



LEGAL UPDATES

Where To, Medicaid? House Legislation Makes Significant Changes; Senate Future is Uncertain

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On May 22, 2025, after a marathon markup session, the U.S. House of Representatives passed a bill containing significant proposed changes to the Medicaid program. The One, Big, Beautiful Bill Act ("the bill"), narrowly passing on a 215 to 214 vote, contains several Medicaid-related provisions that could have sweeping implications for patients, providers and state governments.

On June 4, the Congressional Budget Office (CBO) released estimates of the bill's effects – concluding that 10.9 million more people in 2034 would be without health insurance because of these changes [1]. The CBO estimates that the proposed changes to Medicaid and the Children's Health Insurance Program (CHIP) would cut \$863.4 billion in spending over the next 10 years. Most of the proposed changes target the Medicaid expansion program that has been adopted by 40 states and the District of Columbia (DC) following passage of the Affordable Care Act (ACA) in 2010.

The bill's passage coincides with two other Medicaid-focused developments:

1. The Centers for Medicare & Medicaid Services (CMS) recently issued a proposed rule that would, according to the agency, "end states' ability to exploit a health care-related tax loophole currently used by seven states," which the agency has determined "generate[s] billions in in federal Medicaid payments—without contributing their fair share or expanding care for Medicaid enrollees." The rule is designed to eliminate certain tax practices that involve taxing Medicaid business at a higher rate (as compared to non-Medicaid business), receiving federal matching funds, and then using the payment difference for other state purposes.
2. On June 6, the President released a presidential memoranda titled, "Eliminating Waste, Fraud, and Abuse in Medicaid." This executive action focuses on provider taxes – (discussed further below), characterizing these taxes are a way to "game the system" by allowing states to tax providers and then recoup the taxes through "burden-sharing" funds from the federal government.

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Reduction in Reimbursement Rate to States Providing Coverage for Certain Immigrants

The bill [2] reduces the federal Medicaid reimbursement rate from 90% to 80% for those states that expanded Medicaid coverage to immigrants who are not “a qualified alien” or a “child or pregnant woman who is lawfully residing in the United States.” The Kaiser Family Foundation (KFF) estimates that the bill’s change could affect 14 states and DC that have expanded Medicaid coverage to undocumented immigrants using state, not federal, funds [3]. Additionally, 12 states have “trigger” laws that may end the entire Medicaid expansion created by the ACA, or require changes when federal funding is reduced. States would need to either absorb the reduction in reimbursement to retain their current coverage levels or remove individuals who do not fall within the listed exceptions from coverage under their Medicaid programs in order to comply with this proposed change.

Medicaid Work Requirements

The bill [4] requires states to establish 80 hours per-month work requirements, or other qualifying activities, for “able-bodied” Medicaid recipients. The CBO projects that this requirement will apply to about 18.5 million people. The cost of implementing and administering these requirements falls to states that independently administer their Medicaid programs. The bill contains \$100 million in grants for FY2026 to scale up state systems for tracking compliance with these requirements. Some industry observers have expressed concern that creating an IT infrastructure on the scale necessary to create these complex tracking systems will involve costs that far exceed the proposed budget.

The scope of people who would be affected by this change is also unclear. According to research and reporting by the KFF, 92% of Medicaid recipients already engage in qualifying activities or meet the criteria for an exemption. The CBO estimates that the majority of those who lose coverage due to this requirement will not have access to employer-provided health care, and that none will be eligible for premium tax credits for ACA plans.

Freeze on New and Increased State Provider Taxes; Update to Medicare Physician Fee Schedule

Forty-nine states and DC partially fund their Medicaid programs through a tax on health care providers. Known generally as the “provider tax,” these levies have been in place in some states for over 30 years. Hospitals and nursing homes are the most commonly taxed Medicaid providers. These taxes are subject to a variety of limitations, including that they must 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) Also, states are not allowed to hold the providers harmless for the cost of the provider tax (i.e., states cannot guarantee that providers receive their money back).” [5] These taxes have served as a flexible tool for states to adjust in times of economic distress or to fund changes in their Medicaid programs. Under the bill [6], states would no longer have the ability to implement new or increased provider taxes, which would directly affect state governments’ ability to implement changes in response to the bill’s Medicaid cuts.

