Senate-Passed Reconciliation Key Provisions

Provisions expected to have significant, negative impact from increased administrative burdens and reduced funding:

- **Provider Taxes:** The Senate-passed bill includes a moratorium on new provider taxes, similar to the House-passed bill. The planned phase down of allowable provider tax rates also was included in the bill, with the start of the phase down delayed until 2028 in the final Senate text. *Note*: this delay to 2028 is a positive development compared to the original proposed start of 2026.
- **State-Directed Payments:** The Senate-passed bill modifies the existing grandfathering provision for state-directed payments from the House-passed bill, setting conditions on it so as to eventually lower the maximum rate of all payments down to 100% (for expansion states) or 110% (for non-expansion states) of the equivalent Medicare published payment rate for relevant services. It also extends this phasedown to rural hospitals, phasing them down by 10 percent annually starting with the rating period on or after January 1, 2028.
- **Eligibility Redeterminations:** Similar to the House-passed bill, the Senate-passed bill would require states to conduct more frequent eligibility determinations for the Medicaid expansion population than under current law. Specifically, beginning on December 31, 2026, states would be required to conduct eligibility redeterminations every 6 months (states may currently conduct redeterminations no more than once every 12 months).
- **Work/Community Engagement Requirements:** The work/community engagement requirements are largely the same among the House and Senate bills. However, H.R. 1 exempted anyone who is the parent, guardian or caretaker of a person with disabilities or a dependent child, whereas the Senate text limits this exemption to parents, guardians, and caretakers of children 14 years old or under and people with disabilities, meaning parents, guardians and caretakers of individuals 15 and above would not be exempted.
    - Exemptions from H.R. 1 for those participating in a “drug addiction or alcoholic treatment and rehabilitation program” and individuals with a “disabling mental disorder” or “substance use disorder” are maintained in the Senate text.

Provisions added/adjusted before final Senate passage that lessen expected negative impact:

- **Rural Health Transformation Program:** The Senate-passed bill would also create the Rural Health Transformation Program (Program). The Program is intended to provide relief to rural clinics and hospitals that would be significantly impacted by the bill's Medicaid provisions. Total funding for the Program would be $50 billion, with $10 billion being disbursed each year from 2026 through 2030. Eligible entities include CCBHCs, community mental health centers, opioid treatment programs, FQHCs, RHCs, and several other facility types. States seeking funds through the Program must submit a one-time application, explaining how they plan to spend awarded funds to support at least three of ten listed program activity areas. The bill's definition of CCBHCs is limited to state-certified entities under the demonstration program or a state plan amendment and does not appear to include grantees. The bill's definition of CMHCs also appears to be limited and would likely only encompass a small number of specialty clinics serving Medicare beneficiaries. While this is helpful, it is far from enough to offset the negative impact of the bill's other provisions on eligible providers.
- **Cost-Sharing:** The Senate-passed bill includes language that specifically extends the exceptions to new cost-sharing requirements under the bill to services provided by certified community behavioral health clinics (as above, limited to state-certified entities under the demonstration program or a state plan amendment), federally qualified health centers (FQHCs), and rural health clinics (RHCs), among other clinic types.