

One Big Beautiful Bill Act, Pub. L. No. 119–2 Section by Section Summary

TITLE VII—FINANCE

Subtitle B—Health

Chapter 1 – MEDICAID

SUBCHAPTER A—REDUCING FRAUD AND IMPROVING ENROLLMENT PROCESSES

| Section Number | Name of Section                                                                                          | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Existing Law Changed                                                                                                                                                                                                                                                                                  |
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| 71101          | Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs | <p>This provision imposes a moratorium, <b>until September 30, 2034</b>, on specific provisions in a 2023 Medicaid final rule, “Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment,” (<a href="#">88 Fed. Reg. 65230</a>).</p> <p>The regulation was intended to simplify processes for eligible individuals to enroll and retain eligibility in the Medicare Savings Programs (MSPs); better align enrollment into the MSPs with requirements and processes for other public programs; and reduce the complexity of applications and reenrollment for eligible individuals.</p> <p>The provisions subject to this moratorium are:</p> <ul style="list-style-type: none"><li>• 42 C.F.R. § 406.21(c) (general enrollment period effective dates)</li><li>• 42 C.F.R. § 435.4. (defining Low-Income Subsidy Application data)</li><li>• 42 C.F.R. § 435.601. (defines “family size” for purposes of Medicare Savings Program eligibility)</li><li>• 42 C.F.R. § 435.911. (governs use of certain data sources to streamline eligibility determinations under the Medicare Savings Program)</li><li>• 42 C.F.R. § 435.952 (governing the attestation of certain information by individuals applying for the Medicare Savings Program)</li></ul> <p>HHS appropriated \$1 million to implement this section and section 71102.</p> <p><b>This provision is effective immediately.</b></p> | <p>HHS may not administer, implement or enforce the provisions listed in the prior column.</p> <p>Note: Not all provisions of the final rule are subject to the moratorium. Unaffected provisions are currently in effect and remain unchanged by this section of the One Big Beautiful Bill Act.</p> |

| Section Number | Name of Section                                                                                                                     | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Existing Law Changed                                                                                                                                                                                                                                                                                  |
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| 71102          | <b>Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program</b> | <p>This provision imposes a moratorium, <b>until September 30, 2034</b>, on specific provisions in a 2024 Medicaid final rule, “Medicaid Program; Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes,” (<a href="#">89 Fed. Reg. 22780</a>).</p> <p>The regulation was intended to align enrollment and renewal requirements for most individuals in Medicaid; establish beneficiary protections related to returned mail; create timeliness requirements for redeterminations of eligibility; make transitions between programs easier; eliminate access barriers for children enrolled in CHIP by prohibiting premium lock-out periods, benefit limitations, and waiting periods; and modernize recordkeeping requirements to ensure proper documentation of eligibility determinations.”</p> <p>The provisions subject to this moratorium are:</p> <p><u>42 C.F.R. part 431:</u></p> <ul style="list-style-type: none"> <li>• 42 C.F.R. § 431.213(d) (exceptions to advance notice)</li> </ul> <p><u>42 C.F.R. part 435:</u></p> <ul style="list-style-type: none"> <li>• 42 C.F.R. § 435.222 (state option to provide Medicaid coverage to certain individuals under age 19, 19, 20, or 21)</li> <li>• 42 C.F.R. § 435.407 (citizenship and identity verification procedures)</li> <li>• 42 C.F.R. § 435.907 (regarding application data and processes)</li> <li>• 42 C.F.R. § 435.911(c) (Medicaid eligibility determinations)</li> <li>• 42 C.F.R. § 435.912 (timeliness standards for determining and redetermining Medicaid eligibility)</li> <li>• 42 C.F.R. § 435.916 (Medicaid eligibility renewals)</li> <li>• 42 C.F.R. § 435.919 (changes in circumstance)</li> <li>• 42 C.F.R. § 435.1200(b)(3)(i)-(v) (Medicaid agency coordination with other insurance affordability programs)</li> <li>• 42 C.F.R. § 435.1200(e )(1)(ii) (Medicaid agency coordination with other insurance affordability programs)</li> <li>• 42 C.F.R. § 435.1200(h)(1) (Medicaid agency coordination with other insurance affordability programs)</li> </ul> | <p>HHS may not administer, implement or enforce the provisions listed in the prior column.</p> <p>Note: Not all provisions of the final rule are subject to the moratorium. Unaffected provisions are currently in effect and remain unchanged by this section of the One Big Beautiful Bill Act.</p> |

| Section Number | Name of Section                                                           | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Existing Law Changed                                                        |
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|                |                                                                           | <p><u>42 C.F.R. part 447:</u></p> <ul style="list-style-type: none"> <li>42 C.F.R. § 447.56(a)(1)(v) (limitations on premiums and cost sharing)</li> </ul> <p><u>42 C.F.R. Part 457:</u></p> <ul style="list-style-type: none"> <li>42 C.F.R. § 457.344 (changes in circumstances)</li> <li>42 C.F.R. § 457.960 (changes in circumstances)</li> <li>42 C.F.R. § 457.1140(d)(4) (continued CHIP enrollment)</li> <li>42 C.F.R. § 457.1170 (continued CHIP enrollment)</li> <li>42 C.F.R. § 457.1180 (eligibility notices)</li> </ul> <p>HHS appropriated \$1 million to implement this section and section 71101.</p> <p><b>This provision is effective immediately.</b></p> |                                                                             |
| <b>71103</b>   | <b>Reducing duplicate enrollment under the Medicaid and CHIP programs</b> | <p><b>By January 1, 2027</b>, States must establish a process to regularly obtain Medicaid and CHIP beneficiary address information from reliable data sources, including by requiring state Medicaid and CHIP agencies to collect addresses that Medicaid beneficiaries provided to managed care organizations.</p> <p>By <b>October 1, 2029</b>, HHS must establish a program to prevent enrollment in more than one state Medicaid or CHIP program using Social Security Number submissions.</p> <p>Provides \$10 million for FY 2026 to establish the system and \$20 million for maintenance.</p>                                                                      | Amends sections 1902, 1903, 1932, 2103 and 2107 of the Social Security Act. |
| <b>71104</b>   | <b>Ensuring deceased individuals do not remain enrolled</b>               | <p><b>Beginning January 1, 2027</b>, states must review the SSA Death Master file at least quarterly and determine if beneficiaries are deceased; deceased beneficiaries must be disenrolled.</p> <p>If a state mistakenly disenrolls an individual under this provision, the person must be re-enrolled back to the date of the disenrollment.</p>                                                                                                                                                                                                                                                                                                                         | Amends section 1902 of the Social Security Act.                             |

