

1 **DIVISION F—HEALTH CARE**
2 **EXTENDERS**

3 **SEC. 6001. TABLE OF CONTENTS.**

4 The table of contents of this division is as follows:

DIVISION F—HEALTH CARE EXTENDERS

Sec. 6001. Table of contents.

TITLE I—MEDICAID

- Sec. 6101. Streamlined enrollment process for eligible out-of-State providers under Medicaid and CHIP.
- Sec. 6102. Removing certain age restrictions on Medicaid eligibility for working adults with disabilities.
- Sec. 6103. Medicaid State plan requirement for determining residency and coverage for military families.
- Sec. 6104. State studies and HHS report on costs of providing maternity, labor, and delivery services.
- Sec. 6105. Modifying certain disproportionate share hospital allotments.
- Sec. 6106. Modifying certain limitations on disproportionate share hospital payment adjustments under the Medicaid program.

TITLE II—MEDICARE

- Sec. 6201. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.
- Sec. 6202. Extension of the Medicare-dependent hospital (MDH) program.
- Sec. 6203. Extension of add-on payments for ambulance services.
- Sec. 6204. Extending incentive payments for participation in eligible alternative payment models.
- Sec. 6205. Extension of funding for quality measure endorsement, input, and selection.
- Sec. 6206. Extension of funding outreach and assistance for low-income programs.
- Sec. 6207. Extension of funding for Medicare hospice surveys.
- Sec. 6208. Extension of the work geographic index floor.
- Sec. 6209. Extension of certain telehealth flexibilities.
- Sec. 6210. Extending acute hospital care at home waiver flexibilities.
- Sec. 6211. In-home cardiopulmonary rehabilitation flexibility.
- Sec. 6212. Enhancing certain program integrity requirements for DME under Medicare.
- Sec. 6213. Guidance on furnishing services via telehealth to individuals with limited English proficiency.
- Sec. 6214. Inclusion of virtual diabetes prevention program suppliers in MDPP Expanded Model.
- Sec. 6215. Medication-induced movement disorder outreach and education.
- Sec. 6216. Report on wearable medical devices.
- Sec. 6217. Extension of temporary inclusion of authorized oral antiviral drugs as covered part D drugs.
- Sec. 6218. Extension of adjustment to calculation of hospice cap amount under Medicare.

- Sec. 6219. Adjustments to Medicare part D cost-sharing reductions for low-income individuals.
- Sec. 6220. Requiring Enhanced and Accurate Lists of (REAL) Health Providers Act.
- Sec. 6221. Medicare coverage of multi-cancer early detection screening tests.
- Sec. 6222. Medicare coverage of external infusion pumps and non-self-administrable home infusion drugs.
- Sec. 6223. Assuring pharmacy access and choice for medicare beneficiaries.
- Sec. 6224. Modernizing and ensuring PBM accountability.
- Sec. 6225. Requiring a separate identification number and an attestation for each off-campus outpatient department of a provider.
- Sec. 6226. Revising phase-in of medicare clinical laboratory test payment changes.
- Sec. 6227. Medicare sequestration.
- Sec. 6228. Medicare Improvement Fund.

TITLE III—HUMAN SERVICES

- Sec. 6301. Sexual risk avoidance education extension.
- Sec. 6302. Personal responsibility education extension.
- Sec. 6303. Extension of funding for family-to-family health information centers.
- Sec. 6304. Extension of the Temporary Assistance for Needy Families Program.

TITLE IV—PUBLIC HEALTH AND OTHER EXTENDERS

Subtitle A—Extensions

- Sec. 6401. Extension for community health centers, National Health Service Corps, and teaching health centers that operate GME programs.
- Sec. 6402. Extension of special diabetes programs.
- Sec. 6403. Extension of national health security programs.
- Sec. 6404. No Surprises Act implementation.

Subtitle B—World Trade Center Health Program

- Sec. 6411. 9/11 responder and survivor health funding corrections.

TITLE V—PUBLIC HEALTH PROGRAMS

- Sec. 6501. Preventing maternal deaths.
- Sec. 6502. Organ Procurement and Transplantation Network.
- Sec. 6503. Honor our living donors.
- Sec. 6504. Program for pediatric studies of drugs.
- Sec. 6505. Sickle cell disease prevention and treatment.
- Sec. 6506. Lifespan respite care.
- Sec. 6507. PREEMIE.
- Sec. 6508. Dr. Lorna Breen health care provider protection.

TITLE VI—FOOD AND DRUG ADMINISTRATION

Subtitle A—Mikaela Naylor 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.
- Sec. 6602. Ensuring completion of pediatric study requirements.

- Sec. 6603. FDA report on PREA enforcement.
- Sec. 6604. Extension of authority to issue priority review vouchers to encourage treatments for rare pediatric diseases.
- Sec. 6605. Limitations on exclusive approval or licensure of orphan drugs.

Subtitle B—United States-Abraham Accords Cooperation and Security

- Sec. 6611. Establishment of Abraham Accords Office within Food and Drug Administration.

TITLE VII—LOWERING PRESCRIPTION DRUG COSTS

- Sec. 6701. Oversight of pharmacy benefit management services.
- Sec. 6702. Full rebate pass through to plan; exception for innocent plan fiduciaries.
- Sec. 6703. Increasing transparency in generic drug applications.

1 **TITLE I—MEDICAID**
2 **SEC. 6101. STREAMLINED ENROLLMENT PROCESS FOR ELI-**
3 **GIBLE OUT-OF-STATE PROVIDERS UNDER**
4 **MEDICAID AND CHIP.**

5 (a) IN GENERAL.—Section 1902(kk) of the Social Se-
6 curity Act (42 U.S.C. 1396a(kk)) is amended by adding
7 at the end the following new paragraph:

8 “(10) STREAMLINED ENROLLMENT PROCESS
9 FOR ELIGIBLE OUT-OF-STATE PROVIDERS.—

10 “(A) IN GENERAL.—The State—
11 “(i) adopts and implements a process
12 to allow an eligible out-of-State provider to
13 enroll under the State plan (or a waiver of
14 such plan) to furnish items and services to,
15 or order, prescribe, refer, or certify eligi-
16 bility for items and services for, qualifying
17 individuals without the imposition of
18 screening or enrollment requirements by

1 such State that exceed the minimum nec-
2 essary for such State to provide payment
3 to an eligible out-of-State provider under
4 such State plan (or a waiver of such plan),
5 such as the provider’s name and National
6 Provider Identifier (and such other infor-
7 mation specified by the Secretary); and

8 “(ii) provides that an eligible out-of-
9 State provider that enrolls as a partici-
10 pating provider in the State plan (or a
11 waiver of such plan) through such process
12 shall be so enrolled for a 5-year period, un-
13 less the provider is terminated or excluded
14 from participation during such period.

15 “(B) DEFINITIONS.—In this paragraph:

16 “(i) ELIGIBLE OUT-OF-STATE PRO-
17 VIDER.—The term ‘eligible out-of-State
18 provider’ means, with respect to a State, a
19 provider—

20 “(I) that is located in any other
21 State;

22 “(II) that—

23 “(aa) was determined by the
24 Secretary to have a limited risk
25 of fraud, waste, and abuse for

1 purposes of determining the level
2 of screening to be conducted
3 under section 1866(j)(2), has
4 been so screened under such sec-
5 tion 1866(j)(2), and is enrolled in
6 the Medicare program under title
7 XVIII; or

8 “(bb) was determined by the
9 State agency administering or su-
10 pervising the administration of
11 the State plan (or a waiver of
12 such plan) of such other State to
13 have a limited risk of fraud,
14 waste, and abuse for purposes of
15 determining the level of screening
16 to be conducted under paragraph
17 (1) of this subsection, has been
18 so screened under such para-
19 graph (1), and is enrolled under
20 such State plan (or a waiver of
21 such plan); and

22 “(III) that has not been—

23 “(aa) excluded from partici-
24 pation in any Federal health care

1 program pursuant to section
2 1128 or 1128A;

3 “(bb) excluded from partici-
4 pation in the State plan (or a
5 waiver of such plan) pursuant to
6 part 1002 of title 42, Code of
7 Federal Regulations (or any suc-
8 cessor regulation), or State law;
9 or

10 “(cc) terminated from par-
11 ticipating in a Federal health
12 care program or the State plan
13 (or a waiver of such plan) for a
14 reason described in paragraph
15 (8)(A).

16 “(ii) QUALIFYING INDIVIDUAL.—The
17 term ‘qualifying individual’ means an indi-
18 vidual under 21 years of age who is en-
19 rolled under the State plan (or waiver of
20 such plan).

21 “(iii) STATE.—The term ‘State’
22 means 1 of the 50 States or the District
23 of Columbia.”.

24 (b) CONFORMING AMENDMENTS.—

1 (1) Section 1902(a)(77) of the Social Security
2 Act (42 U.S.C. 1396a(a)(77)) is amended by insert-
3 ing “enrollment,” after “screening,”.

4 (2) The subsection heading for section
5 1902(kk) of such Act (42 U.S.C. 1396a(kk)) is
6 amended by inserting “enrollment,” after “screen-
7 ing,”.

8 (3) Section 2107(e)(1)(G) of such Act (42
9 U.S.C. 1397gg(e)(1)(G)) is amended by inserting
10 “enrollment,” after “screening,”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall take effect on the date that is 3 years
13 after the date of enactment of this Act.

14 **SEC. 6102. REMOVING CERTAIN AGE RESTRICTIONS ON**
15 **MEDICAID ELIGIBILITY FOR WORKING**
16 **ADULTS WITH DISABILITIES.**

17 (a) MODIFICATION OF OPTIONAL BUY-IN GROUPS.—

18 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
19 of the Social Security Act (42 U.S.C.
20 1396a(a)(10)(A)(ii)) is amended—

21 (A) in subclause (XV)—

22 (i) by striking “, but less than 65,”;

23 and

24 (ii) by inserting “, including at least

25 the group described in section

1 1905(a)(xviii)” before the semicolon at the
2 end; and

3 (B) in subclause (XVI), by inserting “in-
4 cluding at least the group described in section
5 1905(a)(xii),” after “the State may establish,”.

6 (2) INDIVIDUALS DESCRIBED.—Section 1905(a)
7 of the Social Security Act (42 U.S.C. 1396d(a)) is
8 amended—

9 (A) in clause (xvi), by striking “or” at the
10 end;

11 (B) in clause (xvii), by adding “or” after
12 the comma at the end; and

13 (C) by adding after clause (xvii) the fol-
14 lowing new clause:

15 “(xviii) individuals who, but for earn-
16 ings in excess of the limit established
17 under subsection (q)(2)(B), would be con-
18 sidered to be receiving supplemental secu-
19 rity income, and who are at least 16 years
20 of age,”.

21 (3) DEFINITION MODIFICATION.—Section
22 1905(v)(1)(A) of the Social Security Act (42 U.S.C.
23 1396d(v)(1)(A)) is amended by striking “, but less
24 than 65,”.

1 (b) APPLICATION TO CERTAIN STATES.—A State
2 that, as of the date of enactment of this Act, provides for
3 making medical assistance available to individuals de-
4 scribed in subclause (XV) or (XVI) of section
5 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C.
6 1396a(a)(10)(A)(ii)) shall not be regarded as failing to
7 comply with the requirements of the amendments made
8 by subsection (a) before January 1, 2028.

9 **SEC. 6103. MEDICAID STATE PLAN REQUIREMENT FOR DE-**
10 **TERMINING RESIDENCY AND COVERAGE FOR**
11 **MILITARY FAMILIES.**

12 (a) IN GENERAL.—Section 1902 of the Social Secu-
13 rity Act (42 U.S.C. 1396a) is amended—

14 (1) in subsection (a)—

15 (A) in paragraph (88), by striking “and”
16 at the end;

17 (B) in paragraph (89), by striking the pe-
18 riod at the end and inserting “; and”; and

19 (C) by inserting after paragraph (89), the
20 following new paragraph:

21 “(90) beginning January 1, 2030, provide, with
22 respect to an active duty relocated individual (as de-
23 fined in subsection (yy)(1))—

24 “(A) that, for purposes of determining eli-
25 gibility for medical assistance under the State

1 plan (or waiver of such plan), such active duty
2 relocated individual is treated as a resident of
3 the State unless such individual voluntarily
4 elects not to be so treated for such purposes;

5 “(B) that if, at the time of relocation (as
6 described in subsection (yy)(1)), such active
7 duty relocated individual is on a home and com-
8 munity-based services waiting list (as defined in
9 subsection (yy)(2)), such individual remains on
10 such list until—

11 “(i) the State completes an assess-
12 ment and renders a decision with respect
13 to the eligibility of such individual to re-
14 ceive the relevant home and community-
15 based services at the time a slot for such
16 services becomes available and, in the case
17 such decision is a denial of such eligibility,
18 such individual has exhausted the individ-
19 ual’s opportunity for a fair hearing; or

20 “(ii) such individual elects to be re-
21 moved from such list; and

22 “(C) payment for medical assistance fur-
23 nished under the State plan (or a waiver of the
24 plan) on behalf of such active duty relocated in-
25 dividual in the military service relocation State

1 (as referred to in subsection (yy)(1)(B)(i)), to
2 the extent that such assistance is available in
3 such military service relocation State in accord-
4 ance with such guidance as the Secretary may
5 issue to ensure access to such assistance.”; and

6 (2) by adding at the end the following new sub-
7 section:

8 “(yy) ACTIVE DUTY RELOCATED INDIVIDUAL; HOME
9 AND COMMUNITY-BASED SERVICES WAITING LIST.—For
10 purposes of subsection (a)(90) and this subsection:

11 “(1) ACTIVE DUTY RELOCATED INDIVIDUAL.—

12 The term ‘active duty relocated individual’ means an
13 individual—

14 “(A) who—

15 “(i) is enrolled under the State plan
16 (or waiver of such plan); or

17 “(ii) with respect to an individual de-
18 scribed in subparagraph (C)(ii), would be
19 so enrolled pursuant to subsection
20 (a)(10)(A)(ii)(VI) if such individual began
21 receiving home and community-based serv-
22 ices;

23 “(B) who—

24 “(i) is a member of the Armed Forces
25 engaged in active duty service and is relo-

1 cated to another State (in this subsection
2 referred to as the ‘military service reloca-
3 tion State’) by reason of such service;

4 “(ii) would be described in clause (i)
5 except that the individual stopped being
6 engaged in active duty service (including
7 by reason of retirement from such service)
8 and the last day on which the individual
9 was engaged in active duty service oc-
10 curred not more than 12 months ago; or

11 “(iii) is a dependent (as defined by
12 the Secretary) of a member described in
13 clause (i) or (ii) who relocates to the mili-
14 tary service relocation State with such
15 member; and

16 “(C) who—

17 “(i) was receiving home and commu-
18 nity-based services (as defined in section
19 9817(a)(2)(B) of the American Rescue
20 Plan Act of 2021) at the time of such relo-
21 cation; or

22 “(ii) if the State maintains a home
23 and community-based services waiting list,
24 was on such home and community-based

1 services waiting list at the time of such re-
2 location.

3 “(2) HOME AND COMMUNITY-BASED SERVICES
4 WAITING LIST.—The term ‘home and community-
5 based services waiting list’ means, in the case of a
6 State that has a limit on the number of individuals
7 who may receive home and community-based services
8 under section 1115(a) or section 1915(c), a list
9 maintained by such State of individuals who are re-
10 questing to receive such services under 1 or more
11 such sections but for whom the State has not yet
12 completed an assessment and rendered a decision
13 with respect to the eligibility of such individuals to
14 receive the relevant home and community-based
15 services at the time a slot for such services becomes
16 available due to such limit.”.

17 (b) IMPLEMENTATION FUNDING.—There are appro-
18 priated, out of any funds in the Treasury not otherwise
19 obligated, \$1,000,000 for each of fiscal years 2026
20 through 2030, to remain available until expended, to the
21 Secretary of Health and Human Services for purposes of
22 implementing the amendments made by subsection (a).

1 **SEC. 6104. STATE STUDIES AND HHS REPORT ON COSTS OF**
2 **PROVIDING MATERNITY, LABOR, AND DELIV-**
3 **ERY SERVICES.**

4 (a) STATE STUDY.—

5 (1) IN GENERAL.—Not later than 30 months
6 after the date of enactment of this Act, and every
7 5 years thereafter, each State (as such term is de-
8 fined in section 1101(a)(1) of the Social Security
9 Act (42 U.S.C. 1301(a)(1)) for purposes of titles
10 XIX and XXI of such Act) shall conduct a study on
11 the costs of providing maternity, labor, and delivery
12 services in applicable hospitals (as defined in para-
13 graph (3)) and submit the results of such study to
14 the Secretary of Health and Human Services (re-
15 ferred to in this section as the “Secretary”) in such
16 form and manner as the Secretary requires.

17 (2) CONTENT OF STUDY.—A State study re-
18 quired under paragraph (1) shall include the fol-
19 lowing information (to the extent practicable and as
20 further defined by the Secretary) with respect to
21 maternity, labor, and delivery services furnished by
22 applicable hospitals located in the State:

23 (A) An estimate of the cost of providing
24 maternity, labor, and delivery services at appli-
25 cable hospitals, based on the expenditures a
26 representative sample of such hospitals incurred

1 for providing such services during the 2 most
2 recent years for which data is available.

3 (B) An estimate of the cost of providing
4 maternity, labor, and delivery services at hos-
5 pitals that would be applicable hospitals (as de-
6 fined in paragraph (3)) if not for ceasing to
7 provide labor and delivery services within the
8 past 5 years, based on the expenditures a rep-
9 resentative sample of such hospitals incurred
10 for providing such services during the 2 most
11 recent years for which data is available.

12 (C) To the extent data allow, an analysis
13 of the extent to which geographic location, com-
14 munity demographics, and local economic fac-
15 tors (as defined by the Secretary) affect the
16 cost of providing maternity, labor, and delivery
17 services at applicable hospitals described in sub-
18 paragraphs (A) and (B), including the cost of
19 services that support the provision of maternity,
20 labor, and delivery services.

21 (D) The amounts applicable hospitals are
22 paid for maternity, labor, and delivery services,
23 by geographic location and hospital size,
24 under—

1 (i) parts A and B of the Medicare
2 program;

3 (ii) the State Medicaid program, in-
4 cluding payment amounts for such services
5 under fee-for-service payment arrange-
6 ments and under managed care (as appli-
7 cable);

8 (iii) the State CHIP plan, including
9 payment amounts for such services under
10 fee-for-service payment arrangements and
11 under managed care (as applicable); and

12 (iv) private health insurance.

13 (E) A comparative payment rate anal-
14 ysis—

15 (i) comparing payment rates for ma-
16 ternity, labor, and delivery services (inclu-
17 sive of all payments received by applicable
18 hospitals for furnishing maternity, labor,
19 and delivery services) under the State
20 Medicaid fee-for-service program to such
21 payment rates for such services under
22 Medicare (including those described in
23 paragraphs (2) and (3) of section
24 447.203(b) of title 42, Code of Federal
25 Regulations), and, to the extent data is

1 available, such payment rates for such
2 services under Medicaid managed care and
3 private health insurers within geographic
4 areas of the State; and

5 (ii) analyzing different payment meth-
6 ods for such services, such as the use of
7 bundled payments, quality incentives, and
8 low-volume adjustments.

9 (F) An evaluation, using such methodology
10 and parameters established by the Secretary, of
11 whether each hospital located in the State that
12 furnishes maternity, labor, and delivery services
13 is expected to experience in the next 3 years
14 significant changes in particular expenditures
15 or types of reimbursement for maternity, labor,
16 and delivery services.

17 (3) APPLICABLE HOSPITAL DEFINED.—For
18 purposes of this subsection, the term “applicable
19 hospital” means any hospital located in a State that
20 meets either of the following criteria:

21 (A) The hospital provides labor and deliv-
22 ery services and more than 50 percent of the
23 hospital’s births (in the most recent year for
24 which such data is available) are financed by
25 the Medicaid program or CHIP.

1 (B) The hospital—

2 (i) is located in a rural area (as de-
3 fined by the Federal Office of Rural
4 Health Policy for the purpose of rural
5 health grant programs administered by
6 such Office);

7 (ii) based on the most recent 2 years
8 of data available (as determined by the
9 Secretary), furnished services for less than
10 an average of 300 births per year; and

11 (iii) provides labor and delivery serv-
12 ices.

13 (4) ASSISTANCE TO SMALL HOSPITALS IN COM-
14 PILING COST INFORMATION.—There are appro-
15 priated to the Secretary for fiscal year 2026,
16 \$10,000,000 for the purpose of providing grants and
17 technical assistance to a hospital described in para-
18 graph (3)(B) to enable such hospital to compile de-
19 tailed information for use in the State studies re-
20 quired under paragraph (1), to remain available
21 until expended.

22 (5) HHS REPORT ON STATE STUDIES.—For
23 each year in which a State is required to conduct a
24 study under paragraph (1), the Secretary shall issue,
25 not later than 18 months after the date on which

1 the State submits to the Secretary the data de-
2 scribed in such paragraph, a publicly available re-
3 port that compiles and details the results of such
4 study and includes the information described in
5 paragraph (2).

6 (b) HHS REPORT ON NATIONAL DATA COLLECTION
7 FINDINGS.—Not later than 3 years and 6 months after
8 the date of enactment of this Act, the Secretary shall sub-
9 mit to Congress, and make publicly available, a report
10 analyzing the first studies conducted by States under sub-
11 section (a)(1), including recommendations for improving
12 data collection on the cost of providing maternity, labor,
13 and delivery services.

14 (c) IMPLEMENTATION FUNDING.—In addition to the
15 amount appropriated under subsection (a)(4), there are
16 appropriated, out of any funds in the Treasury not other-
17 wise obligated, \$3,000,000 for fiscal year 2026, to remain
18 available until expended, to the Secretary of Health and
19 Human Services for purposes of implementing this sec-
20 tion.

