PYA Healthcare Regulatory Roundup #97 – Washington Updates: One Big, Beautiful Bill, Lots of Proposed Rules

Presented July 16, 2025 by PYA's Martie Ross and Kathy Reep | Part of the Healthcare Regulatory Roundup Webinar Series

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WEBINAR SUMMARY

In this episode of PYA's Healthcare Regulatory Roundup, experts Martie Ross and Kathy Reep break down key healthcare provisions in the "One Big Beautiful Bill Act" (OBBBA) and the recently released calendar year (CY) 2026 Centers for Medicare & Medicaid (CMS) proposed payment rules. Topics covered include Medicaid work requirements, state-directed payment caps, provider tax limits, Medicare Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) updates, site-neutral payment expansion, Medicare Physician Fee Schedule (MPFS) adjustments, rural health transformation funding, and new federal transparency mandates.

Key topics include:

- Medicaid eligibility reforms including new work requirements
- Provider tax caps phased in starting 2028
- State-directed payment limits and retroactive coverage changes
- $50 billion Rural Health Transformation Fund and implications for hospital funding
- CMS' proposed 2026 OPPS/ASC and MPFS rules
- Expansion of site-neutral payments and updates to price transparency
- Significant home health payment cuts proposed for CY 2026

WEBINAR HIGHLIGHTS AND FREQUENTLY ASKED QUESTIONS

What are the major Medicaid changes introduced by the One Big Beautiful Bill Act (OBBBA)?

- Starting in 2027, OBBBA mandates Medicaid work requirements for non-exempt individuals (80 hours/month), increases eligibility verification frequency, reduces retroactive coverage, limits eligibility for some immigrant groups, and caps provider taxes.

How will provider taxes be affected?

- For Medicaid expansion states, the maximum allowable provider tax rate will be reduced from 6% to 3.5% over four years starting in 2028. No new or expanded provider taxes will be permitted.

What's changing with state-directed Medicaid payments (SDPs)?

- OBBBA prohibits new state-directed payments exceeding 100% of Medicare rates (110% in non-expansion states) after specific grandfathering dates. Existing SDPs above the limit must be reduced by 10% annually beginning 2028.

What is the Rural Health Transformation Fund?

- $50 billion will be distributed over five years to states with CMS-approved transformation plans. It is not a stabilization fund for lost Medicaid revenue.

Is there a fix for Disproportionate Share Hospital (DSH) cuts?

- No. The Senate bill did not extend the delay on $32 billion in ACA-related DSH reductions. Without further congressional action, $8 billion in annual cuts begin October 1, 2025.

What are the key highlights of the CY 2026 OPPS proposed rule?

- Proposes a 2.4% increase, but many hospitals will effectively see only a 0.88% bump due to the 340B remedy offset. Also includes inpatient-only list changes, survey-based drug cost reporting, and enhanced transparency requirements.

What is proposed for site-neutral payment expansion?

- CMS proposes extending site-neutral payment policies to grandfathered hospital outpatient departments (HOPDs) for drug administration services. Rural sole community hospitals (SCHs) are exempt. CMS seeks feedback on further expanding site neutrality.

How will home health agencies be impacted?

- CMS proposes a 6.4% reduction in home health payments for 2026, tied to a $1.4B recoupment of overpayments due to behavior changes after patient-driven groupings model (PDGM) implementation.

What happens to ACA premium tax credits under OBBBA?

- OBBBA does not extend enhanced ACA subsidies beyond 2025. CBO projects 4.2 million more uninsured by 2034 without Congressional action.

What is WISER and how does it relate to AI?

- WISER is a CMS Innovation Center model launching in 2026 in five states, contracting companies to use AI for Medicare prior authorization reviews, compensated based on savings.

ACTION ITEMS

- Review the changes to provider taxes and state directed payments and prepare for the resulting reductions in Medicaid spending.
- Assess the impact of the changes to the Medicaid disproportionate share (DSH) payments and prepare for the $8 billion annual reduction.
- Review the proposed changes to the Hospital Outpatient Prospective Payment System, including the site-neutral payment policies and price transparency requirements.
- Analyze the impact of the Medicaid work requirements and eligibility changes on provider reimbursement.
- Monitor the political environment and potential legislative efforts to roll back the Medicaid cuts.
- Evaluate the implications of the new rural health transformation program and the broad authority given to the CMS Administrator.

