2025 Budget Reconciliation

Final Summary of Key Human Services Provisions

Last Updated: July 14, 2025

Background: On May 22, 2025, the House of Representatives passed H.R.1. The Senate passed its version on July 1, 2025. On July 3, 2025, the House passed the final version of the bill and President Trump signed it into law on July 4, 2025.

Budget Reconciliation is a special legislative process used by Congress where a simple majority of both the House and Senate is required—thereby avoiding the filibuster in the Senate—but the bill is required to address only certain tax, mandatory spending, and debt limit legislation. Policy changes that do not have a direct or significant budget impact are prohibited under what is called the "Byrd Rule."

Below is a summary of the major human services-related provisions in the Act. Please contact Lexie Kuznick, Director of Policy and Government Relations at APHSA with any questions.

Importantly, based on the bill's anticipated increase to the deficit, experts expect a sequestration of funding of other human services programs will be triggered under the Statutory Pay-As-You-Go Act of 2010 (S-PAYGO). Congress could still take action to prevent S-PAYGO from applying to H.R.1, but if they do not, we believe that S-PAYGO would lead to the complete elimination of funding for 10 years for the Social Service Block Grant (SSBG); Maternal, Infant, Early Child Home Visiting (MIECHV); and Promoting Safe and Stable Families (PSSF), and have small reductions of funding to federal administrative costs related to the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and child support. It would also lead to a 4 percent reduction in Medicare funding. Notably, S-PAYGO has not been triggered since its 2010 passage due to Congressional action to avoid its application.

Table of Contents

SNAP.....2
Medicaid.....4
Other Key Provisions.....12

SNAP

Unless specifically noted otherwise, these changes are written without an implementation date.

Section 10101: Re-evaluation of Thrifty Food Plan

- Specifies percentages of the Thrifty Food Plan for household sizes.
- Specifies the date at which the reevaluation of the Thrifty Food Plan can occur is October 1, 2027.
- Requires that any adjustment be cost neutral.
- Requires the Secretary to adjust the Thrifty Food Plan to reflect changes in the Consumer Price Index each fiscal year and make cost adjustments for Hawaii and the urban and rural parts of Alaska, as well as for Guam and the Virgin Islands. Cost adjustments in Guam and the Virgin Islands are not to exceed the cost of food in the 50 states and DC.

Section 10102: Modifications to SNAP Work Requirements for Able-Bodied Adults

- Changes the Able-Bodied Adults Without Dependents (ABAWD) work requirement age range to those 18-64.
- Changes the exception for those with dependent children to only apply to children under 14.
- Removes the exceptions for people who are experiencing homelessness, are aged 24 or under and were in foster care when they turned 18, or a veteran that were temporarily in place through October 1, 2030.
- Includes a new exemption for individuals who are Indians, Urban Indians, California Indians, and other Indians who are eligible for the Indian Health Services.
- Limits ABAWD waivers to only be permissible if an area has an unemployment rate above 10% and removes the ability for waivers to be based on lack of sufficient jobs.
- For Alaska and Hawai'i only, provides the Secretary with the authority to grant individual exemptions if that state has an unemployment rate that is at or above 1.5 times the national unemployment rate. To be approved, the state agency must demonstrate a good faith effort which would include actions to meet compliance, significant barriers to meeting the requirements, a detailed plan to achieve compliance, and any other criteria determined by the Secretary. If granted, state agencies would also be required to provide quarterly reports on progress. Any granted exemption shall expire no later than December 31, 2028, and cannot be renewed.

Section 10103: Availability of Standard Utility Allowances Based on Receipt of Energy Assistance

- Limits the SNAP and Low-Income Home Energy Assistance Program (LIHEAP) connection (known as Heat & Eat) to only apply to households with an elderly or disabled member.
- Similarly, limits the exclusion of energy assistance from countable income to households with an elderly or disabled member.

Section 10104: Restrictions on Internet Expenses

- Prohibits service fees associated with internet connection from being included in computing the excess shelter expense deduction.

Section 10105: Matching Funds Requirement

- Establishes that beginning in FY28 (October 1, 2027), state agencies will be required to pay at least percentage of SNAP benefit allotments if they have a SNAP Quality Control Payment Error Rate (PER) above 6%. Of note, this language does not alter existing liability and financial penalty requirements for state agencies.
    - For states with a PER below 6%: 0% state match
    - For states with a PER 6-7.99%: 5% state match
    - For states with a PER 8-9.99%: 10% state match
    - For states with a PER at 10% or higher: 15% state match
- For FY28, allows states to choose between using their PER in FY25 or FY26 to calculate their match percentage. Beginning in FY29, and for each subsequent year, requires that states use their PER from three fiscal years prior to determine their match rate. (For example, FY29 state match will be based on FY26 PER, FY30 on FY27 PER, and thereon).
- If, for FY25, the PER of a state multiplied by 1.5 is equal to or above 20%, their initial implementation date of a state match shall be FY29 (instead of FY28). If, for FY26, the PER of a state multiplied by 1.5 is equal to or above 20%, their initial implementation date for this section shall be FY30 (instead of FY28).
- Specifies that the Secretary may not alter a state's assigned cost share, and may not pay more of the cost-share than assigned to the federal government as detailed above.

