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Where Are We Headed?

Navigating Medicaid and Medicare Policy Shifts

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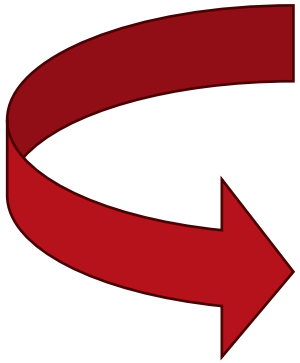

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Agenda

1. Medicare – Implications of Recent Legislation & Rulemaking
2. Medicaid – Changes Impacting Providers
3. What is Going on in Washington?

Note: One Big Beautiful Bill Act was passed by Congress (H.R.-1) on July 3, 2025, and signed into law on July 4, 2025 (P.L. 119-21). We will refer to this legislation as “OBBA” or simply as the “the Bill.”

Medicare

Implications of Recent Legislation & Rulemaking

- Medicare Eligibility, etc.
- Bad Debt
- Sequestration
- Prior Authorization
- Site Neutral Payments
- Uncompensated Care & DSH
- Drug Pricing
- Rural Health
- Other Considerations

Medicare Eligibility & MSA

- Under the Bill the following can newly enroll in Medicare:
  - U.S. citizens
  - Lawful permanent residents (green card holders)
  - Cuban and Haitan Entrants and certain Pacific Island nations with special agreements
- Ending Medicare eligibility for certain lawful immigrants as of January 1, 2027
  - Refugees and people granted asylum
  - People with Temporary Protected Status
- Streamlining Enrollment in Medicare Savings Programs (OMBs, SLMDs, QI and QDWI eligibility) for low-income individuals blocked until 2034

Bad Debt

- The Bill did not directly affect Medicare bad debt policy but loss of Medicare dual eligibles will likely—
  - increase population unable to pay Medicare copays/deductibles
- Hospitals likely will—
  - reduce hospital discounts to low-income patients
  - More carefully scrutinize patients' ability to pay. Eliminate presumptive charity determination?
  - Have to improve documentation for bad debt determinations to maximize cost report reimbursement

Sequestration

- Beginning in 1990, the Statutory Pay As You Go (PAYGO) law required mandatory reduction in non-discretionary spending if spending laws enacted by Congress raises deficit. In 2025 the deficit increase has been calculated to be $2.3 trillion over the next ten years.
- The Bill, itself, would include average deficit increase by $415 billion in FY2026 and a $3.4 trillion increase between 2025-2039.
- BUT PAYGO limits Medicare reductions to 4% or an estimated $45 billion in FY2026.
- As a result, PAYGO requires sequestration of as additional $370 billion for FY2026. ($415B-$45B= $370B)
- Bottom line, without further Congressional action, CBO estimates an additional funding cut of $536 billion between 2026 and 2034.

Prior Authorization Comes to Traditional Medicare

- New 1115 waiver authority to conduct AI-enhanced prior authorization for Medicare-covered certain services: skin and tissue substitutes, implanted electrical nerve stimulators, knee arthroscopy, epidural spinal steroid injections and cervical fusions.
- Runs from January 1, 2026 through December 31, 2031
- Only in Arizona, New Jersey, Ohio, Oklahoma, Texas and Washington.
- Providers must either submit prior authorizations requests or opt for prepayment review after procedure is completed which could result in delayed or denied payment.
- CMS will contract with Medicare Contractors or third-party technology vendors specializing in AI and machine learning to conduct reviews.

