Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

July 7, 2025

"One Big Beautiful Bill" (H.R.-1) Enacted

On July 3, the House of Representatives enacted the Senate's version of H.R. 1. On July 4, the President signed the bill into law.

Being a holiday weekend, and as we write this analysis, several final items still await publication. This analysis is based on the Senate's final actions on the bill as passed on July 1. The House accepted the Senate provisions.

Comments

In a political move, the bill delays many cuts/reductions, especially those to Medicaid until after the 2026 mid-term elections.

Much of the material that follows contains actual legislative language. The text of the bill material below is as of July 1, 2025 (Preprint (Rule)). A copy is at: https://www.govinfo.gov/content/pkg/BILLS-119hr1eas/pdf/BILLS-119hr1eas.pdf.

Page numbers of the 870-page "pdf" file are provided. The effective dates are highlighted in bold text which demonstrates that most will take place after next year's mid-term election cycle.

On a preliminary basis, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation estimate that enacting H.R. 1, will increase deficits over the 2025-2034 period by $3.5 trillion.

The bill's section VII contains changes to health care. CBO says that enactment of section VII would increase the deficit by more than $1.5 trillion over the 2025–2034 period.

CBO estimates the number of people without health insurance would increase by 16.0 million in 2034. Of that number, about 5.1 million stems from policies incorporated into CBO's baseline projections and 10.9 million from provisions that would be enacted under H.R. 1.

SUMMARY OF PROVISIONS AFFECTING HOSPITALS

Title VII Finance

Subtitle B— Health

Chapter 1-MEDICAID

Subchapter A – Reducing Fraud and Improving Enrollment Processes

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Sec. 71101. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment in Medicare Savings Programs (Page 571)

(a) In general –

The Secretary of Health and Human Services shall not, during the period beginning on the date of the enactment of this section and ending September 30, 2034, implement, administer, or enforce the

amendments made by the provisions of the final rule published by the Centers for Medicare & Medicaid Services (CMS) on September 21, 2023, and titled "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment."

(b) Implementation funding—

For the purposes of carrying out the provisions of this section and section 71102, there are appropriated, out of any monies in the Treasury not otherwise appropriated, to the Administrator of the Centers for Medicare & Medicaid Services, $1,000,000 for fiscal year 2026, to remain available until expended.

Sec 71102. Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program (Page 572)

The Secretary of Health and Human Services shall not, during the period beginning on the date of the enactment of this section and ending September 30, 2034, implement, administer, or enforce the amendments made by the provisions of the final rule published by CMS 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 71103. Reducing Duplicate Enrollment under the Medicaid and CHIP Programs (Page 573)

(a) Medicaid

1. In general – Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—
    (A) beginning not later than **January 1, 2027**, in the case of 1 of the 50 States and the District of Columbia, for a process to regularly obtain address information for individuals enrolled under such plan (or a waiver of such plan) in accordance with subsection (vv below); and

    (B) beginning not later than **October 1, 2029**—

(i) for the State to submit to the system established by the Secretary under subsection (uu below), with respect to an individual enrolled or seeking to enroll under such plan, 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;

(ii) for the use of such system to prevent such simultaneous enrollment; and

(iii) in the case that such system indicates that an individual enrolled or seeking to enroll under such plan is enrolled under a State plan of another State, for the taking of appropriate action (as determined by the Secretary) to identify whether such an individual resides in the State and disenroll an individual from the State plan of such State if such individual does not reside in such State (unless such individual meets such an exception as the Secretary may specify).

and; by adding at the following new subsections:

(uu)

Prevention of enrollment under multiple State plans

(1) In general--Not later than **October 1, 2029,** the Secretary shall establish a system to be utilized by the Secretary and States to prevent an individual from being simultaneously enrolled under the State plans (or waivers of such plans) of multiple States. Such system shall—

(A) provide for the receipt of information submitted by a State under subsection (a)(88)(B)(i); and
(B) not less than once each month, transmit information to a State regarding whether an individual enrolled or seeking to enroll under the State plan of such State is enrolled under the State plan of another State.

(2) Standards--The Secretary shall establish such standards as determined necessary by the Secretary to limit and protect information submitted under such system and ensure the privacy of such information.

