

Issue Brief

FEDERAL ISSUE BRIEF



Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

May 26, 2025

House Passes FY 2026 Budget Bill

The U.S. House of Representatives on May 22 passed its version of a Fiscal Year (FY) 2026 Federal Budget by a vote of 215 to 214. The bill, H.R. 1, is titled "One Big Beautiful Bill." The bill contains extensive changes to Medicaid and Health Insurance Marketplaces.

The material presented below is based on the H.R. 1 version dated May 20, 2025. There have been additional changes since May 20. Most involve effective dates.

While we await a final version, the material below reflects a number of those additional changes.

Perhaps the most significant change is the effective date of work requirements from January 1, 2029 to not later than January 1, 2027.

While much attention has been devoted to this bill, it's still not a finished product. The measure now moves to the Senate which is expected to make more changes.

A copy of the May 20 bill text is available at: <https://www.govinfo.gov/content/pkg/BILLS-119hr1rh/pdf/BILLS-119hr1rh.pdf>.

A very helpful 347-page Comparative Print: Bill to Bill Differences Comparing the base document BILLS-119pih with RCP_119-3_FINAL is available at: https://rules.house.gov/sites/evo-subsites/rules.house.gov/files/documents/bill-to-bill_bills-119pih_to_rcp_119-3_final.pdf. "This document was computer-generated to show how legislative text that may be considered by the House proposes to change existing law. It has not been reviewed for accuracy. This document does not represent an official expression by the House and should not be relied on as an authoritative delineation of the proposed change(s) to existing law."

Page numbering in red below is from the Comparative Print. Page numbering in black is from H. R. 1 dated May 20.

SUMMARY OF PROVISIONS AFFECTING HOSPITALS FROM COMPARATIVE PRINT

Title IV Energy and Commerce

Subtitle D— Health

PART 1-MEDICAID

SUBPART A— REDUCING FRAUD AND IMPROVING ENROLLMENT PROCESSES

SEC. 44101. *Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs.* (Page 97) (Page 295)

The Secretary of Health and Human Services (HHS) shall not during the period beginning on the date of the enactment of this section and ending January 1, 2035, implement, administer, or enforce the provisions of the final rule published by the Centers for Medicare Medicaid Services on September 21, 2023, titled "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment."

SEC. 44102. *Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, Chip, and the Basic Health Program.* (Page 97) (Page 295)

The HHS Secretary shall not, during the period beginning on the date of the enactment of this section and ending January 1, 2035, implement, administer, or enforce the provisions of the final rule published by the Centers for Medicare Medicaid Services on April 2, 2024, and titled " Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes "

SEC. 44103. *Ensuring Appropriate Address Verification under the Medicaid and Chip Programs.*
(Page 97) (Page 296)

Beginning not later than January 1, 2027, HHS will require state Medicaid agencies to establish a process to regularly obtain address information for individuals enrolled under Medicaid (or a waiver of such plan).

Beginning not later than October 1, 2029—"for the State to submit with respect to an individual enrolled or seeking to enroll under Medicaid, not less frequently than once each month and during each determination or redetermination of the eligibility of such individual for medical assistance under such plan (or waiver of such plan)—

"(I) the social security number of such individual, if such individual has a social security number and is required to provide such number to enroll under such plan (or waiver); and

"(II) such other information with respect to such individual as determined necessary by the Secretary for purposes of preventing individuals from simultaneously being enrolled under State plans (or waivers of such plans) of multiple States.

SEC. 44104. *Modifying Certain State Requirements for Ensuring Deceased Individuals Do Not Remain Enrolled.* (Page 99) (Page 303)

Beginning January 1, 2028, the State shall, not less frequently than quarterly, review the Death Master File (as such term is defined in section 203(d) of the Bipartisan Budget Act of 2013) to determine whether any individuals enrolled for medical assistance under the State plan (or waiver of such plan) are deceased.

If the State determines, that an individual enrolled for medical assistance under the State plan (or waiver of such plan) is deceased, the State shall—

“(i) treat such information as factual information confirming the death of a beneficiary for purposes of section 431.213(a) of title 42, Code of Federal Regulations (or any successor regulation);

“(ii) disenroll such individual from the State plan (or waiver of such plan); and

“(iii) discontinue any payments for medical assistance under this title made on behalf of such individual (other than payments for any items or services furnished to such individual prior to the death of such individual).”