| Section Number | Name of Section                                                                                               | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Existing Law Changed                                                  |
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| 71105          | Ensuring deceased providers do not remain enrolled                                                            | <b>Effective January 1, 2028</b> , state Medicaid programs must check as part of provider enrollment and reenrollment and, on quarterly basis, the SSA Death Master file to determine whether providers are deceased and enrolled in the Medicaid program.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Amends section 1902 of the Social Security Act.                       |
| 71106          | Payment reduction related to certain erroneous excess payments under Medicaid                                 | <b>Beginning in FY 2030</b> , this provision reduces the amount of erroneous payments HHS can waive. It also expands the definition of erroneous payments to include payments for items and services furnished to individuals who are not eligible for federal reimbursement under Medicaid payments here there is insufficient information to confirm eligibility.                                                                                                                                                                                                                                                                                                                                                                                                                                  | Amends section 1903(u)(1) of the Social Security Act.                 |
| 71107          | Eligibility redeterminations                                                                                  | With respect to annual eligibility renewals <b>scheduled on or after January 1, 2027</b> , states must verify Medicaid eligibility for individuals in the Medicaid adult group (who are enrolled under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act) and individuals who are described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, but are enrolled under a waiver of the plan that provides coverage that is equivalent to minimum essential coverage every 6 months (as opposed to the prior limit allowing for renewals no more than one per year).<br><br>Bi-annual eligibility checks do not apply to certain individuals who are excluded from statutory work requirements.<br><br>HHS to implement guidance no later than 180 days after enactment of OBBBA. | Amends section 1902(e)(14) of the Social Security Act.                |
| 71108          | Revising home equity limit for determining eligibility for long-term care services under the Medicaid program | This provision allows states to impose home equity limits up to \$1 million when determining eligibility for long-term care services for homes that are not in a lot zoned for agricultural use. Home equity limit for homes in a lot zoned for agricultural use may be up to \$750,000.<br><br>Inflation adjustment does not apply to amount specified above for all other homes. If inflation adjustment results in amount that exceeds \$1 million, then the amount will be deemed to be \$1 million.                                                                                                                                                                                                                                                                                             | Amends sections 1917(f)(1) and 1902(r)(2) of the Social Security Act. |

| Section Number | Name of Section                              | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Existing Law Changed                                               |
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|                |                                              | <p>Clarifies that states must apply this provision and impose this asset test when determining eligibility for long-term care services, thereby prohibiting states from excluding home equity using disregards under section 1902(r)(2) of the Social Security Act. adds this clarification to 1902(e)(14)(D)(iv) (MAGI exceptions for long term care determinations)</p> <p><b>Amendments made by this subsection apply beginning on January 1, 2028.</b></p>                                                                                                                                                                                                                                                                                                                   |                                                                    |
| 71109          | <b>Alien Medicaid eligibility</b>            | <p>The provision restricts Medicaid and CHIP eligibility to non-US citizens who are either admitted for permanent residence or who are Cuban/Haitian entrants. Under current law, other individuals admitted for humanitarian purposes (e.g., asylees and refugees) can qualify for Medicaid. The provision eliminates eligibility for these individuals until they obtain their green card (which, for asylees, requires a five-year wait from the date on which they receive approval as asylees).</p> <p>Residency is also required in one of the 50 states, the District of Columbia, or a territory of the U.S.</p> <p>Provides \$15 million for FY 2026 to CMS to implement this section of the bill.</p> <p><b>This provision is effective as of January 1, 2026.</b></p> | Amends sections 1903(v) and 2107(e)(1) of the Social Security Act. |
| 71110          | <b>Expansion FMAP for emergency Medicaid</b> | <p>As of <b>October 1, 2026</b>, the Federal Medical Assistance Percentage (FMAP) for a state paying for emergency medical services for aliens is set at the state's regular match rate (even for someone who would, but for the individual's alien status, be entitled to the expansion match rate).</p> <p>Provides \$1 million for FY 2026 to CMS to implement this section of the bill.</p>                                                                                                                                                                                                                                                                                                                                                                                  | Amends section 1905 of the Social Security Act.                    |