(3) Implementation funding--There are appropriated to the Administrator of CMS, out of amounts in the Treasury not otherwise appropriated, in addition to amounts otherwise available—

(A) for fiscal year 2026, $10,000,000 for purposes of establishing the system and standards required under this subsection, to remain available until expended; and

(B) for fiscal year 2029, $20,000,000 for purposes of maintaining such system, to remain available until expended.

(vv)

Process to obtain enrollee address information

(1) In general—a process to regularly obtain address information for individuals enrolled under a State plan shall obtain address information from reliable data sources described in paragraph (2) and take such actions as the Secretary shall specify with respect to any changes to such address based on such information.
(2) Reliable data sources described
(A) Mail returned to the State by the United States Postal Service with a forwarding address.
(B) The National Change of Address Database maintained by the United States Postal Service.

(C) A managed care entity (as defined in section 1932(a)(1)(B)) or prepaid inpatient health plan or prepaid ambulatory health plan (as such terms are defined in section 1903(m)(9)(D)) that has a contract under the State plan if the address information is provided to such entity or plan directly from, or verified by such entity or plan directly with, such individual.

(D) Other data sources as identified by the State and approved by the Secretary.

Sec 71104. Ensuring Deceased Individuals do not Remain Enrolled (Page 580)

Section 1902 of the Social Security Act, as amended by section 71103, is further amended—to provide that the State shall comply with the eligibility verification requirements under subsection (ww below), except that this paragraph shall apply only in the case of the 50 States and the District of Columbia.

(ww)

Verification of certain eligibility criteria

(1) In general--For purposes of the eligibility verification requirements, beginning **January 1, 2027**, are as follows:

(A) Quarterly screening to verify enrollee status

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) or a successor system that provides such information needed to determine whether any individuals enrolled for medical assistance under the State plan are deceased.

(B) Disenrollment under State plan

(i) If the State determines, based on information obtained from the Death Master File, that an individual enrolled for medical assistance under the State plan (or waiver of such plan) is deceased, the State shall—treat such information as factual information confirming the death of a beneficiary;
(ii) disenroll such individual from the State plan (or waiver of such plan) in accordance with subsection (a)(3); 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).

(C) Reinstatement of coverage in the event of error

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 based on such misidentification, the State shall immediately re-enroll such individual under the State plan, retroactive to the date of such disenrollment.

Sec 71105. Ensuring Deceased Providers do not Remain Enrolled (Page 583)

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 71106. Payment Reduction Related to Certain Erroneous Excess Payments under Medicaid (Page 584)

Section 1903(u)(1) of the Social Security Act (42 U.S.C. 1396b(u)(1)) is amended--by inserting "for audits conducted by the Secretary, or, at the option of the Secretary, audits conducted by the State" after "exceeds 0.03.

The amendment made shall apply beginning with respect to fiscal year 2030.

Sec 71107. Eligibility Redeterminations (Page 586)

Frequency of eligibility redeterminations for certain individuals

(i) In general

Subject to clause (ii), with respect to redeterminations of eligibility for medical assistance under a State plan scheduled on or after the first day of the first quarter that begins after **December 31, 2026,** a State shall make such 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).

(ii) Exemption

The requirements described in clause (i) shall not apply to any individual described in subsection (xx)(9)(A)(ii)(II).

Sec 71108. Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services under the Medicaid Program (Page 588)

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 71109. Alien Medicaid Eligibility (Page 590)

Beginning on **October 1, 2026**, in no event shall payment be made to a State under this section for medical assistance furnished to an individual unless such individual is—

(A) a resident of 1 of the 50 States, the District of Columbia, or a territory of the United States; and

(B) either—

(i) a citizen or national of the United States;

(ii) an alien lawfully admitted for permanent residence as an immigrant as defined by sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act, excluding, among others, alien visitors, tourists, diplomats, and students who enter the United States temporarily with no intention of abandoning their residence in a foreign country;

(iii) an alien who has been granted the status of Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96–422); or

(iv) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 402(b)(2)(G) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Sec. 71110. Expansion FMAP for Emergency Medicaid (Page 592)

Beginning on **October 1, 2026**, the Federal medical assistance percentage for payments for care and services described in paragraph (2) of subsection 1903(v) furnished to an alien described in paragraph (1) of such subsection shall not exceed the Federal medical assistance percentage determined under subsection (b) for such State.