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Site Neutral Payment Policies

- CMS considerations include:
  - CMS belief that patients can safely be treated in non-hospital settings
  - OPPS is one of the fastest areas of growth in Medicare payments
  - Impact on patient cost sharing amounts
- Drug Administration Services
  - 35% increase in volume of services paid through APCs 5991-5694 from 2011-2019
  - 70% increase in chemo administration (HCPCS 96413) from 2011-2019 at excepted hospital outpatient department
    - Payment is $119 under PFS vs. $341 under OPPS
  - Proposed:
    - Pay a PFS-equivalent payment rate for drug administration services APCs (5691-5694) provided at excepted off-campus PBD
      - applies to departments that bill the modifier ‘‘PO’’ on claim lines
      - 2025 PFS-equivalent payment rate is 40% of OPPS payment amount
    - Exempts rural SCHs from payment reduction

Site Neutral Payment Policies *cont.*

- Proposed Elimination of Inpatient Only List & Expansion of ASC Covered Service
  - IPO list eliminated by 1/1/2029 through a 3-year transition. Begins with musculoskeletal services in 2026
  - ASC Covered Procedure List –
    - Proposed to modify general standard and exclusion criteria would be limited to the following:
      - not designated as requiring inpatient care,
      - can only be reported using an unlisted surgical procedure code, or
      - excluded from Medicare coverage (under 411.15)
    - Moved general and other exclusion to criteria to a proposed standard related to “physician considerations” for patient safety
- CMS also considering site neutral payments for:
  - On-Campus Clinic visits
  - ASC covered services

Uncompensated Care & Medicare DSH

- Medicare DSH also reduced based on fewer Medicaid eligible individuals.
  - Work requirements reduces number of “traditional” Medicaid eligibles, increased redeterminations and limits on immigrant eligibility
  - Reduced eligibility for Medicare Savings Programs
- Increased UC but Decreased Medicare DSH Payment
  - Increased number of uncompensated care patients will affect Factors 2 and 3 but will decrease the number of Medicaid eligible population in the numerator of the DSH calculation (Factor 1)
  - Effect may not be immediate because of calculations based on several earlier years

Drug Pricing

- 340B Eligibility
  - Eligibility for 340B discounts may be impacted by decrease in DSH percentage
- Expansion of Orphan Drug Exclusion
  - OBBA expanded the orphan drug exclusion to apply to orphan drugs with one or more orphan designations - orphan drugs that treat multiple rare conditions will now receive a complete exemption from price negotiations, so long as the drug has not been approved for any non-orphan uses
- HHS Policy Shifts
  - Reducing drug payments – surveying hospitals about 340B acquisition costs to support reduction
  - Considering moving Office of Pharmacy Affairs from HRSA to CMS
  - Increased manufactures restrictions on access to 340B contract pharmacies & mixed use replenishment

Rural Health

- Extends eligibility for rural emergency hospitals to additional hospitals that closed between 1/1/2014-12/26/2020 beginning 1/1/2027.
- Creates $50 billion rural hospital fund.
  - States must apply through CMS to provide at least $100 million per year for 5 years to distribute to rural hospitals in state.
  - Remaining 50% of funds will be distributed according to formula developed by CMS Administrator.

Other Considerations

- OBBA/Bill –
  - Temporary PFS increase of 2.5% for 2026
  - Delays federal standards to improve staffing level in nursing homes
- Impacts on GME payments
  - Impact from urban to rural reclass
  - Work authorization of international graduates for residency programs in the U.S.
- Hospital at Home and Telehealth payments and coverage extensions
- Organ Procurement and Transplant increased oversight

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Medicaid – Changes Impacting Providers

- Medicaid Provisions of the “OBBB”
- Erroneous Payments
- Tax Implications
- State Directed Payments
- Rural Health

“One Big Beautiful Bill” Act

H.R.1 (Public Law No: 119-21)
Enacted July 4, 2025

Medicaid Provisions of the Bill

- 21 separate SECTIONS
- Multiple effective dates
- Divided into 5 Subchapters
  A. Reducing Fraud and Improving Enrollment Processes
  B. Preventing Wasteful Spending
  C. Stopping Abusive Financing Practices
  D. Increasing Personal Accountability
  E. Expanding Access to Care

Quick Overview of Select Sections

Alien Medicaid Eligibility

- SEC. 71109: Medicaid and CHIP eligibility for aliens is limited to “green card holders,” certain Cuban and Haitian entrants, and “Citizens of Freely Associated States” (i.e., citizens of the Federated States of Micronesia, the Republic of the Marshall Islands (RMI), and Palau).
- Excluded from eligibility: refugees and asylees.
- Effective October 1, 2026.