## Chapter 1 – MEDICAID

### SUBCHAPTER B—PREVENTING WASTEFUL SPENDING

| Section Number | Name of Section                                                                                                                                    | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Existing Law Changed                                                                                                                                                                                                                                                                                  |
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| 71111          | <b>Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.</b> | <p>This provision imposes a moratorium, <b>until September 30, 2034</b>, on a 2024 regulation titled “` Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" (<a href="#">89 Fed. Reg. 40876</a>).</p> <p>The regulation was intended to establish minimum staffing standards for Medicaid-participating long-term care facilities and require States to report the percent of Medicaid payments for certain Medicaid-covered institutional services that are spent on compensation for direct care workers and support staff.</p> <p>The provisions subject to this moratorium are:</p> <ul style="list-style-type: none"> <li>• 42 C.F.R. § 483.5 (definitions relevant to minimum staffing ratio)</li> <li>• 42 C.F.R. § 483.35 (minimum staffing ratio)</li> </ul> <p><b>The provision is effective immediately, and the moratorium continues through September 30, 2034.</b></p> | <p>HHS may not administer, implement or enforce the provisions listed in the prior column.</p> <p>Note: Not all provisions of the final rule are subject to the moratorium. Unaffected provisions are currently in effect and remain unchanged by this section of the One Big Beautiful Bill Act.</p> |
| 71112          | <b>Reducing State Medicaid costs.</b>                                                                                                              | <p>This provision reduces the period of retroactive Medicaid eligibility for expansion adults to one month prior to application (from three months), and to two months for all other Medicaid enrollees. CHIP is similarly limited to two months of retroactive coverage. The policy extends to the CHIP program as well.</p> <p>Provides \$10,000,000 for fiscal year 2026, to remain available until expended.</p> <p><b>The provision becomes effective beginning in Quarter 1 (January 1) 2027.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Amends sections 1902(a)(34) and 2102 of the Social Security Act.                                                                                                                                                                                                                                      |
| 71113          | <b>Federal payments to prohibited entities.</b>                                                                                                    | <p>This provision prohibits any federal Medicaid funding from being used to make payments to certain clinics that provide family planning services, reproductive health, or abortions (other than abortions necessary to protect the physical health of the pregnant woman or the pregnancy is the result of rape or incest).</p> <p><b>The provision is effective as of October 1, 2025 for one year.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                       |

## Chapter 1 – MEDICAID

### SUBCHAPTER C—STOPPING ABUSIVE FINANCING PRACTICES

| Section Number | Name of Section                             | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Existing Law Changed                                  |
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| 71114          | <b>Sunsetting increased FMAP incentive.</b> | <p>A state’s FMAP is increased by 5% for the first two years after it begins providing services to the ACA expansion population.</p> <p><b>A state will only qualify for this enhanced FMAP if it begins providing services to an expansion population as of January 1, 2026.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Amends section 1905(ii) of the Social Security Act.   |
| 71115          | <b>Provider taxes.</b>                      | <p>A state can provide its share of Medicaid funding with revenues derived from taxes imposed on providers so long as the tax does not contain a “hold harmless” provision (i.e., a provision that guarantees that the hospital does not suffer an economic loss from paying the tax). A hold harmless guarantee is deemed not to exist so long as the revenues derived from the tax are less than 6% of the revenues received by the provider. The legislation generally lowers this safe harbor threshold to 3.5% (phased down over a four-year period beginning in 2028) for a state that has adopted the ACA Medicaid expansion.</p> <p>This provision applies only to the 50 states and DC.</p> <p>Provides \$20,000,000 for fiscal year 2026, to remain available until expended.</p> <p><b>The provision is effective starting October 1, 2026, but the requirement does not become effective until 2028 for expansion states.</b></p> | Amends section 1903(w)(4) of the Social Security Act. |
| 71116          | <b>State directed payments.</b>             | <p>In general, states cannot direct the terms of Medicaid managed care payments. The regulations provide some limited exceptions such as, for example, adopting a minimum fee schedule. Under present law, payments under such a fee schedule cannot exceed the average commercial rate for managed care payments in the state.</p> <p>Under the new legislation, CMS is directed to amend this regulation to limit state-directed payments to 100% of the total established Medicare rate in the state (in the case of states that have expanded Medicaid eligibility under the ACA) or 110% of that amount (for non-expansion states). Rural hospitals that meet the definition of rural hospital provide for in this section are grandfathered for a limited period.</p>                                                                                                                                                                   | CMS directed to revise 42 C.F.R. § 438.6(c)(2)(iii).  |

| Section Number | Name of Section                                                                            | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Existing Law Changed                               |
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|                |                                                                                            | <p>Provides \$7,000,000 for fiscal years 2026 through 2033, to remain available until expended.</p> <p><b>States with state-directed payments that were approved before May 1, 2025 can remain in effect and then phase down by 10% per year beginning in January 2028.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                    |
| 71117          | <b>Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.</b> | <p>States are not permitted to finance their share of Medicaid expenditures with provider taxes unless those provider taxes are broad-based, uniform, and do not contain a “hold harmless” feature. A state can obtain a waiver of the broad based and uniformity requirements if it can show that the tax is “generally redistributive,” meaning that the tax is economically shared across the entire of class of providers in the state that are subject to the tax (for example, the tax cannot have lower rates for providers with fewer Medicaid patients or higher rates for those with more Medicaid patients).</p> <p>The legislation imposes three new tests to determine whether a tax is generally redistributive and therefore eligible for the waiver. In doing so, the provision clarifies definitions of Medicaid and non-Medicaid taxable units and tax rate groups. The new tests, which address perceived abuses that permit states to avoid sharing in the financing burden of the Medicaid program, provide that a tax is not considered to be generally redistributive if any of the following conditions apply:</p> <ul style="list-style-type: none"> <li>I. Within a permissible class, the tax rate imposes on any taxpayer or tax rate group explicitly defines by its relatively lower volume or percentage of Medicaid taxable unites is lower than the tax rate imposed on any other taxpayer or tax rate group explicitly defined by its relatively higher volume or percentage of Medicaid taxable units;</li> <li>II. Within a permissible class, the tax rate imposed on any taxpayer or tax rate group based upon its Medicaid taxable units is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable unit;</li> <li>III. The tax excludes or imposes a lower tax rate on a taxpayer or tax rate group based on or defined by any description that results in the same effect as described in I. or II. for a taxpayer or tax rate group.</li> </ul> <p>This provision applies only to the 50 states and DC.</p> <p><b>The law gives CMS the authority to allow a transition period of up to three fiscal years.</b></p> | Amends section 1903(w) of the Social Security Act. |

