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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

of the

U.S. House of Representatives

"Full Committee Markup of Budget Reconciliation Text"

May 13, 2025

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share comments on Budget Reconciliation Text that is to be considered by the Energy and Commerce Committee.

Medicaid is the largest single source of coverage in the United States, providing health care to more than 72 million Americans. These include children and babies, people with disabilities, the elderly and nursing home patients. In addition, it is a program upon which so many hard-working people depend.

The following comments are specific to Subtitle D of the Committee Print providing for reconciliation pursuant to H. Con. Res. 14, the Concurrent Resolution on the Budget for Fiscal Year 2025.

Section 44132. Moratorium on new or increased provider taxes.

States can finance the non-federal share of the Medicaid program by applying health care-related taxes, often referred to as provider taxes, fees or other assessments. States can implement these taxes through various approaches, including determining which providers to tax (e.g., hospitals and health systems, nursing facilities, managed

care organizations) and on what basis to apply the tax (e.g., per admission or bed, share of net revenue, flat taxes). Forty-nine states and the District of Columbia imposed at least one health care-related tax in fiscal year 2024. Provider taxes currently must be below the threshold of 6% or less of net patient revenues. States and providers rely on provider taxes to fund essential services and provide care for Medicaid beneficiaries. States use these funds to support Medicaid coverage, such as children's behavioral health services, maternal care and rehabilitative services, as well as to offset low Medicaid payment rates.

This section freezes, at current rates and amount, states' provider taxes in effect as of the date of enactment of this legislation and prohibits states from establishing new provider taxes. No federal matching funds would be allowed for state provider taxes imposed after the date of enactment, or any provider taxes that were increased (in amount or rate) after the date of enactment. The legislation also includes a provision that prohibits states from increasing the tax base by expanding items or services, or expanding the tax base to include providers that were previously not included. Our understanding is this would effectively cap provider taxes at the dollar amount in place on the date of enactment.

AHA Position:

The AHA is greatly concerned about the significant disruption this policy change will have on states' ability to fund their Medicaid programs. We believe the proposed restrictions on provider taxes fail to recognize the critical role they play in closing significant gaps in the cost of care for essential services. By freezing the taxes, the proposal ignores circumstances that drive increased health care costs including inflation, increased labor and drug costs, increased utilization and increased population demand for services. The Committee's proposal, based on our reading of the text, does not simply freeze provider percentage tax rates — it also appears to lock in the amount of dollars raised as of enactment of the law into perpetuity. Over time, the restrictions on this legitimate, vital funding tool will lead to diminished critical resources to support Medicaid beneficiaries.

There are significant variations among the Medicaid programs, and this policy change will impact each state differently. We also are concerned that the Committee does not include any alternate funding mechanisms to replace the loss of federal support in the states due to the proposed restrictions placed on provider taxes.

It is our belief that most states would be unable to close this financing gap created by further limiting their ability to tax providers; and as a result, they may need to make significant cuts to their Medicaid programs, including reducing eligibility, eliminating or limiting benefits and further reducing the chronic Medicaid underpayment rates for providers. In addition, states could address financial losses by limiting or eliminating non-mandatory benefits for all Medicaid beneficiaries, such as prescription drug coverage, clinic services, certain behavioral health services, home and community-based services (HCBS), and physical and occupational therapy. We are committed to

preserving hospital and health systems ability to care for Medicaid beneficiaries. We urge the committee to consider the long-term impact of this policy that will pull resources away from essential services upon which everyone in the community relies, including emergency, trauma, maternal and behavioral health care services.

Section 44133. Revising the payment limit for certain state directed payments (SDPs).

States may direct managed care plans to make additional payments to providers to pursue a state's overall Medicaid program and quality goals. The 2024 Medicaid managed care final rule established new requirements for SDPs, including defining the requirements for SDP evaluation plans and setting the average commercial rate (ACR) as the upper payment limit for SDPs for inpatient and outpatient hospital services.

This section directs the Department of Health and Human Services (HHS) to revise current regulations to limit SDPs for services furnished on or after the enactment of this legislation from exceeding the total published Medicare payment rate. This limit applies to SDP programs that were not in place on the date of enactment but does allow for SDP preprints that are in process with HHS to qualify at higher levels. Approved SDPs that are in place on the date of enactment are not subject to the limit, but states could not increase the SDP, and states would be required to submit a preprint for new or modified SDPs, and program renewals, for approval by the Centers for Medicare & Medicaid Services (CMS).

AHA Position:

Supplemental payments are a longstanding, vital tool that states can use to mitigate the chronic underpayments caused by low base rates for services provided to Medicaid patients. SDPs are used to support essential hospital services in our communities, including behavioral health and obstetrical services, and to create incentives to improve quality and health outcomes. They are particularly important in rural areas, where hospitals are sometimes the sole source of care in a community.