21 **SEC. 6105. MODIFYING CERTAIN DISPROPORTIONATE**
22 **SHARE HOSPITAL ALLOTMENTS.**

23 (a) EXTENDING TENNESSEE DSH ALLOTMENTS.—
24 Section 1923(f)(6)(A)(vi) of the Social Security Act (42
25 U.S.C. 1396r-4(f)(6)(A)(vi)) is amended—

1 (1) in the heading, by striking “2025 AND A
2 PORTION OF FISCAL YEAR 2026” and inserting
3 “2027”; and

4 (2) by inserting “, and the DSH allotment for
5 Tennessee for the portion of fiscal year 2026 begin-
6 ning on January 31, 2026, and ending September
7 30, 2026, shall be \$35,351,507, which may be
8 claimed as fiscal year 2026 uncompensated care
9 costs, and the DSH allotment for Tennessee for fis-
10 cal year 2027, shall be \$53,100,000” before the pe-
11 riod.

12 (b) **ELIMINATING CERTAIN DSH ALLOTMENT RE-**
13 **DUCTIONS.**—Section 1923(f)(7)(A) of the Social Security
14 Act (42 U.S.C. 1396r-4(f)(7)(A)) is amended—

15 (1) in clause (i)—

16 (A) in the matter preceding subclause (I),
17 by striking “the period beginning January 31,
18 2026, and ending September 30, 2026, and for
19 each of fiscal years 2027 and 2028” and insert-
20 ing “fiscal year 2028”;

21 (B) in subclause (I), by striking “or pe-
22 riod”; and

23 (C) in subclause (II), by striking “or pe-
24 riod” each place it appears; and

1 (2) in clause (ii), by striking “the period begin-
2 ning January 31, 2026, and ending September 30,
3 2026, and for each of fiscal years 2027 and 2028”
4 and inserting “fiscal year 2028”.

5 **SEC. 6106. MODIFYING CERTAIN LIMITATIONS ON DIS-**
6 **PROPORTIONATE SHARE HOSPITAL PAY-**
7 **MENT ADJUSTMENTS UNDER THE MEDICAID**
8 **PROGRAM.**

9 (a) IN GENERAL.—Section 1923(g) of the Social Se-
10 curity Act (42 U.S.C. 1396r-4(g)) is amended—

11 (1) in paragraph (1)—

12 (A) in subparagraph (A)—

13 (i) in the matter preceding clause (i),
14 by striking “(other than a hospital de-
15 scribed in paragraph (2)(B))”;

16 (ii) in clause (i), by inserting “with
17 respect to such hospital and year” after
18 “described in subparagraph (B)”; and

19 (iii) in clause (ii)—

20 (I) in subclause (I), by striking
21 “and” at the end;

22 (II) in subclause (II), by striking
23 the period and inserting “; and”; and

24 (III) by adding at the end the
25 following new subclause:

1 “(III) payments made under title
2 XVIII or by an applicable plan (as de-
3 fined in section 1862(b)(8)(F)) for
4 such services.”; and

5 (B) in subparagraph (B)—

6 (i) in the matter preceding clause (i),
7 by striking “in this clause are” and insert-
8 ing “in this subparagraph are, with respect
9 to a hospital and a year,”; and

10 (ii) by adding at the end the following
11 new clause:

12 “(iii) Individuals who are eligible for
13 medical assistance under the State plan or
14 under a waiver of such plan and for whom
15 the State plan or waiver is a payor for
16 such services after application of benefits
17 under title XVIII or under an applicable
18 plan (as defined in section 1862(b)(8)(F)),
19 but only if the hospital has in the aggre-
20 gate incurred costs exceeding payments
21 under such State plan, waiver, title XVIII,
22 or applicable plan for such services fur-
23 nished to such individuals during such
24 year.”;

25 (2) by striking paragraph (2);

1 (3) by redesignating paragraph (3) as para-
2 graph (2); and

3 (4) in paragraph (2), as so redesignated, by
4 striking “Notwithstanding paragraph (2) of this
5 subsection (as in effect on October 1, 2021), para-
6 graph (2)” and inserting “Paragraph (2)”.

7 (b) EFFECTIVE DATE.—

8 (1) IN GENERAL.—Except as provided in para-
9 graph (2), the amendments made by this section
10 shall apply to payment adjustments made under sec-
11 tion 1923 of the Social Security Act (42 U.S.C.
12 1396r-4) for Medicaid State plan rate years begin-
13 ning on or after the date of enactment of this Act.

14 (2) STATE OPTION TO DISTRIBUTE UNSPENT
15 DSH ALLOTMENTS FROM PRIOR YEARS UP TO MODI-
16 FIED CAP.—

17 (A) IN GENERAL.—If, for any Medicaid
18 State plan rate year that begins on or after Oc-
19 tober 1, 2022, and before the date of enactment
20 of this Act, a State did not spend the full
21 amount of its Federal fiscal year allotment
22 under section 1923 of the Social Security Act
23 (42 U.S.C. 1396r-4) applicable to that State
24 plan rate year, the State may use the unspent
25 portion of such allotment to increase the

1 amount of any payment adjustment made to a
2 hospital for such rate year, provided that—

3 (i) such payment adjustment (as so
4 increased) is consistent with subsection (g)
5 of such section (as amended by this sec-
6 tion); and

7 (ii) the total amount of all payment
8 adjustments for the State plan rate year
9 (as so increased) does not exceed the dis-
10 proportionate share hospital allotment for
11 the State and applicable Federal fiscal
12 year under subsection (f) of such section.

13 (B) NO RECOUPMENT OF PAYMENTS AL-
14 READY MADE TO HOSPITALS.—A State shall not
15 recoup any payment adjustment made by the
16 State to a hospital for a Medicaid State plan
17 rate year described in subparagraph (A) if such
18 payment adjustment is consistent with section
19 1923(g) of such Act (42 U.S.C. 1396r–4(g)) as
20 in effect on October 1, 2021.

21 (C) AUTHORITY TO PERMIT RETROACTIVE
22 MODIFICATION OF STATE PLAN AMENDMENTS
23 TO ALLOW FOR INCREASES.—

24 (i) IN GENERAL.—Subject to clause

25 (ii), solely for the purpose of allowing a

1 State to increase the amount of a payment
2 adjustment to a hospital for a Medicaid
3 State plan rate year described in subpara-
4 graph (A) pursuant to this paragraph, a
5 State may retroactively modify a provision
6 of the Medicaid State plan, a waiver of
7 such plan, or a State plan amendment that
8 relates to such rate year and the Secretary
9 may approve such modification.

10 (ii) DEADLINE.—A State may not
11 submit a request for approval of a retro-
12 active modification to a provision of the
13 Medicaid State plan, a waiver of such plan,
14 or a State plan amendment for a Medicaid
15 State plan rate year after the date by
16 which the State is required to submit the
17 independent certified audit for such State
18 plan rate year as required under section
19 1923(j)(2) of the Social Security Act (42
20 U.S.C. 1396r-4(j)(2)).

21 (D) REPORTING.—If a State increases a
22 payment adjustment made to a hospital for a
23 Medicaid State plan rate year pursuant to this
24 paragraph, the State shall include information
25 in such form and manner as the Secretary shall

1 specify on such increased payment adjustment
2 as part of the annual report submitted by the
3 State under section 1923(j)(1) of the Social Se-
4 curity Act (42 U.S.C. 1396r-4(j)(1)) for such
5 State plan rate year or, if necessary, as deter-
6 mined by the Secretary, in an amendment to
7 such annual report.

8 **TITLE II—MEDICARE**

9 **SEC. 6201. EXTENSION OF INCREASED INPATIENT HOS-** 10 **PITAL PAYMENT ADJUSTMENT FOR CERTAIN** 11 **LOW-VOLUME HOSPITALS.**

12 (a) IN GENERAL.—Section 1886(d)(12) of the Social
13 Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

14 (1) in subparagraph (B), by striking “during
15 the portion of fiscal year 2026 beginning on January
16 31, 2026, and ending on September 30, 2026, and
17 in fiscal year 2027” and inserting “during the por-
18 tion of fiscal year 2027 beginning on January 1,
19 2027, and ending on September 30, 2027, and in
20 fiscal year 2028”;

21 (2) in subparagraph (C)(i)—

22 (A) in the matter preceding subclause (I),
23 by striking “through 2025 and the portion of
24 fiscal year 2026 beginning on October 1, 2025,
25 and ending on January 30, 2026” and inserting

1 “through 2026 and the portion of fiscal year
2 2027 beginning on October 1, 2026, and ending
3 on December 31, 2026”;

4 (B) in subclause (III), by striking
5 “through 2025 and the portion of fiscal year
6 2026 beginning on October 1, 2025, and ending
7 on January 30, 2026” and inserting “through
8 2026 and the portion of fiscal year 2027 begin-
9 ning on October 1, 2026, and ending on De-
10 cember 31, 2026”; and

11 (C) in subclause (IV), by striking “the por-
12 tion of fiscal year 2026 beginning on January
13 31, 2026, and ending on September 30, 2026,
14 and fiscal year 2027” and inserting “the por-
15 tion of fiscal year 2027 beginning on January
16 1, 2027, and ending on September 30, 2027,
17 and fiscal year 2028”; and

18 (3) in subparagraph (D)—

19 (A) in the matter preceding clause (i), by
20 striking “through 2025 or during the portion of
21 fiscal year 2026 beginning on October 1, 2025,
22 and ending on January 30, 2026” and inserting
23 “through 2026 or during the portion of fiscal
24 year 2027 beginning on October 1, 2026, and
25 ending on December 31, 2026”; and

1 (B) in clause (ii), by striking “through
2 2025 and the portion of fiscal year 2026 begin-
3 ning on October 1, 2025, and ending on Janu-
4 ary 30, 2026” and inserting “through 2026 and
5 the portion of fiscal year 2027 beginning on Oc-
6 tober 1, 2026, and ending on December 31,
7 2026”.

8 (b) IMPLEMENTATION.—Notwithstanding any other
9 provision of law, the Secretary of Health and Human
10 Services may implement the amendments made by this
11 section by program instruction or otherwise.

12 **SEC. 6202. EXTENSION OF THE MEDICARE-DEPENDENT**
13 **HOSPITAL (MDH) PROGRAM.**

14 (a) IN GENERAL.—Section 1886(d)(5)(G) of the So-
15 cial Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amend-
16 ed—

17 (1) in clause (i), by striking “January 31,
18 2026” and inserting “January 1, 2027”; and

19 (2) in clause (ii)(II), by striking “January 31,
20 2026” and inserting “January 1, 2027”.

21 (b) CONFORMING AMENDMENTS.—

22 (1) IN GENERAL.—Section 1886(b)(3)(D) of
23 the Social Security Act (42 U.S.C.
24 1395ww(b)(3)(D)) is amended—

1 (A) in the matter preceding clause (i), by
2 striking “January 31, 2026” and inserting
3 “January 1, 2027”; and

4 (B) in clause (iv), by striking “through fis-
5 cal year 2025 and the portion of fiscal year
6 2026 beginning on October 1, 2025, and ending
7 on January 30, 2026” and inserting “through
8 fiscal year 2026 and the portion of fiscal year
9 2027 beginning on October 1, 2026, and ending
10 on December 31, 2026”.

11 (2) PERMITTING HOSPITALS TO DECLINE RE-
12 CLASSIFICATION.—Section 13501(e)(2) of the Omni-
13 bus Budget Reconciliation Act of 1993 (42 U.S.C.
14 1395ww note) is amended by striking “through fis-
15 cal year 2025, or the portion of fiscal year 2026 be-
16 ginning on October 1, 2025, and ending on January
17 30, 2026” and inserting “through fiscal year 2026,
18 or the portion of fiscal year 2027 beginning on Octo-
19 ber 1, 2026, and ending on December 31, 2026”.

20 **SEC. 6203. EXTENSION OF ADD-ON PAYMENTS FOR AMBU-**
21 **LANCE SERVICES.**

22 Section 1834(l) of the Social Security Act (42 U.S.C.
23 1395m(l)) is amended—

24 (1) in paragraph (12)(A), by striking “January
25 31, 2026” and inserting “January 1, 2028”; and

1 (2) in paragraph (13), by striking “January 31,
2 2026” each place it appears and inserting “January
3 1, 2028” in each such place.

4 **SEC. 6204. EXTENDING INCENTIVE PAYMENTS FOR PAR-**
5 **TICIPATION IN ELIGIBLE ALTERNATIVE PAY-**
6 **MENT MODELS.**

7 (a) IN GENERAL.—Section 1833(z) of the Social Se-
8 curity Act (42 U.S.C. 1395l(z)) is amended—

9 (1) in paragraph (1)(A)—

10 (A) by inserting “, and during 2028,”
11 after “with 2026”; and

12 (B) by inserting “, or, with respect to
13 2028, 3.1 percent” after “1.88 percent”;

14 (2) in paragraph (2)—

15 (A) in subparagraph (B)—

16 (i) in the heading, by inserting “AND
17 2028” after “2026”; and

18 (ii) in the matter preceding clause (i),
19 by inserting “and 2028” after “2026”;

20 (B) in subparagraph (C)—

21 (i) in the heading, by striking “BE-
22 GINNING IN 2027” and inserting “2027 AND
23 2029 AND SUBSEQUENT YEARS”; and

1 (ii) in the matter preceding clause (i),
2 by inserting “and 2029” after “2027”;
3 and
4 (C) in subparagraph (D), by striking “and
5 2026” and inserting “2026, and 2028”; and
6 (3) in paragraph (4)(B), by inserting “, or,
7 with respect to 2028, 3.1 percent” after “1.88 per-
8 cent”.

9 (b) CONFORMING AMENDMENTS.—Section
10 1848(q)(1)(C)(iii) of the Social Security Act (42 U.S.C.
11 1395w-4(q)(1)(C)(iii)) is amended—

12 (1) in subclause (II), by inserting “and 2028”
13 after “2026”; and

14 (2) in subclause (III), by inserting “and 2029”
15 after “2027”.

16 **SEC. 6205. EXTENSION OF FUNDING FOR QUALITY MEAS-**
17 **URE ENDORSEMENT, INPUT, AND SELECTION.**

18 Section 1890(d)(2) of the Social Security Act (42
19 U.S.C. 1395aaa(d)(2)) is amended—

20 (1) in the first sentence—

21 (A) by striking “and \$13,300,000” and in-
22 serting “\$13,300,000”; and

23 (B) by inserting the following before the
24 period at the end: “, and \$15,100,000 for fiscal
25 year 2027”; and

1 (2) in the third sentence, by striking “and
2 2026” and inserting “2026, and 2027”.

3 **SEC. 6206. EXTENSION OF FUNDING OUTREACH AND AS-**
4 **SISTANCE FOR LOW-INCOME PROGRAMS.**

5 (a) STATE HEALTH INSURANCE ASSISTANCE PRO-
6 GRAMS.—Subsection (a)(1)(B) of section 119 of the Medi-
7 care Improvements for Patients and Providers Act of 2008
8 (42 U.S.C. 1395b–3 note) is amended—

9 (1) in clause (xiv), by striking “and” at the
10 end;

11 (2) in clause (xv), by striking the period at the
12 end and inserting “; and”; and

13 (3) by inserting after clause (xv) the following
14 new clause:

15 “(xvi) for the period beginning on
16 January 31, 2026, and ending on Decem-
17 ber 31, 2027, \$30,000,000.”.

18 (b) AREA AGENCIES ON AGING.—Subsection
19 (b)(1)(B) of such section 119 is amended—

20 (1) in clause (xiv), by striking “and” at the
21 end;

22 (2) in clause (xv), by striking the period at the
23 end and inserting “; and”; and

24 (3) by inserting after clause (xv) the following
25 new clause:

1 “(xvi) for the period beginning on
2 January 31, 2026, and ending on Decem-
3 ber 31, 2027, \$30,000,000.”.

4 (c) AGING AND DISABILITY RESOURCE CENTERS.—
5 Subsection (c)(1)(B) of such section 119 is amended—

6 (1) in clause (xiv), by striking “and” at the
7 end;

8 (2) in clause (xv), by striking the period at the
9 end and inserting “; and”; and

10 (3) by inserting after clause (xv) the following
11 new clause:

12 “(xvi) for the period beginning on
13 January 31, 2026, and ending on Decem-
14 ber 31, 2027, \$10,000,000.”.

15 (d) COORDINATION OF EFFORTS TO INFORM OLDER
16 AMERICANS ABOUT BENEFITS AVAILABLE UNDER FED-
17 ERAL AND STATE PROGRAMS.—Subsection (d)(2) of such
18 section 119 is amended—

19 (1) in clause (xiv), by striking “and” at the
20 end;

21 (2) in clause (xv), by striking the period at the
22 end and inserting “; and”; and

23 (3) by inserting after clause (xv) the following
24 new clause:

1 “(xvi) for the period beginning on January
2 31, 2026, and ending on December 31, 2027,
3 \$30,000,000.”.

4 **SEC. 6207. EXTENSION OF FUNDING FOR MEDICARE HOS-**
5 **PICE SURVEYS.**

6 Section 3(a)(2) of the IMPACT Act of 2014 (Public
7 Law 113–185), as amended by section 6205 of division
8 F of the Continuing Appropriations, Agriculture, Legisla-
9 tive Branch, Military Construction and Veterans Affairs,
10 and Extensions Act, 2026 (Public Law 119–37), is
11 amended—

12 (1) in subparagraph (B), by striking “and” at
13 the end;

14 (2) in subparagraph (C), by striking the period
15 at the end and inserting “; and”; and

16 (3) by adding at the end the following new sub-
17 paragraph:

18 “(D) \$4,400,000 for the period beginning
19 on January 31, 2026, and ending on December
20 31, 2026, to remain available until expended.”.

21 **SEC. 6208. EXTENSION OF THE WORK GEOGRAPHIC INDEX**
22 **FLOOR.**

23 Section 1848(e)(1)(E) of the Social Security Act (42
24 U.S.C. 1395w–4(e)(1)(E)) is amended by striking “Janu-
25 ary 31, 2026” and inserting “January 1, 2027”.

1 **SEC. 6209. EXTENSION OF CERTAIN TELEHEALTH FLEXI-**
2 **BILITIES.**

3 (a) REMOVING GEOGRAPHIC REQUIREMENTS AND
4 EXPANDING ORIGINATING SITES FOR TELEHEALTH
5 SERVICES.—Section 1834(m) of the Social Security Act
6 (42 U.S.C. 1395m(m)) is amended—

7 (1) in paragraph (2)(B)(iii), by striking “end-
8 ing January 30, 2026” and inserting “ending De-
9 cember 31, 2027”; and

10 (2) in paragraph (4)(C)(iii), by striking “ending
11 on January 30, 2026” and inserting “ending on De-
12 cember 31, 2027”.

13 (b) EXPANDING PRACTITIONERS ELIGIBLE TO FUR-
14 NISH TELEHEALTH SERVICES.—Section 1834(m)(4)(E)
15 of the Social Security Act (42 U.S.C. 1395m(m)(4)(E))
16 is amended by striking “ending on January 30, 2026” and
17 inserting “ending on December 31, 2027”.

18 (c) EXTENDING TELEHEALTH SERVICES FOR FED-
19 ERALLY QUALIFIED HEALTH CENTERS AND RURAL
20 HEALTH CLINICS.—Section 1834(m)(8)(A) of the Social
21 Security Act (42 U.S.C. 1395m(m)(8)(A)) is amended by
22 striking “ending on January 30, 2026” and inserting
23 “ending on December 31, 2027”.

24 (d) DELAYING THE IN-PERSON REQUIREMENTS
25 UNDER MEDICARE FOR MENTAL HEALTH SERVICES

1 FURNISHED THROUGH TELEHEALTH AND TELE-
2 COMMUNICATIONS TECHNOLOGY.—

3 (1) DELAY IN REQUIREMENTS FOR MENTAL
4 HEALTH SERVICES FURNISHED THROUGH TELE-
5 HEALTH.—Section 1834(m)(7)(B)(i) of the Social
6 Security Act (42 U.S.C. 1395m(m)(7)(B)(i)) is
7 amended, in the matter preceding subclause (I), by
8 striking “on or after January 31, 2026” and insert-
9 ing “on or after January 1, 2028”.

10 (2) MENTAL HEALTH VISITS FURNISHED BY
11 RURAL HEALTH CLINICS.—Section 1834(y)(2) of the
12 Social Security Act (42 U.S.C. 1395m(y)(2)) is
13 amended by striking “January 31, 2026” and in-
14 serting “January 1, 2028”.

15 (3) MENTAL HEALTH VISITS FURNISHED BY
16 FEDERALLY QUALIFIED HEALTH CENTERS.—Section
17 1834(o)(4)(B) of the Social Security Act (42 U.S.C.
18 1395m(o)(4)(B)) is amended by striking “January
19 31, 2026” and inserting “January 1, 2028”.

20 (e) ALLOWING FOR THE FURNISHING OF AUDIO-
21 ONLY TELEHEALTH SERVICES.—Section 1834(m)(9) of
22 the Social Security Act (42 U.S.C. 1395m(m)(9)) is
23 amended by striking “ending on January 30, 2026” and
24 inserting “ending on December 31, 2027”.

1 (f) EXTENDING USE OF TELEHEALTH TO CONDUCT
2 FACE-TO-FACE ENCOUNTER PRIOR TO RECERTIFICATION
3 OF ELIGIBILITY FOR HOSPICE CARE.—

4 (1) IN GENERAL.—Section 1814(a)(7)(D)(i)(II)
5 of the Social Security Act (42 U.S.C.
6 1395f(a)(7)(D)(i)(II)) is amended—

7 (A) by striking “ending on January 30,
8 2026” and inserting “ending on December 31,
9 2027”; and

10 (B) by inserting “, except that this sub-
11 clause shall not apply in the case of such an en-
12 counter with an individual occurring on or after
13 January 31, 2026, if such individual is located
14 in an area that is subject to a moratorium on
15 the enrollment of hospice programs under this
16 title pursuant to section 1866(j)(7), if such in-
17 dividual is receiving hospice care from a pro-
18 vider that is subject to enhanced oversight
19 under this title pursuant to section 1866(j)(3),
20 or if such encounter is performed by a hospice
21 physician or nurse practitioner who is not en-
22 rolled under section 1866(j) and is not an opt-
23 out physician or practitioner (as defined in sec-
24 tion 1802(b)(6)(D))” before the semicolon.

