DIVISION F—HEALTH CARE EXTENDERS

SEC. 6001. TABLE OF CONTENTS.

The table of contents of this division is as follows:

TITLE I—MEDICAID

SEC. 6101. STREAMLINED ENROLLMENT PROCESS FOR ELIGIBLE OUT-OF-STATE PROVIDERS UNDER MEDICAID AND CHIP.

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

''(10) STREAMLINED ENROLLMENT PROCESS FOR ELIGIBLE OUT-OF-STATE PROVIDERS.—

''(A) IN GENERAL.—The State—

''(i) adopts and implements a process to allow an eligible out-of-State provider to enroll under the State plan (or a waiver of such plan) to furnish items and services to, or order, prescribe, refer, or certify eligibility for items and services for, qualifying individuals without the imposition of screening or enrollment requirements by

such State that exceed the minimum necessary for such State to provide payment to an eligible out-of-State provider under such State plan (or a waiver of such plan), such as the provider's name and National Provider Identifier (and such other information specified by the Secretary); and

''(ii) provides that an eligible out-of-State provider that enrolls as a participating provider in the State plan (or a waiver of such plan) through such process shall be so enrolled for a 5-year period, unless the provider is terminated or excluded from participation during such period.

''(B) DEFINITIONS.—In this paragraph:

''(i) ELIGIBLE OUT-OF-STATE PROVIDER.—The term 'eligible out-of-State provider' means, with respect to a State, a provider—

''(I) that is located in any other State;

''(II) that—

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

purposes of determining the level of screening to be conducted under section 1866(j)(2), has been so screened under such section 1866(j)(2), and is enrolled in the Medicare program under title XVIII; or

''(bb) was determined by the State agency administering or supervising the administration of the State plan (or a waiver of such plan) of such other State to have a limited risk of fraud, waste, and abuse for purposes of determining the level of screening to be conducted under paragraph (1) of this subsection, has been so screened under such paragraph (1), and is enrolled under such State plan (or a waiver of such plan); and

''(III) that has not been—

''(aa) excluded from participation in any Federal health care

program pursuant to section 1128 or 1128A;

"(bb) excluded from participation in the State plan (or a waiver of such plan) pursuant to part 1002 of title 42, Code of Federal Regulations (or any successor regulation), or State law; or

"(cc) terminated from participating in a Federal health care program or the State plan (or a waiver of such plan) for a reason described in paragraph (8)(A).

"(ii) QUALIFYING INDIVIDUAL.—The term 'qualifying individual' means an individual under 21 years of age who is enrolled under the State plan (or waiver of such plan).

"(iii) STATE.—The term 'State' means 1 of the 50 States or the District of Columbia.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(77) of the Social Security Act (42 U.S.C. 1396a(a)(77)) is amended by inserting ''enrollment,'' after ''screening,''.

(2) The subsection heading for section 1902(kk) of such Act (42 U.S.C. 1396a(kk)) is amended by inserting ''enrollment,'' after ''screening,''.

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

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

SEC. 6102. REMOVING CERTAIN AGE RESTRICTIONS ON MEDICAID ELIGIBILITY FOR WORKING ADULTS WITH DISABILITIES.

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

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

(A) in subclause (XV)—

(i) by striking '', but less than 65,''; and

(ii) by inserting '', including at least the group described in section

1905(a)(xviii)'' before the semicolon at the end; and

(B) in subclause (XVI), by inserting ''including at least the group described in section 1905(a)(xii),'' after ''the State may establish,''.

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

(A) in clause (xvi), by striking ''or'' at the end;

(B) in clause (xvii), by adding ''or'' after the comma at the end; and

(C) by adding after clause (xvii) the following new clause:

''(xviii) individuals who, but for earnings in excess of the limit established under subsection (q)(2)(B), would be considered to be receiving supplemental security income, and who are at least 16 years of age,''.

