CY 2026 Consolidated Appropriations Act Health Package (Division F): Select Section by Section Analysis

Table of Contents

Title I – Medicaid

Sec. 6101. *Streamlined enrollment process for eligible out-of-state providers under Medicaid and CHIP.*

- Within 3 years of enactment of the Act, a state must implement a process for out-of-state providers to enroll in their Medicaid plan to furnish services to qualifying individuals.
    - "Qualifying individuals" include any individual under 21 years of age who is enrolled under the state Medicaid plan, including those under waiver authority.
- **CBO Score: $197M**

Sec. 6102. *Removing certain age restrictions on Medicaid eligibility for working adults with disabilities.*

- By January 1, 2028, states that operate a Medicaid buy-in program must:
    - Remove the 65-year age cap on buy-in program participation, and
    - Ensure that individuals excluded from SSI (who are also at least 16 and have a disability) due to earnings over the limit qualify for the buy-in program.
- **CBO Score: $443M**

Sec. 6103. *Medicaid State plan requirement for determining residency and coverage for military families.*

- Beginning January 1, 2030, states cannot remove active duty relocated individuals from their home and community-based services waiting lists unless:
    - The individual elects to be removed from such list,
    - The state denies eligibility for such services and the individual exhausts all options for a fair hearing, or
    - Payment for medical assistance or such assistance is determined to be available in the relocation state.
- **CBO Score: $5M**

Sec. 6105 + 6106. *Disproportionate Share Hospital Adjustments Under the Medicaid Program*

- Postpones DSH allotment reductions for fiscal years 2026 and 2027.

- For Medicare rate years beginning October, 1, 2022, states may use State plan Amendment or waiver authorities to redistribute unspent DSH allotments up to newly calculated per-hospital caps.
    - The updated calculated hospital caps incorporate a new definition of uncompensated care that prevents the automatic exclusion of payments made on behalf of dual-eligible beneficiaries or other certain third-party payments.
- **CBO Score: $2.3B**

Title II – Medicare

Sec. 6204. *Extending incentive payments for participation in eligible alternative payment models.*

- Extends and increases payment incentives for providers participating in eligible Alternative Payment Models through Payment Year 2028.
    - The payment incentive is increased from 1.88% for qualifying services to 3.1%.
- **CBO Score: $1.9B**

Sec. 6209. *Extension of certain telehealth flexibilities.*

- Extends Medicare telehealth flexibilities through December 31, 2027. These flexibilities include:
    - Removing requirements regarding originating sites for telehealth services.
    - Expanding practitioners who are eligible for telehealth reimbursement.
    - Extends telehealth authorities for Federally Qualified health Centers (FQHCs) and Rural Hospital Centers (RHCs).
    - Delaying in-person requirements for mental health services and allowance of audio-only services.
- Places new restrictions on the use of telehealth for hospice recertification encounters.
- **CBO Score: $3.8B**

Sec. 6210. *Extending Acute Hospital Care at Home Waiver Flexibilities.*

- Extends the Acute Hospital Care at Home (AHCAH) program, as currently authorized under CMS waivers and flexibilities, through September 30, 2030.
- Requires CMS to conduct a second efficacy study for the Program by September 30, 2029. The report must include outcomes data as well as other performance metrics which would be required to support the potential permanency of the program.
- **CBO Score: $3M**

Sec. 6219. *Adjustments to Medicare Part D cost-sharing reductions for low-income individuals.*

- Eliminates generic drug copayments for Medicare Part D beneficiaries who receive the low-income subsidy beginning in Plan Year 2028.
- Beginning in Plan Year 2028, for preferred multiple source drugs and all other drugs, copayments for LIS beneficiaries will be set at the previous year's copay and then indexed by CPI-U.
- **CBO Score: N/A**

Sec. 6221. *Medicare Coverage of Multi-Cancer Early Detection (MCED) Screen Tests.*

- Beginning January 1, 2029, Medicare will cover MCED testing for certain beneficiaries through the preventive covered services mechanism in Medicare Part B.
    - Coverage decisions for new MCED tests will be made through the National Coverage Determination (NCD) process.
    - For tests furnished from January 1, 2029, to January 1, 2031, reimbursement will be based on a testing proxy (colorectal cancer test).
    - For tests furnished after January 31, 2031, payment will be based on the lesser of the lab fee schedule or proxy colorectal cancer test rate.
    - Only individuals ages 50-64 will have MCED tests covered in 2029, with the upper age limit increasing by one-year annually.
        - However, if an MCED test receives a USPSTF grade A or B, the statutory payment and age limitations no longer apply once coverage is provided as a preventive service under existing Medicare preventive authorities.
- **CBO Score: $2.3B**