| Section Number | Name of Section                                                                            | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Existing Law Changed                            |
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| <b>71118</b>   | <b>Requiring budget neutrality for Medicaid demonstration projects under section 1115.</b> | <p>Although the Office of Management and Budget (OMB) has a policy that Medicaid demonstration projects under section 1115 of the Social Security Act be budget-neutral, that requirement has never been codified. The legislation codifies the requirement and imposes the budget neutrality determination on the CMS actuary. This provision also requires that savings from a waiver period be accounted for in subsequent periods.</p> <p>The requirement applies to new applications for Medicaid demonstration projects under section 1115 of the Social Security Act, as well as renewals and amendments of existing demonstrations.</p> <p>Provides \$5,000,000 for fiscal years 2026 and 2027, to remain available until expended.</p> <p><b>The provision is effective beginning January 1, 2027 and applies to CMS approvals of new and existing 1115 demonstration projects after that date.</b></p> | Amends section 1115 of the Social Security Act. |

## Chapter 1 – MEDICAID

### SUBCHAPTER D—INCREASING PERSONAL ACCOUNTABILITY

| Section Number | Name of Section                                                                                                | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Existing Law Changed                                                                       |
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| <b>71119</b>   | <b>Requirement for States to establish Medicaid community engagement requirements for certain individuals.</b> | <p>This provision mandates that the 50 states and D.C. require most adult Medicaid beneficiaries (i.e., adults group beneficiaries ages 19–64 who are not pregnant, not disabled, and not otherwise exempt) to meet community engagement requirements as a condition of eligibility.</p> <p>Community engagement may be satisfied for a given month by working at least 80 hours, participating in a community service or work program for at least 80 hours, being enrolled at least half-time in an educational program or earning income at or above the minimum wage for 80 hours per month, with flexibility to combine these activities to meet the 80-hour threshold. There are special rules for seasonal workers who meet an income requirement over a six-month period.</p> <p>States may require compliance for up to three consecutive months prior to application and for one or more months between eligibility renewals. There are mandatory and optional exemptions. For example, mandatory</p> | Amends section 1902 of the Social Security Act, including section 1902(a)(10)(A)(i)(VIII). |

| Section Number | Name of Section                                                       | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Existing Law Changed                                                    |
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|                |                                                                       | <p>exemptions include children under 19, Medicare beneficiaries, pregnant and some postpartum women, caregivers to young children or disabled dependents, medically frail individuals, and those already meeting work requirements under other federal programs (i.e., TANF and SNAP). States also have the option to grant exemptions for short-term hardships, like hospitalization or needing to travel for complex medical care.</p> <p>By <b>December 31, 2026 (or, for states electing to implement community engagement requirements on an earlier date, such earlier date)</b>, states must provide outreach to affected individuals about the new community engagement requirements, including notice explaining what is required for compliance, exempt populations, and the consequences of non-compliance.</p> <p>Once the community engagement requirement is in effect, if a state cannot verify an individual’s compliance, the person will be notified and given 30 days to resolve the issue while remaining enrolled in Medicaid. If the person cannot demonstrate compliance or that they meet an exemption, they will receive a disenrollment notice if the state determines they are not eligible under another eligibility group. The notice must specify the fair hearing rights, as well as how to later demonstrate compliance and reapply for Medicaid.</p> <p>This provision specifies that states cannot use managed care entities or other contractors with conflicts of interest to determine compliance with the community engagement requirement.</p> <p>The section includes significant federal grant funding for states to implement these requirements, in addition to \$200,000,000 for CMS implementation for FY 2026, to remain until expended.</p> <p>CMS is directed to promulgate an interim final rule no later than June 1, 2026 to implement the provisions of this section, with explicit language in this section that section 553 of the Administrative Procedure Act (5 U.S.C. § 553) shall not apply to any actions taken to implement section 71119 of the One Big Beautiful Bill Act.</p> <p><b>This community engagement mandate is effective on January 1, 2027 (or earlier at state option under a waiver or demonstration project under section 1115 of the Social Security Act). Waiver of these requirements is prohibited, but states may request a temporary exemption if they demonstrate good faith efforts and face significant barriers, with all exemptions expiring by the end of 2028.</b></p> |                                                                         |
| 71120          | Modifying cost sharing requirements for certain expansion individuals | <p><b>Beginning October 1, 2028</b>, the 50 states and D.C. must impose cost sharing (deductibles, copayments, or similar charges) greater than \$0, up to \$35 for covered services, on Medicaid expansion adults with income</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Amends section 1902(a)(14), 1916, and 1916A of the Social Security Act. |

| Section Number | Name of Section                    | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Existing Law Changed |
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|                | <b>under the Medicaid program.</b> | <p>above 100% of the federal poverty line. This is a significant change for Medicaid expansion/adult group populations, who have generally had minimal cost sharing.</p> <p>Certain services (e.g., preventive services, primary care, mental health, substance use disorder services, FQHC, CCBHC, and rural health clinic services) are excluded from cost-sharing. Prescription drugs are excepted, but subject to their own limits.</p> <p>The total cost-sharing for a family cannot exceed 5% of family income per month or quarter.</p> <p>Providers may require payment as a condition of service but may waive charges on a case-by-case basis.</p> <p>This provision also eliminates premiums or enrollment fees for the adult group/Medicaid expansion population.</p> <p>Provides \$15,000,000 for fiscal year 2026, to remain available until expended.</p> |                      |

