Subtitle D, Health: Budget Language Summary and Home Care Industry Impact

This document provides a comprehensive summary of Subtitle D: Health from the Energy and Commerce Committee's May 11, 2025 budget reconciliation legislation. The analysis is tailored for the home care industry, highlighting provisions in Medicaid policy, eligibility verification, reimbursement structures, and regulatory moratoriums that could impact access, agency operations, or long-term care strategies.

1. FMAP Reduction for States Covering Undocumented Immigrants

Section 44111 introduces a punitive funding formula change that reduces the enhanced Federal Medical Assistance Percentage (FMAP) for Medicaid expansion populations from 90% to 80% in states that provide public coverage or subsidies to undocumented immigrants. States are considered 'specified states' if they offer benefits using state-only dollars or allow undocumented residents to participate in state-based exchanges with subsidies.

For home care providers operating in states such as California, Illinois, New York, and others that have taken steps to provide health benefits to immigrant populations, this policy could pose indirect risks. The loss of 10% in enhanced FMAP could translate to hundreds of millions in lost revenue for Medicaid budgets, putting pressure on state policymakers to cut, delay, or limit Medicaid HCBS expenditures.

Agencies could see stagnation or rollback in HCBS program expansions, reduced reimbursement growth, or increased scrutiny over billing practices as states search for savings. While this section does not mandate any changes to HCBS directly, its fiscal impact may ripple through budgets that support home care access, particularly for expansion populations and lower-income adults who qualify for Medicaid under the ACA.

2. Moratorium on Medicare Savings Program Rule

Section 44101 places a moratorium until January 1, 2035, on CMS’s 2023 final rule regarding Medicare Savings Program eligibility. While not directly targeting home care, this rule was intended to streamline Medicaid processes that affect dual-eligible populations—many of whom require home care. The freeze may delay administrative improvements that would have helped eligible individuals remain continuously enrolled, potentially limiting access to HCBS for vulnerable groups.

3. Moratorium on Medicaid/CHIP Streamlining Rule

Section 44102 similarly halts implementation of CMS’s 2024 final rule designed to simplify Medicaid, CHIP, and Basic Health Program enrollment and renewal processes. This moratorium could keep in place complex and burdensome redetermination processes, increasing the risk of disenrollment for individuals receiving HCBS and other long-term services.

4. Mandatory Address Verification and Anti-Duplication Measures

Section 44103 requires monthly address verification using national databases and establishes a federal system to detect and prevent enrollment in multiple states. Home care providers may see higher rates of coverage termination due to address mismatches, even when beneficiaries remain eligible. Agencies should prepare to assist clients in resolving documentation issues to avoid service disruptions.

5. Death File Verification and Deceased Beneficiary Disenrollment

Section 44104 mandates quarterly checks against the federal Death Master File to ensure that deceased individuals are not retained on Medicaid rolls. If incorrectly implemented, this could lead to erroneous disenrollments and abrupt terminations of home care services. The section includes provisions for retroactive reinstatement in case of mistaken identity.

6. Monthly and Quarterly Medicaid Provider Screening Requirements

Sections 44105 and 44106 significantly increase the frequency and scope of provider screening obligations for state Medicaid programs. Under these provisions, states are required to conduct monthly checks of national databases, including those identifying providers who have been terminated from Medicare or other Medicaid programs, and to verify that enrolled providers are not deceased. These databases include the National Practitioner Data Bank (NPDB), the Death Master File, and others.

For home care agencies, these requirements could have substantial operational implications. Agencies will need to ensure that their internal credentialing systems are synced with state expectations to prevent service disruptions or denials tied to lags in status updates. Particularly in states with high staff turnover or multi-jurisdictional operations, this may require investment in updated compliance software, legal review of HR policies, and tighter coordination with Medicaid enrollment teams. Failure to comply or to respond quickly to false positives (e.g., mistakenly flagged employees) may lead to delays in reimbursement or risk of exclusion from provider networks.

7. Elimination of Good Faith Waivers for Erroneous Payments

Section 44107 removes the option for states to receive waivers for improperly issued Medicaid payments due to administrative errors. This change could prompt states to more aggressively pursue payment recoveries from providers. Home care agencies may face a higher volume of audits or clawbacks for technical or documentation issues.

8. Revised Home Equity Limit for Medicaid LTC Eligibility

Section 44109 introduces an important flexibility for states in determining Medicaid eligibility for long-term care, including home- and community-based services (HCBS). It allows states to adopt a flat home equity cap of up to $1 million (regardless of the federally-set indexed range) and to apply alternative rules for property used for agricultural purposes.

This could significantly expand access to HCBS in regions with high real estate values, where many seniors and adults with disabilities are house-rich but cash-poor. Under current policy, individuals with homes valued above state-specific limits (e.g., $688,000–$1,033,000 in 2025) may be ineligible for Medicaid LTSS unless they take out reverse

mortgages or engage in spend-down strategies. This provision would reduce that burden and allow greater continuity of care in one's own home.

However, since adoption is optional, home care stakeholders must work closely with state Medicaid agencies and legislatures to encourage implementation. Without pressure, some states may retain restrictive thresholds, leaving in place a major financial barrier to HCBS access. Additionally, it will be important to ensure that higher home equity does not disqualify individuals from needed services in ways that conflict with Medicaid's overall LTSS goals.

9. Biannual Redetermination for Medicaid Expansion Enrollees

Section 44108 requires redetermination of Medicaid eligibility every six months for expansion adults beginning in 2027. This will likely increase churn and administrative burden on both enrollees and providers. Home care agencies should prepare for higher rates of service interruption and increased need for care coordination during lapses in coverage.

10. Moratorium on Minimum Nursing Facility Staffing Standards

Section 44121 imposes a moratorium through January 1, 2035, on the implementation of CMS's 2024 rule establishing minimum staffing standards for long-term care facilities, particularly nursing homes. The original rule would have mandated minimum hours per resident day for registered nurses and nurse aides and required 24/7 RN coverage in most facilities.

The moratorium has direct and indirect implications for the home care industry. In the absence of mandated improvements in institutional care settings, policymakers and families may increasingly look to HCBS as an alternative. Home care providers may see increased demand from consumers seeking to avoid under-resourced nursing facilities. This is especially likely if media or advocacy campaigns highlight ongoing deficiencies in facility staffing.

However, the moratorium also means CMS will not move forward with the rule's Medicaid payment transparency provisions, which would have required states to report how much of their nursing facility funding actually went to direct care. That data would have strengthened arguments for rebalancing Medicaid LTSS spending toward HCBS. Without it, home care advocates lose a key lever in pushing for parity.

Finally, increased demand for home care without corresponding investment in workforce or reimbursement could place new strains on agencies. Workforce shortages and service delays may worsen unless Congress or state legislatures pair demand growth with concrete support. Home care stakeholders should use this moratorium window to advocate for workforce investment and rate adequacy across Medicaid HCBS programs.

11. Limit on Retroactive Medicaid and CHIP Eligibility

Section 44122 shortens the retroactive eligibility period for Medicaid and CHIP from three months to one month. This may hurt clients who need urgent home care before coverage

is formally approved, as agencies often rely on retroactive billing in these scenarios. Providers may face higher uncompensated care risk under this new limitation.

12. Medicaid Pharmacy Acquisition Cost Transparency

Section 44123 requires monthly surveys and publication of drug acquisition costs, including enhanced reporting from retail and non-retail pharmacies. Though not directly related to home care, broader Medicaid cost containment efforts stemming from these data may lead to fiscal adjustments that ripple across provider types, including home- and community-based services.