Reducing Retroactive Medicaid Coverage

- SEC. 71112: Reduces retroactive Medicaid coverage.
- Under current law, states are required to provide Medicaid coverage for qualified medical expenses incurred up to **90 days** prior to the date of application for coverage.
- The new requirements limit retroactive coverage to **one month** prior to application for coverage for individuals enrolled through a Medicaid expansion program, and **two months** prior to application for coverage for traditional Medicaid enrollees.
- Effective January 1, 2027.

Quick Overview of Select Sections

Provider Tax Limitations

- Effective date: July 4, 2025.
- SEC. 71115: Restrictions on provider taxes:
  - **No new taxes:** States are prohibited from creating new provider taxes or increasing existing ones.
  - **Existing taxes:** Can remain if unchanged.
- Hold harmless threshold changes:
  - **Current threshold:** 6% of net patient revenue.
  - **Non-expansion states:** Existing taxes (as of 7/4/25) at or below the 6% threshold can remain at that threshold.
  - **Expansion states:** Threshold gradually decreases annually (from FFY 2028 to FFY 2032) to 3.5% – *except for taxes on NFs & ICFs (at or below 6% threshold) in place as of July 4. 2025.*
- Questions about these provisions:
  - "and the Secretary determines that the tax is within the hold harmless threshold as of that date [July 4,2025]."
  - "on such date of enactment, [the tax] is within the hold harmless threshold (as determined by the Secretary)."

Sections With Relatively Little Fanfare, But *Potentially* Big Impact

Erroneous Medicaid Payments

- *Current* Medicaid law:
  - CMS may recoup federal funds from states for "erroneous excess payments" if the state's "error rate" exceeds 3%.
  - CMS may waive all or part of the reduction of federal funds due to "erroneous excess payments" if the state is unable to fall within the 3% error rate despite a good faith effort by the state.
  - "Erroneous excess payments" means:
    - payments under the State plan with respect to ineligible individuals and families, and
    - overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility, and

Erroneous Medicaid Payments

- Effective Oct. 1, 2029, per SEC. 71106 of Bill: "Erroneous excess payments" means:
  - payments under the State plan with respect to ineligible individuals and families,
  - overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility, and
  - payments for items and services furnished to an individual who is not eligible for medical assistance (under the State Plan or a waiver of the State Plan), or payments where insufficient information is available to confirm eligibility.
- Effective Oct. 1, 2029, per SEC. 71106 of Bill, CMS's waiver of the reduction of federal funds due to "erroneous excess payments" if the state is unable to fall within the 3% error rate is limited to these "erroneous excess payments":
  - overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility, and
  - payments for items and services furnished to an individual who is not eligible for medical assistance (under the State Plan or a waiver of the State Plan), or payments where insufficient information is available to confirm eligibility.

Erroneous Medicaid Payments

- No longer able to be waived: payments under the State plan with respect to ineligible individuals and families
- Other noteworthy points:
  - Effective Oct. 1, 2029, per SEC. 71106 of Bill: states may conduct these audits, at option of CMS.
    - Increased recoupment from providers?
    - Applicability of federal statute requiring providers who receive an overpayment of Medicaid funds to return the overpayment within 60 days of identifying the overpayment?
      - Potential False claims Act violation for not doing so.