Subchapter B. Preventing Wasteful Spending

Sec. 71111. Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities under the Medicare and Medicaid Programs (Page 593)

The Secretary shall not, during the period beginning on the date of the enactment of this section and ending September 30, 2034, implement, administer, or enforce the amendments made by the provisions of the final rule published by CMS 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. 71112. Reducing State Medicaid Costs (Page 594)

Section 1905(a) of the Social Security Act is amended by striking "in or after the third month before the month in which the recipient makes application for assistance" and inserting," with respect to an individual described in section 1902(a)(34)(A), in or after the month before the month in which the recipient makes application for assistance, and with respect to an individual described in section 1902(a)(34)(B), in or after the second month before the month in which the recipient makes application for assistance".

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

Sec. 71113. Federal Payments to Prohibited Entities (Page 597)

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 1-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.

Subchapter C Stopping Abusive Financing Practices

Sec.71114. Sunsetting Increased FMAP Incentive (Page 600)

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. 71115. Provider Taxes (Page 601)

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 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.

(a) Change in threshold for hold harmless provision of broad-based health care related taxes.

(1) For fiscal years beginning on or after **October 1, 2026,** the applicable percent determined under subparagraph (D) shall be substituted for 6.0 percent each place it appears after each place it appears;

> (I) for fiscal year 2028, 5.5 percent;
>
> (II) for fiscal year 2029, 5 percent;
>
> (III) for fiscal year 2030, 4.5 percent;
>
> (IV) for fiscal year 2031, 4 percent; and
>
> (V) for fiscal year 2032 and each subsequent fiscal year, 3.5 percent.

Sec 71116. State Directed Payments (Page 605)

(a) Subject to subsection (b), the Secretary 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—

(1) in the case of a State that provides coverage to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act 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) under the State plan of such State under title XIX of such Act, 100 percent of the specified total published Medicare payment rate (or, in the absence of a specified total published Medicare payment rate, the payment rate under a Medicaid State plan (or under a waiver of such plan)); or

(2) in the case of a State other than a State described in paragraph (1), 110 percent of the specified total published Medicare payment rate (or, in the absence of a specified total published Medicare payment rate, the payment rate under a Medicaid State plan).

(b) Grandfathering certain payments

In the case of a payment described in section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations (or a successor regulation) for which written prior approval (or a good faith effort to receive such approval, as determined by the Secretary) was made before May 1, 2025, or a payment described in such section for a rural hospital (as defined in subsection (d)(2)) for which written prior approval (or a good faith effort to receive such approval, as determined by the Secretary) was made by the date of enactment of this Act, for the rating period occurring within 180 days of the date of the enactment of this Act, or a payment so described for such rating period for which a completed preprint was submitted to the Secretary prior to the date of enactment of this Act, beginning with the rating period on or after **January 1, 2028**, the total amount of such payment shall be reduced by 10 percentage points each year until the total payment rate for such service is equal to the rate for such service specified in subsection (a).

(c) Treatment of expansion states

The revisions described in subsection (a) shall provide that, with respect to a State that begins providing the coverage described in paragraph (1) of such subsection on or after the date of the enactment of this Act, the limitation described in such paragraph shall apply to such State with respect to a payment described in section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations (or a successor regulation) for a service furnished during a rating period beginning on or after the date of enactment of this Act.

(d) Definitions

(1) Rating period--The term rating period has the meaning given such term in section 438.2 of title 42, Code of Federal Regulations (or a successor regulation).

(2) Rural hospital--The term rural hospital means the following:

(A) A subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act that—

(i) is located in a rural area (as defined in paragraph (2)(D) of such section);

(ii) is treated as being located in a rural area pursuant to paragraph (8)(E) of such section; or

(iii) is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992).

(B) A critical access hospital (as defined in section 1861(mm)(1) of such Act.

(C) A sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act.

(D) A Medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv) of such Act).

(C) A low-volume hospital (as defined in section 1886(d)(12)(C) of such Act.

(F) A rural emergency hospital (as defined in section 1861(kkk)(2) of such Act.

(3) State--The term *State* means 1 of the 50 States or the District of Columbia.