1 (2) REQUIRING USE OF MODIFIER.—Section
2 1814(a)(7)(D)(i)(II) of the Social Security Act (42
3 U.S.C. 1395f(a)(7)(D)(i)(II)), as amended by para-
4 graph (1), is further amended by inserting “, but
5 only if, in the case of such an encounter occurring
6 on or after January 1, 2027, any hospice claim in-
7 cludes 1 or more modifiers or codes (as specified by
8 the Secretary) to indicate that such encounter was
9 conducted via telehealth” after “as determined ap-
10 propriate by the Secretary”.

11 (g) REQUIRING MODIFIERS FOR TELEHEALTH SERV-
12 ICES IN CERTAIN INSTANCES.—Section 1834(m) of the
13 Social Security Act (42 U.S.C. 1395m(m)) is amended by
14 adding at the end the following new paragraph:

15 “(10) REQUIRED USE OF MODIFIERS IN CER-
16 TAIN INSTANCES.—Not later than January 1, 2027,
17 the Secretary shall establish requirements to include
18 one or more codes or modifiers, as determined ap-
19 propriate by the Secretary, in the case of—

20 “(A) claims for telehealth services under
21 this subsection that are furnished through a
22 telehealth virtual platform—

23 “(i) by a physician or practitioner
24 that contracts with an entity that owns
25 such virtual platform; or

1 “(ii) for which a physician or practi-
2 tioner has a payment arrangement with an
3 entity for use of such virtual platform; and
4 “(B) claims for telehealth services under
5 this subsection that are furnished incident to a
6 physician’s or practitioner’s professional serv-
7 ice.”.

8 (h) IMPLEMENTATION.—Notwithstanding any other
9 provision of law, the Secretary of Health and Human
10 Services may implement the amendments made by this
11 section by program instruction or otherwise.

12 **SEC. 6210. EXTENDING ACUTE HOSPITAL CARE AT HOME**
13 **WAIVER FLEXIBILITIES.**

14 (a) IN GENERAL.—Section 1866G(a)(1) of the Social
15 Security Act (42 U.S.C. 1395cc–7(a)(1)) is amended by
16 striking “January 30, 2026” and inserting “September
17 30, 2030”.

18 (b) REQUIRING ADDITIONAL STUDY AND REPORT.—
19 Section 1866G of the Social Security Act (42 U.S.C.
20 1395cc–7) is amended—

21 (1) in subsection (a)(3)(E)—

22 (A) in clause (ii), by striking “the study
23 described in subsection (b)” and inserting “the
24 studies described in subsections (b) and (c)”;
25 and

1 (B) by adding at the end the following new
2 flush sentence:

3 “The Secretary may require that such data and
4 information be submitted through a hospital’s
5 cost report, through such survey instruments as
6 the Secretary may develop, through medical
7 record information, or through such other
8 means as the Secretary determines appro-
9 priate.”;

10 (2) in subsection (b)—

11 (A) in the subsection heading, by striking
12 “STUDY” and inserting “INITIAL STUDY”; and

13 (B) in paragraph (3), by striking “sub-
14 section” and inserting “section”;

15 (3) by redesignating subsections (c) and (d) as
16 subsections (d) and (e), respectively;

17 (4) by inserting after subsection (b) the fol-
18 lowing new subsection:

19 “(c) SUBSEQUENT STUDY AND REPORT.—

20 “(1) IN GENERAL.—Not later than September
21 30, 2029, the Secretary shall conduct a study to—

22 “(A) analyze, to the extent practicable, the
23 criteria established by hospitals under the Acute
24 Hospital Care at Home initiative to determine

1 which individuals may be furnished services
2 under such initiative; and

3 “(B) analyze and compare (both within
4 and between hospitals participating in the ini-
5 tiative, and relative to comparable hospitals
6 that do not participate in the initiative, for rel-
7 evant parameters such as diagnosis-related
8 groups)—

9 “(i) quality of care furnished to indi-
10 viduals with similar conditions and charac-
11 teristics in the inpatient setting and
12 through the Acute Hospital Care at Home
13 initiative, including health outcomes, hos-
14 pital readmission rates (including readmis-
15 sions both within and beyond 30 days post-
16 discharge), hospital mortality rates, length
17 of stay, infection rates, composition of care
18 team (including the types of labor used,
19 such as contracted labor), the ratio of
20 nursing staff, transfers from the hospital
21 to the home, transfers from the home to
22 the hospital (including the timing, fre-
23 quency, and causes of such transfers),
24 transfers and discharges to post-acute care
25 settings (including the timing, frequency,

1 and causes of such transfers and dis-
2 charges), and patient and caregiver experi-
3 ence of care;

4 “(ii) clinical conditions treated and di-
5 agnosis-related groups of discharges from
6 inpatient settings relative to discharges
7 from the Acute Hospital Care at Home ini-
8 tiative;

9 “(iii) costs incurred by the hospital
10 for furnishing care in inpatient settings
11 relative to costs incurred by the hospital
12 for furnishing care through the Acute Hos-
13 pital Care at Home initiative, including
14 costs relating to staffing, equipment, food,
15 prescriptions, and other services, as deter-
16 mined by the Secretary;

17 “(iv) the quantity, mix, and intensity
18 of services (such as in-person visits and
19 virtual contacts with patients and the in-
20 tensity of such services) furnished in inpa-
21 tient settings relative to the Acute Hospital
22 Care at Home initiative, and, to the extent
23 practicable, the nature and extent of family
24 or caregiver involvement;

1 “(v) socioeconomic information on in-
2 dividuals treated in comparable inpatient
3 settings relative to the initiative, including
4 racial and ethnic data, income, housing,
5 geographic proximity to the brick-and-mor-
6 tar facility and whether such individuals
7 are dually eligible for benefits under this
8 title and title XIX; and

9 “(vi) the quality of care, outcomes,
10 costs, quantity and intensity of services,
11 and other relevant metrics between individ-
12 uals who entered into the Acute Hospital
13 Care at Home initiative directly from an
14 emergency department compared with indi-
15 viduals who entered into the Acute Hos-
16 pital Care at Home initiative directly from
17 an existing inpatient stay in a hospital.

18 “(2) SELECTION BIAS.—In conducting the
19 study under paragraph (1), the Secretary shall, to
20 the extent practicable, analyze and compare individ-
21 uals who participate and do not participate in the
22 initiative controlling for selection bias or other fac-
23 tors that may impact the reliability of data.

1 “(3) REPORT.—Not later than September 30,
2 2029, the Secretary of Health and Human Services
3 shall—

4 “(A) submit to the Committee on Ways
5 and Means of the House of Representatives and
6 the Committee on Finance of the Senate a re-
7 port on the study conducted under paragraph
8 (1); and

9 “(B) make such report publicly available
10 on a website of the Centers for Medicare &
11 Medicaid Services.

12 “(4) FUNDING.—In addition to amounts other-
13 wise available, there is appropriated to the Centers
14 for Medicare & Medicaid Services Program Manage-
15 ment Account for fiscal year 2026, out of any
16 amounts in the Treasury not otherwise appropriated,
17 \$2,500,000, to remain available until expended, for
18 purposes of carrying out this section.”; and

19 (5) in subsection (e), as redesignated by para-
20 graph (3), by striking “and (b)(1)” and inserting “,
21 (b)(1), and (c)(1)”.

22 **SEC. 6211. IN-HOME CARDIOPULMONARY REHABILITATION**
23 **FLEXIBILITY.**

24 (a) IN GENERAL.—Section 1861(eee)(2)(A)(ii) of the
25 Social Security Act (42 U.S.C. 1395x(eee)(2)(A)(ii)) is

1 amended by inserting “(including, with respect to items
2 and services furnished through audio and video real-time
3 communications technology (excluding audio-only) on or
4 after January 31, 2026, and before January 1, 2028, in
5 the home of an individual who is an outpatient of the hos-
6 pital)” after “outpatient basis”.

7 (b) IMPLEMENTATION.—Notwithstanding any other
8 provision of law, the Secretary of Health and Human
9 Services may implement the amendment made by sub-
10 section (a) by program instruction or otherwise.

11 **SEC. 6212. ENHANCING CERTAIN PROGRAM INTEGRITY RE-**
12 **QUIREMENTS FOR DME UNDER MEDICARE.**

13 (a) DURABLE MEDICAL EQUIPMENT.—

14 (1) IN GENERAL.—Section 1834(a) of the So-
15 cial Security Act (42 U.S.C. 1395m(a)) is amended
16 by adding at the end the following new paragraph:

17 “(23) MASTER LIST INCLUSION AND CLAIM RE-
18 VIEW FOR CERTAIN ITEMS.—

19 “(A) MASTER LIST INCLUSION.—Begin-
20 ning January 1, 2029, for purposes of the Mas-
21 ter List described in section 414.234(b) of title
22 42, Code of Federal Regulations (or any suc-
23 cessor regulation), in determining which items
24 have aberrant billing patterns (as such term is
25 used for purposes of such section), the Sec-

1 retary shall also treat an item for which pay-
2 ment may be made under this subsection as
3 having such an aberrant billing pattern if the
4 Secretary determines that, without explanatory
5 contributing factors (such as furnishing emer-
6 gent care services), a substantial number of
7 claims for such items under this subsection are
8 for such items ordered by a physician or practi-
9 tioner who has not previously (during a period
10 of not less than 24 months, as established by
11 the Secretary) furnished to the individual in-
12 volved any item or service for which payment
13 may be made under this title.

14 “(B) CLAIM REVIEW.—With respect to
15 items furnished on or after January 1, 2029,
16 that are included on the Master List pursuant
17 to subparagraph (A), if such an item is not sub-
18 ject to a determination of coverage in advance
19 pursuant to paragraph (15)(C), the Secretary
20 may conduct prepayment review of claims for
21 payment for such item.”.

22 (2) CONFORMING AMENDMENT FOR PROS-
23 THETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—
24 Section 1834(h)(3) of the Social Security Act (42
25 U.S.C. 1395m(h)(3)) is amended by inserting “, and

1 paragraph (23) of subsection (a) shall apply to pros-
2 thetic devices, orthotics, and prosthetics in the same
3 manner as such provision applies to items for which
4 payment may be made under such subsection” be-
5 fore the period at the end.

6 (b) REPORT ON IDENTIFYING CLINICAL DIAGNOSTIC
7 LABORATORY TESTS AT HIGH RISK FOR FRAUD AND EF-
8 FECTIVE MITIGATION MEASURES.—Not later than Janu-
9 ary 1, 2028, the Inspector General of the Department of
10 Health and Human Services shall submit to Congress a
11 report assessing fraud risks relating to clinical diagnostic
12 laboratory tests for which payment may be made under
13 section 1834A of the Social Security Act (42 U.S.C.
14 1395m–1) and effective tools for reducing such fraudulent
15 claims. The report may include, at the Inspector General’s
16 discretion—

17 (1) which, if any, clinical diagnostic laboratory
18 tests are identified as being at high risk of fraudu-
19 lent claims, and an analysis of the factors that con-
20 tribute to such risk;

21 (2) with respect to a clinical diagnostic labora-
22 tory test identified under paragraph (1) as being at
23 high risk of fraudulent claims—

24 (A) the amount payable under such section
25 1834A with respect to such test;

1 (B) the number of such tests furnished to
2 individuals enrolled under part B of title XVIII
3 of the Social Security Act (42 U.S.C. 1395j et
4 seq.);

5 (C) whether an order for such a test was
6 more likely to come from a provider with whom
7 the individual involved did not have a prior re-
8 lationship, as determined on the basis of prior
9 payment experience; and

10 (D) the frequency with which a claim for
11 payment under such section 1834A included the
12 payment modifier identified by code 59 or 91;
13 and

14 (3) suggested strategies for reducing the num-
15 ber of fraudulent claims made with respect to tests
16 so identified as being at high risk, including—

17 (A) an analysis of whether the Centers for
18 Medicare & Medicaid Services can detect aber-
19 rant billing patterns with respect to such tests
20 in a timely manner;

21 (B) any strategies for identifying and mon-
22 itoring the providers who are outliers with re-
23 spect to the number of such tests that such pro-
24 viders order; and

1 (C) targeted education efforts to mitigate
2 improper billing for such tests; and

3 (4) such other information as the Inspector
4 General determines appropriate.

5 (c) FUNDING.—In addition to amounts otherwise
6 available, there is appropriated to the Inspector General
7 of the Department of Health and Human Services, out
8 of any money in the Treasury not otherwise appropriated,
9 \$1,200,000 for fiscal year 2026, to remain available until
10 expended, to carry out this section.

11 **SEC. 6213. GUIDANCE ON FURNISHING SERVICES VIA TELE-**
12 **HEALTH TO INDIVIDUALS WITH LIMITED**
13 **ENGLISH PROFICIENCY.**

14 (a) IN GENERAL.—Not later than 1 year after the
15 date of enactment of this section, the Secretary of Health
16 and Human Services, in consultation with 1 or more enti-
17 ties from each of the categories described in paragraphs
18 (1) through (7) of subsection (b), shall issue and dissemi-
19 nate, or update and revise as applicable, guidance for the
20 entities described in such subsection on the following:

21 (1) Best practices on facilitating and inte-
22 grating use of interpreters during a telemedicine ap-
23 pointment.

24 (2) Best practices on providing accessible in-
25 structions on how to access telecommunications sys-

1 tems (as such term is used for purposes of section
2 1834(m) of the Social Security Act (42 U.S.C.
3 1395m(m)) for individuals with limited English pro-
4 ficiency.

5 (3) Best practices on improving access to dig-
6 ital patient portals for individuals with limited
7 English proficiency.

8 (4) Best practices on integrating the use of
9 video platforms that enable multi-person video calls
10 furnished via a telecommunications system for pur-
11 poses of providing interpretation during a telemedi-
12 cine appointment for an individual with limited
13 English proficiency.

14 (5) Best practices for providing patient mate-
15 rials, communications, and instructions in multiple
16 languages, including text message appointment re-
17 minders and prescription information.

18 (b) ENTITIES DESCRIBED.—For purposes of sub-
19 section (a), an entity described in this subsection is an
20 entity in 1 or more of the following categories:

21 (1) Health information technology service pro-
22 viders, including—

23 (A) electronic medical record companies;

24 (B) remote patient monitoring companies;

25 and

1 (C) telehealth or mobile health vendors and
2 companies.

3 (2) Health care providers, including—

4 (A) physicians; and

5 (B) hospitals.

6 (3) Health insurers.

7 (4) Language service companies.

8 (5) Interpreter or translator professional asso-
9 ciations.

10 (6) Health and language services quality certifi-
11 cation organizations.

12 (7) Patient and consumer advocates, including
13 such advocates that work with individuals with lim-
14 ited English proficiency.

15 **SEC. 6214. INCLUSION OF VIRTUAL DIABETES PREVENTION**
16 **PROGRAM SUPPLIERS IN MDPP EXPANDED**
17 **MODEL.**

18 (a) IN GENERAL.—For the period beginning on Jan-
19 uary 1, 2026, and ending on December 31, 2029—

20 (1) an entity may participate in the MDPP by
21 offering only MDPP services via distance learning or
22 online delivery modalities if such entity meets the
23 conditions for enrollment as an MDPP supplier;

24 (2) if an entity participates in the MDPP in the
25 manner described in paragraph (1), in the case of

1 online MDPP services furnished by such entity to an
2 MDPP beneficiary who was not located in the same
3 State as the entity at the time such services were
4 furnished, the entity shall not be prohibited from
5 submitting a claim for payment for such services
6 solely by reason of the location of such beneficiary
7 at such time; and

8 (3) no limit is applied on the number of times
9 an individual may enroll in the MDPP.

10 (b) DEFINITIONS.—In this section:

11 (1) MDPP.—The term “MDPP” means the
12 Medicare Diabetes Prevention Program (as such
13 term is defined in section 410.79(b) of title 42, Code
14 of Federal Regulations).

15 (2) REGULATORY TERMS.—The terms “distance
16 learning”, “MDPP beneficiary”, “MDPP services”,
17 “MDPP supplier”, and “online” have the meanings
18 given such terms in section 410.79(b) of title 42,
19 Code of Federal Regulations.

20 (3) SECRETARY.—The term “Secretary” means
21 the Secretary of Health and Human Services.

22 (c) IMPLEMENTATION.—Notwithstanding any other
23 provision of law, the Secretary may implement this section
24 by program instruction or otherwise.

1 **SEC. 6215. MEDICATION-INDUCED MOVEMENT DISORDER**
2 **OUTREACH AND EDUCATION.**

3 Not later than January 1, 2028, the Secretary of
4 Health and Human Services shall use existing communica-
5 tions mechanisms to provide education and outreach to
6 physicians and appropriate non-physician practitioners
7 participating under the Medicare program under title
8 XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)
9 with respect to periodic screening for medication-induced
10 movement disorders that are associated with the treat-
11 ment of mental health disorders in at-risk patients, as well
12 as resources related to clinical guidelines and best prac-
13 tices for furnishing such screening services through tele-
14 health. Such education and outreach shall include infor-
15 mation on how to account for such screening services in
16 evaluation and management code selection. The Secretary
17 shall, to the extent practicable, seek input from relevant
18 stakeholders to inform such education and outreach. Such
19 education and outreach may also address other relevant
20 screening services furnished through telehealth, as the
21 Secretary determines appropriate.

22 **SEC. 6216. REPORT ON WEARABLE MEDICAL DEVICES.**

23 Not later than 18 months after the date of the enact-
24 ment of this Act, the Comptroller General of the United
25 States shall conduct a technology assessment of, and sub-
26 mit to Congress a report on, the capabilities and limita-

1 tions of wearable medical devices used to support clinical
2 decision-making. Such report shall include a description
3 of—

4 (1) the potential for such devices to accurately
5 prescribe treatments;

6 (2) an examination of the benefits and chal-
7 lenges of artificial intelligence to augment such ca-
8 pabilities; and

9 (3) policy options to enhance the benefits and
10 mitigate potential challenges of developing or using
11 such devices.

12 **SEC. 6217. EXTENSION OF TEMPORARY INCLUSION OF AU-**
13 **THORIZED ORAL ANTIVIRAL DRUGS AS COV-**
14 **ERED PART D DRUGS.**

15 Section 1860D–2(e)(1)(C) of the Social Security Act
16 (42 U.S.C. 1395w–102(e)(1)(C)) is amended by striking
17 “January 30, 2026” and inserting “December 31, 2026”.

18 **SEC. 6218. EXTENSION OF ADJUSTMENT TO CALCULATION**
19 **OF HOSPICE CAP AMOUNT UNDER MEDI-**
20 **CARE.**

21 Section 1814(i)(2)(B) of the Social Security Act (42
22 U.S.C. 1395f(i)(2)(B)) is amended—

23 (1) in clause (ii), by striking “2033” and in-
24 serting “2035”; and

1 (2) in clause (iii), by striking “2033” and in-
2 serting “2035”.

3 **SEC. 6219. ADJUSTMENTS TO MEDICARE PART D COST-**
4 **SHARING REDUCTIONS FOR LOW-INCOME IN-**
5 **DIVIDUALS.**

6 Section 1860D–14(a) of the Social Security Act (42
7 U.S.C. 1395w–114(a)) is amended—

8 (1) in paragraph (1)(D)(ii), by striking “that
9 does not exceed \$1 for” and all that follows through
10 the period at the end and inserting “that does not
11 exceed— “

12 “(I) for a plan year before
13 2028—

14 “(aa) for a generic drug or a
15 preferred drug that is a multiple
16 source drug (as defined in section
17 1927(k)(7)(A)(i)), \$1 or, if less,
18 the copayment amount applicable
19 to an individual under clause
20 (iii); and

21 “(bb) for any other drug, \$3
22 or, if less, the copayment amount
23 applicable to an individual under
24 clause (iii); and

1 “(II) for plan year 2028 and
2 each subsequent plan year—
3 “(aa) for a generic drug, \$0;
4 “(bb) for a preferred drug
5 that is a multiple source drug (as
6 defined in section
7 1927(k)(7)(A)(i)), the dollar
8 amount applied under this clause
9 for such a drug for the preceding
10 plan year, increased by the an-
11 nual percentage increase in the
12 consumer price index (all items;
13 U.S. city average) as of Sep-
14 tember of such preceding year,
15 or, if less, the copayment amount
16 applicable to an individual under
17 clause (iii); and
18 “(cc) for a drug not de-
19 scribed in either item (aa) or
20 (bb), the dollar amount applied
21 under this clause for such a drug
22 for the preceding plan year, in-
23 creased in the manner specified
24 in item (bb), or, if less, the co-

1 payment amount applicable to an
2 individual under clause (iii).

3 Any amount established under item (bb) or
4 (cc) of subclause (II), that is based on an
5 increase of \$1 or \$3, that is not a multiple
6 of 5 cents or 10 cents, respectively, shall
7 be rounded to the nearest multiple of 5
8 cents or 10 cents, respectively.”; and

9 (2) in paragraph (4)(A)(ii), by inserting “(be-
10 fore 2028)” after “a subsequent year”.

11 **SEC. 6220. REQUIRING ENHANCED AND ACCURATE LISTS**
12 **OF (REAL) HEALTH PROVIDERS ACT.**

13 (a) IN GENERAL.—Section 1852(c) of the Social Se-
14 curity Act (42 U.S.C. 1395w–22(c)) is amended—

15 (1) in paragraph (1)(C)—

16 (A) by striking “plan, and any” and insert-
17 ing “plan, any”; and

18 (B) by inserting the following before the
19 period: “, and, in the case of a specified MA
20 plan (as defined in paragraph (3)(C)), for plan
21 year 2028 and subsequent plan years, the infor-
22 mation described in paragraph (3)(B)”;

23 (2) by adding at the end the following new
24 paragraph:

25 “(3) PROVIDER DIRECTORY ACCURACY.—

1 “(A) IN GENERAL.—For plan year 2028
2 and subsequent plan years, each MA organiza-
3 tion offering a specified MA plan (as defined in
4 subparagraph (C)) shall, for each such plan of-
5 fered by the organization—

6 “(i) maintain, on a publicly available
7 internet website, an accurate provider di-
8 rectory that includes the information de-
9 scribed in subparagraph (B);

10 “(ii) not less frequently than once
11 every 90 days (or, in the case of a hospital
12 or any other facility determined appro-
13 priate by the Secretary, at a lesser fre-
14 quency specified by the Secretary but in no
15 case less frequently than once every 12
16 months), verify the provider directory in-
17 formation of each provider listed in such
18 directory and, if applicable, update such
19 information;

20 “(iii) if the organization is unable to
21 verify such information with respect to a
22 provider, include in such directory an indi-
23 cation that the information of such pro-
24 vider may not be up to date; and

1 “(iv) remove a provider from such di-
2 rectory within 5 business days if the orga-
3 nization determines that the provider is no
4 longer a provider participating in the net-
5 work of such plan.