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

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

SEC. 6103. MEDICAID STATE PLAN REQUIREMENT FOR DETERMINING RESIDENCY AND COVERAGE FOR MILITARY FAMILIES.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) in paragraph (88), by striking ''and'' at the end;

(B) in paragraph (89), by striking the period at the end and inserting ''; and''; and

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

''(90) beginning January 1, 2030, provide, with respect to an active duty relocated individual (as defined in subsection (yy)(1))—

''(A) that, for purposes of determining eligibility for medical assistance under the State

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

"(B) that if, at the time of relocation (as described in subsection (yy)(1)), such active duty relocated individual is on a home and community-based services waiting list (as defined in subsection (yy)(2)), such individual remains on such list until—

"(i) the State completes an assessment and renders a decision with respect to the eligibility of such individual to receive the relevant home and community-based services at the time a slot for such services becomes available and, in the case such decision is a denial of such eligibility, such individual has exhausted the individual's opportunity for a fair hearing; or

"(ii) such individual elects to be removed from such list; and

"(C) payment for medical assistance furnished under the State plan (or a waiver of the plan) on behalf of such active duty relocated individual in the military service relocation State

(as referred to in subsection (yy)(1)(B)(i)), to the extent that such assistance is available in such military service relocation State in accordance with such guidance as the Secretary may issue to ensure access to such assistance.''; and

(2) by adding at the end the following new subsection:

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

''(1) ACTIVE DUTY RELOCATED INDIVIDUAL.—The term 'active duty relocated individual' means an individual—

''(A) who—

''(i) is enrolled under the State plan (or waiver of such plan); or

''(ii) with respect to an individual described in subparagraph (C)(ii), would be so enrolled pursuant to subsection (a)(10)(A)(ii)(VI) if such individual began receiving home and community-based services;

''(B) who—

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

cated to another State (in this subsection referred to as the 'military service relocation State') by reason of such service;

"(ii) would be described in clause (i) except that the individual stopped being engaged in active duty service (including by reason of retirement from such service) and the last day on which the individual was engaged in active duty service occurred not more than 12 months ago; or

"(iii) is a dependent (as defined by the Secretary) of a member described in clause (i) or (ii) who relocates to the military service relocation State with such member; and

"(C) who—

"(i) was receiving home and community-based services (as defined in section 9817(a)(2)(B) of the American Rescue Plan Act of 2021) at the time of such relocation; or

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

services waiting list at the time of such relocation.

''(2) HOME AND COMMUNITY-BASED SERVICES WAITING LIST.—The term 'home and community-based services waiting list' means, in the case of a State that has a limit on the number of individuals who may receive home and community-based services under section 1115(a) or section 1915(c), a list maintained by such State of individuals who are requesting to receive such services under 1 or more such sections but for whom the State has not yet completed an assessment and rendered a decision with respect to the eligibility of such individuals to receive the relevant home and community-based services at the time a slot for such services becomes available due to such limit.''.

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

SEC. 6104. STATE STUDIES AND HHS REPORT ON COSTS OF PROVIDING MATERNITY, LABOR, AND DELIVERY SERVICES.

(a) STATE STUDY.—

(1) IN GENERAL.—Not later than 30 months after the date of enactment of this Act, and every 5 years thereafter, each State (as such term is defined in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act) shall conduct a study on the costs of providing maternity, labor, and delivery services in applicable hospitals (as defined in paragraph (3)) and submit the results of such study to the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') in such form and manner as the Secretary requires.

(2) CONTENT OF STUDY.—A State study required under paragraph (1) shall include the following information (to the extent practicable and as further defined by the Secretary) with respect to maternity, labor, and delivery services furnished by applicable hospitals located in the State:

(A) An estimate of the cost of providing maternity, labor, and delivery services at applicable hospitals, based on the expenditures a representative sample of such hospitals incurred

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

(B) An estimate of the cost of providing maternity, labor, and delivery services at hospitals that would be applicable hospitals (as defined in paragraph (3)) if not for ceasing to provide labor and delivery services within the past 5 years, based on the expenditures a representative sample of such hospitals incurred for providing such services during the 2 most recent years for which data is available.

(C) To the extent data allow, an analysis of the extent to which geographic location, community demographics, and local economic factors (as defined by the Secretary) affect the cost of providing maternity, labor, and delivery services at applicable hospitals described in subparagraphs (A) and (B), including the cost of services that support the provision of maternity, labor, and delivery services.

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

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

(ii) the State Medicaid program, including payment amounts for such services under fee-for-service payment arrangements and under managed care (as applicable);

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

(iv) private health insurance.

(E) A comparative payment rate analysis—

(i) comparing payment rates for maternity, labor, and delivery services (inclusive of all payments received by applicable hospitals for furnishing maternity, labor, and delivery services) under the State Medicaid fee-for-service program to such payment rates for such services under Medicare (including those described in paragraphs (2) and (3) of section 447.203(b) of title 42, Code of Federal Regulations), and, to the extent data is

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

(ii) analyzing different payment methods for such services, such as the use of bundled payments, quality incentives, and low-volume adjustments.

