Modern Medicaid ALLIANCE

Special Report
Prepared by Thorn Run Partners

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KEY HEALTH CARE PROVISIONS IN THE SENATE FINANCE RECONCILIATION BILL

EXECUTIVE SUMMARY

On June 16, Senate Finance Committee Chair Mike Crapo (R-ID) unveiled his committee's portion of the One Big Beautiful Bill Act (bill text; section-by-section). The Finance title includes sweeping tax changes and a broad set of health care provisions, many of which build on or reshape policies included in the House-passed bill (TRP summary).

While the Senate Finance bill maintains the House's focus on Medicaid reform, it introduces several new policies and goes further on others to generate additional savings. These include a phased reduction of the provider tax threshold to 3.5 percent for expansion states and a 10 percent phase down of state directed payments each year until they align with Medicare rates. The bill also preserves, with some modifications, the House's provisions to implement community engagement requirements, shorten Medicaid eligibility look-back periods, and impose cost sharing for Medicaid expansion enrollees above 100 percent of the federal poverty level.

At the same time, the Senate Finance bill omits several high-profile health care items from the House version, including reforms to pharmacy benefit manager (PBM) practices in Medicare, Medicare physician payment updates, the exemption for orphan drugs from Medicare negotiation, and the delay of Medicaid disproportionate share hospital (DSH) reductions. It also excludes a range of House-passed provisions related to the Affordable Care Act (ACA) exchanges, likely in anticipation of a forthcoming rulemaking from the Centers for Medicare & Medicaid Services (CMS) addressing many of the same issues. A full list of the policies omitted in the Senate bill can be found in Appendix I.

As Republicans push to finalize the reconciliation package by July 4, the Finance title's health care provisions have emerged as a major source of internal friction. The proposed Medicaid reforms — among the most consequential and controversial in the bill — have drawn criticism from multiple corners of the Republican conference. Sen. Josh Hawley (R-MO) reiterated his longstanding concerns about Medicaid cuts, while Sen. Susan Collins (R-ME) raised specific objections to changes in provider tax policy. Meanwhile, conservatives like Sen. Rick Scott (R-FL) remain unsatisfied, arguing that the bill still does not go far enough in reducing Medicaid spending.

TRP's special report provides a detailed analysis of the bill's health care provisions and how they differ from the House-passed version.

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REDUCING FRAUD AND IMPROVING ENROLLMENT PROCESSES

Prohibition on Medicaid and CHIP Eligibility and Enrollment Rule — Where the House text would establish a delay, sections 71101 and 71102 of the Senate Finance bill would prohibit implementation of CMS' two-part final rule (September 2023; March 2024) updating eligibility determination, enrollment, and renewal processes for Medicaid and CHIP. Policies finalized under the rules sought to streamline the Medicaid application process and simplify enrollment for eligible individuals who may otherwise opt out of the program as a result of the burdensome application process.

Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs — This provision is identical to section 44103 of House-passed H.R. 1.

Under this provision, all 50 states and the District of Columbia would be required to take steps to prevent individuals from being simultaneously enrolled in Medicaid and CHIP programs across multiple States. By January 1, 2027, section 71103 would require States to establish a process for regularly obtaining enrollees' address information using reliable data sources such as USPS records and managed care entities. By October 1, 2029, States must also begin submitting enrollee data — such as Social Security numbers and other information deemed necessary by the Secretary — on a monthly basis to a new federal system designed to detect duplicate enrollment. States would be required to act on matches identified by the system and disenroll individuals who no longer reside in the State, unless an exception applies.

The bill also directs the Secretary to establish a federal system to receive enrollee data from States and notify them of potential matches indicating duplicate enrollment. The bill provides $30 million — $10 million for fiscal year (FY) 2026 for the purposes of establishing the system and standards and $20 million for FY 2029 for the purposes of maintaining such system — in implementation funding and includes conforming requirements for Medicaid managed care plans and CHIP.

Unenrollment of Deceased Individuals — This provision is identical to section 441034 of House-passed H.R. 1.

Section 71104 of the bill would require States and the District of Columbia to, beginning January 1, 2028, review the Death Master File on at least a quarterly basis to determine if any individuals enrolled in the State Medicaid program are deceased. In the event that a State determines that an individual enrolled for Medicaid is deceased, the State will be required to disenroll the individual from Medicaid and discontinue any Medicaid payments made on behalf of the deceased individual after the death of the individual. Under this provision, a State must immediately reenroll an individual, retroactive to the date of disenrollment, who the State determines was misidentified as deceased. Notably, the requirements under this section do not apply to the U.S. territories.