6 “(B) PROVIDER DIRECTORY INFORMA-
7 TION.—The information described in this sub-
8 paragraph is information enrollees may need to
9 access covered benefits from a provider with
10 which such organization offering such plan has
11 an agreement for furnishing items and services
12 covered under such plan, such as name, spe-
13 cialty, contact information, primary office or fa-
14 cility addresses where items or services are fur-
15 nished, whether the provider is accepting new
16 patients, accommodations for people with dis-
17 abilities, cultural and linguistic capabilities, and
18 telehealth capabilities.

19 “(C) SPECIFIED MA PLAN.—In this para-
20 graph, the term ‘specified MA plan’ means—

21 “(i) a network-based plan (as defined
22 in subsection (d)(5)(C)); or

23 “(ii) a Medicare Advantage private
24 fee-for-service plan (as defined in section
25 1859(b)(2)) that meets the access stand-

1 ards under subsection (d)(4), in whole or
2 in part, through entering into contracts or
3 agreements as provided for under subpara-
4 graph (B) of such subsection.”.

5 (b) ACCOUNTABILITY FOR PROVIDER DIRECTORY
6 ACCURACY.—

7 (1) COST SHARING FOR SERVICES FURNISHED
8 BASED ON RELIANCE ON INCORRECT PROVIDER DI-
9 RECTORY INFORMATION.—Section 1852(d) of the
10 Social Security Act (42 U.S.C. 1395w-22(d)) is
11 amended—

12 (A) in paragraph (1)(C)—

13 (i) in clause (ii), by striking “or” at
14 the end;

15 (ii) in clause (iii), by striking the
16 semicolon at the end and inserting “, or”;
17 and

18 (iii) by adding at the end the fol-
19 lowing new clause:

20 “(iv) for plan year 2028 and subse-
21 quent plan years, in the case of a specified
22 MA plan (as defined in subsection
23 (c)(3)(C)), the services were furnished by a
24 provider that was not participating in the
25 network of such plan but was listed in the

1 provider directory of such plan on the date
2 on which the appointment was made, as
3 described in paragraph (7)(A);” and
4 (B) by adding at the end the following new
5 paragraph:

6 “(7) COST SHARING FOR SERVICES FURNISHED
7 BASED ON RELIANCE ON INCORRECT PROVIDER DI-
8 RECTORY INFORMATION.—

9 “(A) IN GENERAL.—For plan year 2028
10 and subsequent plan years, if an enrollee in a
11 specified MA plan (as defined in subsection
12 (c)(3)(C)) is furnished an item or service by a
13 provider that is not participating in the network
14 of such plan but is listed in the provider direc-
15 tory of such plan (as required to be provided to
16 an enrollee pursuant to subsection (c)(1)(C)) on
17 the date on which the appointment is made,
18 and if such item or service would otherwise be
19 covered under such plan if furnished by a pro-
20 vider that is participating in the network of
21 such plan, the MA organization offering such
22 plan shall ensure that the enrollee is only re-
23 sponsible for the lesser of—

1 “(i) the amount of cost sharing that
2 would apply if such provider had been par-
3 ticipating in the network of such plan; or

4 “(ii) the amount of cost sharing that
5 would otherwise apply (without regard to
6 this subparagraph).

7 “(B) NOTIFICATION REQUIREMENT.—For
8 plan year 2028 and subsequent plan years, each
9 MA organization that offers a specified MA
10 plan shall—

11 “(i) notify enrollees of their cost-shar-
12 ing protections under this paragraph and
13 make such notifications, to the extent
14 practicable, by not later than the first day
15 of an annual, coordinated election period
16 under section 1851(e)(3) with respect to a
17 year;

18 “(ii) include information regarding
19 such cost-sharing protections in the pro-
20 vider directory of each specified MA plan
21 offered by the MA organization.; and

22 “(iii) notify enrollees of their cost-
23 sharing protections under this paragraph
24 in the first explanation of benefits issued
25 in a plan year.”.

1 (2) REQUIRED PROVIDER DIRECTORY ACCU-
2 RACY ANALYSIS AND REPORTS.—

3 (A) IN GENERAL.—Section 1857(e) of the
4 Social Security Act (42 U.S.C. 1395w-27(e)) is
5 amended by adding at the end the following
6 new paragraph:

7 “(6) PROVIDER DIRECTORY ACCURACY ANAL-
8 YSIS AND REPORTS.—

9 “(A) IN GENERAL.—Beginning with plan
10 years beginning on or after January 1, 2028,
11 subject to subparagraph (C), a contract under
12 this section with an MA organization shall re-
13 quire the organization, for each specified MA
14 plan (as defined in section 1852(c)(3)(C)) of-
15 fered by the organization, to annually do the
16 following:

17 “(i) Conduct an analysis estimating
18 the accuracy of the provider directory in-
19 formation of such plan using a random
20 sample of providers included in such pro-
21 vider directory as follows:

22 “(I) Such a random sample shall
23 include a random sample of each spe-
24 cialty of providers with a high inaccu-
25 racy rate of provider directory infor-

1 mation relative to other specialties of
2 providers, as determined by the Sec-
3 retary.

4 “(II) For purposes of subclause
5 (I), one type of specialty may be pro-
6 viders specializing in mental health or
7 substance use disorder treatment.

8 “(ii) Submit to the Secretary a report
9 containing the results of the analysis con-
10 ducted under clause (i), including an accu-
11 racy score for such provider directory in-
12 formation (as determined using a plan
13 verification method specified by the Sec-
14 retary under subparagraph (B)(i)).

15 “(B) DETERMINATION OF ACCURACY
16 SCORE.—

17 “(i) IN GENERAL.—The Secretary
18 shall specify plan verification methods,
19 such as using telephonic verification or
20 other approaches using data sources main-
21 tained by an MA organization or using
22 publicly available data sets, that MA orga-
23 nizations may use for estimating accuracy
24 scores of the provider directory information

1 of specified MA plans offered by such or-
2 ganizations.

3 “(ii) ACCURACY SCORE METHODOLOGY.—With respect to each such meth-
4 OLOGY.—With respect to each such meth-
5 od specified by the Secretary as described
6 in clause (i), the Secretary shall specify a
7 methodology for MA organizations to use
8 in estimating such accuracy scores. Each
9 such methodology shall take into account
10 the administrative burden on plans and
11 providers and the relative importance of
12 certain provider directory information on
13 enrollee ability to access care.

14 “(C) EXCEPTION.—The Secretary may
15 waive the requirements of this paragraph in the
16 case of a specified MA plan with low enrollment
17 (as defined by the Secretary).

18 “(D) TRANSPARENCY.—Beginning with
19 plan years beginning on or after January 1,
20 2029, the Secretary shall post accuracy scores
21 (as reported under subparagraph (A)(ii)), in a
22 machine readable file, on an internet website
23 maintained by the Centers for Medicare & Med-
24 icaid Services.”.

1 (B) PROVISION OF INFORMATION TO
2 BENEFICIARIES.—Section 1851(d)(4) of the So-
3 cial Security Act (42 U.S.C. 1395w–21(d)(4))
4 is amended by adding at the end the following
5 new subparagraph:

6 “(F) PROVIDER DIRECTORY.—Beginning
7 with plan years beginning on or after January
8 1, 2029, in the case of a specified MA plan (as
9 defined in section 1852(e)(3)(C)), the accuracy
10 score of the plan’s provider directory (as re-
11 ported under section 1857(e)(6)(A)(ii)) listed
12 prominently on the plan’s provider directory.”.

13 (C) FUNDING.—In addition to amounts
14 otherwise available, there is appropriated to the
15 Centers for Medicare & Medicaid Services Pro-
16 gram Management Account, out of any money
17 in the Treasury not otherwise appropriated,
18 \$4,000,000 for fiscal year 2026, to remain
19 available until expended, to carry out the
20 amendments made by this paragraph.

21 (3) GAO STUDY AND REPORT.—

22 (A) ANALYSIS.—The Comptroller General
23 of the United States (in this paragraph referred
24 to as the “Comptroller General”) shall conduct
25 a study of the implementation of the amend-

1 ments made by paragraphs (1) and (2). To the
2 extent data are available and reliable, such
3 study shall include an analysis of—

4 (i) the use of cost-sharing protections
5 required under section 1852(d)(7)(A) of
6 the Social Security Act, as added by para-
7 graph (1);

8 (ii) the trends in provider directory in-
9 formation accuracy scores submitted to the
10 Secretary of Health and Human Services
11 under section 1857(e)(6)(A)(ii) of the So-
12 cial Security Act (as added by paragraph
13 (2)(A)), both overall and among providers
14 specializing in mental health or substance
15 use disorder treatment;

16 (iii) provider response rates by plan
17 verification methods;

18 (iv) administrative costs to providers
19 and Medicare Advantage organizations;
20 and

21 (v) other items determined appro-
22 priate by the Comptroller General.

23 (B) REPORT.—Not later than January 15,
24 2033, the Comptroller General shall submit to
25 Congress a report containing the results of the

1 study conducted under subparagraph (A), to-
2 gether with recommendations for such legisla-
3 tion and administrative action as the Comp-
4 troller General determines appropriate.

5 (c) GUIDANCE ON MAINTAINING ACCURATE PRO-
6 VIDER DIRECTORIES.—

7 (1) STAKEHOLDER MEETING.—

8 (A) IN GENERAL.—Not later than 6
9 months after the date of enactment of this Act,
10 the Secretary of Health and Human Services
11 (referred to in this subsection as the “Sec-
12 retary”) shall hold a public meeting to receive
13 input on approaches for maintaining accurate
14 provider directories for Medicare Advantage
15 plans under part C of title XVIII of the Social
16 Security Act (42 U.S.C. 1395w–21 et seq.), in-
17 cluding input on approaches for reducing ad-
18 ministrative burden, such as data standardiza-
19 tion, and best practices to maintain accurate
20 provider directory information.

21 (B) PARTICIPANTS.—Participants of the
22 meeting under subparagraph (A) shall include
23 representatives from the Centers for Medicare &
24 Medicaid Services and the Assistant Secretary
25 for Technology Policy and Office of the Na-

1 tional Coordinator for Health Information
2 Technology. Such meeting shall be open to the
3 public. To the extent practicable, the Secretary
4 shall include health care providers, companies
5 that specialize in relevant technologies, health
6 insurers, and patient advocates.

7 (2) GUIDANCE TO MEDICARE ADVANTAGE OR-
8 GANIZATIONS.—Not later than 18 months after the
9 date of enactment of this Act, the Secretary shall
10 issue guidance to Medicare Advantage organizations
11 offering Medicare Advantage plans under part C of
12 title XVIII of the Social Security Act (42 U.S.C.
13 1395w–21 et seq.) on maintaining accurate provider
14 directories for such plans, taking into consideration
15 input received during the stakeholder meeting under
16 paragraph (1). Such guidance may include the fol-
17 lowing, as determined appropriate by the Secretary:

18 (A) Best practices for Medicare Advantage
19 organizations on how to work with providers to
20 maintain the accuracy of provider directories
21 and reduce provider and Medicare Advantage
22 organization burden with respect to maintaining
23 the accuracy of provider directories.

24 (B) Information on data sets and data
25 sources with information that could be used by

1 Medicare Advantage organizations to maintain
2 accurate provider directories.

3 (C) Approaches for utilizing data sources
4 maintained by Medicare Advantage organiza-
5 tions and publicly available data sets to main-
6 tain accurate provider directories.

7 (D) Information that may be useful to in-
8 clude in provider directories for Medicare bene-
9 ficiaries to use in assessing plan networks when
10 selecting a plan and accessing providers partici-
11 pating in plan networks during the plan year.

12 (3) GUIDANCE TO PART B PROVIDERS.—Not
13 later than 12 months after the date of enactment of
14 this Act, the Secretary shall issue guidance to pro-
15 viders of services and suppliers who furnish items or
16 services for which benefits are available under part
17 B of title XVIII of the Social Security Act (42
18 U.S.C. 1395j et seq.) on when to update the Na-
19 tional Plan and Provider Enumeration System (or a
20 successor system) for information changes.

21 **SEC. 6221. MEDICARE COVERAGE OF MULTI-CANCER EARLY**
22 **DETECTION SCREENING TESTS.**

23 (a) COVERAGE.—Section 1861 of the Social Security
24 Act (42 U.S.C. 1395x) is amended—

25 (1) in subsection (s)(2)—

1 (A) by striking the semicolon at the end of
2 subparagraph (JJ) and inserting “; and”; and

3 (B) by adding at the end the following new
4 subparagraph:

5 “(KK) multi-cancer early detection screening
6 tests (as defined in subsection (nnn));”; and

7 (2) by adding at the end the following new sub-
8 section:

9 “(nnn) MULTI-CANCER EARLY DETECTION SCREEN-
10 ING TESTS.—

11 “(1) IN GENERAL.—The term ‘multi-cancer
12 early detection screening test’ means a test fur-
13 nished to an individual for the concurrent detection
14 of multiple cancer types across multiple organ sites
15 on or after January 1, 2029, that—

16 “(A) is cleared under section 510(k), clas-
17 sified under section 513(f)(2), or approved
18 under section 515 of the Federal Food, Drug,
19 and Cosmetic Act;

20 “(B) is—

21 “(i) a genomic sequencing blood or
22 blood product test that includes the anal-
23 ysis of cell-free nucleic acids; or

24 “(ii) a test based on samples of bio-
25 logical material that provide results com-

1 parable to those obtained with a test de-
2 scribed in clause (i), as determined by the
3 Secretary; and

4 “(C) the Secretary determines is—

5 “(i) reasonable and necessary for the
6 prevention or early detection of an illness
7 or disability; and

8 “(ii) appropriate for individuals enti-
9 tled to benefits under part A or enrolled
10 under part B.

11 “(2) NCD PROCESS.—In making determina-
12 tions under paragraph (1)(C) regarding the coverage
13 of a new test, the Secretary shall use the process for
14 making national coverage determinations (as defined
15 in section 1869(f)(1)(B)) under this title.”.

16 (b) PAYMENT AND STANDARDS FOR MULTI-CANCER
17 EARLY DETECTION SCREENING TESTS.—

18 (1) IN GENERAL.—Section 1834 of the Social
19 Security Act (42 U.S.C. 1395m) is amended by add-
20 ing at the end the following new subsection:

21 “(aa) PAYMENT AND STANDARDS FOR MULTI-CAN-
22 CER EARLY DETECTION SCREENING TESTS.—

23 “(1) PAYMENT AMOUNT.—The payment
24 amount for a multi-cancer early detection screening
25 test (as defined in section 1861(nnn)) is—

1 “(A) with respect to such a test furnished
2 before January 1, 2031, equal to the payment
3 amount in effect on the date of the enactment
4 of this subsection for a multi-target stool
5 screening DNA test covered pursuant to section
6 1861(pp)(1)(D); and

7 “(B) with respect to such a test furnished
8 on or after January 1, 2031, equal to the lesser
9 of—

10 “(i) the amount described in subpara-
11 graph (A); or

12 “(ii) the payment amount determined
13 for such test under section 1834A.

14 “(2) LIMITATIONS.—

15 “(A) IN GENERAL.—No payment may be
16 made under this part for a multi-cancer early
17 detection screening test furnished during a year
18 to an individual if—

19 “(i) such individual—

20 “(I) is under 50 years of age; or

21 “(II) as of January 1 of such
22 year, has attained the age specified in
23 subparagraph (B) for such year; or

24 “(ii) such a test was furnished to the
25 individual during the previous 11 months.

1 “(B) AGE SPECIFIED.—For purposes of
2 subparagraph (A)(i)(II), the age specified in
3 this subparagraph is—

4 “(i) for 2029, 65 years of age; and

5 “(ii) for a succeeding year, the age
6 specified in this subparagraph for the pre-
7 ceding year, increased by 1 year.

8 “(C) STANDARDS FOLLOWING USPSTF
9 RATING OF A OR B.—In the case of a multi-can-
10 cer early detection screening test that is rec-
11 ommended with a grade of A or B by the
12 United States Preventive Services Task Force,
13 beginning on the date on which coverage for
14 such test is provided pursuant to section
15 1861(ddd)(1), the preceding provisions of this
16 paragraph shall not apply.”.

17 (2) CONFORMING AMENDMENTS.—

18 (A) Section 1833 of the Social Security
19 Act (42 U.S.C. 1395l) is amended—

20 (i) in subsection (a)—

21 (I) in paragraph (1)(D)(i)(I), by
22 striking “section 1834(d)(1)” and in-
23 serting “subsection (d)(1) or (aa) of
24 section 1834”; and

1 (II) in paragraph (2)(D)(i)(I), by
2 striking “section 1834(d)(1)” and in-
3 sserting “subsection (d)(1) or (aa) of
4 section 1834”; and

5 (ii) in subsection (h)(1)(A), by strik-
6 ing “section 1834(d)(1)” and inserting
7 “subsections (d)(1) and (aa) of section
8 1834”.

9 (B) Section 1862(a)(1)(A) of the Social
10 Security Act (42 U.S.C. 1395y(a)(1)(A)) is
11 amended—

12 (i) by striking “or additional preven-
13 tive services” and inserting “, additional
14 preventive services”; and

15 (ii) by inserting “, or multi-cancer
16 early detection screening tests (as defined
17 in section 1861(nnn))” after “(as de-
18 scribed in section 1861(ddd)(1))”.

19 (c) RULE OF CONSTRUCTION RELATING TO OTHER
20 CANCER SCREENING TESTS.—Nothing in this section, in-
21 cluding the amendments made by this section, shall be
22 construed—

23 (1) in the case of an individual who undergoes
24 a multi-cancer early detection screening test, to af-
25 fect coverage under part B of title XVIII of the So-

1 fusion drug (as defined in subsection (iii)(3)(C)) or other
2 associated supplies that do not meet the appropriate for
3 use in the home requirement applied to the definition of
4 durable medical equipment under section 414.202 of title
5 42, Code of Federal Regulations (or any successor to such
6 regulation) shall be treated as meeting such requirement
7 if each of the following criteria is satisfied:

8 “(1) The prescribing information approved by
9 the Food and Drug Administration for the home in-
10 fusion drug associated with the pump instructs that
11 the drug should be administered by or under the su-
12 pervision of a health care professional.

13 “(2) A qualified home infusion therapy supplier
14 (as defined in subsection (iii)(3)(D)) administers or
15 supervises the administration of the drug or biological
16 in a safe and effective manner in the patient’s
17 home (as defined in subsection (iii)(3)(B)).

18 “(3) The prescribing information described in
19 paragraph (1) instructs that the drug should be in-
20 fused at least 12 times per year—

21 “(A) intravenously or subcutaneously; or

22 “(B) at infusion rates that the Secretary
23 determines would require the use of an external
24 infusion pump.”.

1 (b) COST SHARING NOTIFICATION.—The Secretary
2 of Health and Human Services shall ensure that patients
3 are notified of the cost sharing for electing home infusion
4 therapy compared to other applicable settings of care for
5 the furnishing of infusion drugs under the Medicare pro-
6 gram.

7 **SEC. 6223. ASSURING PHARMACY ACCESS AND CHOICE FOR**
8 **MEDICARE BENEFICIARIES.**

9 (a) IN GENERAL.—Section 1860D–4(b)(1) of the So-
10 cial Security Act (42 U.S.C. 1395w–104(b)(1)) is amend-
11 ed by striking subparagraph (A) and inserting the fol-
12 lowing:

13 “(A) IN GENERAL.—

14 “(i) PARTICIPATION OF ANY WILLING
15 PHARMACY.—A PDP sponsor offering a
16 prescription drug plan shall permit any
17 pharmacy that meets the standard contract
18 terms and conditions under such plan to
19 participate as a network pharmacy of such
20 plan.

21 “(ii) CONTRACT TERMS AND CONDI-
22 TIONS.—

23 “(I) IN GENERAL.—Notwith-
24 standing any other provision of law,
25 for plan years beginning on or after

1 January 1, 2029, in accordance with
2 clause (i), contract terms and condi-
3 tions offered by such PDP sponsor
4 shall be reasonable and relevant ac-
5 cording to standards established by
6 the Secretary under subclause (II).

7 “(II) STANDARDS.—Not later
8 than the first Monday in April of
9 2028, the Secretary shall establish
10 standards for reasonable and relevant
11 contract terms and conditions for pur-
12 poses of this clause.

13 “(III) REQUEST FOR INFORMA-
14 TION.—Not later than April 1, 2027,
15 for purposes of establishing the stand-
16 ards under subclause (II), the Sec-
17 retary shall issue a request for infor-
18 mation to seek input on trends in pre-
19 scription drug plan and network phar-
20 macy contract terms and conditions,
21 current prescription drug plan and
22 network pharmacy contracting prac-
23 tices, whether pharmacy reimburse-
24 ment and dispensing fees paid by
25 PDP sponsors to network pharmacies

1 sufficiently cover the ingredient and
2 operational costs of such pharmacies,
3 the use and application of pharmacy
4 quality measures by PDP sponsors for
5 network pharmacies, PDP sponsor re-
6 strictions or limitations on the dis-
7 pensing of covered part D drugs by
8 network pharmacies (or any subsets of
9 such pharmacies), PDP sponsor au-
10 diting practices for network phar-
11 macies, areas in current regulations or
12 program guidance related to con-
13 tracting between prescription drug
14 plans and network pharmacies requir-
15 ing clarification or additional speci-
16 ficity, factors for consideration in de-
17 termining the reasonableness and rel-
18 evance of contract terms and condi-
19 tions between prescription drug plans
20 and network pharmacies, and other
21 issues as determined appropriate by
22 the Secretary.”.