If a State determines that an individual was misidentified as deceased based on information obtained from the Death Master File and was erroneously disenrolled from medical assistance under the State plan (or waiver of such plan) based on such misidentification, the State shall immediately re-enroll such individual under the State plan (or waiver of such plan), retroactive to the date of such disenrollment.

SEC. 44105. Medicaid Provider Screening Requirements. (Page 100) (Page 306)

Beginning January 1, 2028, and not less frequently than monthly the State conducts a check of any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act to determine whether the Secretary has terminated the participation of such provider or supplier under title XVIII, or whether any other State has terminated the participation of such provider or supplier under such other State’s State plan under this title (or waiver of the plan), or such other State’s State child health plan under title XXI (or waiver of the plan).

SEC. 44106. Additional Medicaid Provider Screening Requirements. (Page 100) (Page 307)

Beginning January 1, 2028, as part of the enrollment (or reenrollment or revalidation of enrollment) of a provider or supplier under this title, and not less frequently than quarterly during the period that such provider or supplier is so enrolled, the State conducts a check of the Death Master File (as such term is defined in section 203(d) of the Bipartisan Budget Act of 2013) to determine whether such provider or supplier is deceased.

SEC. 44107. Removing Good Faith Waiver for Payment Reduction Related to Certain Erroneous Excess Payments under Medicaid. (Page 101) (Page 308)

Effective FY 2030 the authority of the HHS secretary to waive payment reductions is limited and requires HHS to reduce federal funding to states derived from states making erroneous excess payments for ineligible individuals or services.

SEC. 44108. *Increasing Frequency of Eligibility Redeterminations for Certain Individuals.* (Page 102)
(Page 309)

Effective December 31, 2026 a State shall make a redetermination once every 6 months for the following individuals:

“(i) Individuals enrolled under subsection (a)(10)(A)(i)(VIII),

“(ii) Individuals described in such subsection who are otherwise enrolled under a waiver of such plan that provides coverage that is equivalent to minimum essential coverage (as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and determined in accordance with standards prescribed by the Secretary in regulations) to all individuals described in subsection (a)(10)(A)(i)(VIII).”

SEC. 44109. *Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services under The Medicaid Program.* (Page 102) (Page 310)

Effective January 1, 2028, the Home Equity Interest Limit to determine allowable assets for nursing facility and long-term care medical assistance is increased from \$500,000 to \$1,000,000. In other words, an applicant could not qualify for Medicaid if they have a home that is valued at more than \$1 million.

SEC. 44110. *Prohibiting Federal Financial Participation under Medicaid and CHIP for Individuals Without Verified Citizenship, Nationality, or Satisfactory Immigration Status.* (Page 103) (Page 313)

Beginning October 1, 2026, federal participation for Medicaid and CHIP is prohibited unless a state optionally elects to provide coverage during a 90-day opportunity for individuals to successfully verify their citizenship or immigration status.

SEC. 44111. *Reducing Expansion FMAP for Certain States Providing Payments for Health Care Furnished to Certain Individuals.* (Page 104) (Page 318)

Effective October 1, 2027 the Federal Medical Assistance Percentage (FMAP) is reduced from 90 to 80 percent for the expansion population in states that provide any form of financial assistance, in whole or in part, whether or not made under a State plan (or waiver of such plan) or under another program established by the State, and regardless of the source of funding for such assistance, to or on behalf of

an alien who is not a qualified alien or otherwise lawfully residing in the United States for the purchasing of health insurance coverage (as defined in section 2791(b)(1) of the Public Health Service Act).

SUBPART B— PREVENTING WASTEFUL SPENDING

SEC. 44121. *Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities under the Medicare and Medicaid Programs.* (Page 105) (Page 322)

The Secretary of Health and Human Services shall not, during the period beginning on the date of the enactment of this section and ending January 1, 2035, implement, administer, or enforce the provisions of the final rule published by the Centers for Medicare Medicaid Services on May 10, 2024, and titled “Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting ”

SEC. 44122. *Modifying Retroactive Coverage under the Medicaid and Chip Programs.* (Page 105)
(Page 322)

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by striking “ in or after the third month before the month in which the recipient makes application for assistance ” and inserting “ in or after the month before the month in which the recipient makes application for assistance.”