Medicaid Provider Screening Requirements — Similar to section 44106 of the House-passed H.R. 1, section 7105 of this bill would require States to, at the time of enrollment or reenrollment, as well as on a quarterly basis, check the Death Master File to determine whether a Medicaid provider is deceased.

Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid — As part of the Medicaid Eligibility Quality Control Program, the Secretary may not make payments to a State with respect to the portion of any erroneous payments made on behalf of ineligible persons or any overpayments that exceeds a three percent error rate. As a result, States exceeding the three percent error rate payment threshold may face a disallowance of federal funding unless the State can demonstrate a "good faith" effort to meet the threshold.

Reflective of the changes made in section 44107 of the House bill, section 71106 of the Senate Finance bill places a limit on the amount of the reduction in federal financial participation (FFP) the Secretary may waive in instances in which a State demonstrates a good faith effort to meet the three percent error rate threshold. Under this provision, the Secretary may not waive, for States that do not meet the threshold, a reduction in FFP greater than an amount equal to the reduction originally required minus the sum of any erroneous payments made with respect to ineligible individuals and families and payments for items and services furnished to an eligible individual who is not eligible for the items and services that were provided. The bill expands upon the provisions of the House bill and defines erroneous excess payments to include payments where insufficient information is available to confirm eligibility. Additionally, the Senate broadens the scope of this provision to apply the three percent error rate threshold to any audit conducted by the Secretary. The changes made under this provision would come into effect beginning in fiscal year 2030.

Eligibility Redeterminations Frequency — Under current law, States are generally not permitted to redetermine Medicaid eligibility for the expansion population — adults aged 19 to 64 who have incomes less than 138 percent of the Federal Poverty Level — more than once every 12 months. Similar to section 44108 of the House passed H.R. 1, section 77107 of the legislation would amend these requirements and, beginning on December 31,2026, States would be required to conduct eligibility redeterminations for the expansion population every six months.

Notably, the Senate Finance Committee language would prohibit states from conducting eligibility redeterminations every six months for individuals who are an Indian or an Urban Indian, a California

Indians, or who has otherwise been determined eligible as an Indian for the Indian Health Service. This provision would also clarify that these requirements would only apply to the 50 states and the District of Columbia. Finally, this provision would require CMS to issue guidance related to the implementation of this policy within 180 days of enactment of this bill.

Home Equity Limit — This provision is identical to section 44109 of House-passed H.R. 1.

Generally, under current law, an individual is not eligible for Medicaid long-term services and supports if their financial assets reach a certain threshold, often determined by the State. However, the value of an individual's primary residence is not counted as an asset unless the individual's home equity interest exceeds $500,000 adjusted for inflation. For 2025, the federal floor for an individual's home equity interest is $730,000. Section 77108 of the Senate Finance Committee bill would amend these requirements and would set the home equity limit cap at $750,000 for an individual's home located on a lot zoned for agricultural use. This provision would otherwise cap a State's ability to apply a home equity disregard for primary residences that exceed $1,000,000 in value. Notably, States would also be prohibited from applying asset disregards to waive home equity limits. The amendments made under this section will apply beginning January 1, 2028.

Prohibiting FFP Under Medicaid for Certain Individuals — This section is identical to section 44110 of the House-passed bill.

Under current law, States are required to provide Medicaid coverage to applicants during a "reasonable opportunity period" of 90 days for individuals who otherwise meet Medicaid eligibility requirements but whose citizenship or immigration status cannot be immediately verified. Section 71109 of the bill would remove this requirement and would instead permit States the option to provide Medicaid or CHIP coverage during the reasonable opportunity period for when an applicant must prove citizenship or immigration status. If a State selects such an option, FFP is not available unless the applicant's citizenship or the satisfactory immigration status of the individual is verified by the end of the reasonable opportunity period. These amendments will take effect on October 1, 2026.

Medicaid Eligibility for Qualified Aliens — Under current law, certain non-citizens are permitted Medicaid coverage after the first five years of U.S. residency. Section 71110 of the bill would narrow the scope of Medicaid eligibility and modify the definition of "qualified alien," beginning October 1, 2026, to include: (1) aliens who are lawfully admitted for permanent residence under the Immigration and Nationality Act; (2) certain aliens who are citizens or nationals of Cuba, or (3) an individual who is lawfully residing under the Compacts of Free Association (COFA).

Aliens who are citizens or nationals of Cuba may qualify for Medicaid eligibility if they meet the following requirements: (1) lawfully admitted for permanent residence under the Immigration and Nationality Act ; (2) meets all eligibility requirements for an immigrant visa but for whom such a visa is not immediately available; (3) is not otherwise inadmissible under section 212(a) of the Immigration and Nationality Act; and (4) is physically present in the U.S. pursuant to a grant of parole

in furtherance of the commitment of the U.S. to the minimum level of annual legal migration of Cuban nationals to the U.S.