Setting limits on the amount that can be paid for SDPs into perpetuity will impact the delivery of care for both Medicaid beneficiaries as well as the larger communities served by our hospitals and health systems. Under this policy, funding for essential Medicaid supplemental payments will be frozen in time and will not keep up with year-over-year increases in health care costs. It is important to note that even when supplemental payments are included, Medicaid still pays less than the cost of providing care to Medicaid patients. For example, excluding supplemental payments, Medicaid fee for service payments paid less than 58 cents for every dollar hospitals spent caring for Medicaid patients in 2023, and Medicaid MCOs paid less than 65 cents over the same period. The Medicaid shortfall in hospital payments was $27.5 billion in 2023.

OTHER KEY PROVISIONS

PART 1—MEDICAID

Subpart A—Reducing Fraud and Improving Enrollment Processes

Section 44101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs (MSPs).

This section would rollback requirements in the "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" final rule, including those that: 1.) automatically enroll certain Supplemental Security Income (SSI) recipients in the Qualified Medicare Beneficiary (QMB) eligibility group of the MSP program; 2.) use data from the low-income subsidy program as an application for MSPs and align the family size definitions between the MSP and LIS programs; and 3.) accept self-attestation for certain types of income and resources.

AHA Position:

While the rule has not taken effect, the AHA is concerned about the potential loss of coverage and increase in uncompensated care that may result from delaying implementation.

Section 44102. Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program.

The legislation delays until Jan. 1, 2035, the implementation of the final rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes." The final rule addressed several key barriers to accessing and maintaining coverage for eligible individuals, including individuals who are Aged (65+), Blind, or Disabled (ABD), dually eligible individuals, the medically needy, people receiving Long-Term Services and Supports (LTSS) or Home and Community Based Services (HCBS) and children with disabilities. Provisions of the rule included streamlining verification processes, limiting renewals to no more frequently than every 12 months for high-risk individuals (non-MAGI populations), and establishes minimum timelines for applicants to provide needed information. States must be in full compliance with the provisions of the rule by June 2027, and, therefore, several key provisions have not yet been implemented.

This section prohibits HHS from implementing the rule for 10 years.

AHA Position:

While the rule has not taken effect, the AHA is concerned about the potential loss of coverage and increases in uncompensated care that may result from delaying implementation.

Section 44108. Increasing frequency of eligibility redeterminations for certain individuals.

This section requires states to conduct eligibility determinations for expansion population adults every six months. Current law currently requires such determinations to occur every 12 months.

AHA Position:

The AHA is concerned about the cost and additional administrative burden to the health care system, as well the potential loss of legitimate coverage, that may result from the policy change.

Section 44110. Prohibiting federal financial participation (FFP) under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status.

This section prohibits federal financial participation for Medicaid and CHIP enrollees in a reasonable opportunity period unless the individual successfully verifies their citizenship or immigration status. It is optional for states to provide coverage during the verification period.

AHA Position:

The AHA supports verification of citizenship and immigration status to qualify for Medicaid benefits, but we are concerned about the potential for a delay in coverage and care for individuals who would otherwise be eligible for the program.

Section 44111. Reducing expansion FMAP for certain states providing payments for health care furnished to certain individuals.

Federal funds for care provided to undocumented individuals is available in limited circumstances only. States can cover refugees and asylum seekers upon entering the U.S. (and being designated as such) for up to seven years. Additionally, states can reimburse hospitals for emergency care provided to individuals who meet other Medicaid eligibility requirements, but who do not have eligible immigration status.

This section reduces by 10% the Federal Medical Assistance Percentage (FMAP) for Medicaid expansion states that use their Medicaid infrastructure or another state-based program to provide health care coverage to those who are not qualified aliens otherwise lawfully residing in the U.S. (i.e., undocumented immigrants), reducing the 90% match for a state's expansion population to 80%.

AHA Position:
The AHA is concerned that lower FMAP for expansion states covering undocumented immigrants — with their own state funds — would have a substantial impact on

hospitals, as it would lead to more uncompensated care and potentially lower provider payments in the affected states. It is important to note that hospitals are required to treat patients regardless of immigration status under EMTALA.

Subpart B—Preventing Wasteful Spending

Section 44121. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.

The "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" final rule established minimum nurse staffing requirements for long-term care facilities (LTCFs) of at least 3.48 hours of nursing care a day, including at least 0.55 hours of care from a registered nurse and 2.45 hours of care from a nurse aide, as well as the availability of a registered nurse onsite at a facility 24 hours a day, seven days a week. The rule goes into effect for urban facilities in 2027 and for rural nursing homes in 2029.

