ALSTON & BIRD

TO: American Ambulance Association

FROM: Alston & Bird LLP

DATE: May 23, 2025

RE: A&B Reconciliation Summary - The One, Big, Beautiful Bill

Below is a topline summary of key health care policy provisions in the *One Big Beautiful Bill Act,* as passed by the House of Representatives on May 22, 2025, by a vote of 215-214-1. The summary incorporates revisions from the House Rules Committee Print and 42-page Manager's Amendment, which revised text passed out of the House Committee on Energy and Commerce and House Committee on Ways and Means.

Title IV – Committee on Energy and Commerce, Subtitle D – Health

Subpart B – Preventing Wasteful Spending

- Sec. 44132. Moratorium on New or Increased Provider Taxes
    - Amends the statutory provision that currently allows states to use provider taxes to finance their non-federal share of Medicaid costs, provided that the taxes are broad-based, uniform, and do not hold providers harmless (i.e., guarantee providers that they will receive their money back) to prohibiting states from creating any new provider taxes on or after the enactment of this section.
    - Permits the continued use of provider taxes imposed prior to enactment, but prohibits any increases to the tax rate or expansions to tax base to include class of items or services (or types of providers or activities within such class) that the tax did not previously apply to (unless such increase or expanded use of those provider taxes was provided for in legislation or regulation enacted or adopted prior to the date of enactment of this section).
- Sec. 44133. Revising Payments for Certain State Directed Payments
    - Changes current regulations by lowering the total payment rate limit for state directed payments (for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center) from the average commercial rate (ACR) to:
        - For states that have expanded Medicaid, 100 percent of the published Medicare payment rate; or
        - In states that have not expanded Medicaid, 110 percent of the published Medicare payment rate.

- Grandfathers in/permits existing state directed payments up to the average commercial rate, if written approval was made or a preprint for such payments was submitted to the HHS Secretary, prior to the date of enactment of this section for the rating period occurring as of such date of enactment, and permits the renewal of such payments up to the amount in place prior to enactment in subsequent rating periods.
- With respect to a state that begins providing expanded Medicaid coverage on or after the date of the enactment of this legislation, requires that the limitation apply to such State with respect to state directed payments for a service furnished during a rating period beginning on or after the date on which such state begins providing such coverage.

- Sec. 44134. Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax
    - Modifies the criteria under which a tax is not considered generally redistributive to include, within a permissible class:
        - A lower tax rate on taxpayers or tax rate groups (defined as a group of entities contained within a permissible class of health care related tax that are taxed at the same rate) with lower volumes or percentages of Medicaid taxable units (defined as payments under the program such as Medicaid bed days, Medicaid revenue, program costs including Medicaid charges, claims, or expenditures, and other units as determined by the HHS Secretary) than the tax rate imposed on taxpayers or groups with higher volumes or percentages of Medicaid taxable units.
        - A higher tax rate on taxpayers or groups based on their Medicaid taxable units than the tax rate based on non-Medicaid taxable units.
    - Requires states with tax waivers in place as of the date of enactment to modify them, as needed, to comply with these requirements.
    - This provision is effective upon enactment but provides states up to 3 fiscal years to transition existing, non-permissible arrangements.

Part 3 – Improving Americans' Access to Care

- Sec. 44302. Streamlined Enrollment Process for Eligible Out-Of-State Providers Under Medicaid and CHIP
    - Requires a state to adopt and implement a process to permit an eligible out-of-state provider under Medicaid and CHIP to enroll under the state plan (or a waiver of such plan) to provide items and services to, or order, prescribe, refer, or certify eligibility for items and services for, qualifying individuals without undergoing screening or enrollment requirements that exceed the minimum necessary for such state, such as the provider's name and National Provider Identifier (and other information specified by the HHS Secretary). Such provider that enrolled through such process must be

enrolled for a 5-year period unless the provider is terminated or excluded from participation during such period.
  - Provides that the amendments would apply beginning four years after the date of enactment of this legislation.
- Section 44142. Modifying Cost Sharing Requirements for Certain Expansion Individuals under the Medicaid Program
  - Eliminates enrollment fees and premiums for Medicaid expansion population.
  - Requires states to impose cost sharing greater than $0 up to $35 per service on expansion population individuals with incomes above 100 percent and below 133 percent of the federal poverty level.
  - Limits cost sharing to 5 percent of an individual's family income.
  - Excludes cost sharing on prenatal care, emergency services, family planning services, inpatients at medical facilities, hospice care, approved vaccines, or any primary care services, mental health care services, or substance use disorder services.
  - This provision goes into effect on October 1, 2028.

<u>Title XI – Committee on Ways and Means</u>

Subtitle A – Make American Families and Workers Thrive Again; Part 3 – Investing in Health of American Families and Workers

- Sec. 110203. Employer Credit for CHOICE Arrangement
  - Starting in calendar year 2026, creates a 2-year tax credit for small business employers (with fewer than 50 employees) that offer coverage through CHOICE arrangements for the first time, up to $100 per employee per month in the first year and $50 per employee per month in the second year, adjusted for inflation.
    - The credit period under this provision is limited to the first 2 one-year periods beginning with the month an employer first establishes an employee's CHOICE arrangement.

Subtitle B – Make Rural America and Main Street Grow Again; Part 3 – investing in the Health of Rural America and Main Street

- Sec. 111201. Expanding the Definition of Rural Emergency Hospital Under the Medicare Program
  - Permits facilities that, from January 1, 2014, to December 26, 2020, were either a critical access hospital or a standard acute care hospital ("subsection(d) hospital") with less than 50 beds in a rural area, and were not enrolled in the Medicare program on December 27, 2020, to enroll as a rural emergency hospital.
    - Enrollment may begin on January 1, 2027, and facilities have one year from the beginning of state licensing to apply.

        - Applying facilities that are within 35 miles of a hospital, critical access hospital, or rural emergency hospital must annually certify to the Secretary of HHS that more than 50 percent of its services to Medicare Part A and B beneficiaries qualified as emergency department services and observational care.
        - Rather than submit a detailed transition plan, applying facilities must submit an assessment of the health care needs of the county (or equivalent unit of local government) in which the facility is located and include:
            - A detailed description of any services provided while the facility was enrolled as a Medicare provider during the applicable 2014-2020 period.
            - An explanation as to why the facility was not enrolled in Medicare on December 27, 2020.
            - The population of the county or equivalent local government unit.
            - The percentage of Medicare Part A and B beneficiaries in such county/government unit.
            - A description of the lack of access to health care for these beneficiaries and how re-opening the facility as a rural emergency hospital will help provide access.
    - Prohibits facilities that enroll under the above pathway and are within 35 miles of a hospital, critical access hospital, or rural emergency hospital from receiving the 5 percent adjustment for rural emergency hospitals.
    - Prohibits facilities that enroll under the above pathway and are within 10 miles of a hospital, critical access hospital, or rural emergency hospital from receiving the monthly facility payments for rural emergency hospitals.

For more information on the provisions of the *Big Beautiful Bill Act,* please find a full reconciliation summary and redline summary attached.

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We hope this summary was helpful to you. Please do not hesitate to contact us if you have any questions.