Expansion FMAP for Certain Individuals — Section 71111 of the Senate bill is nearly identical to the House version in that it would reduce the FMAP for the expansion population for states providing payments for health care for undocumented immigrants. Specifically, beginning October 1, 2027, for States that provide either (1) *any* form of financial assistance from a State general fund during a calendar quarter either under Medicaid or another program established by the State for the purchasing of health insurance coverage or (2) any form of comprehensive health benefits coverage during a calendar quarter, regardless of the source of funding, to an alien (and who is not a child or pregnant woman) who is not considered a qualified alien under the definition of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or otherwise lawfully residing in the United States, the FMAP for the expansion population in the State would be reduced from 90 percent to 80 percent.

Expansion FMAP for Emergency Medicaid — Current law permits states to provide Medicaid coverage to non-permanent resident aliens and other non-citizens for emergency medical services, commonly referred to as "emergency Medicaid." Such individuals may qualify for emergency Medicaid so long as they would otherwise be eligible for Medicaid if not for their immigration status. Section 71112 of the bill would narrow emergency Medicaid by limiting the FMAP of emergency Medicaid services to no more than a State's traditional FMAP, preventing States from claiming the 90 percent FMAP for emergency services provided to non-permanent resident aliens who would qualify for Medicaid under expansion.

PREVENTING WASTEFUL SPENDING

Prohibition on Nursing Home Staffing Standard Rule — Reflective of the House-passed bill delaying implementation, section 71113 of the Senate Finance bill would prohibit the Department of Health and Human Services (HHS) Secretary from implementing, administering, or enforcing CMS' final rule instituting minimum staffing standards for long-term care (LTC) facilities as well as reporting requirements for states on Medicaid payments for the compensation of direct care workers and support staff at certain institutions.

Retroactive Coverage — Mirroring the House-passed provision, section 71114 of the Senate bill would shorten the Medicaid eligibility lookback period, though it offers slightly more flexibility for non-expansion populations. Under current law, individuals enrolled in Medicaid may receive retroactive coverage of services that would have otherwise been covered under the program for up to three months prior to the individual's application date, provided that the individual would have been eligible for Medicaid during that time. The House bill would limit this retroactive coverage of services to one month for all populations, beginning with applications filed on December 31, 2026. Notably, section 71114 the Senate bill outlines the same one-month limit for the expansion population, while allowing up to two months of retroactive coverage for all other groups. Both bills

would limit retroactive CHIP coverage to one month prior to application. This provision would be effective on or after the first day of the first quarter that begins after December 31, 2026.

Accurate Payments to Pharmacies —Nearly identical to section 44123 of the House bill, section 71115 of the Senate Finance bill includes a delayed effective date and omits the House provision exempting the pharmacy survey from the Paperwork Reduction Act.

As was advanced in the House bill, this bill would require the Secretary to conduct a nationwide survey of drug prices at retail community pharmacies and applicable non-retail pharmacies to determine the national average drug acquisition cost (NADAC) benchmarks of covered outpatient drugs. The Secretary may contract with a vendor to administer the survey, and states must ensure that all pharmacies receiving Medicaid payments — whether through fee-for-service or managed care — respond to the survey.

The information collected would be made publicly available and include: (1) the monthly survey response rate, including pharmacies found in noncompliance; (2) the sampling methodology and number of pharmacies sampled monthly; and (3) information on prices concessions to the pharmacy. Civil monetary penalties of up to $100,000 per violation may be imposed on pharmacies that fail to comply. States would be prohibited from using pricing data from applicable non-retail pharmacies to determine payment methodologies for retail pharmacies.

The Senate bill mirrors the House's directive for the Secretary to publish guidance by January 1, 2027, identifying pharmacies that meet the definition of an applicable non-retail pharmacy. However, it delays the effective date for the retail pharmacy survey requirement from the first quarter beginning *six* months after enactment to the first quarter beginning *nine* months after enactment. Senators maintained the effective date for non-retail pharmacies as 18 months after the date of enactment. The bill appropriates $8 million annually for FYs 2026 through 2033 for implementation and $5 million in FY 2026 to the HHS Office of Inspector General (OIG) for oversight.

Spread Pricing — This provision is identical to section 44124 of the House-passed bill.

