Providence

Following months of intense advocacy from Providence, AHA and others, Congress passed H.R. 1, the reconciliation bill, and it was signed into law by President Trump on July 4. While the cuts to Medicaid are drastic, **we secured a win in delaying the significant Medicaid reductions to 2028, with an advocacy strategy to push those out further. In addition, we secured a 2.5% increase for our physicians in 2026 resulting in a ~ $20 million increase for our physicians next year.**

Health Care Provisions

H.R. 1 includes significant Medicaid policy as well as provisions affecting Affordable Care Act health insurance coverage, Medicare provisions, and an expansion of health savings accounts. Overall, an initial analysis by the Congressional Budget Office estimates that an additional 11.8 million people would become uninsured by 2034 as a result of the legislation.

Medicaid provisions will cut $1 trillion of Medicaid spending, establish new eligibility conditions, and tighten enrollment requirements. Major provisions include:

- A freeze on the size of Medicaid provider taxes and phased-down tax rates for states that have adopted Medicaid expansion by 0.5 percent annually starting in fiscal year 2028 until the limit reaches 3.5 percent in fiscal year 2032.
- Heightened uniformity requirements to ensure that a tax is not considered to be generally redistributive. These requirements mirror a proposed rule issued by CMS on May 12.
- New limits on the use of Medicaid state directed payments to reduce payments by 10 percent each year starting January 1, 2028 until they reach 100 percent of the applicable Medicare reimbursement in Medicaid expansion states and 110 percent of Medicare payments in non-expansion states.
- A "community engagement" requirement that conditions Medicaid eligibility for individuals ages 19-64 on working (or other qualifying activities) for at least 80 hours per month, with some exceptions.
- State requirement to conduct eligibility redetermination every six months for adults in the Medicaid expansion population.
- A limit of 30 days of retroactive eligibility for expansion enrollees and two months for coverage for traditional enrollees.
- Reduced federal Medicaid matching funds for Medicaid-covered emergency services for non-legal residents.
- State requirement to impose Medicaid cost-sharing of up to $35 per service for Medicaid expansion participants with income 100-138 percent of the federal poverty level but explicitly exempting primary care, mental health, and substance use disorder services, and services provided by federally qualified health centers, behavioral health clinics, and rural health clinics from this requirement.

- Limits on eligibility for marketplace premium tax credits for Medicare and Medicaid for some non-legal residents and reduced federal Medicaid matching funds for states that enroll such individuals in their Medicaid programs.
- More frequent income verification for those seeking marketplace premium tax credits.
- New rules for CMS certification of Section 1115 waiver budget neutrality that focus on avoiding an increase in *federal* expenditures that could result from the waiver rather than maintaining neutral state and federal spending over the lifetime of the waiver.
- A requirement for CMS to reduce federal payments to states with improper payment errors, including an expansion of the definition of an improper payment.
- State requirement for more frequent checks of the national database of terminated Medicare and Medicaid providers as well as quarterly checks of the Social Security Administration's death master file to ensure that Medicaid providers are not deceased.

Other provisions include:

- Creation of a $50 billion "rural health transformation" fund to provide grants to states over five years to be used for payments to rural health care providers.
- Prohibition on implementation or enforcement of the minimum staffing levels in nursing homes until October 1, 2034.
- A 2.5 percent Medicare payment increase for physicians for calendar year 2026.

Though the original House reconciliation bill included a delay to Medicaid DSH cuts, the final bill does not include that provision.

Next Steps

The legislation will require significant implementation activities, with some of the provisions effective upon enactment and others taking effect as soon as January 1, 2026. Some of the policies are initiatives that the administration was already planning to pursue through administrative action and may already have some work underway within CMS.

We will be working closely with Finance to conduct additional analysis of the final legislative language and continue to coordinate with our state and national associations on an advocacy strategy to continue delaying the implementation of the Medicaid cuts.

Our efforts don't stop here and we will continue to advocate against these proposals throughout the implementation process.

Sincerely,

Jacquelyn Bombard

Chief Federal Government Affairs Officer