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

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

(A) The hospital provides labor and delivery services and more than 50 percent of the hospital's births (in the most recent year for which such data is available) are financed by the Medicaid program or CHIP.

(B) The hospital—

(i) is located in a rural area (as defined by the Federal Office of Rural Health Policy for the purpose of rural health grant programs administered by such Office);

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

(iii) provides labor and delivery services.

(4) ASSISTANCE TO SMALL HOSPITALS IN COMPILING COST INFORMATION.—There are appropriated to the Secretary for fiscal year 2026, $10,000,000 for the purpose of providing grants and technical assistance to a hospital described in paragraph (3)(B) to enable such hospital to compile detailed information for use in the State studies required under paragraph (1), to remain available until expended.

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

the State submits to the Secretary the data described in such paragraph, a publicly available report that compiles and details the results of such study and includes the information described in paragraph (2).

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

(c) IMPLEMENTATION FUNDING.—In addition to the amount appropriated under subsection (a)(4), there are appropriated, out of any funds in the Treasury not otherwise obligated, $3,000,000 for fiscal year 2026, to remain available until expended, to the Secretary of Health and Human Services for purposes of implementing this section.

SEC. 6105. MODIFYING CERTAIN DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS.

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

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

(2) by inserting '', and the DSH allotment for Tennessee for the portion of fiscal year 2026 beginning on January 31, 2026, and ending September 30, 2026, shall be $35,351,507, which may be claimed as fiscal year 2026 uncompensated care costs, and the DSH allotment for Tennessee for fiscal year 2027, shall be $53,100,000'' before the period.

(b) ELIMINATING CERTAIN DSH ALLOTMENT REDUCTIONS.—Section 1923(f)(7)(A) of the Social Security Act (42 U.S.C. 1396r–4(f)(7)(A)) is amended—

(1) in clause (i)—

(A) in the matter preceding subclause (I), by striking ''the period beginning January 31, 2026, and ending September 30, 2026, and for each of fiscal years 2027 and 2028'' and inserting ''fiscal year 2028'';

(B) in subclause (I), by striking ''or period''; and

(C) in subclause (II), by striking ''or period'' each place it appears; and

(2) in clause (ii), by striking ''the period beginning January 31, 2026, and ending September 30, 2026, and for each of fiscal years 2027 and 2028'' and inserting ''fiscal year 2028''.

SEC. 6106. MODIFYING CERTAIN LIMITATIONS ON DISPROPORTIONATE SHARE HOSPITAL PAYMENT ADJUSTMENTS UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1923(g) of the Social Security Act (42 U.S.C. 1396r–4(g)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) in the matter preceding clause (i), by striking ''(other than a hospital described in paragraph (2)(B))'';

(ii) in clause (i), by inserting ''with respect to such hospital and year'' after ''described in subparagraph (B)''; and

(iii) in clause (ii)—

(I) in subclause (I), by striking ''and'' at the end;

(II) in subclause (II), by striking the period and inserting ''; and''; and

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

''(III) payments made under title XVIII or by an applicable plan (as defined in section 1862(b)(8)(F)) for such services.''; and

(B) in subparagraph (B)—

(i) in the matter preceding clause (i), by striking ''in this clause are'' and inserting ''in this subparagraph are, with respect to a hospital and a year,''; and

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

''(iii) Individuals who are eligible for medical assistance under the State plan or under a waiver of such plan and for whom the State plan or waiver is a payor for such services after application of benefits under title XVIII or under an applicable plan (as defined in section 1862(b)(8)(F)), but only if the hospital has in the aggregate incurred costs exceeding payments under such State plan, waiver, title XVIII, or applicable plan for such services furnished to such individuals during such year.'';

(2) by striking paragraph (2);

(3) by redesignating paragraph (3) as paragraph (2); and

(4) in paragraph (2), as so redesignated, by striking ''Notwithstanding paragraph (2) of this subsection (as in effect on October 1, 2021), paragraph (2)'' and inserting ''Paragraph (2)''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to payment adjustments made under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) for Medicaid State plan rate years beginning on or after the date of enactment of this Act.

