DEPARTMENT OF HUMAN SERVICES

Summary of Medicaid provisions in the 2025 federal reconciliation bill

This document details Medicaid-specific provisions in the federal reconciliation bill signed by President Trump on July 4, 2025. Medicaid is also known as Medical Assistance in Minnesota.

The Minnesota Department of Human Services continues assessing the impact to Minnesotans. While this analysis will continue as the federal government issues additional guidance, it's obvious this bill is a historic disinvestment in the health and wellbeing of Minnesotans and the state's health care infrastructure.

The impacts on Medical Assistance, Minnesota's Medicaid program, will be significant and felt by all Minnesotans. Preliminary analysis by DHS, based on Congressional Budget Office data, projects that the federal law will eventually result in a loss of coverage for as many as 140,000 Minnesotans. Many provisions specifically impact Medicaid expansion states and the expansion population. The Affordable Care Act allowed states to choose to expand Medicaid eligibility to adults without children whose household income is below 138% of the federal poverty level (currently $21,597 annually). Minnesota is an expansion state.

For a high-level summary, see the department's preliminary analysis of the bill.

Section 71107: Six-month renewals

Requires states to verify Medicaid eligibility (renewals) every six months for low-income adults, rather than every 12 months. The six-month redetermination requirement does not apply to Tribal members and people living in U.S. territories.

Effective date: Dec. 31, 2026

Fiscal impact: Additional annual cost to Minnesota taxpayers of $4.9 million through increased administrative costs to complete the additional data verifications against the federal hub. Costs to counties are still being determined. Additional programmatic impacts to Minnesota's state budget are being estimated.

Impacted group: Low-income adults in the expansion population may lose coverage.

Section 71109: Immigration statuses eligible for Medicaid

Reduces the types of lawful immigration statuses eligible for Medicaid by amending the definition of "qualified alien" under Medicaid law. Eligibility for Medicaid would be limited to lawful permanent residents, certain Cuban immigrants, and Compact of Free Association (COFA) migrants. Under current state law, some who are currently eligible for Medicaid and who are "lawfully present" in the United States may transition to MinnesotaCare, however federal Basic Health Plan funding may be unavailable due to other changes in the legislation.

Effective date: Effective Oct. 1, 2026

Fiscal impact: TBD

Impacted people: Many people currently enrolled in Medicaid would no longer be eligible for Medicaid coverage. People who would lose health coverage due to the new definition include refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, and victims of human trafficking. Work is underway to understand how many may be eligible for MinnesotaCare or insurance affordability programs, such as premium tax credits through MNsure.

Section 71112: Retroactive coverage

This section limits retroactive coverage in Medicaid to:

- One month before the date of application for low-income adults without children
- Two months before the date of application for all other Medicaid eligibility groups.

Retroactive coverage provides an important protection for low-income people who urgently need care but lack health insurance. States have been able to cover medical bills incurred up to 90 days before the date of application for people who meet Medicaid eligibility requirements. Narrowing the period of retroactive coverage will lead to more uncompensated care for providers and additional medical debt for low-income Minnesotans.

Effective date: Jan. 1, 2027

Fiscal impact: Annual loss in federal funding of $31 million and a loss in state spending of $9 million.

Impacted groups: All providers and new Medical Assistance enrollees.

Section 71113: Federal payments to certain family planning providers

Prohibits Medicaid funds to be paid to providers who:

- Primarily engage in family planning or reproductive health care services,
- Perform abortion services, and
- Received $800,000 or more (to either the provider or the provider's affiliates) in payments from Medicaid in 2023.

The prohibition applies to spending provided to carry out a state plan under Title XIX of the Social Security Act and does not apply to MinnesotaCare.

Effective date: Upon enactment for 1 year.

Fiscal impact: Minnesota could lose up to $154 million of federal funding in state fiscal year 2026.

Impacted people: Limits access to reproductive health care and family planning services for Medicaid enrollees nationwide. Family planning clinics are closing in Minnesota in response to other federal funding reductions, and cutting federal Medicaid funding will result in additional facilities closing across the country, limiting access to care for everyone in need of family planning and reproductive health care services.