23 (b) ESSENTIAL RETAIL PHARMACIES.—Section
24 1860D–42 of the Social Security Act (42 U.S.C. 1395w–

1 152) is amended by adding at the end the following new
2 subsection:

3 “(e) ESSENTIAL RETAIL PHARMACIES.—

4 “(1) IN GENERAL.—With respect to plan years
5 beginning on or after January 1, 2028, the Sec-
6 retary shall publish reports, at least once every 2
7 years until 2034, and periodically thereafter, that
8 provide information, to the extent feasible, on—

9 “(A) trends in ingredient cost reimburse-
10 ment, dispensing fees, incentive payments and
11 other fees paid by PDP sponsors offering pre-
12 scription drug plans and MA organizations of-
13 fering MA–PD plans under this part to essen-
14 tial retail pharmacies (as defined in paragraph
15 (2)) with respect to the dispensing of covered
16 part D drugs, including a comparison of such
17 trends between essential retail pharmacies and
18 pharmacies that are not essential retail phar-
19 macies;

20 “(B) trends in amounts paid to PDP spon-
21 sors offering prescription drug plans and MA
22 organizations offering MA–PD plans under this
23 part by essential retail pharmacies with respect
24 to the dispensing of covered part D drugs, in-
25 cluding a comparison of such trends between

1 essential retail pharmacies and pharmacies that
2 are not essential retail pharmacies;

3 “(C) trends in essential retail pharmacy
4 participation in pharmacy networks and pre-
5 ferred pharmacy networks for prescription drug
6 plans offered by PDP sponsors and MA–PD
7 plans offered by MA organizations under this
8 part, including a comparison of such trends be-
9 tween essential retail pharmacies and phar-
10 macies that are not essential retail pharmacies;

11 “(D) trends in the number of essential re-
12 tail pharmacies, including variation in such
13 trends by geographic region or other factors;

14 “(E) a comparison of cost-sharing for cov-
15 ered part D drugs dispensed by essential retail
16 pharmacies that are network pharmacies for
17 prescription drug plans offered by PDP spon-
18 sors and MA–PD plans offered by MA organi-
19 zations under this part and cost-sharing for
20 covered part D drugs dispensed by other net-
21 work pharmacies for such plans located in simi-
22 lar geographic areas that are not essential retail
23 pharmacies;

24 “(F) a comparison of the volume of cov-
25 ered part D drugs dispensed by essential retail

1 pharmacies that are network pharmacies for
2 prescription drug plans offered by PDP spon-
3 sors and MA–PD plans offered by MA organi-
4 zations under this part and such volume of dis-
5 pensing by network pharmacies for such plans
6 located in similar geographic areas that are not
7 essential retail pharmacies, including informa-
8 tion on any patterns or trends in such compari-
9 son specific to certain types of covered part D
10 drugs, such as generic drugs or drugs specified
11 as specialty drugs by a PDP sponsor under a
12 prescription drug plan or an MA organization
13 under an MA–PD plan; and

14 “(G) a comparison of the information de-
15 scribed in subparagraphs (A) through (F) be-
16 tween essential retail pharmacies that are net-
17 work pharmacies for prescription drug plans of-
18 fered by PDP sponsors under this part and es-
19 sential retail pharmacies that are network phar-
20 macies for MA–PD plans offered by MA organi-
21 zations under this part.

22 “(2) DEFINITION OF ESSENTIAL RETAIL PHAR-
23 MACY.—In this subsection, the term ‘essential retail
24 pharmacy’ means, with respect to a plan year, a re-
25 tail pharmacy that—

1 “(A) is not a pharmacy that is an affiliate
2 as defined in paragraph (4); and

3 “(B) is located in—

4 “(i) a rural area in which there is no
5 other retail pharmacy within 10 miles, as
6 determined by the Secretary;

7 “(ii) a suburban area in which there
8 is no other retail pharmacy within 2 miles,
9 as determined by the Secretary; or

10 “(iii) an urban area in which there is
11 no other retail pharmacy within 1 mile, as
12 determined by the Secretary.

13 “(3) LIST OF ESSENTIAL RETAIL PHAR-
14 MACIES.—

15 “(A) PUBLICATION OF LIST OF ESSENTIAL
16 RETAIL PHARMACIES.—For each plan year (be-
17 ginning with plan year 2028), the Secretary
18 shall publish, on a publicly available internet
19 website of the Centers for Medicare & Medicaid
20 Services, a list of retail pharmacies that meet
21 the criteria described in subparagraphs (A) and
22 (B) of paragraph (2) to be considered an essen-
23 tial retail pharmacy.

24 “(B) REQUIRED SUBMISSIONS FROM PDP
25 SPONSORS.—For each plan year (beginning

1 with plan year 2028), each PDP sponsor offer-
2 ing a prescription drug plan and each MA orga-
3 nization offering an MA–PD plan shall submit
4 to the Secretary, for the purposes of deter-
5 mining retail pharmacies that meet the criterion
6 specified in subparagraph (A) of paragraph (2),
7 a list of retail pharmacies that are affiliates of
8 such sponsor or organization, or are affiliates of
9 a pharmacy benefit manager acting on behalf of
10 such sponsor or organization, at a time, and in
11 a form and manner, specified by the Secretary.

12 “(C) REPORTING BY PDP SPONSORS AND
13 MA ORGANIZATIONS.—For each plan year be-
14 ginning with plan year 2027, each PDP sponsor
15 offering a prescription drug plan and each MA
16 organization offering an MA–PD plan under
17 this part shall submit to the Secretary informa-
18 tion on incentive payments and other fees paid
19 by such sponsor or organization to pharmacies,
20 insofar as any such payments or fees are not
21 otherwise reported, at a time, and in a form
22 and manner, specified by the Secretary.

23 “(D) IMPLEMENTATION.—Notwithstanding
24 any other provision of law, the Secretary may

1 implement this paragraph by program instruc-
2 tion or otherwise.

3 “(E) NONAPPLICATION OF PAPERWORK
4 REDUCTION ACT.—Chapter 35 of title 44,
5 United States Code, shall not apply to the im-
6 plementation of this paragraph.

7 “(4) DEFINITION OF AFFILIATE; PHARMACY
8 BENEFIT MANAGER.—In this subsection, the terms
9 ‘affiliate’ and ‘pharmacy benefit manager’ have the
10 meaning given those terms in section 1860D–
11 12(h)(7).”.

12 (c) ENFORCEMENT.—

13 (1) IN GENERAL.—Section 1860D–4(b)(1) of
14 the Social Security Act (42 U.S.C. 1395w–
15 104(b)(1)) is amended by adding at the end the fol-
16 lowing new subparagraph:

17 “(F) ENFORCEMENT OF STANDARDS FOR
18 REASONABLE AND RELEVANT CONTRACT TERMS
19 AND CONDITIONS.—

20 “(i) ALLEGATION SUBMISSION PROC-
21 ESS.—

22 “(I) IN GENERAL.—Not later
23 than January 1, 2029, the Secretary
24 shall establish a process through
25 which a pharmacy may submit to the

1 Secretary an allegation of a violation
2 by a PDP sponsor offering a prescrip-
3 tion drug plan of the standards for
4 reasonable and relevant contract
5 terms and conditions under subpara-
6 graph (A)(ii), or of subclause (VIII)
7 of this clause.

8 “(II) FREQUENCY OF SUBMIS-
9 SION.—

10 “(aa) IN GENERAL.—Except
11 as provided in item (bb), the alle-
12 gation submission process under
13 this clause shall allow pharmacies
14 to submit any allegations of vio-
15 lations described in subclause (I)
16 not more frequently than once
17 per plan year per contract be-
18 tween a pharmacy and a PDP
19 sponsor.

20 “(bb) ALLEGATIONS RELAT-
21 ING TO CONTRACT MODIFICA-
22 TIONS.—In the case where a con-
23 tract between a pharmacy and a
24 PDP sponsor is modified fol-
25 lowing the submission of allega-

1 tions by a pharmacy with respect
2 to such contract and plan year,
3 the allegation submission process
4 under this clause shall allow such
5 pharmacy to submit an additional
6 allegation related to those modi-
7 fications with respect to such
8 contract and plan year.

9 “(III) ACCESS TO RELEVANT
10 DOCUMENTS AND MATERIALS.—A
11 PDP sponsor subject to an allegation
12 under this clause—

13 “(aa) shall provide docu-
14 ments or materials, as specified
15 by the Secretary, including con-
16 tract offers made by such spon-
17 sor to such pharmacy or cor-
18 respondence related to such of-
19 fers, to the Secretary at a time,
20 and in a form and manner, speci-
21 fied by the Secretary; and

22 “(bb) shall not prohibit or
23 otherwise limit the ability of a
24 pharmacy to submit such docu-
25 ments or materials to the Sec-

1 retary for the purpose of submit-
2 ting an allegation or providing
3 evidence for such an allegation
4 under this clause.

5 “(IV) STANDARDIZED TEM-
6 PLATE.—The Secretary shall establish
7 a standardized template for phar-
8 macies to use for the submission of al-
9 legations described in subclause (I).
10 Such template shall require that the
11 submission include a certification by
12 the pharmacy that the information in-
13 cluded is accurate, complete, and true
14 to the best of the knowledge, informa-
15 tion, and belief of such pharmacy.

16 “(V) PREVENTING FRIVOLOUS
17 ALLEGATIONS.—In the case where the
18 Secretary determines that a pharmacy
19 has submitted frivolous allegations
20 under this clause on a routine basis,
21 the Secretary may temporarily pro-
22 hibit such pharmacy from using the
23 allegation submission process under
24 this clause, as determined appropriate
25 by the Secretary.

1 “(VI) EXEMPTION FROM FREE-
2 DOM OF INFORMATION ACT.—Allega-
3 tions submitted under this clause shall
4 be exempt from disclosure under sec-
5 tion 552 of title 5, United States
6 Code.

7 “(VII) RULE OF CONSTRUC-
8 TION.—Nothing in this clause shall be
9 construed as limiting the ability of a
10 pharmacy to pursue other legal ac-
11 tions or remedies, consistent with ap-
12 plicable Federal or State law, with re-
13 spect to a potential violation of a re-
14 quirement described in this subpara-
15 graph.

16 “(VIII) ANTI-RETALIATION AND
17 ANTI-COERCION.—Consistent with ap-
18 plicable Federal or State law, a PDP
19 sponsor shall not—

20 “(aa) retaliate against a
21 pharmacy for submitting any al-
22 legations under this clause; or

23 “(bb) coerce, intimidate,
24 threaten, or interfere with the

1 ability of a pharmacy to submit
2 any such allegations.

3 “(ii) INVESTIGATION.—The Secretary
4 shall investigate, as determined appro-
5 priate by the Secretary, allegations sub-
6 mitted pursuant to clause (i).

7 “(iii) ENFORCEMENT.—

8 “(I) IN GENERAL.—In the case
9 where the Secretary determines that a
10 PDP sponsor offering a prescription
11 drug plan has violated the standards
12 for reasonable and relevant contract
13 terms and conditions under subpara-
14 graph (A)(ii) or the provisions of
15 clause (i)(VIII) of this subparagraph,
16 the Secretary may use authorities
17 under sections 1857(g) and 1860D-
18 12(b)(3)(E) to impose civil monetary
19 penalties or other intermediate sanc-
20 tions.

21 “(II) APPLICATION OF CIVIL
22 MONETARY PENALTIES.—The provi-
23 sions of section 1128A (other than
24 subsections (a) and (b)) shall apply to
25 a civil monetary penalty under this

1 clause in the same manner as such
2 provisions apply to a penalty or pro-
3 ceeding under section 1128A(a).”.

4 (2) CONFORMING AMENDMENT.—Section
5 1857(g)(1) of the Social Security Act (42 U.S.C.
6 1395w–27(g)(1)) is amended—

7 (A) in subparagraph (J), by striking “or”
8 after the semicolon;

9 (B) by redesignating subparagraph (K) as
10 subparagraph (L);

11 (C) by inserting after subparagraph (J),
12 the following new subparagraph:

13 “(K) fails to comply with the standards for
14 reasonable and relevant contract terms and con-
15 ditions under subparagraph (A)(ii) of section
16 1860D–4(b)(1) or violates the provisions of
17 subparagraph (F)(i)(VIII) of such section; or”;

18 (D) in subparagraph (L), as redesignated
19 by subparagraph (B), by striking “through (J)”
20 and inserting “through (K)”; and

21 (E) in the flush matter following subpara-
22 graph (L), as so redesignated, by striking “sub-
23 paragraphs (A) through (K)” and inserting
24 “subparagraphs (A) through (L)”.

1 (d) ACCOUNTABILITY OF PHARMACY BENEFIT MAN-
2 AGERS FOR VIOLATIONS OF REASONABLE AND RELEVANT
3 CONTRACT TERMS AND CONDITIONS.—

4 (1) IN GENERAL.—Section 1860D–12(b) of the
5 Social Security Act (42 U.S.C. 1395w–112) is
6 amended by adding at the end the following new
7 paragraph:

8 “(9) ACCOUNTABILITY OF PHARMACY BENEFIT
9 MANAGERS FOR VIOLATIONS OF REASONABLE AND
10 RELEVANT CONTRACT TERMS AND CONDITIONS.—
11 For plan years beginning on or after January 1,
12 2029, each contract entered into with a PDP spon-
13 sor under this part with respect to a prescription
14 drug plan offered by such sponsor shall provide that
15 any pharmacy benefit manager acting on behalf of
16 such sponsor has a written agreement with the PDP
17 sponsor under which the pharmacy benefit manager
18 agrees to reimburse the PDP sponsor for any
19 amounts paid by such sponsor under section 1860D–
20 4(b)(1)(F)(iii)(I) to the Secretary as a result of a
21 violation described in such section if such violation
22 is related to a responsibility delegated to the phar-
23 macy benefit manager by such PDP sponsor.”.

24 (2) MA–PD PLANS.—Section 1857(f)(3) of the
25 Social Security Act (42 U.S.C. 1395w–27(f)(3)) is

1 amended by adding at the end the following new
2 subparagraph:

3 “(F) ACCOUNTABILITY OF PHARMACY
4 BENEFIT MANAGERS FOR VIOLATIONS OF REA-
5 SONABLE AND RELEVANT CONTRACT TERMS.—
6 For plan years beginning on or after January
7 1, 2029, section 1860D–12(b)(9).”.

8 (e) BIENNIAL REPORT ON ENFORCEMENT AND
9 OVERSIGHT OF PHARMACY ACCESS REQUIREMENTS.—
10 Section 1860D–42 of the Social Security Act (42 U.S.C.
11 1395w–152), as amended by subsection (b), is amended
12 by adding at the end the following new subsection:

13 “(f) BIENNIAL REPORT ON ENFORCEMENT AND
14 OVERSIGHT OF PHARMACY ACCESS REQUIREMENTS.—

15 “(1) IN GENERAL.—Not later than 2 years
16 after the date of enactment of this subsection, and
17 at least once every 2 years thereafter, the Secretary
18 shall publish a report on enforcement and oversight
19 actions and activities undertaken by the Secretary
20 with respect to the requirements under section
21 1860D–4(b)(1).

22 “(2) LIMITATION.—A report under paragraph
23 (1) shall not disclose—

1 “(A) identifiable information about individ-
2 uals or entities unless such information is oth-
3 erwise publicly available; or

4 “(B) trade secrets with respect to any enti-
5 ties.”.

6 (f) FUNDING.—In addition to amounts otherwise
7 available, there is appropriated to the Centers for Medi-
8 care & Medicaid Services Program Management Account,
9 out of any money in the Treasury not otherwise appro-
10 priated, \$188,000,000 for fiscal year 2026, to remain
11 available until expended, to carry out this section.

12 **SEC. 6224. MODERNIZING AND ENSURING PBM ACCOUNT-**
13 **ABILITY.**

14 (a) IN GENERAL.—

15 (1) PRESCRIPTION DRUG PLANS.—Section
16 1860D–12 of the Social Security Act (42 U.S.C.
17 1395w–112) is amended by adding at the end the
18 following new subsection:

19 “(h) REQUIREMENTS RELATING TO PHARMACY BEN-
20 EFIT MANAGERS.—For plan years beginning on or after
21 January 1, 2028:

22 “(1) AGREEMENTS WITH PHARMACY BENEFIT
23 MANAGERS.—Each contract entered into with a
24 PDP sponsor under this part with respect to a pre-
25 scription drug plan offered by such sponsor shall

1 provide that any pharmacy benefit manager acting
2 on behalf of such sponsor has a written agreement
3 with the PDP sponsor under which the pharmacy
4 benefit manager, and any affiliates of such phar-
5 macy benefit manager, as applicable, agree to meet
6 the following requirements:

7 “(A) NO INCOME OTHER THAN BONA FIDE
8 SERVICE FEES.—

9 “(i) IN GENERAL.—The pharmacy
10 benefit manager and any affiliate of such
11 pharmacy benefit manager shall not derive
12 any remuneration with respect to any serv-
13 ices provided on behalf of any entity or in-
14 dividual, in connection with the utilization
15 of covered part D drugs, from any such en-
16 tity or individual other than bona fide serv-
17 ice fees, subject to clauses (ii) and (iii).

18 “(ii) INCENTIVE PAYMENTS.—For the
19 purposes of this subsection, an incentive
20 payment (as determined by the Secretary)
21 paid by a PDP sponsor to a pharmacy
22 benefit manager or an affiliate of a phar-
23 macy benefit manager that is performing
24 services on behalf of such sponsor shall be
25 deemed a ‘bona fide service fee’ (even if

1 such payment does not otherwise meet the
2 definition of such term under paragraph
3 (7)(B)) if such payment is a flat dollar
4 amount, is consistent with fair market
5 value (as specified by the Secretary), is re-
6 lated to services actually performed by the
7 pharmacy benefit manager or affiliate of
8 such pharmacy benefit manager, on behalf
9 of the PDP sponsor making such payment,
10 in connection with the utilization of cov-
11 ered part D drugs, and meets additional
12 requirements, if any, as determined appro-
13 priate by the Secretary.

14 “(iii) CLARIFICATION ON REBATES
15 AND DISCOUNTS USED TO LOWER COSTS
16 FOR COVERED PART D DRUGS.—Rebates,
17 discounts, and other price concessions re-
18 ceived by a pharmacy benefit manager or
19 an affiliate of a pharmacy benefit manager
20 from manufacturers, even if such price
21 concessions are calculated as a percentage
22 of a drug’s price, shall not be considered a
23 violation of the requirements of clause (i)
24 if they are fully passed through to a PDP
25 sponsor and are compliant with all regu-

1 latory and subregulatory requirements re-
2 lated to direct and indirect remuneration
3 for manufacturer rebates, discounts, and
4 other price concessions under this part, in-
5 cluding in cases where a PDP sponsor is
6 acting as a pharmacy benefit manager on
7 behalf of a prescription drug plan offered
8 by such PDP sponsor.

9 “(iv) EVALUATION OF REMUNERATION
10 ARRANGEMENTS.—Components of subsets
11 of remuneration arrangements (such as
12 fees or other forms of compensation paid
13 to or retained by the pharmacy benefit
14 manager or affiliate of such pharmacy ben-
15 efit manager), as determined appropriate
16 by the Secretary, between pharmacy ben-
17 efit managers or affiliates of such phar-
18 macy benefit managers, as applicable, and
19 other entities involved in the dispensing or
20 utilization of covered part D drugs (includ-
21 ing PDP sponsors, manufacturers, phar-
22 macies, and other entities as determined
23 appropriate by the Secretary) shall be sub-
24 ject to review by the Secretary, in con-
25 sultation with the Office of the Inspector

1 General of the Department of Health and
2 Human Services, as determined appro-
3 priate by the Secretary. The Secretary, in
4 consultation with the Office of the Inspec-
5 tor General, shall review whether remu-
6 neration under such arrangements is con-
7 sistent with fair market value (as specified
8 by the Secretary) through reviews and as-
9 sessments of such remuneration, as deter-
10 mined appropriate.

11 “(v) DISGORGEMENT.—The pharmacy
12 benefit manager shall disgorge any remu-
13 neration paid to such pharmacy benefit
14 manager or an affiliate of such pharmacy
15 benefit manager in violation of this sub-
16 paragraph to the PDP sponsor.

17 “(vi) ADDITIONAL REQUIREMENTS.—
18 The pharmacy benefit manager shall—

19 “(I) enter into a written agree-
20 ment with any affiliate of such phar-
21 macy benefit manager, under which
22 the affiliate shall identify and disgorge
23 any remuneration described in clause
24 (v) to the pharmacy benefit manager;
25 and

1 “(II) attest, subject to any re-
2 quirements determined appropriate by
3 the Secretary, that the pharmacy ben-
4 efit manager has entered into a writ-
5 ten agreement described in subclause
6 (I) with any affiliate of the pharmacy
7 benefit manager.

8 “(B) TRANSPARENCY REGARDING GUARAN-
9 TEES AND COST PERFORMANCE EVALUA-
10 TIONS.—The pharmacy benefit manager shall—

11 “(i) define, interpret, and apply, in a
12 fully transparent and consistent manner
13 for purposes of calculating or otherwise
14 evaluating pharmacy benefit manager per-
15 formance against pricing guarantees or
16 similar cost performance measurements re-
17 lated to rebates, discounts, price conces-
18 sions, or net costs, terms such as—

19 “(I) ‘generic drug’, in a manner
20 consistent with the definition of the
21 term under section 423.4 of title 42,
22 Code of Federal Regulations, or a suc-
23 cessor regulation;

24 “(II) ‘brand name drug’, in a
25 manner consistent with the definition

1 of the term under section 423.4 of
2 title 42, Code of Federal Regulations,
3 or a successor regulation;

4 “(III) ‘specialty drug’;

5 “(IV) ‘rebate’; and

6 “(V) ‘discount’;

7 “(ii) identify any drugs, claims, or
8 price concessions excluded from any pric-
9 ing guarantee or other cost performance
10 measure in a clear and consistent manner;
11 and

12 “(iii) where a pricing guarantee or
13 other cost performance measure is based
14 on a pricing benchmark other than the
15 wholesale acquisition cost (as defined in
16 section 1847A(e)(6)(B)) of a drug, cal-
17 culate and provide a wholesale acquisition
18 cost-based equivalent to the pricing guar-
19 antee or other cost performance measure.