In other words, retroactive coverage is being reduced from 90 to 30 days.

The amendments made by this section shall apply to medical assistance and child health assistance, and pregnancy-related assistance with respect to individuals whose eligibility for such medical assistance or assistance, child health assistance, or pregnancy-related assistance is based on an application made on or after December 31, 2026.

SEC. 44123. *Ensuring Accurate Payments to Pharmacies under Medicaid.* (Page 106) (Page 324)

The Secretary shall conduct a survey of retail community pharmacy drug prices and applicable non-retail pharmacy drug prices to determine national average drug acquisition cost benchmarks.

Information on national drug acquisition prices obtained under this paragraph shall be made publicly available in a form and manner to be determined by the Secretary.

The Secretary shall impose a civil money penalty established under this subparagraph on a retail community pharmacy or applicable non-retail pharmacy if—

“(I) the retail pharmacy or applicable non-retail pharmacy refuses or otherwise fails to respond to a request for information about prices in connection with a survey under this subsection;

“(II) knowingly provides false information in response to such a survey; or

“(III) otherwise fails to comply with the requirements established under this paragraph.”

The amendments made by this section shall apply beginning on the first day of the first quarter that begins on or after the date that is 6 months after the date of enactment of this section.

SEC. 44124. Preventing the Use of Abusive Spread Pricing in Medicaid. (Page 109) (Page 337)

A contract between the State and a pharmacy benefit manager (referred to in this paragraph as a ‘PBM’), or a contract between the State and a managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D) and collectively referred to in this paragraph as the ‘entity’) that includes provisions making the entity responsible for coverage of covered outpatient drugs dispensed to individuals enrolled with the entity, shall require that payment for such drugs and related administrative services (as applicable), including payments made by a PBM on behalf of the State or entity, is based on a transparent prescription drug pass-through pricing model under which—

“(i) any payment made by the entity or the PBM (as applicable) for such a drug—

“(I) is limited to—

“(aa) ingredient cost; and

“(bb) a professional dispensing fee that is not less than the professional dispensing fee that the State would pay if the State were making the payment directly in accordance with the State plan;

“(II) is passed through in its entirety (except as reduced under Federal or State laws and regulations in response to instances of waste, fraud, or abuse) by the entity or PBM to the pharmacy or provider that dispenses the drug; and

“(III) is made in a manner that is consistent with sections 447.502, 447.512, 447.514, and 447.518 of title 42, Code of Federal Regulations (or any successor regulation) as if such requirements applied directly to the entity or the PBM, except that any payment by the entity or the PBM for the ingredient cost of such drug purchased by a covered entity (as defined in subsection (a)(5)(B)) may exceed the actual acquisition cost (as defined in 447.502 of title 42, Code of Federal Regulations, or any successor regulation) for such drug if—

“(aa) such drug was subject to an agreement under section 340B of the Public Health Service Act;

“(bb) such payment for the ingredient cost of such drug does not exceed the maximum payment that would have been made by the entity or the PBM for the ingredient cost of such drug if such drug had not been purchased by such covered entity; and

“(cc) such covered entity reports to the Secretary (in a form and manner specified by the Secretary), on an annual basis and with respect to payments for the ingredient costs

of such drugs so purchased by such covered entity that are in excess of the actual acquisition costs for such drugs, the aggregate amount of such excess.”

The amendments made by this section shall apply to contracts between States and managed care entities, other specified entities, or pharmacy benefit managers that have an effective date beginning on or after the date that is 18 months after the date of enactment of this section.

SEC. 44125. Prohibiting Federal Medicaid and Chip Funding for Gender Transition Procedures for Minors. (Page 112) (Page 346)

Prohibits states from receiving federal funds for gender transition procedures any of the following when performed for the purpose of intentionally changing the body of such individual (including by disrupting the body’s development, inhibiting its natural functions, or modifying its appearance) to no longer correspond to the individual’s sex: including—(i) castration; (ii) sterilization; (iii) orchiectomy; (iv) scrotoplasty; (v) vasectomy; (vi) tubal ligation; (vii) hysterectomy; (viii) oophorectomy; (ix) ovariectomy; (x) metoidioplasty; (xi) clitoroplasty; (xii) reconstruction of the fixed part of the urethra with or without a metoidioplasty or a phalloplasty; (xiii) penectomy; (xiv) phalloplasty; (xv) vaginoplasty; (xvi) vaginectomy; (xvii) vulvoplasty; (xviii) reduction thyrochondroplasty; (xix) chondrolaryngoplasty; (xx) mastectomy; and (xxi) any plastic, cosmetic, or aesthetic surgery that feminizes or masculinizes the facial or other body features of an individual.