Sec. 6223. *Assuring pharmacy access and choice for Medicare beneficiaries.*

- Beginning January 1, 2029, Part D Plan (PDP) sponsors must allow any pharmacy that meets its standard contract terms and conditions to participate as a network pharmacy.
- Beginning in Plan Year 2027, PDP sponsors and MA-PD plans must report incentive fees and other pharmacy fees to HHS.
- Compels CMS to establish a national standard for "reasonable and relevant" pharmacy contract terms by April 3, 2028.
    - CMS must issue a request for information on this standard by April 1,2027.
- Beginning 2028, CMS must publish an annual list of essential retail pharmacies.
- By January 1, 2029, CMS must establish a formal process allowing pharmacies to submit allegations of violations of contract-term standards or anti-retaliation rules.
    - Pharmacy Benefit Managers (PBMs) must reimburse PDP sponsors for any penalties paid to CMS regarding these violations. Parallel requirements exist for MA-PD plans.
- **CBO Score: $188M**

Sec. 6224. *Modernizing and ensuring PBM accountability.*

- Effective January 1, 2028, PDP sponsors must ensure that and PBM or PBM-affiliate operating on their behalf meets the following new federal standards:
    - PBMs or affiliates may not receive payment related to Part D drug utilization other than bona fide service fees:
        - These bona fide service fees must be flat dollar amounts and tied to services performed (cannot be linked to rebates, utilization volume, drug price, or formulary placement).
        - Manufacturer rebates, discounts, and price concessions are permitted only if fully passed through to the PDP sponsor and compliant with DIR rules.
- Starting July 1, 2028, PBMs must annually submit reports to CMS and PDP sponsors (covering the prior plan year), which contain:
    - Drug-level utilization, pricing benchmarks (WAC, AWP, NADAC), enrollee out-of-pocket costs, rebates, DIR, and PBM-retained revenue.
    - Coverage decisions disadvantaging generics or biosimilars, including written justifications.
    - Pharmacy reimbursement amounts by dispensing channel (retail, mail, etc.); comparisons between PBM-affiliated and non-affiliated pharmacies; and total gross and net Part D drug spending.
- Allows PDP sponsors to conduct annual independent audits of their PBM.
- Mandates GAO (within 2 years of enactment) and MedPAC (within 2 years of data to be provided by the Secretary) reporting on PBM price-linked compensation and impacts on enrollee/pharmacy costs.
- **CBO Score: -$444M**

Sec. 6226. *Revising phase-in of Medicare clinical laboratory test payment changes.*

- Extends the phase-in of private payor rates for clinical laboratory test Medicare reimbursement until January 1, 2029.
    - Extends a 5% cap in the annual reduction of prices for 2026, while allowing the introduction of a 15% reduction for CY2027 and CY2028.
    - Updates the base year for private payor rate calculations to 2025 (from 2019).
- **CBO Score: -$495M**

Title IV – Public Health and Other Extenders

Sec. 6401. *Extension for community health centers, National Health Service Corps, and teaching health centers that operate GME programs.*

- Provides funding for the Community Health Center Fund and National Health Service Corps Program through December 31, 2026.
- Funds the Teaching Health Center Graduate Medical Education Program through FY2029.
- **CBO Score: $5.6B**

Sec. 6402. *Extension of special diabetes programs.*

- Provides funding for the Special Diabetes Program and Special Diabetes Program for Indians until December 31, 2026.
- **CBO Score: XXXX**

Title V – Public Health Programs

Sec. 6504*. Program for Pediatric Studies of Drugs.*

- Provides funding for the Special Diabetes Program and Special Diabetes Program for Indians until December 31, 2026.
- **CBO Score: XXXX**

Title VI – Food and Drug Administration

Subtitle A—Mikaela Naylon Give Kids a Chance Act

Sec. 6601. *Research into Pediatric Uses of Drugs; Additional Authorities of Food and Drug Administration Regarding Molecularly Targeted Cancer Drugs.*

- Provides FDA with the authority to require pediatric studies for combination cancer therapies.
    - New pediatric studies can only be mandated when there is (1) only a single new active ingredient, or (2) there are multiple active ingredients not previously approved together but each is approved to treat adult cancers.
    - The studies must include age-appropriate formulations, dosing, safety, and preliminary efficacy results.