Sections 71115, 71117: Provider taxes

This provision prohibits all states from establishing any new provider taxes or expanding the base of current taxes that were not in effect upon the date of enactment of the bill and sets new limits on the amount of taxes that can be collected within a provider class.

States are permitted to assess health care provider taxes to fund the nonfederal share of Medicaid within certain parameters set by federal law. Current regulations permit states to tax health care providers up to 6% of taxable revenue. Under new law, the limit will be reduced incrementally to 3.5% for most provider types, but only in states that expanded Medicaid to low-income adults without children. Tax revenues in expansion states must be limited to 5.5% of provider revenue in 2028 and the percentage will decrease by 0.5% each year until 2032. States cannot implement new taxes, and current tax rates cannot be increased after enactment of the federal law, even if current rates are below the percentages specified in the law. There is an exception for two provider types: Nursing facilities and intermediate care facilities for persons with developmental disabilities.

Taxes on these providers cannot be increased after enactment of the federal law, but these providers are not subject to the lower limits. The limit on provider taxes in states that did not expand Medicaid remains at 6%.

Current regulations describe a statistical test that states must pass to be granted a waiver of nonuniform provider taxes. The test fails to control for certain tax programs that collect Medicaid revenues disproportionately relative to other payers. This legislation adds requirements that must be met to qualify for a waiver. Tax programs that assess a rate on Medicaid revenues that is higher than other payers will not be allowed, even if the tax program passes the statistical test. This new requirement is effective with the enactment of the federal law.

Effective date: The safe harbor limit for provider taxes phases down toward 3.5% on Oct. 1, 2028. The new exclusion of certain nonuniform taxes took effect July 4, 2025.

Fiscal impact: The phased down Safe Harbor limit will reduce federal funding available for hospital rate increases through assessment and directed payment enacted during the 2025 session. The department is still assessing the impact, but the preliminary estimate is that hospitals may eventually stand to lose approximately $1 billion per year when the safe harbor limit is phased down to 3.5%. The change to the criteria for granting a waiver for non-uniform taxes likely prohibits federal approval of a new managed care tax enacted by the legislature in 2025.

Impacted people: Minnesota's current provider taxes for inpatient and outpatient hospital services are near the current 6% hold harmless limit. Once the limits begin to drop in 2028, the state will have to lower current tax rates and potentially reduce payments to hospitals that are financed by a portion of the hospital taxes. This legislation targets states that have expanded Medicaid by setting a lower cap on provider taxes that are used to finance the program relative to non-expansion states.

Section 71116: State-directed payments

State-directed payments (SDPs) are provider payment arrangements through managed care that are widely in use, including in Minnesota. Current Medicaid rules allow states to establish SDPs for hospitals, nursing facilities, and academic medical centers up to the average commercial rate. This section lowers the federal limit on SDPs to these providers:

- Expansion states limited to paying 100% of Medicare rate.
- Non-expansion states limited to paying 110% of Medicare rate.

The new limits were effective upon enactment, July 4, 2025, for new payments. However, existing approved payments and those payments currently under review by CMS must phase down the payments by 10 percentage points annually starting in 2028 until the SDP is equal to the new limit.

Effective date: A rating period beginning on or after July 4, 2025.

Fiscal impact: TBD

Section 71119: Work reporting requirements

Requires states to establish "community engagement requirements" for low-income adults without children or disabilities ages 19-64 who are enrolled in the adult expansion group. To meet community engagement requirements a person must be working, engaged in community or public service, actively seeking employment, or engaging in career planning or job training for 80 hours per month.

Community engagement requirements do not apply to:

- Pregnant people
- People under age 19 or over age 64
- Foster care youth and former foster care youth under age 26
- Members of American Indian Tribes
- People who are considered medically frail
- People who are already in compliance with the work reporting requirements under the Temporary Assistance for Needy Families (TANF) program or Supplemental Nutrition Assistance Program (SNAP)
- People who are a parent or caregiver to a dependent child aged 13 or younger or a person with a disability
- People who are incarcerated or released from incarceration within the past 90 days

Effective date: January 1, 2027. States may apply for a two-year extension request if they can show they are making "good faith efforts" to implement.