The above shall not apply to the following when furnished to an individual by a health care provider with the consent of such individual’s parent or legal guardian:

“(A) Puberty suppression or blocking prescription drugs for the purpose of normalizing puberty for an individual experiencing precocious puberty.

“(B) Medically necessary procedures or treatments to correct for—

“(i) a medically verifiable disorder of sex development, including—

“(I) 46,XX chromosomes with virilization;

“(II) 46,XY chromosomes with under virilization; and

“(III) both ovarian and testicular tissue;

“(ii) sex chromosome structure, sex steroid hormone production, or sex hormone action, if determined to be abnormal by a physician through genetic or biochemical testing;

“(iii) infection, disease, injury, or disorder caused or exacerbated by a previous procedure

or a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the individual in imminent danger of death or impairment of a major bodily function unless the procedure is performed, not including procedures performed for the alleviation of mental distress; or

“(iv) procedures to restore or reconstruct the body of the individual in order to correspond to the sex after one or more previous procedures described which may include the removal of a pseudo phallus or breast augmentation.”

The effective date is not specified.

SEC. 44126. Federal Payments to Prohibited Entities. (Page 114) (Page 351)

No Federal funds that are considered direct spending and provided to carry out a State plan under title XIX of the Social Security Act or a waiver of such a plan shall be used to make payments to a prohibited entity for items and services furnished during the 10-year period beginning on the date of the enactment of this Act, including any payments made directly to the prohibited entity or under a contract or other arrangement between a State and a covered organization.

The term “ prohibited entity ” means an entity, including its affiliates, subsidiaries, successors, and clinics—

(A) that, as of the date of enactment of this Act—

(i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

(ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and

(iii) provides for abortions, other than an abortion—

(I) if the pregnancy is the result of an act of rape or incest; or

(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and

(B) for which the total amount of Federal and State expenditures under the Medicaid program under

title XIX of the Social Security Act in fiscal year 2024 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded \$1,000,000.

SUBPART C— STOPPING ABUSIVE FINANCING PRACTICES

SEC. 44131. *Sunsetting Eligibility for Increased FMAP for New Expansion States.* (Page 114) (Page 354)

This section requires states that had not chosen to expand Medicaid pursuant to the Patient Protection and Affordable Care Act prior to March 11, 2021, to do so by January 1, 2026, in order to receive the corresponding enhanced federal matching rate.

Currently 41 states and the District of Columbia have implemented Medicaid expansion.

SEC. 44132. *Moratorium on New or Increased Provider Taxes.* (Page 114) (Page 355)

This section generally precludes states from instituting new or otherwise increasing Medicaid provider taxes if—

The tax is first imposed by the State (or by a unit of local government in the State) on or after the date of the enactment of this subclause (other than such a tax for which the legislation or regulations providing for the imposition of such tax were enacted or adopted prior to such date of enactment); or “(III) on or after the date of the enactment of this subclause, the State (or unit of local government) increases the amount or rate of tax imposed with respect to a class of health care items or services (or with respect to a type of provider or activity within such a class), or increases the base of the tax such that the tax is imposed with respect to a class of items or services (or with respect to a type of provider or activity within such a class) to which the tax did not previously apply, but only to the extent that such revenues are attributable to such increase and only if such increase was not provided for in legislation or regulations enacted or adopted prior to such date of enactment.”

SEC. 44133. *Revising the Payment Limit for Certain State Directed Payments.* (Page 115) (Page 356)

The Secretary of Health and Human Services shall revise section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations (or a successor regulation) such that, with respect to a payment described in such section made for a service furnished during a rating period beginning on or after the date of the enactment of this Act, the total payment rate for such service is limited to 100 percent of the specified total published Medicare payment rate.

