ALSTON & BIRD

TO: American Ambulance Association

FROM: Alston & Bird LLP

DATE: June 16, 2025

RE: A&B Reconciliation Summary - The One, Big, Beautiful Bill (H.R. 1)

On June 16th, Senate Finance Committee (SFC) Chair Mike Crapo (R-ID) unveiled legislative text of the Finance Committee's title of the GOP reconciliation bill. The legislative text builds on the *One Big Beautiful Bill Act (H.R. 1),* as passed by the House of Representatives on May 22, 2025.

Of note, in many cases, the Senate proposes to **implement more significant eligibility or payment reductions in the Medicaid program**, compared with the House-passed legislation. **In particular, the Senate proposal would require the "safe harbor" threshold for provider taxes to be phased down from the current 6 percent to 3.5 percent in Medicaid expansion states**. Both the House and Senate proposals would place a moratorium on expanding or establishing new provider taxes or expanding the items or types of services to which the taxes apply. Regarding state directed payments (SDPs), like the House-passed legislation, the **Senate bill would cap SDPs at 100 percent of Medicare rates in Medicaid expansion states and at 110 percent of Medicare in non-expansion states**.

Now that these proposals have been released, Senate Republicans are working to gain agreement within the Republican caucus to bring the proposals to the full Senate for consideration. Republicans aim to enact and send the legislation to the President by July 4th. However, that timing could slip into July as negotiations among Republicans are ongoing.

Please find below additional detail on the House-passed and newly released Senate health care proposals that have the most potential to impact access to and payment for ambulance services.

Original: Title IV – Committee on Energy and Commerce, Subtitle D – Health			
House: Subpart B – Preventing Wasteful Spending *Senate: Subchapter C – Stopping Abusive Financing Practices*			
Section	House of Representatives Bill Text	**Senate Bill Text**	Key Differences
Sec. 44132. Moratorium on New or Increased Provider Taxes **Senate** Sec. 71120. 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	• Amends the statutory provision that currently allows states to use provider taxes to finance their non-federal share of Medicaid costs—provided the taxes are broad-based, uniform, and do not hold providers harmless—by prohibiting states from imposing any new provider taxes on or after the date of enactment of this section, unless such taxes were already authorized by legislation or regulation enacted or adopted prior to that date. • Permits the continued use of provider taxes imposed prior to enactment, but prohibits any increases to the per-unit amount or rate of the tax, or expansions of the tax base to include new classes of items, services, providers, or activities not previously subject to the tax—unless such changes were	• The Senate text explicitly identifies the types of prohibited increases—per-unit amount, rate, and tax base expansions to new classes of items, services, providers, or activities—whereas the House version refers more generally to tax rate increases and base expansions. • Both versions allow exceptions for taxes or increases authorized prior to enactment, but the Senate text emphasizes this condition more clearly and consistently. • **The Senate proposal would require a phase-down of the threshold for provider taxes from the current 6 percent to 3.5 percent by FY2031. The House proposal allows the threshold to remain at 6 percent but does not allow states to expand their thresholds beyond the level in**

	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).	authorized in legislation or regulation enacted or adopted before the date of enactment. • **Proposes to phase down the "safe harbor" threshold for provider taxes in Medicaid expansion states from the current 6 percent threshold down to 3.5 percent in FY2031 and beyond.** • **Non expansion states would be permitted to remain at the 6 percent provider tax threshold.**	**place upon enactment of the legislation.**
House Sec. 44133. Revising Payments for Certain State Directed Payments **Senate** Sec. 71121. 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	• Requires HHS to revise regulations so that, for services furnished during rating periods beginning on or after the bill's enactment, total payment rates for certain state-directed payments are capped. • Caps payment rates based on a state's Medicaid expansion status: ○ For states that provide **full Medicaid expansion coverage** (as defined under §1902(a)(10)(A)(i)(VIII)), payments are **capped at 100 percent of the published Medicare payment rate** (or the Medicaid State Plan rate if no Medicare rate exists).	• The **House text and Senate text are nearly identical in substance**, both requiring HHS to revise regulations to cap total payment rates for certain state-directed Medicaid payments starting with rating periods after enactment. • Both texts set payment caps based on Medicaid expansion status: 100 percent of the Medicare rate for expansion states and 110 percent for non-expansion states. • Both texts include a grandfathering clause for payments approved or submitted before May 1, 2025, with a gradual 10 percent annual