Section 71116 of the Senate Finance bill explicitly prohibits PBMs and managed care entities from engaging in "spread pricing," or charging more for a drug than the entity paid to acquire the drug, under Medicaid. Specifically, all state Medicaid contracts with PBMs and managed care entities would be required to adopt a transparent, pass through pricing model that limits payments for covered outpatient drugs to the ingredient cost and a professional dispensing fee. These payments would be required to be "passed through" in full to the pharmacy or provider dispensing the drug, except in cases of waste, fraud, or abuse. Administrative fees paid to PBMs and managed care entities would reflect a fair market value as determined by the Secretary.

Additionally, PBMs and managed care entities would be required to provide States, and the Secretary upon request, with cost and payment data related to covered drugs that includes ingredient costs, professional dispensing fees, and post-sale direct and indirect renumeration (DIR) fees. The Senate

bill clarifies that "state" is defined as one of the 50 states, the District of Columbia, or any territory with a rebate agreement in effect. As was advanced by the House, the Secretary would be required to publish an annual report detailing the reported pricing information and the requirements under this provision, which would take effect within 18 months after the date of enactment.

Gender Transition Procedures — This provision is identical to section 44125 of the House-passed bill.

Under this provision, FFP would be prohibited for gender transition procedures, as defined by the legislation, provided to minors or adults. Exceptions would be provided for certain services furnished with the consent of a parent of a legal guardian, including the use of puberty suppression drugs for precocious puberty and certain medically necessary treatments.

Entities Providing Abortion Services — This provision is nearly identical to section 44126 of the House-passed bill, with modest changes to the Medicaid payment threshold and implementation timing.

Like in H.R. 1, section 71118 of the bill would prohibit Medicaid funds from being paid to providers that are considered 501(c)(3) organizations and essential community providers, as described under section 156.235 of title 45 CFR, that provide abortions outside of Hyde Amendment exceptions. However, while the House provision was applicable to organizations that received Medicaid payments exceeding $1,000,000 in 2024, the Senate bill modifies this threshold to organizations that received Medicaid payments exceeding $800,000 in 2023. The Senate bill also delays the determination of a "prohibited entity" from the date of enactment to the first day of the following calendar quarter, giving entities additional time to adjust operations before the funding restriction takes effect.

STOPPING ABUSIVE FINANCING PRACTICES

Sunsetting Increased FMAP for New Expansion States — This provision is identical to section 44131 of the House-passed bill.

Under the American Rescue Plan Act, enacted on March 11, 2021, states were provided an additional five percentage point increase, in addition to the 90 percent FMAP, to their regular federal matching rate for eight quarters after Medicaid expansion takes effect in the state. Section 71119 of the Senate Finance bill would sunset this enhanced match starting on January 1, 2026.

Moratorium on New or Increased Provider Taxes — While similar to the provider tax provision in section 44132 of the House-passed bill, the Senate bill proposes a significantly deeper cut to states' ability to use provider taxes to finance Medicaid.

As in the House bill, section 71120 of the Senate Finance bill would prohibit states from receiving federal Medicaid matching funds for any new or increased provider taxes enacted after the bill's passage, unless already authorized. Notably, the moratorium would apply to increases in the amount

of tax on a per unit basis or the rate of tax imposed with respect to a class of health care items or services or increases in the base of the current provider tax. This effectively places a moratorium on using newly enacted or expanded provider taxes to finance the non-federal share of the Medicaid program.

Additionally, the Senate bill would modify the "hold harmless" standard for health care-related provider taxes under Medicaid, which limits how much states can tax providers without triggering federal penalties. Currently capped at 6 percent, the Senate bill phases down the threshold for expansion states beginning October 1, 2026, to 3.5 percent by FY 2031, while preserving the 6 percent cap for non-expansion states. Notably, the Senate bill would not impact the hold harmless threshold for provider taxes States impose for nursing facility or intermediate care facility services so long as the tax is in effect as of October 1, 2026, within the hold harmless threshold as of May 1, 2025, and the provider tax is not modified or otherwise changed unless to come into compliance with these provisions. The Senate bill clarifies that these provisions only apply to the 50 States and the District of Columbia, therefore excluding the application of this section to the U.S. territories.

The bill provides $6 million to HHS for implementation.

Payment Limit for Certain State Directed Payments —Similar to section 44133 of the House-passed bill, section 71121 of the Senate version includes modest but meaningful changes for the treatment of when no published Medicare rate exists. The bill directs HHS to revise Medicaid managed care regulations so that state-directed payments to providers in Medicaid expansion states cannot exceed 100 percent of the published Medicare payment rate for a given service, while non-expansion states would be permitted to go up to 110 percent. Rather than directing HHS to use an "equivalent Medicare payment rate" when no published rate exists — as the House bill does — the Senate version instead calls for an equivalent payment under the Medicaid State Plan.