SEC. 44134. *Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax.* (Page 115) (Page 358)

Modifies the requirements regarding uniformity of provider taxes and whether a state’s tax is considered “generally redistributive.”

A tax is not considered to be generally redistributive if any of the following conditions apply:

“(I) Within a permissible class, the tax rate imposed on any taxpayer or tax rate group (as defined as group of entities contained within a permissible class of a health care related tax that are taxed at the same rate.” 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.

“(II) Within a permissible class, the tax rate imposed on any taxpayer or tax rate group (as so defined) based upon its Medicaid taxable units (as so defined) is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable unit.

“(III) The tax excludes or imposes a lower tax rate on a taxpayer or tax rate group (as so defined) based on or defined by any description that results in the same effect as described in

(I) or (II) for a taxpayer or tax rate group. Characteristics that may indicate such type of exclusion include the use of terminology to establish a tax rate group—

“(aa) based on payments or expenditures made under the program under this title without mentioning the term ‘ Medicaid ’ (or any similar term) to accomplish the same effect as described in subclause (I) or (II); or

“(bb) that closely approximates a taxpayer or tax rate group under the program under this title, to the same effect as described in subclause (I) or (II).”

SEC. 44135. *Requiring Budget Neutrality for Medicaid Demonstration Projects under Section 1115.* (Page 116) (Page 361)

Beginning on the date of the enactment of this subsection, the Secretary may not approve an application for (or renewal or amendment of) an experimental, pilot, or demonstration project undertaken to promote the objectives of title XIX in a State (in this subsection referred to as a “Medicaid demonstration project”) unless the Secretary certifies that such project is not expected to result in an increase in the amount of Federal expenditures compared to the amount that such expenditures would otherwise be in the absence of such project.

SUBPART D— INCREASING PERSONAL ACCOUNTABILITY

SEC. 44141. *Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals.* (Page 117) (Page 362)

This section requires individuals who are eligible for Medicaid as part of the Medicaid expansion population to engage in community service, work, or other activities in order to qualify for Medicaid.

Sub-regulatory guidance is to be promulgated by HHS by December 31, 2025. Implementation is by January 1, 2027.

Specifically, the section requires individuals to, on a monthly basis, (1) work at least 80 hours, (2) complete at least 80 hours of community service, (3) participate in a work program for at least 80 hours, (4) be enrolled at least half-time in an educational program, or (5) engage in any combination thereof for a total of at least 80 hours. Individuals may also qualify if they have a monthly income that is at least as much as the equivalent of minimum wage multiplied by 80 hours.

Individuals who are applying for Medicaid must demonstrate compliance with these requirements for one month or more (as determined by the state) consecutively and immediately prior to filing an application; individuals who are already enrolled in Medicaid must demonstrate compliance for one month or more (as determined by the state), whether or not consecutive, during the period between the individual's last eligibility determination and the next scheduled eligibility determination.

States must verify an individual's compliance upon a determination or redetermination of eligibility but may also choose to verify compliance more frequently. States may not waive the new requirements. However, states may choose to provide an exception for individuals experiencing short-term hardships (e.g., hospitalization).

The section excludes certain individuals from these requirements, including those with serious medical conditions or dependent children.

The section provides funds for FY 2026 for states and the CMS to implement these requirements.

SEC. 44142. Modifying Cost Sharing Requirements for Certain Expansion Individuals under the Medicaid Program. (Page 117) (Page 382)

Beginning October 1, 2028, this section requires states to institute cost-sharing requirements for individuals who are eligible for Medicaid as part of the Medicaid expansion population and whose family income exceeds the federal poverty line. Cost sharing may not exceed \$35 for an item or service; total cost sharing for all individuals in a family may not exceed 5.0 percent of the family's income.

The requirements do not apply to services for which cost sharing is already prohibited (e.g., emergency services). States may allow providers to condition the provision of services upon the payment of any required cost sharing.

PART 2 — AFFORDABLE CARE ACT

SEC. 44201. Addressing Waste, Fraud, and Abuse in the ACA Exchanges. (Page 123) (Page 386)

Changes the enrollment periods for enrolling in exchanges for plan years beginning on or after January 1, 2026, to beginning on November 1 and ending on December 15 of the preceding calendar year.