(4) Total published Medicare payment rate—The term *total published Medicare payment rate* has the meaning given to such term in section 438.6(a) of title 42, Code of Federal Regulations (or a successor regulation).

(5) Written prior approval--The term written prior approval has the meaning given to such term in section 438.6(c)(2)(i) of title 42, Code of Federal Regulations (or a successor regulation).

(e) Funding

There are appropriated out of any monies in the Treasury not otherwise appropriated $7,000,000 for each of fiscal years 2026 through 2033 for purposes of carrying out this section, to remain available until expended.

Sec. 71117. Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax (Page 609)

(A) 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 in paragraph (7)(J)) explicitly defined by its relatively lower volume or percentage of Medicaid taxable units (as defined in paragraph (7)(H)) 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.

(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 (as defined in paragraph (7)(I)).

(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 subclause (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. 71118. Requiring Budget Neutrality for Medicaid Demonstration Projects under Section 1115 (Page 613)

Beginning **January 1 2027**, the Secretary may not approve an application for (or renewal or amendment of) an experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX in a State (in this subsection referred to as a Medicaid demonstration project) unless the Chief Actuary for CMS certifies that such project, or, in the case of a renewal, the duration of the preceding waiver, 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. For purposes of this subsection, expenditures for the coverage of populations and services that the State could have otherwise provided through its Medicaid State plan or other authority under title XIX, including expenditures that could be made under such authority but for the provision of such services at a different site of service than authorized under such State plan or other authority, shall be considered expenditures in the absence of such a project.

Subchapter D Increasing Personal Accountability

Sec. 71119. Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals (Page 615)

Beginning not later than the first day of the first quarter that begins after **December 31, 2026**, or, at the option of the State under a waiver or demonstration project under section 1115 or the State plan, such earlier date as the State may specify, subject to the succeeding provisions of this subsection, a State shall provide, as a condition of eligibility for medical assistance for an applicable individual, that such individual is required to demonstrate community engagement under paragraph (2).

(1) In general.—

(A) in the case of an applicable individual who has filed an application for medical assistance under a State plan (or a waiver of such plan) under this title, for 1 or more but not more than 3 (as specified by the State) consecutive months immediately preceding the month during which such individual applies for such medical assistance; and

(B) in the case of an applicable individual enrolled and receiving medical assistance under a State plan (or under a waiver of such plan) under this title, for 1 or more (as specified by the State) months, whether or not consecutive—

(i) during the period between such individual's most recent determination (or redetermination, as applicable) of eligibility and such individual's next regularly scheduled redetermination of eligibility (as verified by the State as part of such regularly scheduled redetermination of eligibility);or

(ii) in the case of a State that has elected under paragraph (4) to conduct more frequent verifications of compliance with the requirement to demonstrate community engagement, during the period between the most recent and next such verification with respect to such individual.

(2) Community engagement compliance described.

Subject to paragraph (3), an applicable individual demonstrates community engagement under this paragraph for a month if such individual meets one or more of the following conditions with respect to such month, as determined in accordance with criteria established by the secretary through regulation:

(A) The individual works not less than 80 hours.

(B) The individual completes not less than 80 hours of community service.

(C) The individual participates in a work program for not less than 80 hours.

(D) The individual is enrolled in an educational program at least half-time.

(E) The individual engages in any combination of the activities described in subparagraphs (A) through (D), for a total of not less than 80 hours.

(F) The individual has a monthly income that is not less than the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938, multiplied by 80 hours.

(G) The individual had an average monthly income over the preceding 6 months that is not less than the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938 multiplied by 80 hours, and is a seasonal worker, as described in section 45R(d)(5)(B) of the Internal Revenue Code of 1986 .

(3) Exceptions

(A) Mandatory exception for certain individuals.-

The State shall deem an applicable individual to have demonstrated community engagement under paragraph (2) for a month, and may elect to not require an individual to verify information, resulting in such deeming, if-

(i) for part or all of such month, the individual—

(I) was a specified excluded individual (as defined in paragraph (9)(A)(ii)); or

(II) was—

(aa) under the age of 19;

(bb) entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII; or

(cc) described in any of subclauses (I) through (VII) of subsection (a)(10)(A)(i); or

(ii) at any point during the 3-month period ending on the first day of such month, the individual was an inmate of a public institution.