20 “(C) PROVISION OF INFORMATION.—

21 “(i) IN GENERAL.—Not later than
22 July 1 of each year, beginning in 2028, the
23 pharmacy benefit manager shall submit to
24 the PDP sponsor, and to the Secretary, a
25 report, in accordance with this subpara-

1 graph, and shall make such report avail-
2 able to such sponsor at no cost to such
3 sponsor in a format specified by the Sec-
4 retary under paragraph (5). Each such re-
5 port shall include, with respect to such
6 PDP sponsor and each plan offered by
7 such sponsor, the following information
8 with respect to the previous plan year:

9 “(I) A list of all drugs covered by
10 the plan that were dispensed includ-
11 ing, with respect to each such drug—

12 “(aa) the brand name, ge-
13 neric or non-proprietary name,
14 and National Drug Code;

15 “(bb) the number of plan
16 enrollees for whom the drug was
17 dispensed, the total number of
18 prescription claims for the drug
19 (including original prescriptions
20 and refills, counted as separate
21 claims), and the total number of
22 dosage units of the drug dis-
23 pensed;

24 “(cc) the number of pre-
25 scription claims described in item

1 (bb) by each type of dispensing
2 channel through which the drug
3 was dispensed, including retail,
4 mail order, specialty pharmacy,
5 long term care pharmacy, home
6 infusion pharmacy, or other types
7 of pharmacies or dispensers;

8 “(dd) the average wholesale
9 acquisition cost, listed as cost per
10 day’s supply, cost per dosage
11 unit, and cost per typical course
12 of treatment (as applicable);

13 “(ee) the average wholesale
14 price for the drug, listed as price
15 per day’s supply, price per dos-
16 age unit, and price per typical
17 course of treatment (as applica-
18 ble);

19 “(ff) the total out-of-pocket
20 spending by plan enrollees on
21 such drug after application of
22 any benefits under the plan, in-
23 cluding plan enrollee spending
24 through copayments, coinsurance,
25 and deductibles;

1 “(gg) total rebates paid by
2 the manufacturer on the drug as
3 reported under the Detailed DIR
4 Report (or any successor report)
5 submitted by such sponsor to the
6 Centers for Medicare & Medicaid
7 Services;

8 “(hh) all other direct or in-
9 direct remuneration on the drug
10 as reported under the Detailed
11 DIR Report (or any successor re-
12 port) submitted by such sponsor
13 to the Centers for Medicare &
14 Medicaid Services;

15 “(ii) the average pharmacy
16 reimbursement amount paid by
17 the plan for the drug in the ag-
18 gregate and disaggregated by dis-
19 pensing channel identified in item
20 (cc);

21 “(jj) the average National
22 Average Drug Acquisition Cost
23 (NADAC); and

24 “(kk) total manufacturer-de-
25 rived revenue, inclusive of bona

1 fide service fees, attributable to
2 the drug and retained by the
3 pharmacy benefit manager and
4 any affiliate of such pharmacy
5 benefit manager.

6 “(II) In the case of a pharmacy
7 benefit manager that has an affiliate
8 that is a retail, mail order, or spe-
9 cialty pharmacy, with respect to drugs
10 covered by such plan that were dis-
11 pensed, the following information:

12 “(aa) The percentage of
13 total prescriptions that were dis-
14 pensed by pharmacies that are an
15 affiliate of the pharmacy benefit
16 manager for each drug.

17 “(bb) The interquartile
18 range of the total combined costs
19 paid by the plan and plan enroll-
20 ees, per dosage unit, per course
21 of treatment, per 30-day supply,
22 and per 90-day supply for each
23 drug dispensed by pharmacies
24 that are not an affiliate of the
25 pharmacy benefit manager and

1 that are included in the phar-
2 macy network of such plan.

3 “(cc) The interquartile
4 range of the total combined costs
5 paid by the plan and plan enroll-
6 ees, per dosage unit, per course
7 of treatment, per 30-day supply,
8 and per 90-day supply for each
9 drug dispensed by pharmacies
10 that are an affiliate of the phar-
11 macy benefit manager and that
12 are included in the pharmacy
13 network of such plan.

14 “(dd) The lowest total com-
15 bined cost paid by the plan and
16 plan enrollees, per dosage unit,
17 per course of treatment, per 30-
18 day supply, and per 90-day sup-
19 ply, for each drug that is avail-
20 able from any pharmacy included
21 in the pharmacy network of such
22 plan.

23 “(ee) The difference between
24 the average acquisition cost of
25 the affiliate, such as a pharmacy

1 or other entity that acquires pre-
2 prescription drugs, that initially ac-
3 quires the drug and the amount
4 reported under subclause (I)(jj)
5 for each drug.

6 “(ff) A list inclusive of the
7 brand name, generic or non-pro-
8 prietary name, and National
9 Drug Code of covered part D
10 drugs subject to an agreement
11 with a covered entity under sec-
12 tion 340B of the Public Health
13 Service Act for which the phar-
14 macy benefit manager or an affil-
15 iate of the pharmacy benefit
16 manager had a contract or other
17 arrangement with such a covered
18 entity in the service area of such
19 plan.

20 “(III) Where a drug approved
21 under section 505(c) of the Federal
22 Food, Drug, and Cosmetic Act (re-
23 ferred to in this subclause as the ‘list-
24 ed drug’) is covered by the plan, the
25 following information:

1 “(aa) A list of currently
2 marketed generic drugs approved
3 under section 505(j) of the Fed-
4 eral Food, Drug, and Cosmetic
5 Act pursuant to an application
6 that references such listed drug
7 that are not covered by the plan,
8 are covered on the same for-
9 mulary tier or a formulary tier
10 typically associated with higher
11 cost-sharing than the listed drug,
12 or are subject to utilization man-
13 agement that the listed drug is
14 not subject to.

15 “(bb) The estimated average
16 beneficiary cost-sharing under
17 the plan for a 30-day supply of
18 the listed drug.

19 “(cc) Where a generic drug
20 listed under item (aa) is on a for-
21 mulary tier typically associated
22 with higher cost-sharing than the
23 listed drug, the estimated aver-
24 age cost-sharing that a bene-
25 ficiary would have paid for a 30-

1 day supply of each of the generic
2 drugs described in item (aa), had
3 the plan provided coverage for
4 such drugs on the same for-
5 mulary tier as the listed drug.

6 “(dd) A written justification
7 for providing more favorable cov-
8 erage of the listed drug than the
9 generic drugs described in item
10 (aa).

11 “(ee) The number of cur-
12 rently marketed generic drugs
13 approved under section 505(j) of
14 the Federal Food, Drug, and
15 Cosmetic Act pursuant to an ap-
16 plication that references such
17 listed drug.

18 “(IV) Where a reference product
19 (as defined in section 351(i) of the
20 Public Health Service Act) is covered
21 by the plan, the following information:

22 “(aa) A list of currently
23 marketed biosimilar biological
24 products licensed under section
25 351(k) of the Public Health

1 Service Act pursuant to an appli-
2 cation that refers to such ref-
3 erence product that are not cov-
4 ered by the plan, are covered on
5 the same formulary tier or a for-
6 mulary tier typically associated
7 with higher cost-sharing than the
8 reference product, or are subject
9 to utilization management that
10 the reference product is not sub-
11 ject to.

12 “(bb) The estimated average
13 beneficiary cost-sharing under
14 the plan for a 30-day supply of
15 the reference product.

16 “(cc) Where a biosimilar bi-
17 ological product listed under item
18 (aa) is on a formulary tier typi-
19 cally associated with higher cost-
20 sharing than the reference prod-
21 uct, the estimated average cost-
22 sharing that a beneficiary would
23 have paid for a 30-day supply of
24 each of the biosimilar biological
25 products described in item (aa),

1 had the plan provided coverage
2 for such products on the same
3 formulary tier as the reference
4 product.

5 “(dd) A written justification
6 for providing more favorable cov-
7 erage of the reference product
8 than the biosimilar biological
9 products described in item (aa).

10 “(ee) The number of cur-
11 rently marketed biosimilar bio-
12 logical products licensed under
13 section 351(k) of the Public
14 Health Service Act, pursuant to
15 an application that refers to such
16 reference product.

17 “(V) Total gross spending on
18 covered part D drugs by the plan, not
19 net of rebates, fees, discounts, or
20 other direct or indirect remuneration.

21 “(VI) The total amount retained
22 by the pharmacy benefit manager or
23 an affiliate of such pharmacy benefit
24 manager in revenue related to utiliza-
25 tion of covered part D drugs under

1 that plan, inclusive of bona fide serv-
2 ice fees.

3 “(VII) The total spending on cov-
4 ered part D drugs net of rebates, fees,
5 discounts, or other direct and indirect
6 remuneration by the plan.

7 “(VIII) An explanation of any
8 benefit design parameters under such
9 plan that encourage plan enrollees to
10 fill prescriptions at pharmacies that
11 are an affiliate of such pharmacy ben-
12 efit manager, such as mail and spe-
13 cialty home delivery programs, and re-
14 tail and mail auto-refill programs.

15 “(IX) The following information:

16 “(aa) A list of all brokers,
17 consultants, advisors, and audi-
18 tors that receive compensation
19 from the pharmacy benefit man-
20 ager or an affiliate of such phar-
21 macy benefit manager for refer-
22 rals, consulting, auditing, or
23 other services offered to PDP
24 sponsors related to pharmacy
25 benefit management services.

1 “(bb) The amount of com-
2 pensation provided by such phar-
3 macy benefit manager or affiliate
4 to each such broker, consultant,
5 advisor, and auditor.

6 “(cc) The methodology for
7 calculating the amount of com-
8 pensation provided by such phar-
9 macy benefit manager or affil-
10 iate, for each such broker, con-
11 sultant, advisor, and auditor.

12 “(X) A list of all affiliates of the
13 pharmacy benefit manager.

14 “(XI) A summary document sub-
15 mitted in a standardized template de-
16 veloped by the Secretary that includes
17 such information described in sub-
18 clauses (I) through (X).

19 “(ii) WRITTEN EXPLANATION OF CON-
20 TRACTS OR AGREEMENTS WITH MANUFAC-
21 TURERS.—

22 “(I) IN GENERAL.—The phar-
23 macy benefit manager shall, not later
24 than 30 days after the finalization of
25 any contract or agreement between

1 such pharmacy benefit manager or an
2 affiliate of such pharmacy benefit
3 manager and a manufacturer (or sub-
4 sidiary, agent, or entity affiliated with
5 such manufacturer) that makes re-
6 bates, discounts, payments, or other
7 financial incentives related to one or
8 more covered part D drugs or other
9 prescription drugs, as applicable, of
10 the manufacturer directly or indirectly
11 contingent upon coverage, formulary
12 placement, or utilization management
13 conditions on any other covered part
14 D drugs or other prescription drugs,
15 as applicable, submit to the PDP
16 sponsor a written explanation of such
17 contract or agreement.

18 “(II) REQUIREMENTS.—A writ-
19 ten explanation under subclause (I)
20 shall—

21 “(aa) include the manufac-
22 turer subject to the contract or
23 agreement, all covered part D
24 drugs and other prescription
25 drugs, as applicable, subject to

1 the contract or agreement and
2 the manufacturers of such drugs,
3 and a high-level description of
4 the terms of such contract or
5 agreement and how such terms
6 apply to such drugs; and

7 “(bb) be certified by the
8 Chief Executive Officer, Chief Fi-
9 nancial Officer, or General Coun-
10 sel of such pharmacy benefit
11 manager, or affiliate of such
12 pharmacy benefit manager, as
13 applicable, or an individual dele-
14 gated with the authority to sign
15 on behalf of one of these officers,
16 who reports directly to the offi-
17 cer.

18 “(III) DEFINITION OF OTHER
19 PRESCRIPTION DRUGS.—For purposes
20 of this clause, the term ‘other pre-
21 scription drugs’ means prescription
22 drugs covered as supplemental bene-
23 fits under this part or prescription
24 drugs paid outside of this part.

25 “(D) AUDIT RIGHTS.—

1 “(i) IN GENERAL.—Not less than once
2 a year, at the request of the PDP sponsor,
3 the pharmacy benefit manager shall allow
4 for an audit of the pharmacy benefit man-
5 ager to ensure compliance with all terms
6 and conditions under the written agree-
7 ment described in this paragraph and the
8 accuracy of information reported under
9 subparagraph (C).

10 “(ii) AUDITOR.—The PDP sponsor
11 shall have the right to select an auditor.
12 The pharmacy benefit manager shall not
13 impose any limitations on the selection of
14 such auditor.

15 “(iii) PROVISION OF INFORMATION.—
16 The pharmacy benefit manager shall make
17 available to such auditor all records, data,
18 contracts, and other information necessary
19 to confirm the accuracy of information re-
20 ported under subparagraph (C), subject to
21 reasonable restrictions on how such infor-
22 mation must be reported to prevent re-
23 disclosure of such information.

24 “(iv) TIMING.—The pharmacy benefit
25 manager must provide information under

1 clause (iii) and other information, data,
2 and records relevant to the audit to such
3 auditor within 6 months of the initiation of
4 the audit and respond to requests for addi-
5 tional information from such auditor with-
6 in 30 days after the request for additional
7 information.

8 “(v) INFORMATION FROM AFFILI-
9 ATES.—The pharmacy benefit manager
10 shall be responsible for providing to such
11 auditor information required to be reported
12 under subparagraph (C) or under clause
13 (iii) of this subparagraph that is owned or
14 held by an affiliate of such pharmacy ben-
15 efit manager.

16 “(2) ENFORCEMENT.—

17 “(A) IN GENERAL.—Each PDP sponsor
18 shall—

19 “(i) disgorge to the Secretary any
20 amounts disgorged to the PDP sponsor by
21 a pharmacy benefit manager under para-
22 graph (1)(A)(v);

23 “(ii) require, in a written agreement
24 with any pharmacy benefit manager acting
25 on behalf of such sponsor or affiliate of

1 such pharmacy benefit manager, that such
2 pharmacy benefit manager or affiliate re-
3 imburse the PDP sponsor for any civil
4 money penalty imposed on the PDP spon-
5 sor as a result of the failure of the phar-
6 macy benefit manager or affiliate to meet
7 the requirements of paragraph (1) that are
8 applicable to the pharmacy benefit man-
9 ager or affiliate under the agreement; and
10 “(iii) require, in a written agreement
11 with any such pharmacy benefit manager
12 acting on behalf of such sponsor or affil-
13 iate of such pharmacy benefit manager,
14 that such pharmacy benefit manager or af-
15 filiate be subject to punitive remedies for
16 breach of contract for failure to comply
17 with the requirements applicable under
18 paragraph (1).

19 “(B) REPORTING OF ALLEGED VIOLA-
20 TIONS.—The Secretary shall make available and
21 maintain a mechanism for manufacturers, PDP
22 sponsors, pharmacies, and other entities that
23 have contractual relationships with pharmacy
24 benefit managers or affiliates of such pharmacy
25 benefit managers to report, on a confidential

1 basis, alleged violations of paragraph (1)(A) or
2 subparagraph (C).

3 “(C) ANTI-RETALIATION AND ANTI-COER-
4 CION.—Consistent with applicable Federal or
5 State law, a PDP sponsor shall not—

6 “(i) retaliate against an individual or
7 entity for reporting an alleged violation
8 under subparagraph (B); or

9 “(ii) coerce, intimidate, threaten, or
10 interfere with the ability of an individual
11 or entity to report any such alleged viola-
12 tions.

13 “(3) CERTIFICATION OF COMPLIANCE.—

14 “(A) IN GENERAL.—Each PDP sponsor
15 shall furnish to the Secretary (at a time and in
16 a manner specified by the Secretary) an annual
17 certification of compliance with this subsection,
18 as well as such information as the Secretary de-
19 termines necessary to carry out this subsection.

20 “(B) IMPLEMENTATION.—Notwithstanding
21 any other provision of law, the Secretary may
22 implement this paragraph by program instruc-
23 tion or otherwise.

24 “(4) RULE OF CONSTRUCTION.—Nothing in
25 this subsection shall be construed as—

1 “(A) prohibiting flat dispensing fees or re-
2 imbursement or payment for ingredient costs
3 (including customary, industry-standard dis-
4 counts directly related to drug acquisition that
5 are retained by pharmacies or wholesalers) to
6 entities that acquire or dispense prescription
7 drugs; or

8 “(B) modifying regulatory requirements or
9 sub-regulatory program instruction or guidance
10 related to pharmacy payment, reimbursement,
11 or dispensing fees.

12 “(5) STANDARD FORMATS.—

13 “(A) IN GENERAL.—Not later than June
14 1, 2027, the Secretary shall specify standard,
15 machine-readable formats for pharmacy benefit
16 managers to submit annual reports required
17 under paragraph (1)(C)(i).

18 “(B) IMPLEMENTATION.—Notwithstanding
19 any other provision of law, the Secretary may
20 implement this paragraph by program instruc-
21 tion or otherwise.

22 “(6) CONFIDENTIALITY.—

23 “(A) IN GENERAL.—Information disclosed
24 by a pharmacy benefit manager, an affiliate of
25 a pharmacy benefit manager, a PDP sponsor,

1 or a pharmacy under this subsection that is not
2 otherwise publicly available or available for pur-
3 chase shall not be disclosed by the Secretary or
4 a PDP sponsor receiving the information, ex-
5 cept that the Secretary may disclose the infor-
6 mation for the following purposes:

7 “(i) As the Secretary determines nec-
8 essary to carry out this part.

9 “(ii) To permit the Comptroller Gen-
10 eral to review the information provided.

11 “(iii) To permit the Director of the
12 Congressional Budget Office to review the
13 information provided.

14 “(iv) To permit the Executive Direc-
15 tor of the Medicare Payment Advisory
16 Commission to review the information pro-
17 vided.

18 “(v) To the Attorney General for the
19 purposes of conducting oversight and en-
20 forcement under this title.

21 “(vi) To the Inspector General of the
22 Department of Health and Human Serv-
23 ices in accordance with its authorities
24 under the Inspector General Act of 1978

1 (section 406 of title 5, United States
2 Code), and other applicable statutes.

3 “(B) RESTRICTION ON USE OF INFORMA-
4 TION.—The Secretary, the Comptroller General,
5 the Director of the Congressional Budget Of-
6 fice, and the Executive Director of the Medicare
7 Payment Advisory Commission shall not report
8 on or disclose information disclosed pursuant to
9 subparagraph (A) to the public in a manner
10 that would identify—

11 “(i) a specific pharmacy benefit man-
12 ager, affiliate, pharmacy, manufacturer,
13 wholesaler, PDP sponsor, or plan; or

14 “(ii) contract prices, rebates, dis-
15 counts, or other remuneration for specific
16 drugs in a manner that may allow the
17 identification of specific contracting parties
18 or of such specific drugs.

19 “(7) DEFINITIONS.—For purposes of this sub-
20 section:

21 “(A) AFFILIATE.—The term ‘affiliate’
22 means, with respect to any pharmacy benefit
23 manager or PDP sponsor, any entity that, di-
24 rectly or indirectly—

1 “(i) owns or is owned by, controls or
2 is controlled by, or is otherwise related in
3 any ownership structure to such pharmacy
4 benefit manager or PDP sponsor; or

5 “(ii) acts as a contractor, principal, or
6 agent to such pharmacy benefit manager
7 or PDP sponsor, insofar as such con-
8 tractor, principal, or agent performs any of
9 the functions described under subpara-
10 graph (C).

11 “(B) BONA FIDE SERVICE FEE.—The term
12 ‘bona fide service fee’ means a fee that is reflec-
13 tive of the fair market value (as specified by the
14 Secretary, through notice and comment rule-
15 making) for a bona fide, itemized service actu-
16 ally performed on behalf of an entity, that the
17 entity would otherwise perform (or contract for)
18 in the absence of the service arrangement and
19 that is not passed on in whole or in part to a
20 client or customer, whether or not the entity
21 takes title to the drug. Such fee must be a flat
22 dollar amount and shall not be directly or indi-
23 rectly based on, or contingent upon—

1 “(i) drug price, such as wholesale ac-
2 quisition cost or drug benchmark price
3 (such as average wholesale price);

4 “(ii) the amount of discounts, rebates,
5 fees, or other direct or indirect remunera-
6 tion with respect to covered part D drugs
7 dispensed to enrollees in a prescription
8 drug plan, except as permitted pursuant to
9 paragraph (1)(A)(ii);

10 “(iii) coverage or formulary placement
11 decisions or the volume or value of any re-
12 ferrals or business generated between the
13 parties to the arrangement; or

14 “(iv) any other amounts or meth-
15 odologies prohibited by the Secretary.

16 “(C) PHARMACY BENEFIT MANAGER.—The
17 term ‘pharmacy benefit manager’ means any
18 person or entity that, either directly or through
19 an intermediary, acts as a price negotiator or
20 group purchaser on behalf of a PDP sponsor or
21 prescription drug plan, or manages the pre-
22 scription drug benefits provided by such spon-
23 sor or plan, including the processing and pay-
24 ment of claims for prescription drugs, the per-
25 formance of drug utilization review, the proc-

1 essing of drug prior authorization requests, the
2 adjudication of appeals or grievances related to
3 the prescription drug benefit, contracting with
4 network pharmacies, controlling the cost of cov-
5 ered part D drugs, or the provision of related
6 services. Such term includes any person or enti-
7 ty that carries out one or more of the activities
8 described in the preceding sentence, irrespective
9 of whether such person or entity calls itself a
10 ‘pharmacy benefit manager’.”.

11 (2) MA–PD PLANS.—Section 1857(f)(3) of the
12 Social Security Act (42 U.S.C. 1395w–27(f)(3)), as
13 amended by section 6223(d)(2), is amended by add-
14 ing at the end the following new subparagraph:

15 “(G) REQUIREMENTS RELATING TO PHAR-
16 MACY BENEFIT MANAGERS.—For plan years be-
17 ginning on or after January 1, 2028, section
18 1860D–12(h).”.