## Chapter 1 – MEDICAID

### SUBCHAPTER E—EXPANDING ACCESS TO CARE

| Section Number | Name of Section                                                                     | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Existing Law Changed                               |
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| <b>71121</b>   | <b>Making certain adjustments to coverage of home and community-based services.</b> | <p>Starting <b>July 1, 2028</b>, states may apply for a standalone 1915(c) waiver to cover home and community-based services (HCBS) that do not require an institutional level of care determination. Individuals covered under the waiver will need to meet needs-based criteria approved by the state and the Secretary.</p> <p>Waiver approvals may initially be 3 years and can be renewed for 5-year periods. The waivers must comply with existing rules for HCBS waivers, but funds under this section may not be used by a state to pay third parties for benefits such as health insurance, skills training or other benefits customary for employees (see 42 C.F.R. § 447.10(i)). The waiver must meet additional requirements, including that the services under the waiver may not increase waiting times for those already eligible for HCBS and per capita spending on these</p> | Amends section 1915(c) of the Social Security Act. |

| Section Number | Name of Section | Summary                                                                                                                                                                                                                             | Existing Law Changed |
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|                |                 | <p>new beneficiaries may not exceed the average cost of institutional care. States must provide data to CMS about services and costs under these standalone waivers.</p> <p>Provides implementation funding for states and CMS.</p> |                      |

**Chapter 2 – MEDICARE**

**SUBCHAPTER A—STRENGTHENING ELIGIBILITY REQUIREMENTS**

| Section Number | Name of Section                                           | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Existing Law Changed                           |
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| <b>71201</b>   | <b>Limiting Medicare coverage of certain individuals.</b> | <p>This provision amends Title XVIII of the Social Security Act, or the Medicare statute, to add new § 1899C (<i>Limiting Medicare Coverage of Certain Individuals</i>), thereby limiting the scope of non-citizens who can receive Medicare benefits.</p> <p>Pursuant to this amendment, only the following individuals are entitled to, or may enroll for, Medicare benefits:</p> <ul style="list-style-type: none"> <li>• U.S. citizens</li> <li>• Aliens with lawful permanent resident status, pursuant to the Immigration and Nationality Act (INA)</li> <li>• Aliens granted the status of Cuban and Haitian entrant, as defined in § 501(e) of the Refugee Education Assistance Act of 1980</li> <li>• Individuals lawfully residing in the U.S., in accordance with a Compact of Free Association (see § 402(b)(2)(G) of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996)</li> <li>• Applicable to individuals who are entitled to, or enrolled in, Medicare benefits as of the date of enactment of this provision: the above eligibility limitations will apply 18 months after the date of enactment of these updates.</li> </ul> <p>Within one year of enactment of these changes, the Social Security Commissioner must review all individuals entitled to, or enrolled in, Medicare benefits, as of the date of enactment, to identify any enrolled individuals</p> | Amends title XVIII of the Social Security Act. |

| Section Number | Name of Section | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Existing Law Changed |
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|                |                 | <p>who do not meet the eligibility requirements. The Commissioner then must notify all individuals identified as such that their Medicare benefits will be terminated 18 months after the date of enactment of this section.</p> <p>Notification must be made “as soon as practicable,” and communicated in a manner understandable to the identified individual(s).</p> <p><b>This section is effective immediately with delayed applicability for affected beneficiaries who are entitled to or enrolled for benefits as of the date of enactment.</b></p> |                      |

**Chapter 2 – MEDICARE**

**SUBCHAPTER B—IMPROVING SERVICES FOR SENIORS**

| Section Number | Name of Section                                                                                                      | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Existing Law Changed                                                                                                                                                                                            |
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| <b>71202</b>   | <b>Temporary Payment Increase Under the Medicare Physician Fee Schedule to Account for Exceptional Circumstances</b> | <p>This amendment provides a 2.5% payment increase to the MPFS conversion factor (CF) for calendar year (CY) 2026, from January 1, 2026 through January 1, 2027.</p> <p>These changes adjust the Medicare Physician Fee Schedule (MPFS) for 2026, noting the statute presently applies to changes in payment for physicians’ services during 2021, 2022, 2023, and 2024.</p> <p><b>The 2.5% increase will be effective in CY 2026.</b></p>                       | Amends Section 1848(t) of the Social Security Act ( <i>Payment for Physicians’ Services: Supporting Physicians and Other Professionals in Adjusting to Medicare Payment Changes During 2021 Through 2024</i> ). |
| <b>71203</b>   | <b>Expanding and Clarifying the Exclusion for Orphan Drugs Under the Drug Price Negotiation Program</b>              | Amends the IRA’s “certain orphan drug” exception for the Medicare Drug Price Negotiation Program to include orphan drugs with more than one orphan indication (presently, only drugs or biologicals with a single orphan designation may be exempt from price negotiation). Under this provision, a drug or biological with multiple orphan indications could be exempted from negotiation, so long as the drug or biological only has those orphan indications. | Amends § 1192(e) of the Social Security Act, which established the Medicare Drug Price Negotiation Program (under the Inflation Reduction Act, or IRA), to revise the exception for orphan drugs.               |

| Section Number | Name of Section | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Existing Law Changed |
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|                |                 | <p>For drugs or biologicals that lose their orphan status by obtaining a non-orphan indication, the HHS Secretary cannot consider the time during which the drug (or biological) had “orphan” status when determining the date when the drug or biological will be eligible for negotiation (presently, drugs have a seven-year delay, and biologicals have an 11-year delay, from their date of approval and marketing, before they are eligible for price negotiation). Under this amendment, the timeline for the delay would begin on the date of the non-orphan approval.</p> <p><b>These amendments would apply to initial price applicability years (IPAYs) beginning on or after January 1, 2028.</b></p> |                      |