(B) Optional exception for short-term hardship events

(i) In general--The State plan may provide, in the case of an applicable individual who experiences a short-term hardship event during a month, that the State shall, under procedures established by the State (in accordance with standards specified by the Secretary), in the case of a short-term hardship event described in clause (ii)(II) and, upon the request of such individual, a short-term hardship event described in subclause (I) or (III) of clause (ii), deem such individual to have demonstrated community engagement under paragraph (2) for such month.

(ii) Short-term hardship event defined-

For purposes of this subparagraph, an applicable individual experiences a short-term hardship event during a month if, for part or all of such month—

(I) such individual receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services of similar acuity (including outpatient care relating to other services specified in this subclause) as the Secretary determines appropriate;

(II) such individual resides in a county (or equivalent unit of local government)—

(aa) in which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or

(bb) that, subject to a request from the State to the Secretary, made in such form, at such time, and containing such information as the Secretary may require, has an unemployment rate that is at or above the lesser of—

(AA) 8 percent; or

(BB) 1.5 times the national unemployment rate; or

(III) such individual or their dependent must travel outside of their community for an extended period of time to receive medical services necessary to treat a serious or complex medical condition (as described in paragraph (9)(A)(ii)(V)(ee)) that are not available within their community of residence.

(4) Option to conduct more frequent compliance verifications

With respect to an applicable individual enrolled and receiving medical assistance under a State plan (or a waiver of such plan) under this title, the State shall verify (in accordance with procedures specified by the Secretary) that each such individual has met the requirement to demonstrate community engagement under paragraph (1) during each such individual's regularly scheduled redetermination of eligibility, except that a State may provide for such verifications more frequently.

(5) Ex parte verifications

For purposes of verifying that an applicable individual has met the requirement to demonstrate community engagement under paragraph (1), or determining such individual to be deemed to have demonstrated community engagement under paragraph (3), or that an individual is a specified excluded individual under paragraph (9)(A)(ii), the State shall, in accordance with standards established by the Secretary, establish processes and use reliable information available to the State (such as payroll data or payments or encounter data under this title for individuals and data on payments to such individuals for the provision of services covered under this title) without requiring, where possible, the applicable individual to submit additional information.

(6) Procedure in the case of noncompliance

(A) In general--

If a State is unable to verify that an applicable individual has met the requirement to demonstrate community engagement under paragraph 1, (including, if applicable, by verifying that such individual was seemed to have demonstrated community engagement under paragraph 3, the state shall--

(i) provide such individual with the notice of noncompliance described in subparagraph B;

(ii)

(I) provide such individual with a period of 30 calendar days, beginning on the date on which such notice of noncompliance is received by the individual, to—

(aa) make a satisfactory showing to the State of compliance with such requirement (including, if applicable, by showing that such individual was or should be deemed to have demonstrated community engagement under paragraph (3);

(bb) make a satisfactory showing to the State that such requirement does not apply to such individual on the basis that such individual does not meet the definition of applicable individual under paragraph (9)(A); and

(II) if such individual is enrolled under the State plan under this title, continue to provide such individual with medical assistance during such 30-calendar-day period; and

(iii) if no such satisfactory showing is made and the individual is not a specified excluded

individual described in paragraph (9)(A)(ii), deny such individual's application for medical assistance under the state plan or, as applicable, disenroll such individual from the plan, not later than the end of the month following the month in which such 30 calendar day ends, provided that—

(I) the State first determines whether, with respect to the individual, there is any other basis for eligibility for medical assistance under the State plan or for another insurance affordability program; and

(II) the individual is provided written notice and granted an opportunity for a fair hearing in accordance with subsection (a)(3).

(B) Notice

The notice of noncompliance provided to an applicable individual under subparagraph (A)(i) shall include information (in accordance with standards specified by the Secretary) on—

(i) how such individual may make a satisfactory showing of compliance with such requirement (as described in subparagraph (A)(ii)) or make a satisfactory showing that such requirement does not apply to such individual on the basis that such individual does not meet the definition of applicable individual under paragraph (9)(A); and

(ii) how such individual may reapply for medical assistance under the State plan (or a waiver of such plan) under this title in the case that such individuals' application is denied or, as applicable, in the case that such individual is disenrolled from the plan (or waiver).