(2) STATE OPTION TO DISTRIBUTE UNSPENT DSH ALLOTMENTS FROM PRIOR YEARS UP TO MODIFIED CAP.—

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

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

(i) such payment adjustment (as so increased) is consistent with subsection (g) of such section (as amended by this section); and

(ii) the total amount of all payment adjustments for the State plan rate year (as so increased) does not exceed the disproportionate share hospital allotment for the State and applicable Federal fiscal year under subsection (f) of such section.

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

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

(i) IN GENERAL.—Subject to clause (ii), solely for the purpose of allowing a

State to increase the amount of a payment adjustment to a hospital for a Medicaid State plan rate year described in subparagraph (A) pursuant to this paragraph, a State may retroactively modify a provision of the Medicaid State plan, a waiver of such plan, or a State plan amendment that relates to such rate year and the Secretary may approve such modification.

(ii) DEADLINE.—A State may not submit a request for approval of a retroactive modification to a provision of the Medicaid State plan, a waiver of such plan, or a State plan amendment for a Medicaid State plan rate year after the date by which the State is required to submit the independent certified audit for such State plan rate year as required under section 1923(j)(2) of the Social Security Act (42 U.S.C. 1396r–4(j)(2)).

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

specify on such increased payment adjustment as part of the annual report submitted by the State under section 1923(j)(1) of the Social Security Act (42 U.S.C. 1396r–4(j)(1)) for such State plan rate year or, if necessary, as determined by the Secretary, in an amendment to such annual report.

TITLE II—MEDICARE

SEC. 6201. EXTENSION OF INCREASED INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR CERTAIN LOW-VOLUME HOSPITALS.

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

(1) in subparagraph (B), by striking ''during the portion of fiscal year 2026 beginning on January 31, 2026, and ending on September 30, 2026, and in fiscal year 2027'' and inserting ''during the portion of fiscal year 2027 beginning on January 1, 2027, and ending on September 30, 2027, and in fiscal year 2028'';

(2) in subparagraph (C)(i)—

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

''through 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026'';

(B) in subclause (III), by striking ''through 2025 and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026'' and inserting ''through 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026''; and

(C) in subclause (IV), by striking ''the portion of fiscal year 2026 beginning on January 31, 2026, and ending on September 30, 2026, and fiscal year 2027'' and inserting ''the portion of fiscal year 2027 beginning on January 1, 2027, and ending on September 30, 2027, and fiscal year 2028''; and

(3) in subparagraph (D)—

(A) in the matter preceding clause (i), by striking ''through 2025 or during the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026'' and inserting ''through 2026 or during the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026''; and

(B) in clause (ii), by striking ''through 2025 and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026'' and inserting ''through 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026''.

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

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

(a) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''January 31, 2026'' and inserting ''January 1, 2027''; and

(2) in clause (ii)(II), by striking ''January 31, 2026'' and inserting ''January 1, 2027''.

(b) CONFORMING AMENDMENTS.—

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

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

(B) in clause (iv), by striking ''through fiscal year 2025 and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026'' and inserting ''through fiscal year 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''through fiscal year 2025, or the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026'' and inserting ''through fiscal year 2026, or the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026''.

SEC. 6203. EXTENSION OF ADD-ON PAYMENTS FOR AMBULANCE SERVICES.

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

(1) in paragraph (12)(A), by striking ''January 31, 2026'' and inserting ''January 1, 2028''; and

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

SEC. 6204. EXTENDING INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.

(a) IN GENERAL.—Section 1833(z) of the Social Security Act (42 U.S.C. 1395l(z)) is amended—

(1) in paragraph (1)(A)—

(A) by inserting '', and during 2028,'' after ''with 2026''; and

(B) by inserting '', or, with respect to 2028, 3.1 percent'' after ''1.88 percent'';

(2) in paragraph (2)—

(A) in subparagraph (B)—

(i) in the heading, by inserting ''AND 2028'' after ''2026''; and

(ii) in the matter preceding clause (i), by inserting ''and 2028'' after ''2026'';

(B) in subparagraph (C)—

(i) in the heading, by striking ''BEGINNING IN 2027'' and inserting ''2027 AND 2029 AND SUBSEQUENT YEARS''; and

(ii) in the matter preceding clause (i), by inserting ''and 2029'' after ''2027''; and

(C) in subparagraph (D), by striking ''and 2026'' and inserting ''2026, and 2028''; and

(3) in paragraph (4)(B), by inserting '', or, with respect to 2028, 3.1 percent'' after ''1.88 percent''.