**Chapter 3 – HEALTH TAX**

**SUBCHAPTER A – IMPROVING ELIGIBILITY CRITERIA**

| Section Number | Name of Section                                                   | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Existing Law Changed                                                        |
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| <b>71301</b>   | <b>Permitting premium tax credit only for certain individuals</b> | <p>Under current law, advance premium tax credits (APTC) under the ACA are only available to an individual who is “lawfully present” in the United States. The Internal Revenue Code, however, has a circular definition of “lawfully present” (“a citizen or national of the United States or an alien lawfully present in the United States”). Internal Revenue Code § 36B(e)(2).</p> <p>This provision effectively limits the definition of lawful presence to non-US citizens or nationals who are (1) green card holders; (2) Cuban and Haitian entrants; or (3) part of the Compact of Free Association (generally limited to residents of Micronesia, the Marshall Islands, or Palau). The most immediate effect of this change is that asylees and refugees, prior to obtaining their green cards, will not qualify for APTCs, even though they do qualify under present law.</p> <p><b>This provision is effective for taxable years beginning after December 31, 2026.</b></p> | Internal Revenue Code § 36B(e)(2), Section 1411 of the Affordable Care Act. |
| <b>71302</b>   | <b>Disallowing premium tax credit during</b>                      | Advance payment of premium tax credits are generally not available to individuals with income below 100% of the federal poverty level. An exception applies, however, for non-US citizens who do not qualify for Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Internal Revenue Code § 36B(c)(1).                                          |

| Section Number | Name of Section                                               | Summary                                                                                                                                                                                                | Existing Law Changed |
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|                | <b>periods of Medicaid ineligibility due to alien status.</b> | <p>because of their citizenship status; in the case of such individuals, they may qualify for APTCs. This provision repeals this exception.</p> <p>This provision is effective at the end of 2025.</p> |                      |

**Chapter 3 – HEALTH TAX**

**SUBCHAPTER B – PREVENTING WASTE, FRAUD, AND ABUSE**

| Section Number | Name of Section                                                     | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Existing Law Changed                                                                     |
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| <b>71303</b>   | <b>Requiring Verification of Eligibility for Premium Tax Credit</b> | <p>This section changes the rules for how people qualify for the premium tax credit.</p> <p><b>Verification Requirement</b></p> <p><u>Verification requirement:</u> A person cannot count a month as a “coverage month” (a month that qualifies for the premium tax credit) unless the Exchange has verified that person’s eligibility for both enrolling in the plan and for receiving advance payments of the premium tax credit.</p> <p>The Exchange must use information provided or confirmed by the applicant to do this verification.</p> <p><u>Applicable Enrollment Information:</u></p> <ul style="list-style-type: none"> <li>• The applicant’s household income and family size.</li> <li>• Whether the applicant is an eligible alien (if relevant).</li> <li>• The applicant’s current health coverage status or eligibility for other coverage.</li> <li>• The applicant’s place of residence.</li> <li>• Any other information the Secretary of the Treasury (in consultation with the Secretary of Health and Human Services) decides is necessary for proper verification.</li> </ul> | Amends Section 36B(c) of the Internal Revenue Code to add new verification requirements. |

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|       |                                                                                                                | <p><u>Verification of Past Months</u>: If a person’s eligibility is verified after the fact (for a month that has already started), that month can still count as a “coverage month” for the credit, as long as the Exchange confirms the person was eligible for both enrollment and advance payments for that month.</p> <p><u>Exchange Participation; Coordination With Other Procedures for Determining Eligibility</u>: If a person does not meet these verification requirements for a particular month, it does not mean they are automatically ineligible to enroll in a health plan through the Exchange for that month. It just means that month does not count for the premium tax credit.</p> <p><u>Special Enrollment Period Waiver</u>: The Secretary can waive the verification requirements in the case of an individual who enrolls in a qualified health plan for one or more months of the taxable year during a special enrollment period on the basis of change in family size.</p> <p><u>Information and Reliance on Third-Party Sources</u>: The Exchange is allowed to use any data it has access to, as well as reliable information from third-party sources, to help verify the applicant’s information.</p> <p><u>Exchange Must Meet Federal Filing Requirements</u>: If the Exchange does not meet certain federal reporting requirements (specifically, those in section 155.305(f)(4)(iii) of federal regulations, as updated in June 2025), then any month where the Exchange fails to comply does not count as a “coverage month” for the premium tax credit for any individual affected.</p> <p><u>Pre-Enrollment Verification Process</u>: The law now requires that, starting no later than August 1 before each new plan year, the Exchange must have a process in place so that applicants can verify their household income and eligibility for enrollment before they actually sign up for a plan for the next year.</p> <p><b>Applies to taxable years after 12/31/2027.</b></p> |                                                                                                                                        |
| 71304 | <b>Disallowing Premium Tax Credit in Case of Certain Coverage Enrolled in During Special Enrollment Period</b> | <p>This provision changes the rules for who can receive the premium tax credit when enrolling during certain special enrollment periods.</p> <p><u>Restriction on Premium Tax Credit for Certain Special Enrollment Periods</u>: If a person enrolls in a health plan through the Exchange during a special enrollment period that is available solely because their expected household income is at or below a certain percentage of the federal poverty line (or another threshold set by the Secretary of Health and Human Services), that plan will not be considered a “qualified health plan” for the purpose of receiving the premium tax credit. In other words, if the only reason someone is allowed to enroll outside the regular open enrollment period is because of their income level (and not because of a specific life event or change in circumstances), they will not be eligible for the premium tax credit for that plan.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Amends Section 36B(c)(3)(A) of the Internal Revenue Code to add a new clause excluding these plans from being eligible for the credit. |