On April 7, the U.S. District Court for the Northern District of Texas vacated the 2024 CMS minimum staffing standards for long-term care facilities.

This section prohibits HHS from implementing the rule for 10 years.

AHA Position:

The AHA supports the rescission of this rule as it does not consider existing workforce shortages and could lead to additional challenges for hospitals to discharge patients to LTCFs. The AHA filed a friend-of-the-court brief in the case and last year urged CMS not to finalize the mandate but instead develop more patient- and workforce-centered approaches focused on ensuring a continual process of safe staffing in nursing facilities.

Section 44122. Modifying retroactive coverage under the Medicaid and CHIP programs.

Current statute requires that states cover Medicaid state plan services at least three months (90 days) prior to the month that the eligible individual applies for Medicaid coverage. Individuals must have been determined eligible for Medicaid at the time that they received the services within the retroactive coverage period. States can reduce or eliminate the retroactive coverage period through the Section 1115 demonstration waiver. This section limits retroactive coverage in Medicaid to one month prior to an individual's application date.

AHA Position: Limiting the scope of retroactive coverage would impact both patients and providers. We are reviewing this policy to better understand what implications it may have for patients' access to care.

Subpart C—Stopping Abusive Financing Practices

Section 44131. Sunsetting eligibility for increased FMAP for new expansion states.

The American Rescue Plan Act (ARPA) provided an opportunity for states to receive an additional five percentage point increase for their traditional FMAP if they choose to expand. The additional match would be in effect for two years after the state expanded. There was no set expiration for the FMAP increase. At the time ARPA was enacted, 12 states had not expanded Medicaid. Since then, two states, Missouri and Oklahoma, expanded Medicaid and received the full eight quarters of the FMAP increase, and two states are currently receiving the FMAP increase — North Carolina and South Dakota. There are 10 states that have not yet expanded their Medicaid program. This section sunsets the temporary 5% enhanced FMAP but would apply the policy prospectively, to not impact states currently receiving an enhanced federal match under this authority.

AHA Position:

The AHA has supported incentives for states to expand their Medicaid programs. It is unclear whether additional states will be using this incentive in the short term.

Section 44134. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.

This section modifies the requirements regarding uniformity of provider taxes and, specifically, whether a state's tax is considered "generally redistributive." Under the draft legislation, a tax is not considered generally redistributive if:

- Within a permissible class, lower Medicaid volume health care entities are taxed at a lower rate than higher Medicaid volume health care entities.
- Within a permissible class, high Medicaid volume health care entities are taxed more heavily than non-Medicaid health care entities.
- The tax excludes or imposes a lower tax rate on health care entities based upon Medicaid participation status, whether the term "Medicaid" is mentioned.

AHA Position:

We are concerned this policy change will undermine state Medicaid financing arrangements and could have implications for coverage disruption.

Subpart D—Increasing Personal Accountability

Section 44141. Requirement for states to establish Medicaid community engagement requirements for certain individuals.

Under the prior Trump administration, many states sought to require some populations to demonstrate that they are working as a condition of eligibility for Medicaid. As of April 2025, Georgia is the only state to implement community engagement requirements as approved by CMS, although three states (Arizona, Arkansas, and Ohio) have waivers pending with the agency.

This section establishes community engagement requirements for certain Medicaid beneficiaries. Beginning Jan. 1, 2029, states are required to establish community engagement requirements for non-exempt expansion adults aged 19-64. Individuals must work or engage in qualifying activities (e.g., community service, educational programs, job training) for not less than 80 hours/month. Mandatory exceptions include specified excluded individuals (e.g., caretakers, disabled veterans, medically frail individuals), individuals under the age of 19, pregnant or post-partum women, individuals enrolled in Medicare part A or part B, and institutionalized individuals. Optional exceptions for short-term hardship events include individuals receiving inpatient hospital services, nursing facility services, or inpatient psychiatric services; individuals in disaster zones; and individuals in areas with high unemployment. Compliance is verified during the initial eligibility determination, as well as part of subsequent eligibility redetermination, or more frequently as determined by the state. States may use data sources like payroll data to verify compliance. If the state is unable to verify that the individual has met the community engagement requirements, the individual will have 30 days to demonstrate compliance before they are disenrolled. States must determine whether an individual would qualify for Medicaid under other eligibility pathways before disenrolling. If an individual is eligible for Medicaid but is disenrolled due to not meeting community engagement requirements, that individual is not eligible for premium tax subsidies in the health care marketplace. The legislation provides $100 million in grants in fiscal year 2026 for system development.

AHA Position:

We appreciate that the Committee provided thoughtful criteria regarding those who should be subject to this provision.