- FDA must issue draft guidance within 12 months of enactment of the Act, and final guidance must be issued within 12 months of the closure of the comment period.

Sec. 6602. *Ensuring Completion of Pediatric Study Requirements.*

- Provides FDA with the authority to sanction drug or biologic sponsors who fail to meet pediatric study requirements under Section 303 of the Food, Drug, and Cosmetic Act.
    - FDA must complete "due diligence" before concluding a company failed to meet the requirement, which includes:
        - The issuance and evaluation of a non-compliance letter, to which sponsors have 45 days to respond.
- This provision becomes enforceable 180 days following the enactment of the Act.

Sec. 6603. *FDA report on PREA enforcement.*

- Mandates that FDA evaluate compliance with deadlines for pediatric study deferrals and deferral extensions under the Pediatric Research Equity Act.
    - FDA must also report on enforcement actions (penalties, settlements, or payments) taken under Section 303 of the Food, Drug, and Cosmetic Act.

Sec. 6604. *Extension of Authority to Issue Priority Review Vouchers to Encourage Treatments for Rare Pediatric Diseases.*

- Extends the Rare Pediatric Disease Priority Review Voucher (PRV) Program through September 30, 2029.
- Mandates GAO provide a PRV Program evaluation report to Congress within 5 years of enactment of the Act, which includes the:
    - Extent to which unmet pediatric needs were met by voucher approvals.
    - Company size of voucher recipients and users.
    - Value and use of PRVs, including transfer activity.
    - Motivational effect of PRVs on rare pediatric drug development.

Sec. 6605. *Limitations on Exclusive Approval or Licensure of Orphan Drugs.*

- Updates statute to clarify that FDA may approve drugs for the same rare disease within a product's 7-year exclusivity window so long as the product is not for the same use or indication and meets unmet need.
- **CBO scoring note on the Mikaela Nylon Give Kids a Chance Act (H.R.1262), as passed out of the House:** Section 3 would increase revenues by an insignificant amount. Section 10 would reduce direct spending and increase revenues for a net $1.219 billion reduction in the deficit. Section 11 would appropriate $1.219 billion to the Medicare Improvement Fund. On net, the bill would reduce the deficit by an insignificant amount over the 2026-2035 period.
    - Sections 10 and 11 have been moved to other parts of Division F; making the impact of the provisions as included in Division F budget neutral.

Title VII – Lowering Prescription Drug Costs

Sec. 6701. *Oversight of pharmacy benefit management services.*

- For plan years beginning 30 months after the enactment of the Act, PBMs must submit semiannual (or quarterly upon request) reports to group health plans that include:
    - NDC-level information on:
        - Amounts paid by the plan/issuer to the PBM and to pharmacies
        - Spread between PBM and pharmacy payments
        - Drug identity, dispensing channel, utilization metrics, and days' supply
        - Gross vs. net prices after rebates and fees
        - Total participant out-of-pocket spending
    - Gross and net spending by therapeutic class, rebate amounts, utilization management tools, formulary tiering, and average net costs per 30- and 90-day supply.
    - Disclosure of all rebates, fees, and other discounts including how much is retained by the PBM versus passed through to plans.
- **CBO Score: -$22M**

Sec. 6702. *Full rebate pass through to plan; exception for innocent plan fiduciaries.*

- Starting 30 months after enactment of the Act, PBM contracts governed by ERISA must fully pass through 100% of rebates, fees, alternative discounts, and other drug-related remuneration to the group health plan (or to the issuer on behalf of the plan).
    - This standard only applies to new contracts, renewals or extensions after the effective date.
    - PBMs must also ensure that all downstream contracts (e.g. rebate aggregators or GPOs) also provide for 100% pass-through of drug-related remuneration to the plan.
- Establishes that PBMs must transfer rebates to sponsors on a quarterly basis, and the transfer must be complete within 90 days of the end of the quarter. Rebates and other payments must also be fully disclosed and itemized.
    - GPOs and rebate aggregators must provide rebates to PBMs within 45 days after the end of each quarter so the PBM can meet the deadline to sponsors.
- Creates a limited safe harbor for "innocent" plan fiduciaries where a PBM fails to remit required amounts.
- **CBO Score: N/A**