	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.	○ For **non-expansion states**, payments **are capped at 110 percent of the published Medicare payment rate** (or equivalent Medicaid rate). • Grandfathers certain payments that received written approval or had a preprint submitted before May 1, 2025, for rating periods within 180 days of enactment. These payments will be phased down by 10 percentage points annually starting January 1, 2027, until they meet the new capped rates. • Applies the capped rate to newly expanding states starting from the rating period in which they begin offering Medicaid expansion coverage, even if prior approval for higher payments was granted before expansion.	reduction starting January 1, 2027, until capped rates are met. • Both texts apply the capped rates to newly expanding states starting from the rating period in which expansion begins, even if prior approvals were granted.

House
Sec. 44134. Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax
 	
Senate
Sec. 71122. 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
		• 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 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 units such as Medicaid bed days, Medicaid revenue, Medicaid-related costs including charges, claims, or expenditures, and other units as determined by the HHS Secretary) than the tax rate imposed on those with higher volumes or percentages of Medicaid taxable units.
		  ○ A higher tax rate on taxpayers or tax rate groups based on their Medicaid taxable units than the tax rate imposed on those based on non-Medicaid taxable units (defined as units such
			• The House text includes only two criteria for determining when a tax is not generally redistributive:
			  ○ A lower tax rate on groups with lower Medicaid taxable units.
			  ○ A higher tax rate based on Medicaid taxable units compared to non-Medicaid taxable units.
			• The Senate text includes a third criterion not explicitly stated in the House version:
			  ○ A tax structure that excludes or imposes a lower rate on a group based on characteristics that effectively replicate the outcomes of the first two criteria.

	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.	as non-Medicaid bed days, revenue, and costs not associated with Medicaid). o A tax structure that excludes or imposes a lower rate on a taxpayer or tax rate group based on characteristics that effectively replicate the outcomes described above, even if the term "Medicaid" is not explicitly used (e.g., using alternative terminology or closely approximating Medicaid-related groups). • Effective upon enactment, with a transition period of up to 3 fiscal years as determined appropriate by the Secretary of Health and Human Services.	
House: Subpart 3 – Improving Americans' Access to Care *Senate: Subchapter D – Increasing personal Accountability*			
Sec. 44302. Streamlined Enrollment Process for Eligible Out-Of-State Providers Under	• 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	Provision not included in the Senate proposal.	House includes the provision, the Senate does not include the proposal.

Medicaid and CHIP	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.		
House Section 44142. Modifying Cost Sharing Requirements for Certain Expansion Individuals under the	• 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.	• Eliminates enrollment fees and premiums for "specified individuals" under Medicaid beginning October 1, 2028. These individuals are defined as those with incomes above the federal poverty line who are enrolled through Medicaid expansion or under a waiver providing equivalent minimum essential coverage.	• The House text focuses on simplifying the enrollment process for out-of-state Medicaid and CHIP providers, allowing them to enroll with only the minimum necessary information and remain enrolled for five years unless removed for cause. • The Senate text addresses cost-sharing rules for Medicaid expansion populations, eliminating premiums and

Medicaid Program
 	
Senate
Sec. 71125 Modifying Cost Sharing Requirements for Certain Expansion Individuals under the Medicaid Program
	• 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.
		• Requires states to impose cost sharing (greater than $0) on specified individuals for certain services, as determined by the state, starting October 1, 2028.
		• Prohibits cost sharing for the following services:
		  o Services listed in subparagraphs (B) through (J) of Section 1916(a)(2), including prenatal care, emergency services, family planning, inpatient hospital services, hospice care.
		  o Any primary care, mental health care, or substance use disorder services.
		Limits total cost sharing to no more than 5 percent of family income, applied on a monthly or quarterly basis, as specified by the state.
			enrollment fees for certain individuals starting in 2028.
			• Both the House and Senate text require some cost sharing for certain services and cap cost sharing per service at $35.

<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	Provision not included in the Senate proposal.	House includes the provision, the Senate does not include the proposal.

	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	Provision not included in the Senate proposal.	House includes the provision, the Senate does not include the proposal.

	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.		

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