The Senate bill also takes a stricter approach to grandfathered payments. While the House bill would allow grandfathered payments to continue at existing levels, the Senate version phases them down by 10 percentage points annually starting in 2027 until they meet the applicable cap. It also broadens eligibility for grandfathering to include cases where states made a good faith effort to secure prior approval. The section appropriates $7 million per year from FY 2026 to FY 2033 to support implementation.

Waiver of Uniform Medicaid Provider Tax Requirement — Nearly identical to section 44134 of the House-passed bill, section 71122 of the Senate version includes a notable addition that would allow states to revise existing provider taxes to comply with the new standards without being penalized.

Under the bill, states' ability to obtain waivers from the uniform tax requirement for Medicaid provider taxes would be limited. Specifically, the bill would prohibit waivers for tax structures that impose lower rates on providers with less Medicaid volume, or higher rates to those with more. The section includes definitions for "Medicaid taxable unit," "non-Medicaid taxable unit," and "tax rate group" to help identify impermissible structures and makes clear that attempts to achieve the same

effect through indirect language is also prohibited, effectively closing any loopholes to the restriction. These changes would take effect immediately upon the bill's enactment, with a transition period of up to three fiscal years at the Secretary's discretion. The Senate bill adds that states will not be considered in violation if they are changing their taxes to comply with the new requirements and clarifies that these provisions only apply to the 50 States and the District of Columbia, therefore excluding the application of this section to the U.S. territories.

Budget Neutrality for Section 1115 Demonstration Projects — As outlined in section 44135 of the House bill, section 71123 of the Senate bill would mandate that all new, renewed, or amended Medicaid demonstration projects be budget neutral. However, while the House bill would require certification by the Secretary of this neutrality, the Senate bill shifts this responsibility to CMS' Chief Actuary. The Senate bill also clarifies that expenditures for services or populations that could otherwise be covered under the State plan — including those provided at different sites of service — will be treated as baseline expenditures, helping states demonstrate that their demonstrations do not increase overall Medicaid spending.

If the Secretary concludes that a project would result in federal savings, the Secretary must establish a methodology for how those savings will be accounted for in future approval periods. Additionally, the Senate bill provides $5 million in each of FYs 2026 and 2027 for implementation — funding not included in the House version.

PERSONAL ACCOUNTABILITY: COMMUNITY ENGAGEMENT REQUIREMENTS

Section 77124 of Subpart D of the Senate Finance Committee budget reconciliation legislation would create community engagement requirements for certain individuals as a condition of enrolling in or maintaining Medicaid eligibility. If enacted, beginning December 31, 2026, States must require that certain individuals have demonstrated compliance with community engagement activities as a condition of receiving Medicaid coverage.

Notably, this provision would require that, prior to enrollment in the Medicaid program, individuals who have filed an application for Medicaid coverage demonstrate compliance with community engagement requirements for one or more, **but not more than three**, (as determined by the State) consecutive months immediately preceding the month in which the individual applies for Medicaid coverage. For individuals already enrolled in the Medicaid program, the individual must demonstrate compliance with community engagement requirements for at least one or more months (as determined by the State) during the period between the individual's most recent eligibility determination and the individual's next regularly scheduled redetermination. Similar to the House passed bill, the Senate Finance legislation prohibits these requirements from being waived under section 1115 authority.

Individuals subject to community engagement requirements — States may only impose community engagement requirements on an individual who is: (1) aged 19-64, who is not pregnant, not eligible for or enrolled in Medicare, and not eligible for Medicaid under other mandatory groups; or (2) who

is otherwise eligible to enroll in Medicaid under a waiver of the State plan that provides coverage equivalent to minimum essential coverage and who is aged 19-64, not pregnant, not eligible for or enrolled in Medicare, and is not otherwise eligible to enroll under the state plan or waiver.

This provision also excludes certain specified individuals from community engagement requirements, including an individual who is:

- Former foster youth up to age 26;
- Indian or an Urban Indian;
- California Indians;
- Otherwise determined eligible as an Indian for the Indian Health Service;
- Parent, guardian, or caretaker relative of a disabled individual or dependent child **under the age of 14**;
- Medically frail or otherwise has special medical needs;
- Compliant with any requirements under the SNAP program or is a member of a household that receives SNAP and is not exempt from work requirements;
- Participating in a drug addiction or alcoholic treatment and rehabilitation program;
- Inmates of a public institution; or
- **Individuals who are pregnant or entitled to postpartum medical assistance.**

For the purposes of the community engagement requirements, individuals are deemed to be medically frail if they: (1) are blind or disabled; (2) have a substance use disorder; (3) have a disabling mental disorder; (4) have a physical, intellectual, or developmental disorder that significantly impairs the ability to perform one or more activities of daily living; (5) have a serious and complex medical condition; or (6) have any other medical condition identified by the State (subject to the approval of the Secretary).