An Exchange may not provide for, with respect to enrollment for plan years beginning on or after January 1, 2026—

“(A) an annual open enrollment period other than the period described above; or

“(B) a special enrollment period described in subparagraph (B) of such subsection.

PART 3 — IMPROVING AMERICANS’ ACCESS TO CARE

SEC. 44302. *Streamlined Enrollment Process for Eligible Out-Of-State Providers under Medicaid and Chip.* (Page 132) (Page 411)

Adopts and implements a process to allow an eligible out-of-State provider to enroll under the State plan (or a waiver of such plan) to furnish items and services to, or order, prescribe, refer, or certify eligibility for items and services for, qualifying individuals without the imposition of screening or enrollment requirements by such State that exceed the minimum necessary for such State to provide payment to an eligible out-of-State provider under such State plan (or a waiver of such plan), such as the provider’s name and National Provider Identifier (and such other information specified by the Secretary); and provides that an eligible out-of-State provider that enrolls as a participating provider in the State plan (or a waiver of such plan) through such process shall be so enrolled for a 5-year period, unless the provider is terminated or excluded from participation during such period.

The amendments made by this section shall apply beginning on the date that is 4 years after the date of enactment of this Act.

SEC. 44303. *Delaying DSH Reductions.* (Page 132) (Page 415)

Delays the Medicaid Disproportionate Share reductions scheduled from 2026 through 2028 to 2029 through 2031.

SEC. 44304. *Modifying Update to the Conversion Factor under the Physician Fee Schedule under The Medicare Program.* (Page 132) (Page 416)

Update for 2026 and Subsequent Years.— Creates a single conversion factor.

“(A) for 2026 is 75 percent of the Secretary’s estimate of the percentage increase in the Medicare Economic Index (MEI) (as defined in section 1842(i)(3)) for the year; and

“(B) for 2027 and each subsequent year is 10 percent of the Secretary’s estimate of the percentage increase in the MEI for the year.”

Title XI Ways and Means

Subtitle B— Make Rural America and Main Street Grow Again

SEC. 111201. *Expanding the Definition of Rural Emergency Hospital (REH) under the Medicare Program. (Page 293) (Page 937)*

Would allow a facility that “(i) submits an application under section 1866(j) to enroll under this title as a rural emergency hospital—

“(I) in the case that such facility is located in a State that, as of January 1, 2027, provides for the licensing of rural emergency hospitals under State or applicable local law not later than December 31, 2027; and

“(II) in the case that such facility is located in a State that, as of January 1, 2027, does not provide for the licensing of such rural emergency hospitals under State or applicable local law not later than the date that is 1 year after the date on which such State begins to provide for such licensing; and

“(ii) in the case that such facility is located less than 35 miles away from the nearest hospital, critical access hospital, or rural emergency hospital as of the date on which such facility submits an application under section 1866(j) to enroll under this title as a rural emergency hospital, beginning not later than 1 year after the end of the first full cost reporting period for which the facility is so enrolled, demonstrates annually, in a form and manner determined appropriate by the Secretary, that more than 50 percent of the services furnished for the most recent cost reporting period were services described in paragraph (1)(A)(i), as determined based on discharges of individuals entitled to benefits under part A or enrolled under part B during such cost reporting period.”

Final Comments

As noted earlier, this bill is far from finished. Already, a number of Republican Senators are expressing that the House bill will increase the federal deficit from \$3 to \$4 trillion over the next 10 years. As such they are seeking additional reductions and changes in spending. The debate with the Senate is certain to be contentious to say the least.

It is interesting to note that the House bill does not reflect individual estimates of savings or costs. The House is relying on estimates from the Congressional Budget Office. To achieve payment objectives Medicaid is being subject to reductions between \$700 to over \$800 billion.

Note that the Medicaid changes do not directly alter payments to providers. Rather, they impact eligibility and state funding.

The latest estimates suggest a reduction of healthcare spending of at least \$715 billion, and 8.6 million individuals losing healthcare coverage.

Until the Senate acts, it is impossible to ascertain final Medicaid changes.

The Senate may also seek changes to Medicare as well.

On a final note, the material presented, to a large extent, is based on select portions of the legislation itself. We have done this to try and insure the changes being made actually reflect such changes.

*Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance,
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