(7) Treatment of noncompliant individuals in relation to certain other provisions

(A) Certain FMAP increases

A State shall not be treated as not providing medical assistance to all individuals described in section 1902(a)(10)(A)(i)(VIII), or as not expending amounts for all such individuals under the State plan, solely because such an individual is determined ineligible for medical assistance under the State plan on the basis of a failure to meet the requirement to demonstrate community engagement under paragraph (1).

(B) Other provisions

For purposes of section 36B(c)(2)(B) of the Internal Revenue Code of 1986, an individual shall be deemed to be eligible for minimum essential coverage described in section 5000A(f)(1)(A)(ii) of such Code for a month if such individual would have been eligible for medical assistance under a State plan (or a waiver of such plan) under this title but for a failure to meet the requirement to demonstrate community engagement under paragraph (1).

(8) Outreach

(A) In general.—

In accordance with standards specified by the Secretary, beginning not later than the date that precedes December 31, 2026 (or, if the State elects under paragraph (1) to specify an earlier date, such earlier date) by the number of months specified by the State under paragraph (1)(A) plus 3 months, and periodically thereafter, the State shall notify applicable individuals enrolled under a State plan (or waiver) under this title of the requirement to demonstrate community engagement under this subsection. Such notice shall include information on—

(i) how to comply with such requirement, including an explanation of the exceptions to such requirement under paragraph (3) and the definition of the term applicable individual under paragraph (9)(A);

(ii) the consequences of noncompliance with such requirement; and

(iii) how to report to the State any change in the individual's status that could result in—

(I) the applicability of an exception under paragraph 3 or the end of the applicability of such an exception;

(II) the individual qualifying as a specified excluded individual under paragraph (9)(A)(ii).

(B) Form of outreach notice

A notice required under subparagraph (A) shall be delivered—

(i) by regular mail (or, if elected by the individual, in an electronic format); and

(ii) in 1 or more additional forms, which may include telephone, text message, an internet website, other commonly available electronic means, and such other forms as the Secretary determines appropriate.

Comment

The is much more detail in this section.

Sec. 71120. Modifying Cost Sharing Requirements for Certain Expansion Individuals under the Medicaid Program (Page 639)

Special rules for certain expansion individuals—

(1) Premiums

Beginning October 1, 2028, the State plan shall provide that in the case of a specified individual (as defined in paragraph (3)) who is eligible under the plan, no enrollment fee, premium, or similar charge will be imposed under the plan.

(2) Required imposition of cost sharing

(A) In general.—

Subject to subparagraph (B) and subsection (j), in the case of a specified individual, the State plan shall, beginning **October 1, 2028**, provide for the imposition of such deductions, cost sharing, or similar charges determined appropriate by the State (in an amount greater than $0) with respect to certain care, items, or services furnished to such an individual, as determined by the State.

(B) Limitations.—

(i) Exclusion of certain services.—

In no case may a deduction, cost sharing, or similar charge be imposed under the State plan with respect to care, items, or services described in any of subparagraphs (B) through (J) of subsection (a)(2), or any primary care services, mental health care services, substance use disorder services, or services provided by a Federally qualified health center (as defined in 1905(l)(2)), certified community behavioral health clinic (as defined in section 1905(jj)(2)), or rural health clinic (as defined in 1905(l)(1)), furnished to a specified individual.

(ii) Item and service limitation.—

(I) In general.—

Except as provided in subclause (II), in no case may a deduction, cost sharing, or similar charge imposed under the State plan with respect to care or an item or service furnished to a specified individual exceed $35.

(II) Special rules for prescription drugs—

In no case may a deduction, cost sharing, or similar charge imposed under the State plan with respect to a prescription drug furnished to a specified individual exceed the limit that would be applicable under paragraph (2)(A)(i) or (2)(B) of section 1916A(c) with respect to such drug and individual if such drug so furnished were subject to cost sharing under such section.

