



H.R.1 Reconciliation Legislation: Key Provisions Relevant for Children's Health and Hospitals

Summary

On July 4, 2025, President Trump signed the budget reconciliation bill, [H.R. 1](#), into law. The law makes significant changes to the Medicaid program. In particular, the law more strictly limits use of provider taxes and state directed payments (SDPs), constraining the ways states can raise revenue to finance their share of their Medicaid programs, among other cuts to Medicaid. Other provisions make changes regarding the Marketplace, Medicare, and immigrant access to federal health programs.

Below are the provisions within the law that are most relevant to children and children's hospitals. Please reach out to [Aimee Ossman](#) and [Milena Berhane](#) with questions.

Provision	Description	Effective Date
Key Medicaid Provisions		
Establishing a Moratorium on Future New or Increased Provider Taxes (Section 71115)	Imposes a freeze on new or increased provider taxes, in addition to new restrictions on provider taxes. - For <u>expansion states</u>, the law reduces the existing 6% cap on provider taxes by 0.5 percentage points per year beginning in federal fiscal year (FFY) 2028, until the cap reaches 3.5% in FFY 2032. This reduction does not apply to taxes on skilled nursing facilities or intermediate care facilities. - For <u>non-expansion states</u>, existing provider taxes can remain at their current levels and keep pace with inflation. The law effectively “grandfathers” the tax rate applied to existing provider taxes, not simply the dollar amount. Note: CMS will need to clarify the difference between enacted and imposed provider taxes, and how those relate to the new restrictions in the bill.	Freeze on new or increased provider taxes: July 4, 2025 Reduction in provider tax threshold for existing taxes in expansion states: Oct. 1, 2027 (FFY 2028)

Limiting State Directed Payments (SDPs) (Section 71116)	New SDPs Limits the scope of any new SDPs to 100% of Medicare rates for expansion states and 110% of Medicare rates for non-expansion states. Existing SDPs States with existing SDPs above Medicare rates will need to reduce payments by 10 percentage points per year beginning in 2028 until the SDPs are no greater than 100% of Medicare payment levels for expansion states or 110% of Medicare payment levels for non-expansion states. • <u>Existing</u> – or “grandfathered” – SDPs are those that (1) have been approved by CMS prior to May 1, 2025 (or the Secretary determines the state made a good faith effort to secure approval); or (2) for rural hospitals specifically, approved by CMS (or a good faith effort to secure approval) prior to July 4, 2025; or (3) those that have been submitted to CMS prior July 4, 2025. Note: The language in the bill refers to the Medicare fee schedule regarding Medicare rates.	New SDP limits starting at Medicare rates: July 4, 2025 Existing SDPs phase down to Medicare rates: rate years starting on or after Jan 1, 2028
Prohibiting Certain Existing Provider Taxes – Waiver of Uniform Tax Requirement for Provider Taxes (Section 71117)	Modifies the criteria the Department of Health and Human Services (HHS) must consider when determining whether certain health care-related taxes are generally redistributive. • This would prohibit any tax—MCO tax or otherwise—that either (1) imposes a lower tax rate on providers with lower Medicaid volumes compared to those providers with higher Medicaid volumes or (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service. • Taxes that would have the “same effect” as in (1) and (2) would also be prohibited. This provision would be effective upon this bill’s date of enactment. On May 15, CMS released a proposed rule that would impose substantially the same policy as is proposed in this legislation. CHA submitted comments in response to this rule.	July 4, 2025, however, the HHS Secretary may allow for a transition period of up to three years from July 4, 2025 for states to modify noncompliant taxes

Modifying Retroactive Coverage Under the Medicaid Program (Section 71112)	Alters retroactive coverage for children and other non-expansion populations covered by Medicaid and CHIP from 90 days to 60 days. The bill also allows for 60 days of retroactive coverage for CHIP beneficiaries. Reduces retroactive coverage for the Medicaid expansion population from 90 to 30 days.	Jan. 1, 2027
Moratorium on the Medicaid and CHIP Eligibility and Enrollment Final Rules (Section 71102)	Delays the implementation and enforcement of some of the provisions of the two CMS final eligibility and enrollment rules until October 1, 2034. • This delay does not include the provisions that prohibit states from locking out children for non-payment of CHIP premiums, applying a waiting period prior to enrolling in CHIP, and establishing a CHIP annual or lifetime limit, because these provisions are already in effect. These provisions were removed from the previous version of the bill, following feedback from the Senate Parliamentarian. Since these provisions of the rules are already in effect, they cannot be delayed and will continue to be in effect.	July 4, 2025
Prohibiting Federal Financial Participation Under Medicaid and CHIP for Individuals Without Verified Citizenship, Nationality, or Satisfactory Immigration Status (Section 71109)	Prohibits federal financial participation under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status. States will be permitted to provide coverage to these groups using their own funding. States are still able to cover certain populations using federal funding including: • Lawfully residing children and/or pregnant women, whom states may choose to cover (without a five-year waiting period) under the so-called CHIPRA 214 state option	Oct. 1, 2026

Other Medicaid and Health Care-Related Provisions of Interest to Children’s Hospitals

Rural Health Transformation Fund (Section 71401)

Establishes a \$50 billion fund for rural health care providers. To qualify for funding, states must submit an application to CMS this year (date to be determined); CMS is required to approve or deny applications by Dec. 31, 2025.