Section 10106: Administrative Cost Sharing

- Effective beginning FY27 (October 1, 2026) and each year thereafter, reduces the federal portion of administrative costs from 50% to 25% and therefore increases the state's share of administrative costs to 75%.

Section 10107: National Education and Obesity Prevention Grant Program Repealer

- Sunsets funding for the SNAP-Ed program at the end of FY25 (September 30, 2025).

Section 10108: Alien SNAP Eligibility

- Limits SNAP eligibility to those who reside in the United States and are:
  - A citizen
  - Lawfully admitted for permanent residence (excluding those who are visitors, tourists, diplomats, students with no intention of abandoning their residence in a foreign country, among others)
  - Cuban and Haitian entrants
  - Allowed to live and work in the US under the Compacts of Free Association (COFA).
- Removes eligibility for refugees and those granted asylum, as well as any others not explicitly included in the above.
- Requires that all non-eligible, non-citizen financial resources in any SNAP household be included in eligibility and benefit determination, even for those who are not receiving benefits.

Medicaid

This summary covers key provisions of the Medicaid-related bill but is not a comprehensive analysis. Additional provisions cover the allowed uses of Medicaid funding, payments to pharmacies, and more.

Sections 71101: Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs & Section 71102: Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program

- Places a moratorium ending September 30, 2034, on implementation of provision s of two final Centers for Medicare & Medicaid Services (CMS) rules related to Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment:

- September 2023 rule entitled, "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" (88 Fed. Reg. 65230).
- April 2024 rule entitled "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" (89 Fed. Reg. 22780).

Section 71103: Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs

- States must implement new systems and processes that include:
  - No later than October 1, 2029, regularly obtain and verify enrollee address information using reliable sources named in the bill (e.g., USPS forwarding addresses, the National Change of Address database, or address information obtained by a contracted managed care organization).
  - Submit monthly enrollee data including Social Security numbers to a new federal system monthly and at each eligibility determination or redetermination starting no later than October 1, 2029, to identify individuals enrolled in more than one state.
  - Disenroll individuals confirmed to be residing in another state unless they meet a federal exception.
  - The U.S. Department of Health and Human Services (HHS) may waive state participation in the Public Assistance Reporting Information System (PARIS) once this new system is in place.

Section 71104: Ensuring Deceased Individuals Do Not Remain Enrolled

- Starting January 1, 2027, state Medicaid programs must check the Social Security Administration's Death Master File on at least a quarterly basis to determine whether Medicaid enrollees are deceased and disenroll individuals who are determined to be deceased. This information would be considered verified upon receipt.
- If found to be deceased, the individual must be disenrolled and payments discontinued. If it is found that coverage was stopped incorrectly, they must be reinstated and covered retroactively. States may also use additional electronic data sources to identify deceased individuals.

Section 71105: Ensuring Deceased Providers Do Not Remain Enrolled

- States must enhance provider screening protocols starting January 1, 2028, including:

- Monthly checks of whether providers have been terminated by Medicare or any other state's Medicaid or CHIP program.
- Quarterly checks to confirm that enrolled providers or suppliers are not deceased using the Social Security Administration's Death Master File.

Section 71106: Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid

- Beginning in FY 2030, this provision expands the definition of "erroneous excess payments" under Medicaid to include payments made when there is insufficient information to verify a beneficiary's eligibility or when services are provided to ineligible individuals. It authorizes the Secretary of HHS to use state-conducted audits, in addition to federal audits, to determine whether states exceed the 3% allowable error rate.
- The Secretary may waive repayment for erroneous payments only in cases of administrative error—and not for payments lacking adequate eligibility documentation—and only to the extent that erroneous payments exceed the 3% threshold. This provision allows recovery of improper payments beyond what is captured in the PERM process, increasing federal recoupment authority.

Section 71107: Eligibility Redeterminations

- Beginning December 31, 2026, state agencies must conduct redeterminations of eligibility for adults enrolled under the Affordable Care Act (ACA) expansion group (Medicaid subsection (a)(10)(A)(i)(VIII)) once every six months (currently once every 12 months).
- Exemptions are included for those who receive Social Security Income benefits. Tribal members are also exempt.
- HHS must issue guidance within 180 days of the law's enactment to support implementation.