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

(1) in subclause (II), by inserting ''and 2028'' after ''2026''; and

(2) in subclause (III), by inserting ''and 2029'' after ''2027''.

SEC. 6205. EXTENSION OF FUNDING FOR QUALITY MEASURE ENDORSEMENT, INPUT, AND SELECTION.

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

(1) in the first sentence—

(A) by striking ''and $13,300,000'' and inserting ''$13,300,000''; and

(B) by inserting the following before the period at the end: '', and $15,100,000 for fiscal year 2027''; and

(2) in the third sentence, by striking ''and 2026'' and inserting ''2026, and 2027''.

SEC. 6206. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note) is amended—

(1) in clause (xiv), by striking ''and'' at the end;

(2) in clause (xv), by striking the period at the end and inserting ''; and''; and

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

''(xvi) for the period beginning on January 31, 2026, and ending on December 31, 2027, $30,000,000.''.

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

(1) in clause (xiv), by striking ''and'' at the end;

(2) in clause (xv), by striking the period at the end and inserting ''; and''; and

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

''(xvi) for the period beginning on January 31, 2026, and ending on December 31, 2027, $30,000,000.''.

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

(1) in clause (xiv), by striking ''and'' at the end;

(2) in clause (xv), by striking the period at the end and inserting ''; and''; and

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

''(xvi) for the period beginning on January 31, 2026, and ending on December 31, 2027, $10,000,000.''.

(d) COORDINATION OF EFFORTS TO INFORM OLDER AMERICANS ABOUT BENEFITS AVAILABLE UNDER FEDERAL AND STATE PROGRAMS.—Subsection (d)(2) of such section 119 is amended—

(1) in clause (xiv), by striking ''and'' at the end;

(2) in clause (xv), by striking the period at the end and inserting ''; and''; and

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

''(xvi) for the period beginning on January 31, 2026, and ending on December 31, 2027, $30,000,000.''.

SEC. 6207. EXTENSION OF FUNDING FOR MEDICARE HOSPICE SURVEYS.

Section 3(a)(2) of the IMPACT Act of 2014 (Public Law 113–185), as amended by section 6205 of division F of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (Public Law 119–37), is amended—

(1) in subparagraph (B), by striking ''and'' at the end;

(2) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

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

''(D) $4,400,000 for the period beginning on January 31, 2026, and ending on December 31, 2026, to remain available until expended.''.

SEC. 6208. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''January 31, 2026'' and inserting ''January 1, 2027''.

SEC. 6209. EXTENSION OF CERTAIN TELEHEALTH FLEXIBILITIES.

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

(1) in paragraph (2)(B)(iii), by striking ''ending January 30, 2026'' and inserting ''ending December 31, 2027''; and

(2) in paragraph (4)(C)(iii), by striking ''ending on January 30, 2026'' and inserting ''ending on December 31, 2027''.

(b) EXPANDING PRACTITIONERS ELIGIBLE TO FURNISH TELEHEALTH SERVICES.—Section 1834(m)(4)(E) of the Social Security Act (42 U.S.C. 1395m(m)(4)(E)) is amended by striking ''ending on January 30, 2026'' and inserting ''ending on December 31, 2027''.

(c) EXTENDING TELEHEALTH SERVICES FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—Section 1834(m)(8)(A) of the Social Security Act (42 U.S.C. 1395m(m)(8)(A)) is amended by striking ''ending on January 30, 2026'' and inserting ''ending on December 31, 2027''.

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

FURNISHED THROUGH TELEHEALTH AND TELECOMMUNICATIONS TECHNOLOGY.—

(1) DELAY IN REQUIREMENTS FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH.—Section 1834(m)(7)(B)(i) of the Social Security Act (42 U.S.C. 1395m(m)(7)(B)(i)) is amended, in the matter preceding subclause (I), by striking ''on or after January 31, 2026'' and inserting ''on or after January 1, 2028''.

(2) MENTAL HEALTH VISITS FURNISHED BY RURAL HEALTH CLINICS.—Section 1834(y)(2) of the Social Security Act (42 U.S.C. 1395m(y)(2)) is amended by striking ''January 31, 2026'' and inserting ''January 1, 2028''.

