AMERICAN ACADEMY of FAMILY PHYSICIANS

Summary of Certain Health Care Provisions Contained in the Consolidation Appropriations Act of 2026, of Relevance to Family Medicine

February 3, 2026

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

- Requires states to implement a process for out-of-state providers to enroll in and provide services without screening or enrollment requirements beyond what is necessary to pay them, and ensures they can be enrolled for a five-year period without having to go through the process again.

Sec. 6104. State studies and HHS report on costs of providing maternity, labor, and delivery services.

- Requires each state to conduct a study every five years on the costs of providing maternity, labor and delivery services in applicable hospitals and submit the results to HHS. Applicable hospitals are those located in rural areas (using FORHP definition) that provide L&D services and more than 50% are paid for by Medicaid/CHIP.
- Requires HHS to conduct a report analyzing the first studies conducted by states with recommendations for improving data collection on costs.

Sec. 6201. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.

- Extended through December 31, 2026.

Sec. 6202. Extension of the Medicare-dependent hospital (MDH) program.

- Extended through December 31, 2026.

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

- Reauthorizes the previously expired AAPM incentive payments at 3.1% for performance year 2028 (payment year 2026).

Sec. 6206. Extension of funding outreach and assistance for low-income programs.

- Extends funding for state health insurance assistance programs, area agencies on aging, aging and disability resource centers, and coordination of efforts to inform older Americans about benefits available under federal and state programs.

Sec. 6208. Extension of the work geographic index floor.

- Extends the physician work GPCI floor of 1.0 through December 31, 2026.

Sec. 6209. Extension of certain telehealth flexibilities.

- Extends Medicare telehealth flexibilities through December 31, 2027.

Sec. 6210. Extending acute hospital care at home waiver flexibilities.

- Extends the hospital at home program through September 30, 3030 and requires HHS to conduct a study and submit a report to Congress by September 30, 2029.

Sec. 6213. Guidance on furnishing services via telehealth to individuals with limited English proficiency

- Requires HHS, in consultation with designated stakeholders, to issue and disseminate guidance on best practices for facilitating use of interpreters during telehealth, providing accessible instructions on how to access telehealth services, improving access to digital patient portals, enabling multi-person video calls, and providing written materials for patients with limited English proficiency. Physicians are among the list of designated stakeholders.
- This is the language proposed in the SPEAK Act, which the AAFP has endorsed.

Sec. 6216. Report on wearable medical devices.

- Requires the Comptroller General to conduct a technology assessment of the capabilities and limitations of wearable medical devices used to support clinical decision-making, in addition to submitting a report to Congress on the assessment.

Sec. 6220. Requiring Enhanced and Accurate Lists of (REAL) Health Providers Act.

- Beginning in plan year 2028, MAOs will be required to maintain a publicly available, accurate provider directory that is verified and updated not less than every 90 days.
- If they are unable to verify information and determines the provider is no longer participating in the network, the MAO must remove them from the directory within five business days.
- If an enrollee receives a service from a now out-of-network provider that was listed in the plan's directory, the MAO must ensure the enrollee is responsible for the lesser of: the cost-sharing if the provider was in-network, or the amount of cost-sharing that would otherwise apply.
- MAOs must notify enrollees of their cost-sharing protections.

Sec. 6221. Medicare coverage of multi-cancer early detection screening tests.

- Requires Medicare to cover FDA-cleared or approved multi-cancer early detection screening tests beginning in 2029.

Sec. 6224. Modernizing and ensuring PBM accountability.

- Ensures that PBMs cannot derive any remuneration for services other than bona fide service fees and implements additional transparency requirements, such as providing a written explanation of any contracts or agreements with drug manufacturers to the PDP sponsor.

Sec. 6225. Requiring a separate identification number and an attestation for each off-campus outpatient department of a provider.

- Requires off-campus hospital outpatient departments (HOPDs) to use a separate NPI from the hospital or other parent facility in order to receive Medicare payments.

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

- Further delays changes to Medicare clinical lab test payments through December 31, 2029, including delays to potential payment cuts of up to 15%.

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

- Extends funding and authorization for CHCs through December 31, 2026. $4.6 billion was provided for FY26 (Sept 2025 – Sept 2026) and $1.16 billion for the period of October – December 2026.
- Extends funding and authorization for the NHSC through December 31, 2026. $350 million was provided for FY26 (Sept 2025 – Sept 2026) and $88.2 million for the period of October – December 2026.
- Extends funding and authorization for the THCGME program through FY2029. Provides $250 million for FY27, $275 million for FY28, and $300 million for FY29.

Sec. 6402. Extension of special diabetes programs.

- Extends the special diabetes program for type 1 and the special diabetes program for Indians through December 31, 2026.

Sec. 6501. Preventing maternal deaths

- Reauthorizes programs that expired in 2023 under the Preventing Maternal Deaths Act, which the AAFP has endorsed. Extends authorizations for maternal mortality review committees. It also requires HHS to identify and disseminate to health care providers and others best practices related to preventing maternal morbidity and mortality, updated at least once per fiscal year.

Sec. 6507. PREEMIE.

- Implements the PREEMIE Reauthorization Act, which the AAFP endorsed, to continue authorization of research relating to preterm L&D and care, treatment, and outcomes of preterm and low birthweight infants.
- Requires the HHS Secretary to establish an interagency working group on research related to preterm and low birthweight infants.
- Requires HHS to contract with NASEM to convene a committee of experts in maternal health to study premature births in the US and issue a report on the results of the authorized study on premature births.

Sec. 6508. Dr. Lorna Breen health care provider protection.

- Reauthorizes the Dr. Lorna Breen Health Care Provider Protection Act, which the AAFP has strongly endorsed. This extends authorization for an education and awareness initiative encouraging the use of mental health and SUD services by clinicians, and programs to promote mental wellbeing among clinicians.

Sec. 6602. Ensuring completion of pediatric study requirements.

- Implements pieces of the Innovation in Pediatric Drugs Act, which the AAFP has endorsed, including ensuring that Pediatric Research Equity Act (PREA) studies of certain new drugs in children are actually being completed.

Sec. 6603. FDA report on PREA enforcement.

- Requires reporting from the FDA on completion of PREA studies and adds reporting on penalties, settlements, or payments applied for failure to comply with the requirements.

Sec. 6701. Oversight of pharmacy benefit management services.

- Requires PBMs to submit regular reports to group health plan sponsors about drugs covered by the plan, such as a list of drugs for which a claim was filed and the contracted compensation paid by the plan.

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

- Requires PBMs to remit 100% of any rebates, fees, alternative discounts, or other remuneration received related to utilization of drugs or drug spending to the group health plan or issuer.