(iii) Maximum limit on cost sharing.—

total aggregate amount of deductions, cost sharing, or similar charges imposed under the State plan for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

Subchapter E Expanding Access to Care

Sec. 71121. Making Certain Adjustments to Coverage of Home or Community-based Services under Medicaid (Page 644)

Expanding coverage for home or community-based services

(A) In general.—

Beginning **July 1, 2028**, notwithstanding paragraph (1), the Secretary may approve a waiver that is standalone from any other waiver approved under this subsection to include as medical assistance under the State plan of such State payment for part or all of the cost of home or community-based services (other than room and board (as described in paragraph (1))) approved by the Secretary which are provided pursuant to a written plan of care to individuals described in subparagraph (B)(iii).

A waiver approved under this paragraph shall be for an initial term of 3 years and, upon the request of the State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the requirements specified under this subsection (excluding those excepted under subparagraph (B)) have not been met.

(B) State requirements

In addition to the requirements specified under this subsection (except for the requirements described in subparagraphs (C) and (D) of paragraph (2) and any other requirement specified under this subsection that the Secretary determines to be inapplicable in the context of a waiver that does not require individuals to have a determination described in paragraph (1)), a State shall meet the following requirements as a condition of waiver approval:

(i) As of the date that such State requests a waiver under this subsection to provide home or community-based services to individuals described in clause (iii), all other waivers (if any) granted under this subsection to such State meet the requirements of this subsection.

(ii) The State demonstrates to the Secretary that approval of a waiver under this subsection with respect to individuals described in clause (iii) will not result in a material increase of the average amount of time that individuals with respect to whom a determination described in paragraph (1) has been made will need to wait to receive home or community-based services under any other waiver granted under this subsection, as determined by the Secretary.

(iii) The State establishes needs-based criteria, subject to the approval of the Secretary, regarding who will be eligible for home or community-based services under a waiver approved under this paragraph without requiring such individuals to have a determination described in paragraph (1), and specifies the home or community-based services such individuals so eligible will receive.

(iv) The State establishes needs-based criteria for determining whether an individual described in clause (iii) requires the level of care provided in a hospital, nursing facility, or an intermediate care facility for individuals with developmental disabilities under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under clause (iii) for determining eligibility for home or community-based services.

(v) The State attests that the State's average per capita expenditure for medical assistance under the State plan (or waiver of such plan) provided with respect to such individuals enrolled in a waiver under this paragraph will not exceed the State's average per capita expenditure for medical assistance for individuals receiving institutional care under the State plan for the duration that the waiver under this paragraph is in effect.

(vi) The State provides to the Secretary data (in such form and manner as the Secretary may specify) regarding the number of individuals described in clause (iii) with respect to a State seeking approval of a waiver under this subsection, to whom the State will make such services available under such waiver.

(vii) The State agrees to provide to the Secretary, not less frequently than annually, data for purposes of paragraph (2)(E) (in such form and manner as the Secretary may specify) regarding, with respect to each preceding year in which a waiver under this subsection to provide home or community-based services to individuals described in clause (iii) was in effect—

(I) the cost (as such term is defined by the Secretary) of such services furnished to individuals described in clause (iii), broken down by type of service;

(II) with respect to each type of home or community-based service provided under the waiver, the length of time that such individuals have received such service;

(III) a comparison between the data described in subclause (I) and any comparable data available with respect to individuals with respect to whom a determination described in paragraph (1) has been made and with respect to individuals receiving institutional care under this title; and

(IV) the number of individuals who have received home or community-based services under the waiver during the preceding year.

Chapter 2 Medicare

Subchapter A Strengthening eligibility requirements

Sec. 71201. Limiting Medicare Coverage of Certain Individuals. (Page 650)

Limiting Medicare coverage of certain individuals

In general.—

(A) Subject to subsection (B), an individual may be entitled to, or enrolled for, benefits under this title only if the individual is—

(1) a citizen or national of the United States;

(2) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act;

(3) an alien who has been granted the status of Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96–422); or

(4) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 402(b)(2)(G) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(B) Application to individuals currently entitled to or enrolled for benefits

(1) In general.—

In the case of an individual who is entitled to, or enrolled for, benefits under this title as of the date of the enactment of this section, subsection (a) shall apply beginning on the date that is 18 months after such date of enactment.