Activities that qualify as community engagement — Under this provision, an individual is deemed to be compliant with community engagement requirements for one month, as determined in accordance to criteria established by the Secretary through rulemaking, if the individual: (1) works at least 80 hours; (2) completes at least 80 hours of community service; (3) participates in a work program for at least 80 hours; (4) is enrolled in an educational program for at least 40 hours; engages in any combination of these activities for at least 80 hours; or (5) the individual has a monthly income that is not less than $580 (the applicable minimum wage requirement multiplied by 80 hours).

Notably, the bill provides both a mandatory and optional exemption from community engagement Requirements, though these exemptions differ from the House passed H.R. 1.

- **Mandatory exception** — Specifically, the State must deem an individual as having demonstrated compliance with community engagement requirements, and may elect to not require an individual to verify such information, for a month if, for all or part of the month, the individual was a member of an excluded group (as described above) or if the individual was under the age of 19, ,was entitled to, or enrolled in Medicare, or is an individual who is described in sections 1902(a)(10)(A)(i)(I) through (VII). States must also provide and deem

a beneficiary as compliant with community engagement requirements for a month if the individual was an inmate of a public institution at any point during the three-month period ending on the first day of such month.

- **Optional short-term hardship exception** — Under procedures established by the State, a State may provide, through its state plan or a waiver of the state plan, an exception to community engagement requirements if an individual experiences a short-term hardship event during the month. For the purposes of this section, a short-term hardship event has taken place if:
    - the individual received inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or other services of similar acuity (including outpatient care relating to other services) deemed appropriate by the Secretary of HHS;
    - the individual resides in a county in which there exists an emergency or disaster declared by the President or the unemployment rate of the State is at or above the lesser of eight percent or 1.5 times the national unemployment rate; or
    - the individual must travel outside of their community for an extended period of time to receive medical services to treat a serious or complex medical condition that are not available within the individual's community. **Notably, this optional exception to the community engagement requirements was not included in the House passed H.R. 1.** Per the Senate Finance legislative text, the individual must submit a request to the state in order to utilize this optional exception.

Verifications of compliance with community engagement requirements — The legislation requires States to verify, in a manner determined by the Secretary, that an individual receiving Medicaid under the state plan or a waiver of such plan has met the community engagement requirements during the individual's regularly scheduled redetermination of eligibility. Notably, States have the option to provide for more regular verifications of compliance with community engagement requirements. Furthermore, the legislation would require States to establish a process and use reliable information available to the State, such as payroll data, without requiring the applicable individual to submit additional information to verify compliance with community engagement requirements.

In the instance a State is unable to verify that an individual has met the community engagement requirements, the State would be required to provide the individual with a notice of noncompliance and provide the individual with 30 calendar days, beginning on the date the notice of noncompliance is received, to make a satisfactory showing of compliance with the requirements or make a satisfactory showing to the State that such community engagement requirements do on apply to the individual. If the individual is currently enrolled in the Medicaid program, the State must continue to provide Medicaid coverage during the 30-calendar day period. If the individual does not provide a satisfactory showing of compliance to the State and the individual is not exempt from the requirements, the State must deny the application for Medicaid or disenroll the individual from the plan at the end of the month following the month in which the 30-calendar-day period ends so long as the State determines whether there is any other basis for Medicaid eligibility or another insurance

program and the individual is provided written notice and granted an opportunity for a fair hearing before being disenrolled from Medicaid. Notably, individuals who are disenrolled from Medicaid as a result of noncompliance with community engagement requirements may not be eligible for premium tax credit subsidies under the ACA.

Outreach — Under this provision, States will be required to notify individuals enrolled under the Medicaid state plan of the community engagement requirements, beginning December 31, 2026. Notably, this notice must include information on how to comply with the requirements, an explanation of the exceptions to the requirements, the consequences of noncompliance, and how to report to the State any change in the individual's status that could result in the applicability of a short-term hardship or that the individual qualifies for an exclusion to the community engagement activities. The outreach must be delivered by regular mail and in one or more additional forms, including telephone, text message, or internet website.