Sec. 6703. *Increasing transparency in generic drug applications.*

- Upon request or during ANDA review, FDA must inform an ANDA applicant prospective applicant whether its proposed drug is:
    - Qualitatively the same (same inactive ingredients); and

    - Quantitatively the same (same concentrations of inactive ingredients) as a reference product.
- If FDA determines a proposed drug is not the same as the reference product, it must disclose to the application sponsor:
    - Which inactive ingredient(s) differ; and
    - The extent of any quantitative deviation for those ingredients.
- This section is effective upon enactment of the Act. FDA must still issue draft guidance on how it will assess qualitative and quantitative sameness within 12 months of enactment.
- **CBO Score: -$847M**

Appendix A – Additional Sections Included In Division F of the Consolidated Appropriations Act, 2026

Sec. 6104. State Studies and HHS Report on Costs of Providing Maternity, Labor, and Delivery Services. This section requires State Medicaid programs to conduct studies on the costs of providing maternity, labor, and delivery services in rural hospitals and hospitals that serve a high proportion of Medicaid beneficiaries, and submit a report detailing the results of this study to the Department of Health and Human Services (HHS).

Sec. 6201. Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals. This section extends the Medicare low-volume hospital payment adjustment through December 31, 2026.

Sec. 6202. Extension of the Medicare-Dependent Hospital (MDH) Program. This section extends the Medicare-dependent Hospital (MDH) program through December 31, 2026.

Sec. 6203. Extension of Add-On Payments for Ambulance Services. This section extends Medicare ground ambulance add-on payments through December 31, 2027.

Sec. 6206. Extension of Funding Outreach and Assistance for Low-Income Programs. This section provides $100 million for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and a contract with an entity to inform older Americans about benefits available under Federal and State programs through December 31, 2027.

Sec. 6207. Extension of funding for Medicare hospice surveys. This section extends funding first allocated in the IMPACT Act of 2014 for the survey and certification of hospice providers through December 31, 2026. These funds will remain available until expended.

Sec. 6208. Extension of the Work Geographic Index Floor. This section extends the 1.0 work

geographic practice cost index (GPCI) floor used in the calculation of payments under the Medicare physician fee schedule through December 31, 2026.

Sec. 6211. In-Home Cardiopulmonary Rehabilitation Flexibilities. This section would allow cardiopulmonary rehabilitation services to be furnished via telehealth at a beneficiary's home under Medicare in 2026 and 2027.

Sec. 6212. Enhancing Certain Program Integrity Requirements for DME Under Medicare. This section enacts certain oversight measures to improve program integrity, such as with respect to aberrant billing practices and sources of waste, fraud, and abuse. This section also requires the HHS Office of the Inspector General (OIG) to conduct a study examining clinical lab tests at high risk of fraud.

Sec. 6213. Guidance on Furnishing Services via Telehealth to Individuals with Limited English Proficiency. This section requires HHS to issue guidance with best practices on providing telehealth services accessibly.

Sec. 6214. Inclusion of Virtual Diabetes Prevention Program Suppliers in MDPP Expanded Model. This section expands participation in the Medicare Diabetes Prevention Program (MDPP) Expanded Model to virtual until December 31, 2029, and allows beneficiaries to participate through online models or through distance learning.

Sec. 6215. Medication-Induced Movement Disorder Outreach and Education. This section directs HHS to conduct outreach and education to relevant providers on screening for medication-induced movement disorders among at-risk beneficiaries via telehealth.

Sec. 6216. Report on Wearable Medical Devices. This section directs GAO to conduct a technology assessment and issue a report on wearable medical devices.

Sec. 6217. Extension of Temporary Inclusion of Authorized Oral Antiviral Drugs as Covered Part D Drugs. This section extends Medicare Part D coverage of certain oral antiviral drugs through December 31, 2026.

Sec. 6218. Extension of Adjustment to Calculation of Hospice Cap Amount under Medicare. This section extends, for two additional years, the change to the annual updates to the hospice aggregate cap. Specifically, this section applies the hospice payment update percentage, rather than the medical expenditure component of the Consumer Price Index for Urban Consumers (CPI–U), to the hospice aggregate cap through FY 2035.

Sec. 6222. Medicare Coverage of External Infusion Pumps and Non-Self-Administrable Home Infusion Drugs. This section would codify the Joe Fiandra Access to Home Infusion Act, enabling beneficiaries to receive certain infusion treatments in the home under Medicare.