Waiver of Uniform Tax Requirement for Medicaid Provider Tax (SEC. 71117)

- Adds new restrictions on Medicaid provider taxes.
- Effective date: July 4, 2025.
- Applies to all classes of providers, services, and items that may assessed under a Medicaid provider tax – not only MCOs.
- Absent a waiver from CMS, a state's Medicaid Provider Tax must be imposed uniformly and on a broad-based basis.
- Medicaid statutes and regulations establish the criteria for obtaining waivers of the uniform and/or broad-based requirements for Medicaid provider taxes.

Waiver of Uniform Tax Requirement for Medicaid Provider Tax (SEC. 71117)

- These criteria are in the form of statistical tests designed to ensure that non-uniform or non-broad-based taxes are "generally redistributive."
- CMS claims to have found a "loophole" in these long-standing statistical tests that allows some taxes to be imposed at higher tax rates on Medicaid taxable units than non-Medicaid taxable units, contrary to statutory and regulatory intent for Medicaid provider taxes to be "generally redistributive."
- Per SEC. 71117: A Medicaid provider tax is not considered "generally redistributive" (and therefore not permissible) if any of the following apply:
  - Tax rates are lower for providers with lower Medicaid volume than for those with higher Medicaid volume.
  - Tax rates are higher for Medicaid-related units than for non-Medicaid units.
  - Tax has the same effect as a tax described in I or II, even if the term "Medicaid" is not used.

Waiver of Uniform Tax Requirement for Medicaid Provider Tax (SEC. 71117)

- CMS may establish a transition period to implement SEC. 71117, not to exceed 3 federal fiscal years.
- On May 15, 2025, prior to the enactment of the Bill, CMS issued a proposed rule that is based on the same criteria included in SEC. 71117.
  - Comments on the proposed rule were due July 14, 2025.
- **Very** simply stated, SEC 71117 (and CMS's May 15, 2025 proposed rule) may be summarized as follows:

  "A Medicaid provider tax is impermissible, despite satisfying the applicable statistical tests, if a class of providers with relatively lower Medicaid utilization (in comparison with the same class of providers with relatively higher Medicaid utilization) are exempted from the tax or have a lower tax rate."
- Threatens potential havoc with current provider tax programs (both economic modeling and political support).

Lot's of Conversation About These . . .

State Directed Payments (SEC. 71116)

- Section 71116 of the Bill caps payment rates for any state directed payment ("SDP") for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center, furnished during a rating period beginning on or after July 4, 2025, at:
  - 100% of Medicare payment rate for expansion states.
  - 110% of the published Medicare payment rate for non-expansion states.
  - Allows the "grandfathering" of certain SDPs.
- Grandfathering:
  - Grandfathered SDPs are exempt from the new limits until the rating period beginning on or after January 1, 2028.
  - Starting January 1, 2028, the total payment rate is reduced by 10 percentage points annually. Reductions continue each year until the payment rate equals 100% or 110% of the Medicare rate, based on state expansion status.

State Directed Payments (SEC. 71116)

- **Key** grandfathering guidance: CMS September 9, 2025 "Dear Colleague" letter.
  - Grandfathering applies to SDPs in rating periods that include any days from January 5, 2025 through July 3, 2025 or July 5, 2025 through December 31, 2025.
  - CMS is considering total payment rate caps for SDPs for other services in addition to the 4 services specified in SEC. 71116.
  - A proposed rule regarding SDPs is currently under review at OMB.

Rural Health Transformation Program (SEC. 71401)

- SEC. 71401: The "Rural Health Transformation Program" is designed to provide financial support to rural health care providers to help mitigate the impact of the Bill's Medicaid provisions.
- The program appropriates a total of $50 billion over five federal fiscal years, equating to $10 billion per year.
- Funding is managed by CMS and distributed to eligible states. The initial $10 billion allotment is available for the federal fiscal year beginning October 1, 2025.
- For the five consecutive federal fiscal years beginning on and after October 1, 2025, CMS shall distribute 50 percent of the year's allotment (i.e., annually distribute $5 billion of the $10 billion yearly allotment) equally among all states with an approved application.