Special Implementation Rule — The Senate Finance legislation includes a provision, which was not in the House bill, that would provide the Secretary with the authority to exempt a State from compliance with community engagement requirements if: (1) the State submits a request to the Secretary for the exemption, and (2) the Secretary determines that the State is demonstrating a good faith effort to comply with the requirements. In determining whether a State is demonstrating a good faith effort, the Secretary must consider any actions taken by the State toward compliance, any significant barriers to or challenges in meeting the requirements (such as funding, design, development, procurement, or installation of necessary system resources), the State's plan and timeline for achieving full compliance with such requirements, and any other criteria determined appropriate by the Secretary.

States that receive an exemption described above must provide quarterly progress reports on the State's status in achieving any milestones toward compliance as well as information on specific risks or new barriers to full compliance.

Notably, if a State receives an exemption from implementing community engagement requirements, such exemption will expire by December 31, 2028. However, the Secretary may terminate the exemption early if the Secretary has determined that the State has failed to comply with reporting requirements or if the State has failed to make continued good faith efforts towards compliance.

Conflicts of Interest — The Senate Finance legislation includes a provision, which was not in the House bill, that would prohibit the State from using a Medicaid managed care entity or other specified entity, or other contractor to determine beneficiary compliance with community engagement requirements unless the contractor has no direct or indirect financial relationship with any Medicaid managed care entity that is responsible for providing or arranging for coverage of Medicaid.

Development of Government Efficiency Grants — Under this provision, States will receive funding for the purpose of carrying out activities related to implementing community engagement requirements. Specifically, the bill would appropriate $100 million for FY 2026 for grant awards to States, which

would be allocated based on a statutory formula described in the bill. The legislation would also allocate an additional $100 million for grant awards to States, which would be allocated equally among States.

Interim Final Rule — While the House passed language would require CMS to issue guidance for the implementation of this provision, the Senate Finance text would require CMS to issue an interim final rule by June 1, 2026, for the purposes of implementing the community engagement requirements.

Implementation Funding — This provision would appropriate $50 million to HHS for FY 2026 for the purposes of carrying out the implementation of community engagement requirements.

PERSONAL ACCOUNTABILITY: COST SHARING REQUIREMENTS

Nearly identical to section 44142 of the House-passed bill, the Senate Finance bill includes a clarification that explicitly extends the cost-sharing limitations to certain non-emergency services furnished in hospital emergency departments, aligning them with existing Medicaid cost-sharing rules.

Under current law, states may charge premiums and establish nominal out-of-pocket cost sharing requirements for certain Medicaid enrollees. While states can impose higher cost-sharing for targeted groups, certain populations — including children and pregnant women — are exempt from most out of pocket costs and some copayment cannot be charged for certain services. Beginning October 1, 2028, the bill would require states to impose cost-sharing for covered services in Medicaid expansion enrollees with family incomes exceeding 100 percent of the federal poverty line. Notably, this provision would allow states to permit Medicaid providers to require, as a condition of the provision of Medicaid services, the payment of any cost sharing obligations by the Medicaid beneficiary.

The provision includes several limitations on the cost-sharing obligations required under this bill. Specifically, states may not impose any cost-sharing requirements with respect to: (1) any pregnancy-related services, including tobacco cessation; (2) services furnished to an individual who is an inpatient in a hospital, nursing facility, or other institutions who must contribute all of their income toward the cost of their care; (3) emergency services; (4) family planning services; (5) services furnished to an individual who is receiving hospice care; and (6) the administration of vaccines. Notably, cost sharing for a specified item or service furnished to an individual who is eligible for Medicaid under Medicaid expansion is limited to $35, and the total aggregate amount of cost sharing that a state may impose for all individuals in the family may not exceed five percent of the family income, as applied on a quarterly or monthly basis. For outpatient prescription drugs and certain non-emergency services delivered in hospital emergency departments, cost sharing must comply with existing federal limits under current law.

MEDICARE

Limiting Eligibility for Immigrants — Under current law, U.S. citizens and permanent residents are eligible for premium-free Medicare Part A at age 65 if they have worked for at least 40 quarters (10 years) in jobs where they or their spouse paid Medicare payroll taxes. Legal immigrants aged 65 or older who do not meet this work history requirement can buy Medicare Part A after living legally in the U.S. for five continuous years. Legal immigrants under 65 with disabilities may also become eligible but generally must first qualify for SSDI (Social Security Disability Insurance), which requires having worked and paid Social Security taxes long enough to earn between 20 and 40 work credits (equivalent to 5–10 years of work). Notably, newly arrived immigrants are not eligible for Medicare, regardless of age. However, once legal residency and other eligibility criteria are met, immigrants can enroll in Medicare on the same basis as other U.S. residents.