19 (3) NONAPPLICATION OF PAPERWORK REDUC-
20 TION ACT.—Chapter 35 of title 44, United States
21 Code, shall not apply to the implementation of this
22 subsection.

23 (4) FUNDING.—

24 (A) SECRETARY.—In addition to amounts
25 otherwise available, there is appropriated to the

1 Centers for Medicare & Medicaid Services Pro-
2 gram Management Account, out of any money
3 in the Treasury not otherwise appropriated,
4 \$113,000,000 for fiscal year 2026, to remain
5 available until expended, to carry out this sub-
6 section.

7 (B) OIG.—In addition to amounts other-
8 wise available, there is appropriated to the In-
9 specter General of the Department of Health
10 and Human Services, out of any money in the
11 Treasury not otherwise appropriated,
12 \$20,000,000 for fiscal year 2026, to remain
13 available until expended, to carry out this sub-
14 section.

15 (b) GAO STUDY AND REPORT ON PRICE-RELATED
16 COMPENSATION ACROSS THE SUPPLY CHAIN.—

17 (1) STUDY.—The Comptroller General of the
18 United States (in this subsection referred to as the
19 “Comptroller General”) shall conduct a study de-
20 scribing the use of compensation and payment struc-
21 tures related to a prescription drug’s price within
22 the retail prescription drug supply chain in part D
23 of title XVIII of the Social Security Act (42 U.S.C.
24 1395w–101 et seq.). Such study shall summarize in-
25 formation from Federal agencies and industry ex-

1 perts, to the extent available, with respect to the fol-
2 lowing:

3 (A) The type, magnitude, other features
4 (such as the pricing benchmarks used), and
5 prevalence of compensation and payment struc-
6 tures related to a prescription drug's price,
7 such as calculating fee amounts as a percentage
8 of a prescription drug's price, between inter-
9 mediaries in the prescription drug supply chain,
10 including—

11 (i) pharmacy benefit managers;

12 (ii) PDP sponsors offering prescrip-
13 tion drug plans and Medicare Advantage
14 organizations offering MA–PD plans;

15 (iii) drug wholesalers;

16 (iv) pharmacies;

17 (v) manufacturers;

18 (vi) pharmacy services administrative
19 organizations;

20 (vii) brokers, auditors, consultants,
21 and other entities that—

22 (I) advise PDP sponsors offering
23 prescription drug plans and Medicare
24 Advantage organizations offering MA–

1 PD plans regarding pharmacy bene-
2 fits; or

3 (II) review PDP sponsor and
4 Medicare Advantage organization con-
5 tracts with pharmacy benefit man-
6 agers; and

7 (viii) other service providers that con-
8 tract with any of the entities described in
9 clauses (i) through (vii) that may use
10 price-related compensation and payment
11 structures, such as rebate aggregators (or
12 other entities that negotiate or process
13 price concessions on behalf of pharmacy
14 benefit managers, plan sponsors, or phar-
15 macies).

16 (B) The primary business models and com-
17 pensation structures for each category of inter-
18 mediary described in subparagraph (A).

19 (C) Variation in price-related compensation
20 structures between affiliated entities (such as
21 entities with common ownership, either full or
22 partial, and subsidiary relationships) and unaf-
23 filiated entities.

24 (D) Potential conflicts of interest among
25 contracting entities related to the use of pre-

1 prescription drug price-related compensation struc-
2 tures, such as the potential for fees or other
3 payments set as a percentage of a prescription
4 drug's price to advantage formulary selection,
5 distribution, or purchasing of prescription drugs
6 with higher prices.

7 (E) Notable differences, if any, in the use
8 and level of price-based compensation struc-
9 tures over time and between different market
10 segments, such as under part D of title XVIII
11 of the Social Security Act (42 U.S.C. 1395w-
12 101 et seq.) and the Medicaid program under
13 title XIX of such Act (42 U.S.C. 1396 et seq.).

14 (F) The effects of drug price-related com-
15 pensation structures and alternative compensa-
16 tion structures on Federal health care programs
17 and program beneficiaries, including with re-
18 spect to cost-sharing, premiums, Federal out-
19 lays, biosimilar and generic drug adoption and
20 utilization, drug shortage risks, and the poten-
21 tial for fees set as a percentage of a drug's
22 price to advantage the formulary selection, dis-
23 tribution, or purchasing of drugs with higher
24 prices.

1 (G) Other issues determined to be relevant
2 and appropriate by the Comptroller General.

3 (2) REPORT.—Not later than 2 years after the
4 date of enactment of this section, the Comptroller
5 General shall submit to Congress a report containing
6 the results of the study conducted under paragraph
7 (1), together with recommendations for such legisla-
8 tion and administrative action as the Comptroller
9 General determines appropriate.

10 (c) MEDPAC REPORTS ON AGREEMENTS WITH
11 PHARMACY BENEFIT MANAGERS WITH RESPECT TO PRE-
12 SCRIPTIION DRUG PLANS AND MA-PD PLANS.—

13 (1) IN GENERAL.—The Medicare Payment Ad-
14 visory Commission shall submit to Congress the fol-
15 lowing reports:

16 (A) INITIAL REPORT.—Not later than the
17 first March 15 occurring after the date that is
18 2 years after the date on which the Secretary
19 makes the data available to the Commission, a
20 report regarding agreements with pharmacy
21 benefit managers with respect to prescription
22 drug plans and MA–PD plans. Such report
23 shall include, to the extent practicable—

24 (i) a description of trends and pat-
25 terns, including relevant averages, totals,

1 and other figures for the types of informa-
2 tion submitted;

3 (ii) an analysis of any differences in
4 agreements and their effects on plan en-
5 rollee out-of-pocket spending and average
6 pharmacy reimbursement, and other im-
7 pacts; and

8 (iii) any recommendations the Com-
9 mission determines appropriate.

10 (B) FINAL REPORT.—Not later than 2
11 years after the date on which the Commission
12 submits the initial report under subparagraph
13 (A), a report describing any changes with re-
14 spect to the information described in subpara-
15 graph (A) over time, together with any rec-
16 ommendations the Commission determines ap-
17 propriate.

18 (2) FUNDING.—In addition to amounts other-
19 wise available, there is appropriated to the Medicare
20 Payment Advisory Commission, out of any money in
21 the Treasury not otherwise appropriated,
22 \$1,000,000 for fiscal year 2026, to remain available
23 until expended, to carry out this subsection.

1 **SEC. 6225. REQUIRING A SEPARATE IDENTIFICATION NUM-**
2 **BER AND AN ATTESTATION FOR EACH OFF-**
3 **CAMPUS OUTPATIENT DEPARTMENT OF A**
4 **PROVIDER.**

5 (a) IN GENERAL.—Section 1833(t) of the Social Se-
6 curity Act (42 U.S.C. 1395l(t)) is amended by adding at
7 the end the following new paragraph:

8 “(23) USE OF UNIQUE HEALTH IDENTIFIERS;
9 ATTESTATION.—

10 “(A) IN GENERAL.—No payment may be
11 made under this subsection (or under an appli-
12 cable payment system pursuant to paragraph
13 (21)) for items and services furnished on or
14 after January 1, 2028, by an off-campus out-
15 patient department of a provider (as defined in
16 subparagraph (C)) unless—

17 “(i) such department has obtained,
18 and such items and services are billed
19 under, a National Provider Identifier that
20 is separate from such identifier for such
21 provider;

22 “(ii) such provider has submitted to
23 the Secretary, during the 2-year period
24 ending on the date such items and services
25 are so furnished, an initial provider-based
26 status attestation that such department is

1 compliant with the requirements described
2 in section 413.65 of title 42, Code of Fed-
3 eral Regulations (or a successor regula-
4 tion), which, until the Secretary establishes
5 the process described in subparagraph (B),
6 may include an attestation submitted in
7 accordance with paragraph (b)(3) of such
8 section (as in effect on the date of enact-
9 ment of this paragraph); and

10 “(iii) after such provider has sub-
11 mitted an attestation under clause (ii),
12 such provider has submitted a subsequent
13 attestation within the timeframe specified
14 by the Secretary.

15 “(B) PROCESS FOR SUBMISSION AND RE-
16 VIEW.—

17 “(i) IN GENERAL.—The Secretary
18 shall, through notice and comment rule-
19 making, establish a process for each pro-
20 vider with an off-campus outpatient de-
21 partment of a provider to submit an initial
22 and subsequent attestation pursuant to
23 clauses (ii) and (iii), respectively, of sub-
24 paragraph (A), and for the Secretary to re-
25 view each such attestation and determine,

1 through site visits, remote audits, or other
2 means (as determined appropriate by the
3 Secretary), whether such department is
4 compliant with the requirements described
5 in such subparagraph.

6 “(ii) FUNDING.—In addition to
7 amounts otherwise available, there is ap-
8 propriated to the Centers for Medicare &
9 Medicaid Services Program Management
10 Account for fiscal year 2026, out of any
11 amounts in the Treasury not otherwise ap-
12 propriated, \$20,000,000, to remain avail-
13 able until expended, for purposes of car-
14 rying out this subparagraph.

15 “(C) OFF-CAMPUS OUTPATIENT DEPART-
16 MENT OF A PROVIDER DEFINED.—For purposes
17 of this paragraph, the term ‘off-campus out-
18 patient department of a provider’ means a de-
19 partment of a provider (as defined in section
20 413.65 of title 42, Code of Federal Regulations,
21 or any successor regulation) that is not lo-
22 cated—

23 “(i) on the campus (as defined in such
24 section) of such provider; or

1 “(ii) within the distance (described in
2 such definition of campus) from a remote
3 location of a hospital facility (as defined in
4 such section).”.

5 (b) HHS OIG ANALYSIS.—Not later than January
6 1, 2030, the Inspector General of the Department of
7 Health and Human Services shall submit to Congress—

8 (1) an analysis of the process established by the
9 Secretary of Health and Human Services to conduct
10 the reviews and determinations described in section
11 1833(t)(23)(B) of the Social Security Act, as added
12 by subsection (a) of this section; and

13 (2) recommendations based on such analysis, as
14 the Inspector General determines appropriate.

15 **SEC. 6226. REVISING PHASE-IN OF MEDICARE CLINICAL**
16 **LABORATORY TEST PAYMENT CHANGES.**

17 (a) REVISED PHASE-IN OF REDUCTIONS FROM PRI-
18 VATE PAYOR RATE IMPLEMENTATION.—Section
19 1834A(b)(3) of the Social Security Act (42 U.S.C.
20 1395m–1(b)(3)) is amended—

21 (1) in subparagraph (A), by striking “2028”
22 and inserting “2029”; and

23 (2) in subparagraph (B)—

24 (A) in clause (ii), by striking “2025 and
25 for the period beginning on January 1, 2026,

1 and ending on January 30, 2026” and inserting
2 “2026”; and

3 (B) in clause (iii), by striking “the period
4 beginning on January 31, 2026, and ending on
5 December 31, 2026, and for each of 2027 and
6 2028” and inserting “each of 2027 through
7 2029”.

8 (b) REVISED DATA COLLECTION PERIOD FOR RE-
9 PORTING OF PRIVATE SECTOR PAYMENT RATES FOR ES-
10 TABLISHMENT OF MEDICARE PAYMENT RATES.—Section
11 1834A(a)(4)(B) of the Social Security Act (42 U.S.C.
12 1395m–1(a)(4)(B)) is amended by striking “2019” each
13 place it appears and inserting “2025” in each such place.

14 (c) REVISED REPORTING PERIOD FOR REPORTING
15 OF PRIVATE SECTOR PAYMENT RATES FOR ESTABLISH-
16 MENT OF MEDICARE PAYMENT RATES.—Section
17 1834A(a)(1)(B) of the Social Security Act (42 U.S.C.
18 1395m–1(a)(1)(B)) is amended—

19 (1) in clause (i), by striking “January 31” and
20 inserting “April 30”; and

21 (2) in clause (ii), by striking “February 1,
22 2026, and ending April 30, 2026” and inserting
23 “May 1, 2026, and ending July 31, 2026”.

24 (d) IMPLEMENTATION.—Notwithstanding any other
25 provision of law, the Secretary of Health and Human

1 Services may implement the amendments made by this
2 section by program instruction or otherwise.

3 **SEC. 6227. MEDICARE SEQUESTRATION.**

4 Section 251A(6) of the Balanced Budget and Emer-
5 gency Deficit Control Act of 1985 (2 U.S.C. 901a(6)) is
6 amended—

7 (1) in subparagraph (D), by striking “such
8 that,” and all that follows and inserting “such that
9 the payment reduction shall be 2.0 percent for such
10 fiscal year.”; and

11 (2) by adding at the end the following:

12 “(F) On the date on which the President sub-
13 mits the budget under section 1105 of title 31,
14 United States Code, for fiscal year 2033, the Presi-
15 dent shall order a sequestration of payments for the
16 Medicare programs specified in section 256(d), effec-
17 tive upon issuance, such that, notwithstanding the 2
18 percent limit specified in subparagraph (A) for such
19 payments—

20 “(i) with respect to the first 5 months in
21 which such order is effective for such fiscal
22 year, the payment reduction shall be 2.0 per-
23 cent; and

24 “(ii) with respect to the last 7 months in
25 which such order is effective for such fiscal

1 year, the payment reduction shall be 0 per-
2 cent.”.

3 **SEC. 6228. MEDICARE IMPROVEMENT FUND.**

4 Section 1898(b)(1) of the Social Security Act (42
5 U.S.C. 1395iii(b)(1)) is amended by striking
6 “\$1,403,000,000” and inserting “\$2,062,000,000”.

7 **TITLE III—HUMAN SERVICES**

8 **SEC. 6301. SEXUAL RISK AVOIDANCE EDUCATION EXTEN-**
9 **SION.**

10 Section 510 of the Social Security Act (42 U.S.C.
11 710) is amended—

12 (1) in subsection (a)—

13 (A) in paragraph (1)—

14 (i) by striking “2025, and for the pe-
15 riod beginning on October 1, 2025, and
16 ending on January 30, 2026” and insert-
17 ing “2026, and for the period beginning on
18 October 1, 2026, and ending on December
19 31, 2026”; and

20 (ii) by striking “fiscal year 2026” and
21 inserting “fiscal year 2027”; and

22 (B) in paragraph (2)—

23 (i) in subparagraph (A)—

24 (I) by striking “through 2025”
25 and inserting “through 2026”; and

1 (II) by striking “fiscal year
2 2026” each place it appears and in-
3 serting “fiscal year 2027”; and

4 (ii) in subparagraph (B)(i), by strik-
5 ing “2026” and inserting “2027”; and

6 (2) in subsection (f)(1) by striking “2025, and
7 for the period beginning on October 1, 2025, and
8 ending on January 30, 2026, an amount equal to
9 the pro rata portion of the amount appropriated for
10 the corresponding period for fiscal year 2025” and
11 inserting “2026, and for the period beginning on Oc-
12 tober 1, 2026, and ending on December 31, 2026,
13 an amount equal to the pro rata portion of the
14 amount appropriated for the corresponding period
15 for fiscal year 2026”.

16 **SEC. 6302. PERSONAL RESPONSIBILITY EDUCATION EXTEN-**
17 **SION.**

18 Section 513 of the Social Security Act (42 U.S.C.
19 713) is amended—

20 (1) in subsection (a)(1)—

21 (A) in subparagraph (A), in the matter
22 preceding clause (i), by striking “2025, and for
23 the period beginning on October 1, 2025, and
24 ending on January 30, 2026” and inserting
25 “2026, and for the period beginning on October

1 1, 2026, and ending on December 31, 2026”;
2 and

3 (B) in subparagraph (B)(i), by striking
4 “fiscal years 2024 and 2025, and for the period
5 beginning on October 1, 2025, and ending on
6 January 30, 2026” and inserting “fiscal years
7 2025 and 2026, and for the period beginning
8 on October 1, 2026, and ending on December
9 31, 2026”;

10 (2) in subsection (c)(3), by striking “2026” and
11 inserting “2027”; and

12 (3) in subsection (f), by striking “2025, and for
13 the period beginning on October 1, 2025, and ending
14 on January 30, 2026, an amount equal to the pro
15 rata portion of the amount appropriated for the cor-
16 responding period for fiscal year 2025” and insert-
17 ing “2026, and for the period beginning on October
18 1, 2026, and ending on December 31, 2026, an
19 amount equal to the pro rata portion of the amount
20 appropriated for the corresponding period for fiscal
21 year 2026”.

22 **SEC. 6303. EXTENSION OF FUNDING FOR FAMILY-TO-FAM-**
23 **ILY HEALTH INFORMATION CENTERS.**

24 Section 501(c)(1)(A) of the Social Security Act (42
25 U.S.C. 701(c)(1)(A)) is amended—

1 (1) in clause (viii), by striking “for fiscal year
2 2025” and inserting “for each of fiscal years 2025
3 and 2026”; and

4 (2) in clause (ix), by striking “October 1, 2025,
5 and ending on January 30, 2026, an amount equal
6 to the pro rata portion of the amount appropriated
7 for fiscal year 2025” and inserting “October 1,
8 2026, and ending on December 31, 2026, an amount
9 equal to the pro rata portion of the amount appro-
10 priated for fiscal year 2026”.

11 **SEC. 6304. EXTENSION OF THE TEMPORARY ASSISTANCE**
12 **FOR NEEDY FAMILIES PROGRAM.**

13 Activities authorized by part A of title IV of the So-
14 cial Security Act (other than under section 403(c) or 418
15 of such Act) and section 1108(b) of the Social Security
16 Act shall continue through December 31, 2026, in the
17 manner authorized for fiscal year 2025, and out of any
18 money in the Treasury of the United States not otherwise
19 appropriated, there are hereby appropriated such sums as
20 may be necessary for such purpose.

1 **TITLE IV—PUBLIC HEALTH AND**
2 **OTHER EXTENDERS**
3 **Subtitle A—Extensions**

4 **SEC. 6401. EXTENSION FOR COMMUNITY HEALTH CENTERS,**
5 **NATIONAL HEALTH SERVICE CORPS, AND**
6 **TEACHING HEALTH CENTERS THAT OPERATE**
7 **GME PROGRAMS.**

8 (a) EXTENSION FOR COMMUNITY HEALTH CEN-
9 TERS.—Section 10503(b)(1) of the Patient Protection and
10 Affordable Care Act (42 U.S.C. 254b–2(b)(1)) is amended
11 by striking subparagraphs (H), (I), (J), and (K) and in-
12 serting the following:

13 “(H) \$4,236,712,328 for fiscal year 2024;

14 “(I) \$4,295,287,671 for fiscal year 2025;

15 “(J) \$4,600,000,000 for fiscal year 2026;

16 and

17 “(K) \$1,159,452,055 for the period begin-
18 ning on October 1, 2026, and ending on De-
19 cember 31, 2026; and”.

20 (b) EXTENSION FOR THE NATIONAL HEALTH SERV-
21 ICE CORPS.—Section 10503(b)(2) of the Patient Protec-
22 tion and Affordable Care Act (42 U.S.C. 254b–2(b)(2))
23 is amended by striking subparagraphs (I), (J), (K), and
24 (L) and inserting the following:

25 “(I) \$341,208,605 for fiscal year 2024;

1 “(J) \$349,736,600 for fiscal year 2025;

2 “(K) \$350,000,000 for fiscal year 2026;

3 and

4 “(L) \$88,219,178 for the period beginning
5 on October 1, 2026, and ending on December
6 31, 2026.”.

7 (c) TEACHING HEALTH CENTERS THAT OPERATE
8 GRADUATE MEDICAL EDUCATION PROGRAMS.—Section
9 340H(g)(1) of the Public Health Service Act (42 U.S.C.
10 256h(g)(1)) is amended by striking subparagraphs (D),
11 (E), (F), and (G) and inserting the following: “

12 “(D) \$168,915,878 for fiscal year 2024;

13 “(E) \$181,563,574 for fiscal year 2025;

14 “(F) \$225,000,000 for fiscal year 2026;

15 “(G) \$250,000,000 for fiscal year 2027;

16 “(H) \$275,000,000 for fiscal year 2028;

17 and

18 “(I) \$300,000,000 for fiscal year 2029.”.

19 (d) APPLICATION OF PROVISIONS.—Amounts appro-
20 priated pursuant to the amendments made by this section
21 shall be subject to the requirements contained in Public
22 Law 118–47 for funds for programs authorized under sec-
23 tions 330 through 340 of the Public Health Service Act
24 (42 U.S.C. 254b et seq.).

1 (e) CONFORMING AMENDMENTS.—Section
2 3014(h)(4) of title 18, United States Code, is amended
3 by striking “and section 6101(d) of the Continuing Appro-
4 priations, Agriculture, Legislative Branch, Military Con-
5 struction and Veterans Affairs, and Extensions Act,
6 2026” and inserting “section 6101(d) of the Continuing
7 Appropriations, Agriculture, Legislative Branch, Military
8 Construction and Veterans Affairs, and Extensions Act,
9 2026, and section 6401(d) of the Consolidated Appropria-
10 tions Act, 2026”.

11 **SEC. 6402. EXTENSION OF SPECIAL DIABETES PROGRAMS.**

12 (a) EXTENSION OF SPECIAL DIABETES PROGRAMS
13 FOR TYPE I DIABETES.—Section 330B(b)(2) of the Pub-
14 lic Health Service Act (42 U.S.C. 254c–2(b)(2)) is amend-
15 ed by striking subparagraphs (E), (F), (G), and (H) and
16 inserting the following:

17 “(E) \$155,619,196 for fiscal year 2024, to
18 remain available until expended;

19 “(F) \$159,228,188 for fiscal year 2025, to
20 remain available until expended;

21 “(G) \$200,000,000 for fiscal year 2026, to
22 remain available until expended; and

23 “(H) \$50,410,959 for the period beginning
24 on October 1, 2026, and ending on December
25 31, 2026, to remain available until expended.”.