WEBINAR OUTLINE

Introduction to the Webinar Topics

- Martie Ross outlines the structure of the webinar: first half on healthcare provisions of the bill, second half on CMS proposed payment rules for calendar year 2026.
- Martie and Kathy Reep note the OPPS rule was released at 4:15 PM Eastern Time on July 15.
- Martie explains the webinar will cover key elements of the new regulation, including Medicaid and ACA Premium Tax Credit provisions.

Medicaid and ACA Premium Tax Credit Provisions

- Work requirements for Medicaid eligibility will be implemented in 2027, requiring individuals to work or participate in qualifying activities for 80 hours per month.
- States may request an additional two years for implementation and verification procedures.
- HHS will issue interim regulations by the end of next year, and $200 million is appropriated to assist states with implementation.
- States must conduct regular verification of compliance with work requirements and may provide hardship exceptions.

Other Medicaid Eligibility Provisions

- Delay in implementation of Biden era eligibility and enrollment final rules until 2035, tagged at $167 billion in savings.
- States will be required to conduct eligibility redeterminations every six months for the expansion population, tagged at $62 billion.
- States will phase in additional screening and verification procedures to prevent improper enrollment, with $30 million appropriated to CMS for system implementation.
- Medicaid eligibility will be limited to refugees, asylees, and humanitarian parolees, with a $6 billion reduction in Medicaid spending.

Provider Taxes and State Directed Payments

- Provider taxes are used by states to generate revenue for federal matching funds, capped at 6% of net patient revenue for expansion states.
- The threshold for provider tax dollars will decrease over a number of years, starting in 2028.
- Non-expansion states can keep current provider taxes but cannot impose new taxes or expand existing ones.
- State directed payments will be capped at 110% of Medicare rates for non-expansion states and 100% for expansion states, with exceptions for new state directed payments submitted by May 1, 2025.

Additional Medicaid Provisions

- Retroactive coverage for Medicaid will be limited to one month for the expansion population and two months for the non-expansion population.
- Cost sharing requirements will be imposed on expansion adults with incomes between 100% and 138% of the federal poverty level, with exceptions for preventative care services.
- States with high error rates in Medicaid payments will face reductions in their Federal Medical Assistance Percentage (FMAP).
- A moratorium on the enforcement of nursing facility minimum staffing requirements through 2034.

ACA Marketplace Premium Tax Credits and Other Provisions

- Cuts to ACA marketplace premium tax credits will increase the uninsured by 4.2 million by 2034.
- The new ACA marketplace integrity and affordability final rule is expected to add another 900,000 individuals to the uninsured.
- The Rural Health Transformation Program will provide $50 billion over five years, starting next year, to states for distribution.
- The program requires states to submit an application by December 31, 2025, and to use funds for specified purposes, including improving rural health.

CMS Proposed Payment Rules for Calendar Year 2026

- The proposed rule includes a 2.4% increase in the conversion factor for the Hospital Outpatient Prospective Payment System.
- The outlier threshold will be reduced from $7,175 to $6,450, making it easier for services to qualify as outliers.
- The 340B remedy will reduce the conversion factor by 2% per year for six years, affecting hospitals enrolled in Medicare after January 1, 2018.
- The inpatient only list will be phased out over three years, removing 285 services, with 271 moving to the covered procedures list for ambulatory surgical centers.

Price Transparency and Site Neutral Payments

- Hospitals will be required to report payer-specific Medicare Advantage payment rates by DRG on the cost report.
- New requirements for price transparency will include encoding the name of the CEO or other official designated to oversee reporting and the National Provider Identifier.
- Site neutral payments will be applied to 61 codes related to drug administration in off-campus provider-based departments, reducing payments to 40% of the hospital outpatient department rate.
- Rural sole community hospitals are exempted from the site neutral payment reforms.

Quality Reporting and Home Health Provisions

- Changes to the outpatient Quality Reporting Program include modifying certain measures to be reported.
- The star rating changes will cap the number of stars a hospital can achieve if it falls in the lowest quartile of the safety of care measure group.
- The proposed rule for Home Health includes a 6.4% reduction in current payments, a $1.4 billion decrease from 2025 to 2026.
- The reduction is based on a behavioral assumption that changes in payment methodology led to overpayments, with a focus on recouping past overpayments.

Wiser Model and Final Remarks

- The Wiser model is a new CMS Innovation Center model where companies contract with CMS to perform prior authorization reviews, compensated from savings to CMS.
- The initial program is limited to five states, starting in January 2026, with a focus on using artificial intelligence for prior authorization reviews.