Section 71201 of the Senate bill mirrors the corresponding section of the House bill and would amend these eligibility requirements for immigrants to only permit Medicare coverage for: (1) U.S. citizens; (2) aliens who are lawfully admitted for permanent residence under the Immigration and Nationality Act; (3) aliens who are citizens or nationals of Cuba;(4) individuals residing under the Compacts of Free Association (COFA); (5) aliens who meet all eligibility requirements for an immigrant visa but for whom such a visa is not immediately available; (6) aliens who are not otherwise inadmissible under section 212(a) of the Immigration and Nationality Act; and (7) aliens who are physically present in the U.S. pursuant to a grant of parole in furtherance of the commitment of the U.S. to the minimum level of annual legal migration of Cuban nationals to the U.S. Notably, this provision would terminate Medicare coverage for individuals with temporary protected status and refugees, as well as those seeking asylum in the United States.

EXCHANGES & TAX CREDITS

Immigrant Eligibility — Mirroring the restrictions imposed on Medicare coverage for immigrants, the Senate bill would also narrow eligibility for PTCs to only "eligible aliens." Currently, all "lawfully present" immigrants can qualify for premium subsidies and cost-sharing reductions (CSRs) under the ACA. Section 71301 would narrow the premium tax credit eligibility to only "eligible aliens," defined in the text as lawful permanent residents (green card holders), COFA migrants residing in the U.S., and certain immigrants from Cuba. Section 71302 outlines the lawfully present groups that would lose eligibility under this change, including those granted immigration status by asylum, parole, temporary protected status, deferred enforced departure, and withholding of removal. Additionally, section 71302 would prevent lawfully present immigrants from receiving PTCs during any period that they are ineligible for Medicaid due to their immigration status — reversing current policy that allows such individuals to receive subsidies despite being barred from Medicaid.

Eligibility Verification — Reflective of section 112201 of the House bill, the Senate bill would require active, annual verification of key eligibility factors — including income, immigration status, health coverage status or eligibility, place of residence, family size, and any other information deemed

necessary by the HHS Secretary — before individuals can receive APTCs or CSRs. Under current law, individuals may enroll in a Marketplace plan by attesting to their information, which is then electronically verified against federal databases. If discrepancies arise, enrollees have 90 days to resolve them. While consumers may still enroll in a plan under Section 71303, they would not receive financial assistance until their eligibility is confirmed. The provision would also effectively eliminate auto-renewals. Unique to the Senate bill, the Secretary would be permitted to waive the verification requirement for an individual who enrolls in an SEP due to change in family size. This change would take effect for taxable years beginning after December 31, 2027.

SEPS & Tax Credit Eligibility — As detailed above, the bill would eliminate SEPs based solely on an individual's income relative to the FPL, effectively ending the 150 percent FPL SEP that currently allows year-round enrollment for individuals eligible for APTCs with projected household incomes at or below 150 percent of the FPL. Additionally, section 71304 would go further by prohibiting eligibility for PTCs or CSRs for individuals who enroll during these income-based SEPs. The bill directs the Secretaries of Treasury and HHS to issue regulations and guidance to implement this change, which would take effect three months after enactment. These provisions are identical to the corresponding section of the House text.

APTC Recapture — Under current law, individuals who receive excess PTCs due to their estimated income being lower than their actual income are required to repay the difference, but most are protected by income-based repayment caps. Section 71305 of the bill would eliminate these caps, requiring all PTC recipients — regardless of income — to repay the full amount of any excess credits. This change would take effect for taxable years beginning after December 31, 2025. Unlike the House bill, the Senate bill would not apply this provision to individuals with estimated annual income at or above 100 percent FPL that received an advanced PTC when actual income is less than 100 percent of the FPL. This exception would not apply to individuals determined by the Secretary to have intentionally provided inaccurate information or provided information with "reckless disregard for the facts."

APPENDIX I

OMITTED HOUSE-PASSED PROVISIONS

Fraud, Waste, and Abuse in ACA Exchanges

- Open Enrollment
- Special Enrollment Periods
- Income Verification
- File and Reconcile
- Levels of Coverage
- Past-Due Premiums
- Premium Threshold & Adjustment Percentage
- Automatic Reenrollment & Eligibility Redetermination
- Sex-Trait Modification
- DACA
- Cost-Sharing Reduction Payments

Medicare

- Orphan Drug Exclusion
- Medicare Physician Payment
- PBM Accountability
- Rural Emergency Hospitals
- Artificial Intelligence

Other Provisions

- Streamlined Enrollment Process for Out-of-State Providers
- Medicaid DSH Reduction Delay
- Additional Medicaid Provider Screening Requirements for Deceased Providers