We are, however, concerned about the implementation challenges of reporting requirements and the option for states to conduct more frequent compliance checks than during the redetermination period. We would encourage more opportunities for beneficiaries to come into compliance before termination. In addition, we are concerned about the provision that those who are disenrolled due to failure to meet community engagement requirements would not be eligible for premium tax credits and, therefore, would not be able to afford coverage through their state's marketplace.

Some analysis indicates that community engagement requirements as a condition of coverage for the Medicaid population could result in loss of coverage. This also could result in additional uncompensated care for hospitals.

Section 44142. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program.

Currently, states have the option to set cost-sharing requirements for certain enrollees above 100% of the federal poverty level (FPL). The maximum allowable deductible and copayment amounts are set by CMS, and can be applied to institutional care, non-institutional care, non-emergency use of the emergency department and prescription drugs services and supplies. For inpatient hospital care, for example, the maximum allowable copayment is $75 at 100% FPL, 10% of the cost the agency pays for 100-150% FPL and 20% of the cost the agency pays for those who are above150% FPL. No out-of-pocket costs may be imposed for emergency services, family planning services, preventive services for children and pregnancy services. Out-of-pocket costs are capped at 5% of family income.

This section requires states to impose cost sharing requirements at an amount greater than $0 and not exceeding $35 on Medicaid expansion enrollees. Total cost sharing may not exceed 5% of family income. States may allow providers to require payment as a condition of providing services, though providers may waive cost-sharing requirements on a case-by-case basis. The legislation would not permit cost-sharing on primary care, prenatal care, pediatric care, or emergency room care (except for non-emergency care provided in an emergency room).

AHA Position:

The AHA is concerned about the challenges providers face in collecting cost-sharing from low-income patients. We also are concerned that cost sharing requirements are both a burden on low-income patients and can be a significant barrier to coverage, particularly when consequences, such as potential loss of health care services, are applied for failure to pay.

PART 2—AFFORDABLE CARE ACT

Section 44201. Addressing waste, fraud, and abuse in the ACA exchanges.

This section codifies most of the proposed policies in the 2025 Marketplace Integrity rule, including: shortening the Health Insurance Marketplace open enrollment period, removing the low-income special enrollment period, changing the premium adjustment percentage methodology, allowing insurers to require that enrollees pay past-due premiums before renewing coverage, implementing more stringent eligibility verification processes, disallowing DACA recipients to receive premium tax credits or cost-sharing reductions and prohibiting gender-affirming care as an essential health benefit. The draft legislation does not include the proposal that would improve transparency of agency, broker, and web-broker behavior, and varies in its language regarding the de minimus range, which impacts the value of coverage within each metal tier. The provisions within this section would take effect for plan years beginning on or after Jan. 1, 2026.

AHA Position:

The AHA is concerned that this section would codify parts of the rule that could impact coverage, including shortening the Health Insurance Marketplace open enrollment period, removing the low-income special enrollment period, changing the premium adjustment percentage methodology, allowing insurers to require that enrollees pay past-due premiums before renewing coverage and implementing more stringent eligibility verification processes. Coverage loss associated with these policies, combined with additional changes to the Medicaid program resulting in coverage loss, would have substantial consequences for patient access to care as well as the financial stability of hospitals, health systems and other providers.

PART 3—IMPROVING AMERICANS' ACCESS TO CARE

Section 44302. Streamlined enrollment process for eligible out-of-state providers under Medicaid and CHIP.

For purposes of improving access to necessary out-of-state care for children enrolled in Medicaid and CHIP, this section requires states to establish a process through which qualifying pediatric out-of-state providers may enroll as participating providers without undergoing additional screening requirements.

AHA Position:

The AHA supports efforts to improve access to care for Medicaid and CHIP beneficiaries.

Section 44303. Delaying DSH reductions.
This section delays the Medicaid Disproportionate Share Hospital (DSH) reductions, currently $8 billion reductions per year that are set to take effect for fiscal years 2026 through 2028, to instead take effect for fiscal years 2029 through 2031. This section also extends funding for Tennessee's DSH program, which is set to expire at the end of this fiscal year, through fiscal year 2028.

AHA Position:

The AHA supports a delay in the start of the remaining DSH cuts.

Section 44304. Modifying update to the conversion factor under the physician fee schedule under the Medicare program.

This section applies a new single conversion factor for Physician Fee Schedule services under the Medicare program starting in 2026 (as opposed to the two distinct ones scheduled for implementation under current law: one for physicians participating in alternative payment models and another for those who are not). For 2026, the update to

the single conversion factor would be 75% of the percentage increase in the Medicare Economic Index (MEI), for 2027 it would be 10% of the percentage increase in the MEI. This provision would not be retroactive.

AHA Position:

The AHA supports the Committee's efforts to address payments for our nation's physicians.