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|              |                                                                                     | <p><b>No Impact on Other Special Enrollment Events:</b> This restriction does not apply to special enrollment periods triggered by specific events or changes in circumstances, such as losing other health coverage, getting married, having a baby, or similar qualifying life events. For those situations, individuals may still be eligible for the premium tax credit.</p> <p><b>Applies to plan years after 12/31/2025.</b></p>                                                                                                                                                                                                                                                                                                     |                                                                                                                                       |
| <b>71305</b> | <b>Eliminating Limitation on Recapture of Advance Payment of Premium Tax Credit</b> | <p>This provision changes how the IRS handles situations where a taxpayer receives more advance premium tax credit (APTC) than they are ultimately eligible for when they file their tax return.</p> <p>Under current law, if someone receives more advance premium tax credit than they are eligible for based on their final income for the year, there is a limit (a “cap”) on how much households under the poverty level have to pay back to the IRS.</p> <p>This provision removes that cap. After this change, if a low-income taxpayer receives more APTC than they are eligible for, they will have to repay the entire excess amount, regardless of their income level.</p> <p><b>Applies to tax years after 12/31/2025.</b></p> | Amends Section 36B(f)(2) of the Internal Revenue Code by striking subparagraph (B), which previously limited the amount to be repaid. |

**Chapter 3 – HEALTH TAX**

**SUBCHAPTER B – ENHANCING CHOICE FOR PATIENTS**

| Section Number | Name of Section                                                                             | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Existing Law Changed                                                                                   |
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| <b>71306</b>   | <b>Permanent Extension of Safe Harbor for Absence of Deductible for Telehealth Services</b> | <p>This provision updates the rules for high-deductible health plans (HDHPs) in relation to telehealth and other remote care services.</p> <p><u>Permanent Safe Harbor for Absence of Deductible for Telehealth:</u> The law is amended so that a health plan will not lose its status as a high-deductible health plan (HDHP) because it fails to have a deductible for telehealth and other remote care services.</p> <p>The provision also removes language that limited this safe harbor to certain months or plan years.</p> | Amends Section 223(c)(2)(E) of the Internal Revenue Code to make the telehealth safe harbor permanent. |

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|              |                                                                                              | <b>Applies to plan years after 12/31/2024.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                 |
| <b>71307</b> | <b>Allowance of Bronze and Catastrophic Plans in Connection with Health Savings Accounts</b> | <p>This provision changes the rules for what types of health insurance plans can be considered HDHPs, which are required for individuals to contribute to Health Savings Accounts (HSAs).</p> <p><u>Bronze and Catastrophic Plans Now Qualify as HDHPs:</u> The law is amended so that any health insurance plan that is:</p> <ul style="list-style-type: none"> <li>(i) available as individual coverage through an Exchange, and</li> <li>(ii) is either a "bronze" plan or a "catastrophic" plan as defined by the ACA, will now be treated as a high deductible health plan (HDHP) for tax purposes.</li> </ul> <p>This means that people who enroll in these types of plans will be eligible to contribute to an HSA, provided they meet other HSA requirements.</p> <p><u>What Are Bronze and Catastrophic Plans?</u></p> <p>Bronze plans are one of the four main "metal" levels of coverage on the ACA Marketplace, generally offering lower premiums and higher deductibles. "A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan."</p> <p>Catastrophic plans are designed for people under 30 or those with a hardship exemption, offering very high deductibles and lower monthly premiums, and are intended to protect against very high costs in a worst-case scenario.</p> <p><b>Applies to months after 12/31/2025.</b></p> | Amends Section 223(c)(2) of the Internal Revenue Code to include these plans as high-deductible health plans.                                                                                                   |
| <b>71308</b> | <b>Treatment of Direct Primary Care Service Arrangements</b>                                 | <p>This provision clarifies how direct primary care service arrangements interact with HSAs and expands what can be paid for with HSA funds.</p> <p><u>Direct Primary Care Service Arrangements Not Treated as Disqualifying Health Plans:</u> The law is amended so that a "direct primary care service arrangement" will not be considered a separate health plan for the purpose of HSA eligibility. This means that if an individual has a direct primary care arrangement, it will not prevent the person from being eligible to contribute to an HSA, as long as all other requirements are met.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Amends Section 223(c)(1) and 223(d)(2)(C) of the Internal Revenue Code to clarify treatment of direct primary care arrangements and allow HSA funds to pay for them. Adds inflation adjustment for the fee cap. |