1 (b) EXTENDING FUNDING FOR SPECIAL DIABETES
2 PROGRAMS FOR INDIANS.—Section 330C(e)(2) of the
3 Public Health Service Act (42 U.S.C. 254e–3(e)(2)) is
4 amended by striking subparagraphs (E), (F), (G), and
5 (H) and inserting the following:

6 “(E) \$155,619,196 for fiscal year 2024, to
7 remain available until expended;

8 “(F) \$159,228,188 for fiscal year 2025, to
9 remain available until expended;

10 “(G) \$200,000,000 for fiscal year 2026, to
11 remain available until expended; and

12 “(H) \$50,410,959 for the period beginning
13 on October 1, 2026, and ending on December
14 31, 2026, to remain available until expended.”.

15 **SEC. 6403. EXTENSION OF NATIONAL HEALTH SECURITY**
16 **PROGRAMS.**

17 (a) Section 319(e)(8) of the Public Health Service
18 Act (42 U.S.C. 247d(e)(8)) is amended by striking “Janu-
19 ary 30, 2026” and inserting “December 31, 2026”.

20 (b) Section 319L(e)(1)(D) of the Public Health Serv-
21 ice Act (42 U.S.C. 247d–7e(e)(1)(D)) is amended by strik-
22 ing “January 30, 2026” and inserting “December 31,
23 2026”.

1 (c) Section 319L-1(b) of the Public Health Service
2 Act (42 U.S.C. 247d-7f(b)) is amended by striking “Jan-
3 uary 30, 2026” and inserting “December 31, 2026”.

4 (d) Section 2811A(g) of the Public Health Service
5 Act (42 U.S.C. 300hh-10b(g)) is amended by striking
6 “January 30, 2026” and inserting “December 31, 2026”.

7 (e) Section 2811B(g)(1) of the Public Health Service
8 Act (42 U.S.C. 300hh-10c(g)(1)) is amended by striking
9 “January 30, 2026” and inserting “December 31, 2026”.

10 (f) Section 2811C(g)(1) of the Public Health Service
11 Act (42 U.S.C. 300hh-10d(g)(1)) is amended by striking
12 “January 30, 2026” and inserting “December 31, 2026”.

13 (g) Section 2812(c)(4)(B) of the Public Health Serv-
14 ice Act (42 U.S.C. 300hh-11(c)(4)(B)) is amended by
15 striking “January 30, 2026” and inserting “December 31,
16 2026”.

17 **SEC. 6404. NO SURPRISES ACT IMPLEMENTATION.**

18 Section 118(a) of division BB of the Consolidated
19 Appropriations Act, 2021 (Public Law 116-260) is
20 amended—

21 (1) in paragraph (1), by striking “January 30,
22 2026” and inserting “December 31, 2026”; and

23 (2) in paragraph (2)—

24 (A) by striking “\$14,000,000” and insert-
25 ing “\$42,100,000”; and

1 (B) by striking “January 30, 2026” and
2 inserting “December 31, 2026”.

3 **Subtitle B—World Trade Center**
4 **Health Program**

5 **SEC. 6411. 9/11 RESPONDER AND SURVIVOR HEALTH FUND-**
6 **ING CORRECTIONS.**

7 (a) IN GENERAL.—Section 3351(a)(2)(A) of the
8 Public Health Service Act (42 U.S.C. 300mm–
9 61(a)(2)(A)) is amended—

10 (1) in clause (x), by striking “; and” and insert-
11 ing a semicolon;

12 (2) by redesignating clause (xi) as clause (xii);
13 and

14 (3) by inserting after clause (x), the following:

15 “(xi) for each of fiscal years 2026
16 through 2040—

17 “(I) the amount determined
18 under this subparagraph for the pre-
19 vious fiscal year multiplied by 1.07;
20 multiplied by

21 “(II) the ratio of—

22 “(aa) the total number of
23 individuals enrolled in the AC
24 Program on July 1 of such pre-
25 vious fiscal year; to

1 “(bb) the total number of
2 individuals so enrolled on July 1
3 of the fiscal year prior to such
4 previous fiscal year; and”.

5 (b) REPORT TO CONGRESS.—

6 (1) IN GENERAL.—Not later than 3 years after
7 the date of enactment of this Act, the Secretary of
8 Health and Human Services (referred to in this sub-
9 section as the “Secretary”) shall conduct an assess-
10 ment of anticipated budget authority and outlays of
11 the World Trade Center Health Program (referred
12 to in this subsection as the “Program”) through the
13 duration of the Program and submit a report sum-
14 marizing such assessment to—

15 (A) the Speaker and minority leader of the
16 House of Representatives;

17 (B) the majority and minority leaders of
18 the Senate;

19 (C) the Committee on Health, Education,
20 Labor, and Pensions and the Committee on the
21 Budget of the Senate; and

22 (D) the Committee on Energy and Com-
23 merce and the Committee on the Budget of the
24 House of Representatives.

1 (2) INCLUSIONS.—The report required under
2 paragraph (1) shall include—

3 (A) a projection of Program budgetary
4 needs on a per-fiscal year basis through fiscal
5 year 2090;

6 (B) a review of Program modeling for each
7 of fiscal years 2017 through the fiscal year
8 prior to the fiscal year in which the report is
9 issued to assess how anticipated budgetary
10 needs compared to actual expenditures;

11 (C) an assessment of the projected budget
12 authority and expenditures of the Program
13 through fiscal year 2090 by comparing—

14 (i) such projected authority and ex-
15 penditures resulting from application of
16 section 3351(a)(2)(A) of the Public Health
17 Service Act (42 U.S.C. 300mm-
18 61(a)(2)(A)), as amended by subsection
19 (a); and

20 (ii) such projected authority and ex-
21 penditures that would result if such section
22 were amended so that the formula under
23 clause (xi) of such section, as amended by
24 subsection (a), were to be extended
25 through fiscal year 2090; and

1 (D) any recommendations of the Secretary
2 to make changes to the formula under such sec-
3 tion 3351(a)(2)(A), as so amended, to fully off-
4 set anticipated Program expenditures through
5 fiscal year 2090.

6 (c) TECHNICAL AMENDMENTS.—Title XXIII of the
7 Public Health Service Act (42 U.S.C. 300mm et seq.) is
8 amended—

9 (1) in section 3352(d) (42 U.S.C. 300mm–
10 62(d)), by striking “Any amounts” and inserting
11 “Any unobligated amounts”;

12 (2) in section 3353(d) (42 U.S.C. 300mm–
13 63(d)), by striking “Any amounts” and inserting
14 “Any unobligated amounts”; and

15 (3) in section 3354(d) (42 U.S.C. 300mm–
16 64(d)), by striking “Any amounts” and inserting
17 “Any unobligated amounts”.

18 **TITLE V—PUBLIC HEALTH**
19 **PROGRAMS**

20 **SEC. 6501. PREVENTING MATERNAL DEATHS.**

21 (a) MATERNAL MORTALITY REVIEW COMMITTEES.—
22 Section 317K(d) of the Public Health Service Act (42
23 U.S.C. 247b–12(d)) is amended—

1 (1) in paragraph (1)(A), by inserting “(includ-
2 ing obstetricians and gynecologists)” after “clinical
3 specialties”; and

4 (2) in paragraph (3)(A)(i)—

5 (A) in subclause (I), by striking “as appli-
6 cable” and inserting “if available”; and

7 (B) in subclause (III), by striking “, as ap-
8 propriate” and inserting “and coordinating with
9 individuals responsible for certifying deaths to
10 improve the collection and quality of death
11 record reports, including by amending errors
12 and missing or incomplete information to cause-
13 of-death information on a death certificate, as
14 appropriate”.

15 (b) **MATERNAL MORTALITY.**—Section 317K of the
16 Public Health Service Act (42 U.S.C. 247b–12) is amend-
17 ed—

18 (1) by redesignating subsections (e) and (f) as
19 subsections (f) and (g), respectively; and

20 (2) by inserting after subsection (d) the fol-
21 lowing:

22 “(e) **BEST PRACTICES RELATING TO THE PREVEN-**
23 **TION OF MATERNAL MORTALITY.**—

24 “(1) **IN GENERAL.**—The Secretary, acting
25 through the Director of the Centers for Disease

1 Control and Prevention, shall, in consultation with
2 the Administrator of the Health Resources and Serv-
3 ices Administration, identify and disseminate to
4 health care providers, relevant professional societies,
5 and perinatal quality collaboratives, best practices
6 related to preventing maternal morbidity and mor-
7 tality, taking into consideration any relevant find-
8 ings from other Federal maternal health programs.

9 “(2) FREQUENCY.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall disseminate the best
12 practices referred to in paragraph (1) not less than
13 once per fiscal year.”.

14 (c) AUTHORIZATION OF APPROPRIATIONS.—Sub-
15 section (g) of section 317K of the Public Health Service
16 Act (42 U.S.C. 247b–12), as redesignated by subsection
17 (b)(1), is amended by striking “\$58,000,000 for each of
18 fiscal years 2019 through 2023” and inserting
19 “\$100,000,000 for each of fiscal years 2026 through
20 2030”.

21 **SEC. 6502. ORGAN PROCUREMENT AND TRANSPLANTATION**
22 **NETWORK.**

23 Section 372 of the Public Health Service Act (42
24 U.S.C. 274) is amended—

25 (1) in subsection (b)(2)—

1 (A) by moving the margins of subpara-
2 graphs (M) through (O) 2 ems to the left;

3 (B) in subparagraph (A)—

4 (i) in clause (i), by striking “, and”
5 and inserting “; and”; and

6 (ii) in clause (ii), by striking the
7 comma at the end and inserting a semi-
8 colon;

9 (C) in subparagraph (C), by striking
10 “twenty-four-hour telephone service” and in-
11 serting “24-hour telephone or information tech-
12 nology service”;

13 (D) in each of subparagraphs (B) through
14 (M), by striking the comma at the end and in-
15 serting a semicolon;

16 (E) in subparagraph (N), by striking
17 “transportation, and” and inserting “transport-
18 ation;”;

19 (F) in subparagraph (O), by striking the
20 period and inserting a semicolon; and

21 (G) by adding at the end the following:

22 “(P) encourage the integration of electronic
23 health records systems through application program-
24 ming interfaces (or successor technologies) among
25 hospitals, organ procurement organizations, and

1 transplant centers, including the use of automated
2 electronic hospital referrals and the grant of remote,
3 electronic access to hospital electronic health records
4 of potential donors by organ procurement organiza-
5 tions, in a manner that complies with the privacy
6 regulations promulgated under the Health Insurance
7 Portability and Accountability Act of 1996, at part
8 160 of title 45, Code of Federal Regulations, and
9 subparts A, C, and E of part 164 of such title (or
10 any successor regulations); and

11 “(Q) consider establishing a dashboard to dis-
12 play the number of transplants performed, the types
13 of transplants performed, the number and types of
14 organs that entered the Organ Procurement and
15 Transplantation Network system and failed to be
16 transplanted, and other appropriate statistics, which
17 should be updated more frequently than annually.”;
18 and

19 (2) by adding at the end the following:

20 “(d) REGISTRATION FEES.—

21 “(1) IN GENERAL.—The Secretary may collect
22 registration fees from any member of the Organ
23 Procurement and Transplantation Network for each
24 transplant candidate such member places on the list
25 described in subsection (b)(2)(A)(i). Such registra-

1 tion fees shall be collected and distributed only to
2 support the operation of the Organ Procurement
3 and Transplantation Network. Such registration fees
4 are authorized to remain available until expended.

5 “(2) COLLECTION.—The Secretary may collect
6 the registration fees under paragraph (1) directly or
7 through awards made under subsection (b)(1)(A).

8 “(3) DISTRIBUTION.—Any amounts collected
9 under this subsection shall—

10 “(A) be credited to the currently applicable
11 appropriation, account, or fund of the Depart-
12 ment of Health and Human Services as discre-
13 tionary offsetting collections; and

14 “(B) be available, only to the extent and in
15 the amounts provided in advance in appropria-
16 tions Acts, to distribute such fees among
17 awardees described in subsection (b)(1)(A).

18 “(4) TRANSPARENCY.—The Secretary shall—

19 “(A) promptly post on the website of the
20 Organ Procurement and Transplantation Net-
21 work—

22 “(i) the amount of registration fees
23 collected under this subsection from each
24 member of the Organ Procurement and
25 Transplantation Network; and

1 “(ii) a list of activities such fees are
2 used to support; and

3 “(B) update the information posted pursu-
4 ant to subparagraph (A), as applicable for each
5 calendar quarter for which fees are collected
6 under paragraph (1).

7 “(5) GAO REVIEW.—Not later than 2 years
8 after the date of enactment of this subsection, the
9 Comptroller General of the United States shall, to
10 the extent data are available—

11 “(A) conduct a review concerning the ac-
12 tivities under this subsection; and

13 “(B) submit to the Committee on Health,
14 Education, Labor, and Pensions and the Com-
15 mittee on Finance of the Senate and the Com-
16 mittee on Energy and Commerce of the House
17 of Representatives, a report on such review, in-
18 cluding related recommendations, as applicable.

19 “(6) SUNSET.—The authority to collect reg-
20 istration fees under paragraph (1) shall expire on
21 the date that is 3 years after the date of enactment
22 of the Consolidated Appropriations Act, 2026.”.

1 **SEC. 6503. HONOR OUR LIVING DONORS.**

2 (a) NO CONSIDERATION OF INCOME OF ORGAN RE-
3 CIPIENT.—Section 377 of the Public Health Service Act
4 (42 U.S.C. 274f) is amended—

5 (1) by redesignating subsections (e) through (f)
6 as subsections (d) through (g), respectively;

7 (2) by inserting after subsection (b) the fol-
8 lowing:

9 “(c) NO CONSIDERATION OF INCOME OF ORGAN RE-
10 CIPIENT.—The recipient of a grant under this section, in
11 providing reimbursement to a donating individual through
12 such grant, shall not give any consideration to the income
13 of the organ recipient.”; and

14 (3) in subsection (f), as so redesignated—

15 (A) in paragraph (1), by striking “sub-
16 section (e)(1)” and inserting “subsection
17 (d)(1)”; and

18 (B) in paragraph (2), by striking “sub-
19 section (e)(2)” and inserting “subsection
20 (d)(2)”.

21 (b) REMOVAL OF EXPECTATION OF PAYMENTS BY
22 ORGAN RECIPIENTS.—Section 377(e) of the Public
23 Health Service Act (42 U.S.C. 274f(e)), as redesignated
24 by subsection (a)(1), is amended—

25 (1) in paragraph (1), by adding “or” at the
26 end;

1 (2) in paragraph (2), by striking “; or” and in-
2 serting a period; and

3 (3) by striking paragraph (3).

4 (c) ANNUAL REPORT.—Section 377 of the Public
5 Health Service Act (42 U.S.C. 274f), as amended by sub-
6 sections (a) and (b), is amended by adding at the end the
7 following:

8 “(h) ANNUAL REPORT.—Not later than December 31
9 of each year, beginning in fiscal year 2027, the Secretary
10 shall—

11 “(1) prepare, submit to the Congress, and make
12 public a report on whether grants under this section
13 provided adequate funding during the preceding fis-
14 cal year to reimburse all donating individuals par-
15 ticipating in the grant program under this section
16 for all qualifying expenses; and

17 “(2) include in each such report—

18 “(A) the estimated number of all donating
19 individuals participating in the grant program
20 under this section who did not receive reim-
21 bursement for all qualifying expenses during
22 the preceding fiscal year; and

23 “(B) the total amount of funding that is
24 estimated to be necessary to fully reimburse all
25 donating individuals participating in the grant

1 program under this section for all qualifying ex-
2 penses.”.

3 **SEC. 6504. PROGRAM FOR PEDIATRIC STUDIES OF DRUGS.**

4 Section 409I(d)(1) of the Public Health Service Act
5 (42 U.S.C. 284m(d)(1)) is amended by striking “section,”
6 and all that follows through the period at the end and
7 inserting “section, \$25,000,000 for each of fiscal years
8 2026 through 2028.”.

9 **SEC. 6505. SICKLE CELL DISEASE PREVENTION AND TREAT-**
10 **MENT.**

11 (a) IN GENERAL.—Section 1106(b) of the Public
12 Health Service Act (42 U.S.C. 300b–5(b)) is amended—

13 (1) in paragraph (1)(A)(iii), by striking “pre-
14 vention and treatment of sickle cell disease” and in-
15 serting “treatment of sickle cell disease and the pre-
16 vention and treatment of complications of sickle cell
17 disease”;

18 (2) in paragraph (2)(D), by striking “preven-
19 tion and treatment of sickle cell disease” and insert-
20 ing “treatment of sickle cell disease and the preven-
21 tion and treatment of complications of sickle cell dis-
22 ease”;

23 (3) in paragraph (3)—

24 (A) in subparagraph (A), by striking
25 “enter into a contract with” and inserting

1 “make a grant to, or enter into a contract or
2 cooperative agreement with,”; and

3 (B) in subparagraph (B), in each of
4 clauses (ii) and (iii), by striking “prevention
5 and treatment of sickle cell disease” and insert-
6 ing “treatment of sickle cell disease and the
7 prevention and treatment of complications of
8 sickle cell disease”; and

9 (4) in paragraph (6), by striking “\$4,455,000
10 for each of fiscal years 2019 through 2023” and in-
11 serting “\$8,205,000 for each of fiscal years 2026
12 through 2030”.

13 (b) SENSE OF CONGRESS.—It is the sense of Con-
14 gress that further research should be undertaken to ex-
15 pand the understanding of the causes of, and to find cures
16 for, heritable blood disorders, including sickle cell disease.

17 **SEC. 6506. LIFESPAN RESPITE CARE.**

18 (a) DEFINITION OF FAMILY CAREGIVER.—Section
19 2901(5) of the Public Health Service Act (42 U.S.C.
20 300ii(5)) is amended by striking “unpaid adult” and in-
21 serting “unpaid individual”.

22 (b) FUNDING.—Section 2905 of the Public Health
23 Service Act (42 U.S.C. 300ii–4) is amended by striking
24 “fiscal years 2020 through fiscal year 2024” and inserting
25 “fiscal years 2026 through 2030”.

1 **SEC. 6507. PREEMIE.**

2 (a) RESEARCH RELATING TO PRETERM LABOR AND
3 DELIVERY AND THE CARE, TREATMENT, AND OUTCOMES
4 OF PRETERM AND LOW BIRTHWEIGHT INFANTS.—

5 (1) IN GENERAL.—Section 3(e) of the Pre-
6 maturity Research Expansion and Education for
7 Mothers who deliver Infants Early Act (42 U.S.C.
8 247b–4f(e)) is amended by striking “fiscal years
9 2019 through 2023” and inserting “fiscal years
10 2026 through 2030”.

11 (2) TECHNICAL CORRECTION.—Effective as if
12 included in the enactment of the PREEMIE Reau-
13 thorization Act of 2018 (Public Law 115–328), sec-
14 tion 2 of such Act is amended, in the matter pre-
15 ceding paragraph (1), by striking “Section 2” and
16 inserting “Section 3”.

17 (b) INTERAGENCY WORKING GROUP.—Section 5(a)
18 of the PREEMIE Reauthorization Act of 2018 (Public
19 Law 115–328) is amended by striking “The Secretary of
20 Health and Human Services, in collaboration with other
21 departments, as appropriate, may establish” and inserting
22 “Not later than 18 months after the date of the enactment
23 of the Consolidated Appropriations Act, 2026, the Sec-
24 retary of Health and Human Services, in collaboration
25 with other departments, as appropriate, shall establish”.

26 (c) STUDY ON PRETERM BIRTHS.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services shall enter into appropriate ar-
3 rangements with the National Academies of
4 Sciences, Engineering, and Medicine under which
5 the National Academies shall—

6 (A) not later than 30 days after the date
7 of enactment of this Act, convene a committee
8 of experts in maternal health to study pre-
9 mature births in the United States; and

10 (B) upon completion of the study under
11 subparagraph (A)—

12 (i) approve by consensus a report on
13 the results of such study;

14 (ii) include in such report—

15 (I) an assessment of each of the
16 topics listed in paragraph (2);

17 (II) the analysis required by
18 paragraph (3); and

19 (III) the raw data used to de-
20 velop such report; and

21 (iii) not later than 24 months after
22 the date of enactment of this Act, transmit
23 such report to—

24 (I) the Secretary of Health and
25 Human Services;

1 (II) the Committee on Energy
2 and Commerce of the House of Rep-
3 resentatives; and

4 (III) the Committee on Finance
5 and the Committee on Health, Edu-
6 cation, Labor, and Pensions of the
7 Senate.

8 (2) ASSESSMENT TOPICS.—The topics listed in
9 this subsection are each of the following:

10 (A) The financial costs of premature birth
11 to society, including—

12 (i) an analysis of stays in neonatal in-
13 tensive care units and the cost of such
14 stays;

15 (ii) long-term costs of stays in such
16 units to society and the family involved
17 post-discharge; and

18 (iii) health care costs for families
19 post-discharge from such units (such as
20 medications, therapeutic services, co-pay-
21 ments for visits, and specialty equipment).

22 (B) The factors that impact preterm birth
23 rates.

24 (C) Opportunities for earlier detection of
25 premature birth risk factors, including—

1 (i) opportunities to improve maternal
2 and infant health; and

3 (ii) opportunities for public health
4 programs to provide support and resources
5 for parents in-hospital, in non-hospital set-
6 tings, and post-discharge.

7 (3) ANALYSIS.—The analysis required by this
8 subsection is an analysis of—

9 (A) targeted research strategies to develop
10 effective drugs, treatments, or interventions to
11 bring at-risk pregnancies to term;

12 (B) State and other programs' best prac-
13 tices with respect to reducing premature birth
14 rates; and

15 (C) precision medicine and preventative
16 care approaches starting early in the life course
17 (including during pregnancy) with a focus on
18 behavioral and biological influences on pre-
19 mature birth, child health, and the trajectory of
20 such approaches into adulthood.

21 **SEC. 6508. DR. LORNA BREEN HEALTH CARE PROVIDER**
22 **PROTECTION.**

23 (a) DISSEMINATION OF BEST PRACTICES.—Section
24 2 of the Dr. Lorna Breen Health Care Provider Protection