The law defines rural health facilities to include hospitals located in a rural area, critical access hospitals, sole community hospitals, Medicare-dependent small rural hospitals, low-volume hospitals, rural emergency hospitals, rural health clinics, federally qualified health centers, and community mental health centers, among other categories. While children’s hospitals are not specified as a rural health facility type, states are not obligated to limit their funding to these types of facilities.

Available funding:

- Allocates \$10 billion for each of FFYs 2026–2030 for a total of \$50 billion.

Distribution approach:

- 50% of the funding will be allocated equally across all states with approved applications.
 - The remaining 50% will be distributed to states by the CMS Administrator based on a number of factors, including the state’s percentage of rural residents and the share of rural health care facilities in the state compared to such facilities nationwide. This portion of funds must be provided to at least one quarter of the states with an approved application.

Allowable uses of the funds:

- Gives CMS and states significant discretion to determine how to use these funds and the types of entities that can receive such funds.
- The provision includes a long list of allowable activities—including payments to health care providers, promoting evidence-based interventions to improve prevention and disease management, workforce recruitment in rural areas and technology innovation—and requires states to fund at least three of them.
- While the CMS Administrator must consider the number of “rural health care facilities” in a state when deciding how to distribute 50% of the available funding, states are not obligated to limit their funding to these types of

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	facilities. No more than 10% of a state's allotment can be used on administrative expenses. Limitations: States will not be allowed to use the funding as the non-federal share of Medicaid payments.	
Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs (Section 71103)	Requires states to establish processes to regularly update addresses information for Medicaid and CHIP enrollees using data received from managed care plans, the National Change of Address Database, returned mail, and other data sources identified by the HHS Secretary. This also requires HHS to establish a new database by October 1, 2029, that will identify individuals simultaneously enrolled in Medicaid in more than one state.	Jan. 1, 2027
Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115 (Section 71118)	Codifies CMS' longstanding requirement that demonstrations authorized under section 1115 of the Social Security Act not cost the government more than the state's Medicaid program would cost without the demonstration. Modifies the current process by requiring the Chief Actuary of CMS to certify that the demonstration will be budget neutral.	Jan. 1, 2027
Ensuring Deceased Individuals Do Not Remain Enrolled (Section 71104)	Requires state Medicaid programs to check the Social Security Administration's Death Master File on a quarterly basis to determine whether Medicaid enrollees are deceased and to disenroll individuals who are determined to be deceased from Medicaid coverage.	Jan. 1, 2027
Additional Medicaid Provider Screening Requirements (Section 71105)	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. Also codifies requirements that state Medicaid programs check, on a quarterly basis, whether providers are deceased in the state's Medicaid program.	Jan. 1, 2028

Mandatory Work Requirements for Certain Medicaid Enrollees (Section 71119)	Requires certain specified non-pregnant, non-disabled, childless adults, aged 19 through 64, to complete a minimum of 80 hours of qualifying community engagement activities prior to initial application as a condition of Medicaid eligibility. These work requirements apply to individuals enrolled through Medicaid expansion or a section 1115 demonstration providing minimum essential coverage (MEC). • Populations exempted from this requirement include (1) parents, guardians, and caretaker relatives of children aged 14 or under or a disabled individual, and (2) foster care youth through the age of 26, among other groups. • This bill also permits states to exempt “applicable individuals” from this requirement for certain short-term hardships during a month. States can opt to implement these requirements earlier via a state plan amendment or Medicaid section 1115 waiver. They also can delay implementation for up to two years (through Dec. 31, 2028) with the Secretary’s approval.	Jan. 1, 2027
Eligibility Redeterminations for Certain Individuals (Section 71107)	Requires states to conduct eligibility determinations for expansion population adults every six months. Today, states may redetermine eligibility for expansion adults no more frequently than annually or unless information received by a state indicates a change in circumstances.	Jan. 1, 2027
Barring Federal Payments to “Prohibited Entities” That Provide Abortion Services (Section 71113)	Prohibits Medicaid participation by certain “prohibited entities” or providers, including Planned Parenthood, that offer so-called elective abortion services for the one-year period following the law’s enactment. “Prohibited Entities” are defined as nonprofit organizations that meet the definition of an essential community provider; entities that are primarily engaged in family planning services or reproductive health or that provide abortion services in circumstances beyond those that qualify for federal funding under the Hyde Amendment; and entities that received \$800,000 or more (to either the provider or the provider’s affiliates) in Medicaid payments in FFY 2023.	July 4, 2025
Sunseting Eligibility for Increased FMAP for Expansion States (Section 71114)	Sunset 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.	Jan. 1, 2026