Rural Health Transformation Program (SEC. 71401)

- Assuming all 50 states timely apply for the Program, each participating state's minimum allotment for each federal fiscal year, including the federal fiscal year beginning October 1, 2025, would be $100 million. This amount will be greater if some states do not successfully apply for the Program.
- The program appropriates a total of $50 billion over five federal fiscal years, equating to $10 billion per year. This funding is managed by CMS and distributed to eligible states. The initial $10 billion allotment is available for the federal fiscal year beginning October 1, 2025.
- For the five consecutive federal fiscal years of the program, CMS shall distribute to *some* or all participating states the remaining 50 percent of the year's allotment (remaining $5 billion of the annual allotment.
- The remaining annual amount will be based on the scoring of a number of factors.

Rural Health Transformation Program (SEC. 71401)

- Amounts distributed to a state must be used for 3 or more of several certain designated activities, including:
  - Providing payments to health care providers, as specified by CMS.
  - Recruiting and retaining clinical workforce talent to rural areas.
  - Assisting rural communities to "right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
  - Providing software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve health outcomes.
- Application deadline is November 5, 2025, no later than 11:59 p.m. ET.
- Awards will be announced by 11:59 p.m. ET on December 31, 2025.

What Is Going On In Washington?

Questions

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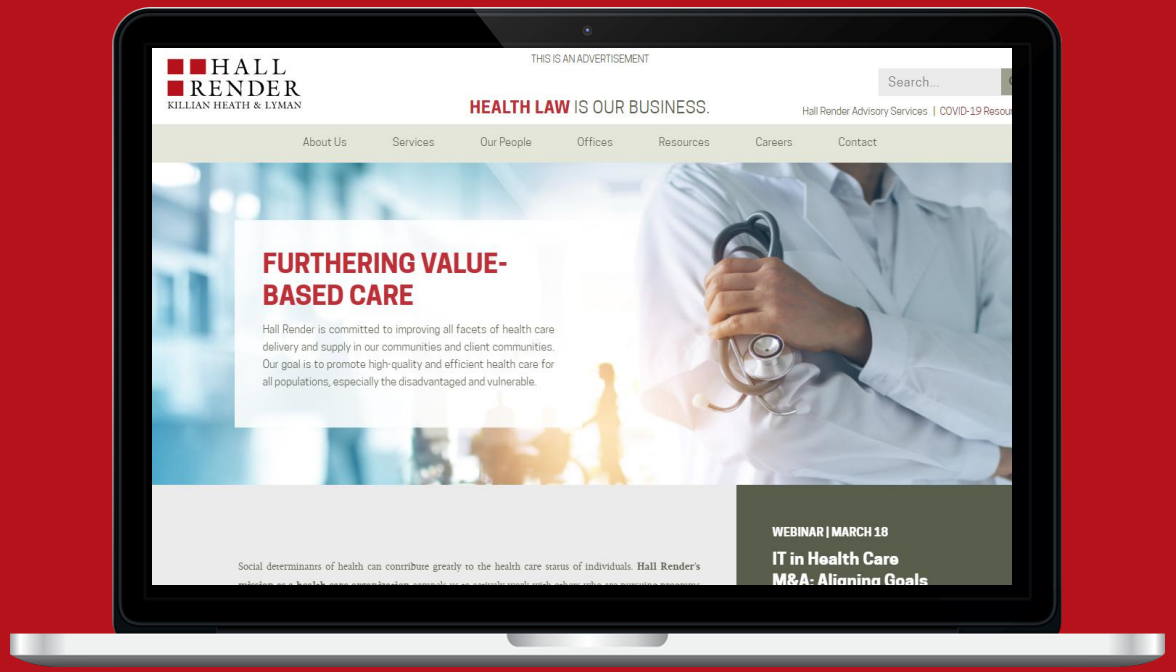