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|  |  | <p><b><u>What Is a Direct Primary Care Service Arrangement?</u></b> It is an arrangement where an individual pays a fixed, regular fee to a primary care provider in exchange for a defined set of primary care services. The care must be provided by a "primary care practitioner" (as defined in the Social Security Act), and the only payment for the care is the fixed periodic fee.</p> <p>The arrangement cannot be considered a direct primary care service arrangement for HSA purposes if the total monthly fees for all such arrangements for an individual exceed \$150 (or \$300 if the arrangement covers more than one person, such as a family).</p> <p><b><u>What Is Excluded from "Primary Care Services"?</u></b></p> <p>The following are specifically not considered primary care services under this provision:</p> <ul style="list-style-type: none"><li>• Procedures that require general anesthesia</li><li>• Prescription drugs (except for vaccines)</li><li>• Laboratory services that are not typically done in a primary care office setting</li></ul> <p>The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, will issue further guidance on these definitions.</p> <p>The law is also amended so that the fees paid for a direct primary care service arrangement can be treated as qualified medical expenses.</p> <p><b><u>Inflation Adjustment:</u></b> The \$150 monthly cap (or \$300 for arrangements covering more than one person) will be adjusted for inflation for tax years beginning after 2026.</p> <p><b>Applies to months after 12/31/2025.</b></p> |  |
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Chapter 4 – PROTECTING RURAL HOSPITALS AND PROVIDERS

| Section Number | Name of Section                     | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Existing Law Changed                            |
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| 71401          | Rural Health Transformation Program | <p><b>Overview:</b></p> <p>This provision amends Section 2105 of the Social Security Act (42 U.S.C. 1397ee) to establish the “Rural Health Transformation Program” to support rural healthcare.</p> <p>Allocates \$50 billion total (\$10 billion over five years, <b>for FYs 2026-2030</b>) across all states to CMS “Administrator” to fund the program.</p> <p>CMS must distribute these funds to the fifty States through annual allotments: 50% of each year’s appropriation is divided equally among all participating States with approved applications, while the remaining 50% is allocated according to population and need—using a formula that accounts for the percentage of each State’s population living in rural census tracts, the share of national rural health facilities located in the State relative to the number of rural health facilities nationwide, and the financial condition of its hospitals.</p> <p>A “rural health facility” is defined as a hospital (1) located in a rural area; (2) treated as being located in a rural area; or (3) located in a rural census tract of a metropolitan statistical area.</p> <p>States may retain allotted funds for the fiscal year of award and the following fiscal year; unspent amounts are subject to periodic redistribution, and any funds still unexpended or unobligated by October 1, 2032, revert to the Treasury.</p> <p>CMS may also withhold, reduce, or recoup payments if a State misuses the funds.</p> <p>The statute exempts the program from several CHIP administrative requirements, bars mandatory State matching contributions, and prohibits judicial or administrative review of CMS’s allocation, redistribution, or recoupment decisions. It also amends related CHIP provisions to integrate the new program while clarifying that funds may be used solely for the rural transformation purposes described above.</p> | Amends Section 2105 of the Social Security Act. |

| Section Number | Name of Section | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Existing Law Changed |
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|                |                 | <p><u>Application Requirements:</u></p> <p>To qualify, a State must submit a one-time application (<b>due no later than December 31, 2025</b>) containing a detailed rural health transformation plan that addresses at least eight specified objectives:</p> <ul style="list-style-type: none"> <li>• Improve access to hospitals, other healthcare providers, and health care items and services furnished to rural residents of the state;</li> <li>• Improve healthcare outcomes of rural residents of the state;</li> <li>• Prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management;</li> <li>• Initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other health care providers in order to promote measurable quality improvement, increase financial stability, maximize economies of scale and share best practices in care delivery;</li> <li>• Enhance economic opportunity for, and the supply of, health care clinicians through enhanced recruitment and training;</li> <li>• Prioritize data and technology-driven solutions that help hospitals and other rural health care providers furnish high-quality health care services as close to a patient's home as is possible;</li> <li>• Outline strategies to manage long-term financial solvency and operating models of rural hospitals in the state; and</li> <li>• Identify specific causes driving the accelerating rate of stand-alone rural hospitals becoming at risk of closure, conversion or service reduction. The application must also certify that none of the federal funds will be used to finance the State's non-federal share of Medicaid or CHIP expenditures.</li> </ul> <p>States must certify that none of the amounts provided by this provision will be used by a state for intergovernmental transfers, certified public expenditure, or other expenditure to finance the non-federal share of expenditures required under any provision of law (including under the state plan established under the Medicaid or CHIP programs or under a waiver under those programs).</p> <p><u>Deadline:</u> CMS Administrator must approve or deny all applications by December 31, 2025. Once approved, a State remains eligible for annual allotments throughout the five-year program period (FYs 2026-2030) unless funds are recouped for non-compliance/misuse.</p> <p><u>Only the 50 states</u> are eligible for allotment, and the Administrator determines the amount of the allotment for each fiscal year (2026-2030).</p> |                      |

| Section Number | Name of Section | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Existing Law Changed |
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|                |                 | <p><u>Terms + Conditions:</u></p> <p>Each State must submit a plan to use its allotment to carry out 3 or more of 10 enumerated activities, and annual reports on the use of allotments.</p> <p>States can use up to 10% (max) of the amount allotted for a fiscal year on administrative expenses.</p> <p>A state approved for an allotment is not required to provide any matching funds as a condition for receiving payment.</p> <p>States may spend their allotments on a broad array of rural health initiatives, provided they undertake at least 3 of the following health-related activities:</p> <ul style="list-style-type: none"> <li>• Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.</li> <li>• Providing payments to health care providers, as defined by the CMS Administrator, for the provision of health care items or services (as specified by the CMS Administrator).</li> <li>• Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.</li> <li>• Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.</li> <li>• Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of five years.</li> <li>• Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.</li> <li>• Assisting rural communities to right-size their healthcare delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.</li> <li>• Supporting access to opioid use disorder treatment services (as defined in section 1861(jjj)(1) of the SSA), other substance use disorder treatment services, and mental health services.</li> </ul> |                      |

| Section Number | Name of Section | Summary                                                                                                                                                                                                                                                                                                                                                      | Existing Law Changed |
|----------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
|                |                 | <ul style="list-style-type: none"><li>• Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.</li><li>• Additional uses designed to promote sustainable access to high-quality rural health care services, as determined by the CMS Administrator.</li></ul> |                      |