A second provision also affects the use of provider taxes [7]. It mandates that certain existing provider taxes can no longer be used to pay for Medicaid. This provision codifies a stricter version than the proposed rule discussed above. It also imposes more rigorous requirements for securing a waiver from the general rule that provider taxes must be imposed in a uniform manner. Like the freeze on new and increased provider taxes, this change would significantly curtail states’ ability to adapt to potential changes in Medicaid funding.

Additionally, the bill includes a modification to the Medicare Physician Fee Schedule (MPFS) [8] This change would link MPFS rates to the Medicare Economic Index (starting in 2026), which brings physician payment into better alignment with inflation. This also makes the change permanent; going forward, the update would be tied a percentage of inflation. The initial result for providers would be a 2026 payment increase of 2.25%, a change from the falling rates of previous years.

Delay in Implementation of Final Rules Intended to Streamline Enrollment

The bill would also delay (until 2034) implementation of final rules issued by CMS in 2023 and 2024 related to eligibility and enrollment for Medicaid, CHIP and the Basic Health Program. These rules – titled “Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment” [9] and “Streamlining the Medicaid, Children’s Health Insurance Program and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes” [10] – were designed to simplify the enrollment process by aligning enrollment requirements with other public programs and reducing administrative burden on states and eligible individuals. This moratorium would keep existing state enrollment practices in place.

The CMS rules were designed to bring more eligible individuals into the Medicaid program. By delaying their implementation, some eligible individuals may remain unenrolled.

Increased Frequency of Medicaid Eligibility Determinations

The bill [11] requires states to switch from conducting Medicaid eligibility determinations annually to doing so every six-months. This change will likely result in more procedural hurdles for states to maneuver in order to administer these checks more frequently.

Additional Effects of Proposed Changes

According to CBO estimates, 1.4 million people who are eligible for dual enrollment in Medicaid and Medicare could lose their Medicaid coverage over the next 10 years. Loss of Medicaid coverage would result in loss of enrollment in the Low Income Subsidy (LIS) program, which was created when Medicare Part D was enacted under the 2003 Medicare Modernization Act. The LIS program provides subsidies to eligible individuals to help defray the cost of premiums, copays and prescription drugs. This benefit loss could lead to a decrease in filling prescriptions – a particularly significant problem for individuals with multiple chronic conditions.

Conclusion

The Medicaid provisions in the bill are currently under negotiation in the Senate and will certainly be subject to revision. Some Senate Republicans have expressed misgivings about the Medicaid cuts included in the bill, while others have asserted that the cuts do not go far enough. This all remains a controversial and ever-moving target. Current proposals in the Senate, for example, would broaden the Medicaid work requirements to include parents of children older than 14, and would also gradually reduce the cap on provider taxes that states can impose to 3.5% (in 2031, with certain exceptions). Senate Democrats have introduced their own legislation, but without a majority that bill appears doomed.

If you have questions about the bill’s Medicaid implications for your organization, please contact **Jesse Berg** or your regular Lathrop GPM attorney.

Emily Sparling, a 2025 summer associate working with our Health Care & Nonprofit Organizations group, contributed to this legal alert.

[1] https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

[2] The One, Big, Beautiful Bill Act of 2025, H.R. 1, 119th Congress, § 44110

[3] <https://www.kff.org/policy-watch/implementing-work-requirements-on-a-national-scale-what-we-know-from-state-waiver-experience/>

[4] Bill § 44141

[5] https://www.congress.gov/crs_external_products/RS/PDF/RS22843/RS22843.28.pdf

[6] Bill § 44132

[7] Bill § 44134

[8] Bill § 44304

[9] <https://www.federalregister.gov/documents/2023/09/21/2023-20382/streamlining-medicaid-medicare-savings-program-eligibility-determination-and-enrollment>

[10] <https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health>

[11] Bill § 44108