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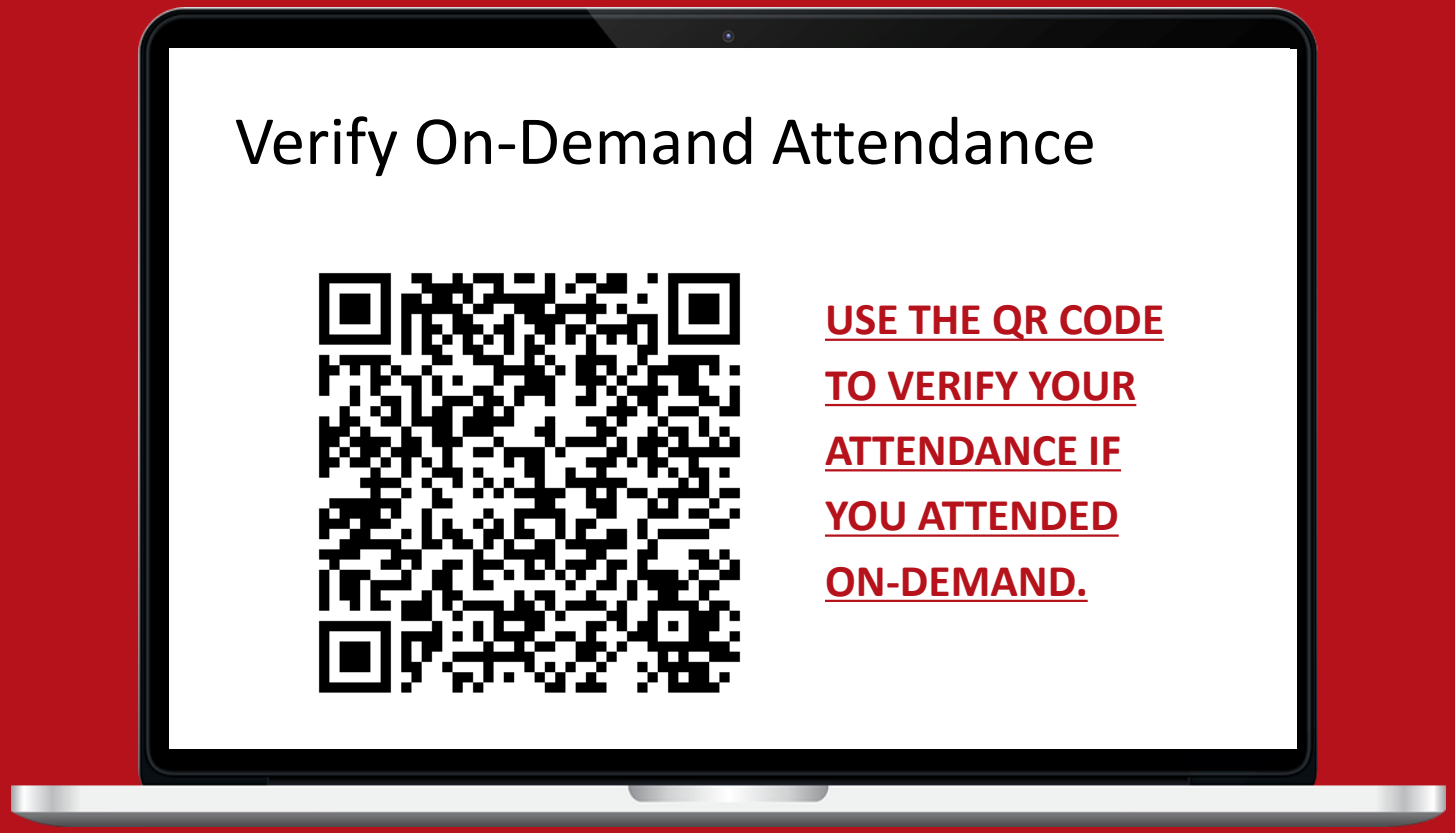

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