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

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

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

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

(A) by striking ''ending on January 30, 2026'' and inserting ''ending on December 31, 2027''; and

(B) by inserting '', except that this subclause shall not apply in the case of such an encounter with an individual occurring on or after January 31, 2026, if such individual is located in an area that is subject to a moratorium on the enrollment of hospice programs under this title pursuant to section 1866(j)(7), if such individual is receiving hospice care from a provider that is subject to enhanced oversight under this title pursuant to section 1866(j)(3), or if such encounter is performed by a hospice physician or nurse practitioner who is not enrolled under section 1866(j) and is not an opt-out physician or practitioner (as defined in section 1802(b)(6)(D))'' before the semicolon.

(2) REQUIRING USE OF MODIFIER.—Section 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)), as amended by paragraph (1), is further amended by inserting ", but only if, in the case of such an encounter occurring on or after January 1, 2027, any hospice claim includes 1 or more modifiers or codes (as specified by the Secretary) to indicate that such encounter was conducted via telehealth'' after ''as determined appropriate by the Secretary''.

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

''(10) REQUIRED USE OF MODIFIERS IN CERTAIN INSTANCES.—Not later than January 1, 2027, the Secretary shall establish requirements to include one or more codes or modifiers, as determined appropriate by the Secretary, in the case of—

''(A) claims for telehealth services under this subsection that are furnished through a telehealth virtual platform—

''(i) by a physician or practitioner that contracts with an entity that owns such virtual platform; or

''(ii) for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform; and

''(B) claims for telehealth services under this subsection that are furnished incident to a physician's or practitioner's professional service.''.

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

SEC. 6210. EXTENDING ACUTE HOSPITAL CARE AT HOME WAIVER FLEXIBILITIES.

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

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

(1) in subsection (a)(3)(E)—

(A) in clause (ii), by striking ''the study described in subsection (b)'' and inserting ''the studies described in subsections (b) and (c)''; and

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

''The Secretary may require that such data and information be submitted through a hospital's cost report, through such survey instruments as the Secretary may develop, through medical record information, or through such other means as the Secretary determines appropriate.'';

(2) in subsection (b)—

(A) in the subsection heading, by striking ''STUDY'' and inserting ''INITIAL STUDY''; and

(B) in paragraph (3), by striking ''subsection'' and inserting ''section'';

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

(4) by inserting after subsection (b) the following new subsection:

''(c) SUBSEQUENT STUDY AND REPORT.—

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

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

which individuals may be furnished services under such initiative; and

''(B) analyze and compare (both within and between hospitals participating in the initiative, and relative to comparable hospitals that do not participate in the initiative, for relevant parameters such as diagnosis-related groups)—

''(i) quality of care furnished to individuals with similar conditions and characteristics in the inpatient setting and through the Acute Hospital Care at Home initiative, including health outcomes, hospital readmission rates (including readmissions both within and beyond 30 days post-discharge), hospital mortality rates, length of stay, infection rates, composition of care team (including the types of labor used, such as contracted labor), the ratio of nursing staff, transfers from the hospital to the home, transfers from the home to the hospital (including the timing, frequency, and causes of such transfers), transfers and discharges to post-acute care settings (including the timing, frequency,

and causes of such transfers and discharges), and patient and caregiver experience of care;

''(ii) clinical conditions treated and diagnosis-related groups of discharges from inpatient settings relative to discharges from the Acute Hospital Care at Home initiative;

''(iii) costs incurred by the hospital for furnishing care in inpatient settings relative to costs incurred by the hospital for furnishing care through the Acute Hospital Care at Home initiative, including costs relating to staffing, equipment, food, prescriptions, and other services, as determined by the Secretary;

''(iv) the quantity, mix, and intensity of services (such as in-person visits and virtual contacts with patients and the intensity of such services) furnished in inpatient settings relative to the Acute Hospital Care at Home initiative, and, to the extent practicable, the nature and extent of family or caregiver involvement;

''(v) socioeconomic information on individuals treated in comparable inpatient settings relative to the initiative, including racial and ethnic data, income, housing, geographic proximity to the brick-and-mortar facility and whether such individuals are dually eligible for benefits under this title and title XIX; and

''(vi) the quality of care, outcomes, costs, quantity and intensity of services, and other relevant metrics between individuals who entered into the Acute Hospital Care at Home initiative directly from an emergency department compared with individuals who entered into the Acute Hospital Care at Home initiative directly from an existing inpatient stay in a hospital.

