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House Energy and Commerce Subcommittee Propose Massive Medicaid Reductions

By Felicia Sze

Late May 11, 2025, the House Energy and Commerce Subcommittee released the Republican proposal for Medicaid and other healthcare programs (the "HEC Proposal"). The most obvious policy proposal is significant reductions in Medicaid expenditures arising from enrollment and eligibility changes, limitations on state financing mechanisms, and restrictions on provider payments. There are a few targeted increases such as the delay of DSH cuts, but the overall goal is to scale back federal Medicaid spending and limit coverage protections. These proposals could significantly impact both new and existing Medicaid financing arrangements. We will continue to evaluate the specific implications for affected programs and will analyze any amendments to these proposals.

The major proposals fall into the following categories:

Medicaid Financing	Provider Payments	Provider Enrollment
Benefits	Eligibility and Enrollment	Other Changes

MEDICAID FINANCING

- Reduces federal matching assistance percentage for the ACA expansion population to 80% for states that provide health coverage for undocumented individuals, starting October 1, 2027. (§ 44111.)
- Prohibits enhanced FMAP for newly eligible for states that have not yet expanded. (§ 44131.)
- Prohibits new healthcare-related taxes (first imposed on or after the date of enactment) or increased healthcare-related taxes (increases the amount or rate of tax imposed or increases the base of the tax – but only if the increase was not provided for in legislation or regulations enacted or adopted prior to the date of enactment). (§ 44132.)
- Prohibits a waiver of the uniformity requirement for healthcare-related taxes where the tax rate is explicitly defined or results in a lower rate imposed on providers of lower volume or percentage of Medicaid taxable units or a higher rate on providers of higher volume or percentage of Medicaid taxable units. This would have a significant impact on currently existing healthcare-related taxes as most programs that operate under waivers of uniformity distinguish rates that are based on or could result in rates being based in part on Medicaid utilization. This provision takes effect on the date of enactment, but the Secretary of Health and Human Services is given the create a transition period of up to 3 fiscal years. (§ 44134.)

PROVIDER PAYMENTS

- Prohibits directed payments from exceeding 100 percent of the Medicare payment rate, starting rating periods beginning on or after the date of enactment. Exempts directed payments for which written prior approval was made prior to the date of enactment; exemption applies to subsequent rating periods if the amount of payment does not exceed the payment amount in the prior approval. (§ 44133.)

- Prohibits federal Medicaid funding for payments to nonprofit, essential community providers that provides for abortions and that received Medicaid expenditures in fiscal year 2024 exceeding $1,000,000, i.e., Planned Parenthood. (§ 44126.)
- Delays Medicaid DSH reductions for another three years. (§ 44303.)

PROVIDER ENROLLMENT

- Creates a streamlined process for states to enroll out-of-state providers that are considered "limited risk" by Health and Human Services or a state Medicaid agency, and has not been excluded or terminated from federal and state health programs. This process applies to services to individuals under 21 years of age enrolled in Medicaid and allows enrollment without the imposition of screening or enrollment requirements that exceed the minimum necessary to provide payment (such as the provider's name and NPI), and allows for enrollment for 5 years. (§ 44302.)
- Monthly state screening of enrolled Medicaid providers against Medicare and other state Medicaid and CHIP enrollments for terminations, starting January 1, 2028. (§ 44105.)
- Quarterly screening of enrolled Medicaid providers against the death master file, starting January 1, 2028. (§ 44106.)

BENEFITS

- Prohibits coverage of gender affirming care under Medicaid to individuals under 18 years of age. Creates exemptions for certain procedures with the consent of the individual's parent or legal guardian (e.g., puberty suppression or blocking drugs for precocious puberty, medically necessary for certain chromosomal or ovarian and testicular tissue disorders, etc.), but explicitly limiting such exceptions for the "alleviation of mental distress." (§ 44125.)
- Imposes cost-sharing on ACA expansion enrollees whose income exceeds 100% of the federal poverty limit, not to exceed 5 percent of family income. (§ 44142.)

ELIGIBILITY AND ENROLLMENT

- Imposes work requirements or other "community engagement" requirements on individuals applying for or receiving Medicaid coverage. Required "community engagement" includes working for not less than 80 hours, completion of not less than 80 hours of community service, participation in a work program for not less than 80 hours, enrolled in an educational program at least half time, or a combination of the above. Excludes individuals who are under 19 years of age, pregnant or postpartum, enrolled in Medicare, or incarcerated; also includes a short term hardship exception (hospitalization or other institutionalization, natural disasters, etc.). Requires states to confirm community engagement at least as frequently as eligibility verifications. Requires implementing regulations no later than July 1, 2027. (§ 44141.)
- Limits retroactive coverage under Medicaid to the month before the month in which the individual applies for Medicaid, instead of three months before the month in which the individual applies for Medicaid. (§ 44122.)
- Requires eligibility redeterminations for the ACA expansion population every six months, starting October 1, 2027. (§ 44108.)

- Instead of issuing formal rulemaking to withdraw the 2024 final rule simplifying eligibility and enrollment processes under Medicaid, the Children's Health insurance Program and the Basic Health Program, the HEC Proposal would delay implementation, administration or enforcement of that rule until January 1, 2035. (§ 44102.)
- Increased verification of enrollee addresses and cross-checks against other state Medicaid databases, starting January 1, 2027. (§ 44103.)
- Quarterly screening of Medicaid enrollees against death master file, starting January 1, 2028. (§ 44104.)
- Increases the long-term care Medicaid home asset limit to $1,000,000 for homes not located on lots zoned for agricultural use, which amount cannot $1,000,000, even after application of inflation factors. Further provides that long-term care limit applies notwithstanding state flexibility to alter asset limits for determining Medicaid eligibility, starting January 1, 2028. (§ 44109.)
- Prohibits federal financial participation under Medicaid and CHIP for individuals without verified citizenship or satisfactory immigration status, starting October 1, 2026. (§ 44110.)

OTHER CHANGES

- For payments to physicians under the Medicare Physician Fee Schedule, for FY 2026 and beyond, eliminates the separate, fixed conversion factor updates for APM and non-APM participants and replaces them with a single update tied to MEI – 75% of MEI in 2026 and 10% annually thereafter. (§ 44304.)
- Codifies CMS requirement that Section 1115 Medicaid waivers must be budget neutral, prohibiting approval of any waiver that is expected to increase federal spending. (§ 44135.)
- Moratorium on staffing requirements on long-term care facilities until January 1, 2035. (§ 44121.)
- Reduces the formula for erroneous excess payments permitted currently under the Medicaid Act, starting fiscal year 2030. (§ 44107.)
- Imposes new restrictions on ACA Exchange enrollment and coverage, including limiting open and special enrollment periods, reducing premium tax credits for re-enrollees, prohibiting coverage of gender transition procedures as essential health benefits, and clarifying that DACA recipients are not considered to be "lawfully present" for ACA exchange purposes.
- Proposed changes to drug pricing and pharmacy benefit manager programs.

We will continue to monitor updates as Congress continues to look to reform Medicaid and other federal health programs. Stakeholders may wish to consider providing input to federal decisionmakers. For more information on the current federal proposals and its impact on healthcare entities, please contact Felicia Sze. Kyle Brierly and Avi Rutschman contributed to this alert.