024 Reg. Sess. (Miss. 2024). https://billstatus.ls.state.ms.us/documents/2024/html/cr/HB1725CR.htm
9. O'Donnell, B., Gerhardt, G., & Burton, R. (2024). Considering approaches for updating the Medicare physician fee schedule. MedPAC. https://www.medpac.gov/wp-content/uploads/2023/10/Approaches-for-PFS-update-April-2024-SEC.pdf

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