KHA's Federal Advocate
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House Narrowly Passes Reconciliation Budget Bill

Early this morning, the House of Representatives passed H.R. 1, the "One Big Beautiful Bill Act" on a vote of 215-214 after making several last-minute changes to appease GOP conservatives. It now goes to the Senate where work will begin quickly if they intend to send a final product to President Donald Trump's desk by the July 4 recess. Kansas Hospital Association staff have been working diligently throughout the month to ensure Kansas providers' interests are protected despite the various Medicaid funding caps and policy changes that are present in the bill.

In particular, the bill as passed caps provider assessment rates at currently imposed levels. This means states whose legislative branches have already enacted laws to create new assessment rates by the time this bill goes into effect are allowed to continue working on the Centers for Medicare & Medicaid Services approval for the new rate. On this point, Kansas' increase from three percent to six percent is allowable under the bill. However, state directed payments are treated differently. Any new SDPs whose preprint has not been submitted to CMS as of the time the bill goes into effect are capped at 100 percent of the Medicare rate in expansion states and 110 percent in non-expansion states. Any SDP already in place or whose preprint is submitted to CMS by the enactment date are grandfathered in at the higher average commercial rate.

Kansas' situation in this regard is tenuous. The Kansas Legislature passed a bill to include Critical Access Hospitals in the Provider Assessment Program earlier this year, but the Kansas Department of Health and Human Services has not yet submitted the updated preprint to CMS. We have been working with KDHE to help speed this process along, knowing that we are under a time crunch.

The base bill's Medicaid title, as written by the House Energy and Commerce Committee, would not have allowed KDHE to proceed even in submitting its preprint for consideration. The original bill said only SDPs previously approved by CMS could grandfather in their rates under the ACR cap. We worked with Representative Derek Schmidt (R-KS) and Representative Tracey Mann (R-KS) to amend the bill, and the committee made the above change specifically to help Kansas.

We are grateful to both congressmen, as well as their staffers Clint Blaes (Representative Schmidt's Legislative Director) and Sarah Farrell (Representative Mann's Legislative Director) for their effort on our state's behalf regarding an extremely complicated but vitally important matter.

Going into the Senate, we will continue to work with our delegation on gaining clarity to ensure the SDP language does not disadvantage Kansas hospitals. We are already working with Senators Jerry Moran and Roger Marshall's offices on these matters.

H.R. 1 also makes changes to the Rural Emergency Hospital Program. The bill allows CAHs and rural hospitals with less than 50 beds that closed between Jan. 1, 2014, and Dec. 26, 2020, to reopen as REHs. However, if such facility is located less than 35 miles away from the nearest hospital, it must annually demonstrate that more than 50 percent of its furnished services in its most recent cost reporting period were emergency department services or observation care provided to Medicare beneficiaries. Also, if the reopening hospital is less than 35 miles from the nearest hospital, it does not get the +5 percent bump on its Outpatient Prospective Payment System rate, and if it is less than 10 miles from nearest hospital, it would not receive a +5 percent bump or additional monthly payment.

There are concerns that this bill overall, by increasing the nation's budget deficit beyond its current baseline by roughly $3.6 trillion over 10 years, will trigger cuts to Medicare by requiring that a higher sequestration percentage be applied to the program under the Pay as You Go law. While increases to the annual deficit automatically trigger the Office of Management and Budget to sequester the amount necessary to eliminate such deficit increase, Congress has always waived these cuts when they pass their annual budget. Any PAYGO override requires 60 votes in the Senate, but since all appropriations bills must meet the 60-vote threshold anyway, the coalition in place to pass the budget already has those votes lined up. While past performance doesn't guarantee future performance, this type of scenario is and has been common on Capitol Hill. KHA opposes all Medicare sequestration, and our delegation is aware of this.

In addition to our central concerns on Capitol Hill, we were encouraged to see today that CMS will increase the amount and frequency of audits on Medicare Advantage plans. In a statement, CMS Administrator Mehmet Oz said, "While the Administration values the work that Medicare Advantage plans do, it is time CMS faithfully executes its duty to audit these plans and ensure they are billing the government accurately for the coverage they provide to Medicare patients." While encouraging, we know there is more work to be done. In particular, we continue to support Senator Marshall's efforts regarding the Improving Seniors' Timely Access to Care Act as Congress looks to solve MA plans' abuses in denying prior authorizations for necessary patient care.