Section 71108: Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services Under the Medicaid Program

- Starting January 1, 2028, 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 71109: Alien Medicaid Eligibility

- Limits federal Medicaid funding only to U.S. citizens, nationals, lawful permanent residents, those granted the status of Cuban and Haitian entrants, and individuals under Compacts of Free Association, beginning October 1, 2026.

Section 71110: Expansion FMAP for Emergency Medicaid

- Limits states to receiving only their regular FMAP rate for federal matching funds for emergency medical care provided to immigrants.

Section 71111: Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities Under the Medicare and Medicaid Program

- Requires HHS to delay implementation, administration, or enforcement of the provisions of the final rule titled "Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" (89 Fed. Reg. 40876) until October 1, 2034.

Section 71112: Modifying Retroactive Coverage Under the Medicaid and CHIP Program

- Beginning January 1, 2027, retroactive Medicaid and CHIP coverage would be limited for new applicants as follows:
    - One month for adults in the expansion population;
    - Two months for individuals in other Medicaid eligibility categories; and
    - Two months for CHIP enrollees.

Section 71114: Sunsetting Eligibility for Increased FMAP for New Expansion States

- Sunsets the temporary 5% FMAP increase to states that opted to expand Medicaid after March 11, 2021, from the American Rescue Plan Act.
- Applies on a prospective basis, so any state must begin expending funding for the expansion population prior to January 1, 2026, to receive the enhanced match.

Section 71115: Provider Taxes

- Directly upon enactment, states are prohibited from implementing new provider taxes or increasing existing ones unless legislation or regulations authorizing those changes were already in place beforehand:
    - A technical revision sets the threshold at 0% for new taxes to effectively freeze provider tax levels, according to Senate rules.

- Incrementally lowers the allowable rate of provider taxes, beginning in FY28 at 5.5% to 3.5% by FY32, for expansion states only.
- The existing 6% "safe harbor" threshold is preserved for non-expansion states.
- Provider taxes on nursing facilities and intermediate care facilities (ICFs) in effect as of May 1, 2025, are exempt from the lower thresholds—provided they remain unchanged.

Section 71116: State Directed Payments

- Requires the Secretary of HHS to revise regulations to limit the total payment rates allowed through Medicaid managed care State Directed Payments (SDP's) starting with services provided after this law takes effect as follows:
  - For expansion states: Payments for services must not exceed 100% of the Medicare rate (or an equivalent if no Medicare rate is published).
  - For non-expansion states: Payments must not exceed 110% of the Medicare rate (or an equivalent if no Medicare rate is published).
- Beginning January 1, 2028, grandfathered SDP's will be reduced by 10 percentage points annually until they reach the applicable Medicare-based cap (100% or 110%).
- To be considered *grandfathered*, the SDP must:
  - Have received written CMS approval or a good faith submission before May 1, 2025, for a rating period within 180 days of enactment,
  - Have had a completed preprint submitted before enactment; or
  - Be for a rural hospital with written approval or good faith effort submitted by the enactment date for a rating period within 180 days.
- New Expansion States:
  - If a state begins providing ACA expansion coverage on or after the enactment date, it is immediately subject to the 100% Medicare cap for SDPs, regardless of any prior approval.

Section 71117: Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax

- Beginning upon enactment of this legislation and with up to a three-year transition period, modifies the criteria HHS must consider when determining whether certain health care-related taxes are 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 the state.
- Clarifies this provision does not apply to territories.

Section 71118: Requiring Budget Neutrality for Medicaid Demonstrations Projects Under Section 1115

- Requires HHS to certify that federal costs do not exceed what would have been spent without the waiver.
- Applies to all demonstration projects under Section 1115 of the Social Security Act.
- Directs HHS to specify the methodology for applying project-generated savings to allowable costs in project extensions and future approvals.

Section 71119: Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals

- Effective December 31, 2026, states must require "able-bodied adults" aged 19 to 64 without dependents and who are enrolled in the adult expansion or waiver program equivalent to minimum essential coverage to complete 80 hours/month of work, education, community service, or a combination, or earn an income representing at least 80 hours of minimum wage per month.
- Defines parents exempt for community engagement requirements to a parent of a dependent child aged 13 or younger.
- Exemptions include:
    - Pregnant women
    - People under 19 or over 64
    - Former foster youth under 26
    - Tribal members and Alaska Natives
    - Veterans with rated disabilities