Sec. 6227. Medicare Sequestration. This section extends current law mandatory 2 percent Medicare payment reductions under sequestration through the first 5 months of FY 2033.

Sec. 6228. Medicare Improvement Fund. This section increases the amount of funding in the Medicare Improvement Fund from $1.403 billion to $2.062 billion.

Sec. 6301. Sexual Risk Avoidance Education Extension. This section extends the Sexual Risk Avoidance Education (SRAE) program under Title V of the Social Security Act through December 31, 2026.

Sec. 6302. Personal Responsibility Education Program Extension. This section extends the Personal Responsibility Education Program (PREP) under Title V of the Social Security Act through December 31, 2026.

Sec. 6303. Extension of Funding for Family-to-Family Health Information Centers. This section extends the Family-to-Family Health Information Centers program under Title V of the Social Security Act through December 31, 2026.

Sec. 6304. Extension of the Temporary Assistance for Needy Families Program. This section extends the Temporary Assistance for Needy Families (TANF) program under Part A of Title IV of the Social Security Act through December 31, 2026.

Sec. 6403. Extension of National Health Security Programs. This section reauthorizes certain existing authorities related to emergency preparedness and response activities and functions through December 31, 2026.

Sec. 6404. No Surprises Act Implementation. This section would extend implementation funding for the No Suprises Act and appropriate an additional $28.1 million to the Department of Health and Human Services (HHS) for such purposes through December 31, 2026.

Sec. 6411. 9/11 Responder and Survivor Health Funding Corrections. This section updates the funding formula for the World Trade Center Health Program for FY 2026 through 2040, and requires a report to Congress from the Secretary of HHS that assesses the anticipated budgetary needs of the Program.

Sec. 6501. Preventing Maternal Deaths. This section reauthorizes support for State-based maternal mortality review committees through FY 2030. Additionally, this section directs HHS to disseminate best practices on maternal mortality prevention to hospitals, professional societies, and perinatal quality collaboratives.

Sec. 6502. Organ Procurement and Transplantation Network. This section authorizes the Secretary of HHS to collect registration fees from any member of the Organ Procurement and Transplantation Network (OPTN) for each transplant candidate such member places on the list and to distribute these fees to support the operation of OPTN, for three years.

Sec. 6503. Honor Our Living Donors. This section amends current law to prohibit the consideration of the organ recipient's income when determining whether a living donor is eligible for qualified reimbursements for living organ donation. This section also removes language that indicates an organ recipient's ability to pay for a donor's expenses cannot be a

factor in considering a donor's eligibility for reimbursement and requires an annual report to Congress to examine the sufficiency of funding of this program.

Sec. 6505. Sickle Cell Disease Prevention and Treatment. This section reauthorizes through FY 2030 and clarifies sickle cell disease prevention and treatment programs to improve prevention and treatment of complications from the disease in populations with a high proportion of individuals with sickle cell disease.

Sec. 6506. Lifespan Respite Care. This section reauthorizes the Lifespan Respite Care program through FY 2030 and clarifies the definition of "family caregiver" to include individuals under age 18.

Sec. 6507. Prematurity Research Expansion and Education for Mothers who Deliver Infants Early (PREEMIE). This section reauthorizes public health and prevention activities related to preterm birth through FY 2030. Additionally, this section directs the Secretary of HHS to establish a working group to coordinate federal activities related to preterm birth, infant mortality, and other adverse birth outcomes. Lastly, it directs the National Academies of Sciences, Engineering, and Medicine (NASEM) to conduct a study and issue a report on the costs of preterm birth and the factors and gaps in public health programs that contribute to preterm birth.

Sec. 6508. Dr. Lorna Breen Health Care Provider Protection. This section updates a requirement for the Secretary of HHS to release best practices for suicide prevention and improving mental health and resiliency among health care professionals. This section also reauthorizes an education and awareness initiative to promote the use of mental health and substance use services by health care providers through FY 2030. This section also reauthorizes through FY 2030 grant programs to promote mental health within the health care workforce by improving awareness of and access to mental health services and training.

Sec. 6611. Establishment of Abraham Accords Office within Food and Drug Administration. This section requires the FDA to establish an office in an Abraham Accords country to enhance facilitation with the agency and require the Secretary of HHS to submit a report to Congress three years after the date of enactment of this Act to evaluate the office's progress.