Fiscal impact: Potential of increase in local and tribal administrative costs of $160 million annually, an increase in state administrative costs of $5 million, a reduction in federal program funding of $200 million. Additional programmatic fiscal impacts to Minnesota's state budget are being estimated.

Impacted people: The requirements are expected to impact the Medical Assistance program in three primary ways. First, an estimated 20% of those enrollees subjected to the work requirements will have their coverage terminated either through additional income, non-compliance, or administrative burden. Second, there will be an increase in physician visits as a portion of the caseload will seek a medically frail or mentally unfit exemption. Third, some adult enrollees will seek a disability determination if they don't see themselves as able to satisfy the work requirements. The provision will also increase the burden on county and Tribal workers trying to determine eligibility for Minnesotans.

Section 71120: Cost sharing in MA expansion population

Requires states to impose cost sharing on Medicaid expansion adults with incomes over 100% percent of the federal poverty level. Cost sharing requirements exempt primary care, mental health, and substance use disorder services, as well as services provided by federally qualified health centers, behavioral health clinics, and rural health clinics. Cost sharing may not exceed 5% of the individual's income or $35 per service. American Indians and Alaska Natives are exempt from cost-sharing requirements.

Effective date: October 1, 2028

Fiscal impact: Increased out of pocket cost for Medical Assistance enrollees that total $4 million annually.

Impacted group: Increased costs for adult expansion population. Many studies have found even very modest increases in cost-sharing lead to avoidance of care, which ultimately leads to more expensive care and more serious health risks. Additionally, where individuals are not able to pay their cost-sharing requirement this becomes uncompensated care for providers.

Section 71401: Rural Health Transformation Program

Appropriates $50 billion over five years to invest in rural health services and infrastructure. Half of funds will be distributed equally among all 50 states and half of funds will be allotted based on percentage of the population living in rural areas, the proportion of rural health facilities in the state relative to number of rural health facilities nationwide, and the situation of hospitals.

Examples of how the funds can be used include: promoting evidence-based interventions to improve chronic disease management, payments to health care providers, consumer-facing IT systems to prevent and manage chronic diseases, etc.

There is a Dec. 31, 2025, deadline for states to apply for consideration.

Effective date: $10 billion per fiscal year available nationally beginning October 1, 2026

F**iscal impact**: NA

Section 71106: Reduced funding related to Medicaid payment errors

Section 1903(u) of the Social Security Act requires each state to report the ratio of its erroneous excess payments under the state plan to its total Medicaid payments. Payments for people ineligible for the program or overpayments for eligible people in excess of the 3%-error threshold during the fiscal year are considered overpayments. CMS may waive penalties where states demonstrate a good faith effort to correct payment errors. This legislation limits CMS' authority to waive penalties for eligibility errors in excess of the threshold and allows CMS to apply penalties to additional audits with findings related to eligibility errors. Additional CMS guidance is needed to understand the impact of this provision.

Effective date: October 1, 2029

Fiscal impact: There is significant uncertainty regarding the impact of this provision, but states are likely to face new penalties and sanctions that cannot be waived by CMS. The penalty for exceeding the 3% threshold could be as much as $20 million for 0.1% over the threshold.

Section 71110: Reduced funding for Emergency Medical Assistance

Emergency Medical Assistance (EMA) covers emergency care services for people who meet financial and other requirements for Medical Assistance but are ineligible for coverage because of their immigration status. EMA covers the health care and medical services needed to treat emergency medical conditions defined in federal law as those that, if people don't get medical care within 24 to 48 hours, will place a person's health in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction to any organs or body parts.

The bill reduces to a state's base Federal Medical Assistance Percentage amount (in Minnesota this is just over 50%) the federal share of funding for emergency Medicaid services provided to undocumented people that would be eligible for the Medicaid expansion but for their immigration status. Currently, the state receives a federal match of 90% for this population.

Effective date: Oct. 1, 2026

Fiscal impact: Annual loss of $13.6 million in federal funding.