  - Medically frail individuals
  - People participating in a substance use or alcohol use disorder treatment program
  - People who are compliant with TANF/SNAP work requirements
  - People who are parents or caregivers of a dependent child 13 years of age and under or someone with a disability
  - People who are currently incarcerated or have been released within the past 90 days
  - Family caregiver as defined in RAISE Family Caregivers Act
- At the state option, allows short-term hardship waivers for:
  - People who are receiving in-person hospital services, skilled nursing, inpatient psychiatric treatment, or other medical services of similar acuity including outpatient care as determined by the Secretary,
  - Natural disasters,
  - Counties in which there is an unemployment rate of over 8% or 1.5 times the national rate, and
  - Individuals receiving outpatient care or traveling long distances to receive specialized care.
- States must verify compliance at minimum for the month preceding enrollment and redetermination, or more frequently if the state chooses.
- Requires states to streamline and simplify verifications where possible, similar to ex parte renewals.
- For those in non-compliance, the state must provide individual outreach and provide 30 days for the individual to make a satisfactory showing that the requirements are being met or are not applicable. States must continue to provide coverage during the 30-day window of notification of non-compliance.
- Permits people to continue to receive minimum essential coverage even if the requirement is not met.
- Beginning no later than October 1, 2026, and at least 3 months prior to the state's compliance date if opted to be earlier, requires states to provide targeted outreach to those who will be required to demonstrate community engagement on how to comply, the consequences of noncompliance, and how to report a change in compliance. Outreach must be done by regular mail and at least one additional method (e.g., phone, text, or email).
- Allows states to ask the Secretary for additional exemptions, but any additional exemptions granted will automatically expire December 31, 2028.
- Prohibits the community engagement requirement from being waived via a 1115 demonstration waiver.

- HHS is required to issue final rule by June 1, 2026.
- Appropriates $100 million for FY26 to states and DC based on the proportion of impacted individuals in their state and $100 million in grants to states and DC, distributed equally, and an additional $200 million to HHS-CMS to support the implementation of this section.

Section 71120: Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program

- Beginning October 1, 2028, requires states to impose cost sharing on expansion adults with incomes over 100% the federal poverty level (FPL).
- Requires that cost sharing be between $0 to $35 (currently $100) per service and may not be more than 5% of an individual's income, consistent with existing Medicaid rules.
- Retains current cost sharing limits on prescription drugs for those at or below 150% FPL at $4 for preferred drugs and $8 for no-preferred (and up to 20% of drug's Medicaid cost for people above 150% FPL).
- Prohibits cost sharing for primary care, prenatal care, pediatric services, and emergency care, except for non-emergency use of the ER.
- Exempts services provided by federally qualified health centers, behavioral health clinics, and rural health clinics.

Section 71121: Making Certain Adjustments to Coverage of Home or Community-Based Services Under Medicaid

- Effective July 1, 2028, states can request standalone §1915(c) waivers to provide HCBS without requiring institutional level of care determinations.
- In order to receive state approvals:
    - All existing §1915(c) waivers must be compliant with federal law.
    - The standalone waiver must not increase wait times for services under other waivers.
    - States must use HHS-approved needs-based criteria for eligibility.
    - States must use stricter criteria to assess institutional-level care than for HCBS eligibility.
    - Cost neutrality is required: per capita costs for the waiver must not exceed those of institutional care.
- The initial term of the waiver is 3 years, with automatic 5-year renewals if compliant.

Other Key Provisions

Section 70104: Extension and Enhancement of Increased Child Tax Credit (CTC)

- Effective for tax years beginning after December 31, 2024.
- Removes the previous expiration date of January 1, 2026, and makes the expanded CTC permanent.
- Increased the maximum credit from $2,000 to $2,200 starting in 2025.
- To claim the credit, the taxpayer must provide:
    - Their own Social Security number (or one spouses on a joint return), and
    - The qualifying child's Social Security number.
    - SSNs must be issued by the SSA to a U.S. citizen or qualifying non-citizen before the return's due date.
- Beginning in 2025, the $1,400 refundable portion will be adjusted for inflation.
- Beginning in 2026, the full $2,200 credit will be adjusted for inflation.
- Adjustments will be rounded down to the nearest $100.
- The refundable portion of the credit remains capped at $1,400 per child, regardless of other factors.

Section 71401: Rural Health Transformation Program

- This new section of the bill creates a Rural Health Transformation Program under the Social Security Act to support rural health systems. It provides $50 billion in funding (FY26–30) to states to improve access, outcomes, and sustainability of rural health care through a competitive, one-time application process.
- Application process: states (not including DC or territories) must apply to HHS by December 31, 2025, with a detailed rural health transformation plan, a certification that the funds won't be used for the state share of Medicaid, and other required information.
- Distribution of funds: 50% equally among states with approved applications, and 50% based on each state's rural population, share of rural health facilities, and the condition of its hospitals.
- Unspent Funds: Must be returned to the Treasury if unspent by FY32.
- Redistribution: CMS can redistribute unspent funds annually beginning March 31, 2028, through March 31, 2032.