(2) Review by Commissioner of Social Security

(A) In general.—

Not later than 1 year after the date of the enactment of this section, the Commissioner of Social Security shall complete a review of individuals entitled to, or enrolled for, benefits under this title as of such date of enactment for purposes of identifying individuals not described in any of paragraphs (1) through (4) of subsection (A).

(C) Notice.—

The Commissioner of Social Security shall notify each individual identified under the review conducted under subparagraph (A) that such individual's entitlement to, or enrollment for, benefits under this title will be terminated as of the date that is 18 months after the date of the enactment of this section. Such notification shall be made as soon as practicable after such identification and in a manner designed to ensure such individual's comprehension of such notification

Subchapter B Improving Services for Seniors

Sec. 71202. Temporary Payment Increase under the Medicare Physician Fee Schedule to Account for Exceptional Circumstances (Page 653)

For services furnished on or after **January 1, 2026**, and before January 1, 2027, the physician update is increased by 2.5 percent.

Chapter 3—Health Tax

Comment

There are a number of changes in this chapter that we are not describing.

Sec. 71306. Permanent Extension of Safe Harbor for Absence of Deductible for Telehealth Services (Page 666)

A plan shall not fail to be treated as a high-deductible health plan by reason of failing to have a deductible for telehealth and other remote care services.

The amendments made by this section shall apply to plan years beginning after December 31, 2024.

Sec. 71401. Rural Health Transformation Program (Page 671)

(A) In General—There are appropriated, out of any money in the Treasury not otherwise appropriated, to the Administrator of CMS to provide allotments to States for purposes of carrying out the activities described in paragraph (6)—

(i) $10,000,000,000 for fiscal year 2026;

(ii) $10,000,000,000 for fiscal year 2027;

(iii) $10,000,000,000 for fiscal year 2028;

(iv) $10,000,000,000 for fiscal year 2029; and

(v) $10,000,000,000 for fiscal year 2030.

(B) To be eligible for an allotment under this subsection, a State shall submit to the Administrator during an application submission period to be specified by the Administrator (but that ends not later than December 31, 2025) an application in such form and manner as the Administrator may specify, that includes—

(i) a detailed rural health transformation plan—

(I) to improve access to hospitals, other health care providers, and health care items and services furnished to rural residents of the State;

(II) to improve health care outcomes of rural residents of the State;

(III) to prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management;

(IV) to initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals

and other health care providers in order to promote measurable quality improvement, increase financial stability, maximize economies of scale, and share best practices in care delivery;

(V) to enhance economic opportunity for, and the supply of, health care clinicians through enhanced recruitment and training;

(VI) to prioritize data and technology driven solutions that help rural hospitals and other rural health care providers furnish high-quality health care services as close to a patient's home as is possible;

(VII) that outlines strategies to manage long-term financial solvency and operating models of rural hospitals in the State; and

'(VIII) that identifies specific causes driving the accelerating rate of stand-alone rural hospitals becoming at risk of closure, conversion, or service reduction;

(ii) a certification that none of the amounts provided under this subsection shall be used by the State for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law, including under the State plan established under this title, the State plan established under title XIX, or under a waiver of such plans; and

(iii) such other information as the Administrator may require.

(C) Deadline for Approval.—Not later than December 31, 2025, the Administrator shall approve or deny all applications submitted for an allotment under this subsection.

Sec. 81001. Establishment of Loan Limits for Graduate and Professional Students and Parent Borrowers; Termination of Graduate and Professional Plus Loans. (Page 690)

Limits amount of student loan for graduate professional students, including medical students, to $50,000 per year to a maximum of $200,000.

Final Comments

As noted in the media, the reductions to the Medicaid program are enormous to say the least. While States will have burdens to comply with eligibility and other provisions, the emphasis in payment losses will accrue to providers.

One must question if States will be able to comply with many statutory deadlines outlined in the law. Many must be made by the end of this year.

While the cited "pdf" of the bill appears to be the latest and upon which this analysis is based, please be mindful that minor changes may still take place.

As always, to insure complete understanding of the changes, one needs to review the legislation, itself.

Washington Perspectives is published as a service to clients and others in the health care industry by Larry Goldberg, Larry Goldberg Consulting, 3106 Wheatland Farms Ct., Oakton, VA 22124. Email larry004b@gmail.com

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