''(2) SELECTION BIAS.—In conducting the study under paragraph (1), the Secretary shall, to the extent practicable, analyze and compare individuals who participate and do not participate in the initiative controlling for selection bias or other factors that may impact the reliability of data.

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

''(A) submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the study conducted under paragraph (1); and

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

''(4) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2026, out of any amounts in the Treasury not otherwise appropriated, $2,500,000, to remain available until expended, for purposes of carrying out this section.''; and

(5) in subsection (e), as redesignated by paragraph (3), by striking ''and (b)(1)'' and inserting '', (b)(1), and (c)(1)''.

SEC. 6211. IN-HOME CARDIOPULMONARY REHABILITATION FLEXIBILITY.

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

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

(b) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendment made by subsection (a) by program instruction or otherwise.

SEC. 6212. ENHANCING CERTAIN PROGRAM INTEGRITY REQUIREMENTS FOR DME UNDER MEDICARE.

(a) DURABLE MEDICAL EQUIPMENT.—

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

''(23) MASTER LIST INCLUSION AND CLAIM REVIEW FOR CERTAIN ITEMS.—

''(A) MASTER LIST INCLUSION.—Beginning January 1, 2029, for purposes of the Master List described in section 414.234(b) of title 42, Code of Federal Regulations (or any successor regulation), in determining which items have aberrant billing patterns (as such term is used for purposes of such section), the Sec-

retary shall also treat an item for which payment may be made under this subsection as having such an aberrant billing pattern if the Secretary determines that, without explanatory contributing factors (such as furnishing emergent care services), a substantial number of claims for such items under this subsection are for such items ordered by a physician or practitioner who has not previously (during a period of not less than 24 months, as established by the Secretary) furnished to the individual involved any item or service for which payment may be made under this title.

''(B) CLAIM REVIEW.—With respect to items furnished on or after January 1, 2029, that are included on the Master List pursuant to subparagraph (A), if such an item is not subject to a determination of coverage in advance pursuant to paragraph (15)(C), the Secretary may conduct prepayment review of claims for payment for such item.''.

(2) CONFORMING AMENDMENT FOR PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—Section 1834(h)(3) of the Social Security Act (42 U.S.C. 1395m(h)(3)) is amended by inserting '', and

paragraph (23) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provision applies to items for which payment may be made under such subsection'' before the period at the end.

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

(1) which, if any, clinical diagnostic laboratory tests are identified as being at high risk of fraudulent claims, and an analysis of the factors that contribute to such risk;

(2) with respect to a clinical diagnostic laboratory test identified under paragraph (1) as being at high risk of fraudulent claims—

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

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

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

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

(3) suggested strategies for reducing the number of fraudulent claims made with respect to tests so identified as being at high risk, including—

(A) an analysis of whether the Centers for Medicare & Medicaid Services can detect aberrant billing patterns with respect to such tests in a timely manner;

(B) any strategies for identifying and monitoring the providers who are outliers with respect to the number of such tests that such providers order; and

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

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

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

SEC. 6213. GUIDANCE ON FURNISHING SERVICES VIA TELEHEALTH TO INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.

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

(1) Best practices on facilitating and integrating use of interpreters during a telemedicine appointment.

(2) Best practices on providing accessible instructions on how to access telecommunications sys-

tems (as such term is used for purposes of section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) for individuals with limited English proficiency.

(3) Best practices on improving access to digital patient portals for individuals with limited English proficiency.

(4) Best practices on integrating the use of video platforms that enable multi-person video calls furnished via a telecommunications system for purposes of providing interpretation during a telemedicine appointment for an individual with limited English proficiency.

(5) Best practices for providing patient materials, communications, and instructions in multiple languages, including text message appointment reminders and prescription information.

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

(1) Health information technology service providers, including—

(A) electronic medical record companies;

(B) remote patient monitoring companies; and

(C) telehealth or mobile health vendors and companies.

(2) Health care providers, including—

(A) physicians; and

(B) hospitals.

(3) Health insurers.

(4) Language service companies.

(5) Interpreter or translator professional associations.

(6) Health and language services quality certification organizations.

(7) Patient and consumer advocates, including such advocates that work with individuals with limited English proficiency.

SEC. 6214. INCLUSION OF VIRTUAL DIABETES PREVENTION PROGRAM SUPPLIERS IN MDPP EXPANDED MODEL.

(a) IN GENERAL.—For the period beginning on January 1, 2026, and ending on December 31, 2029—

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

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

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

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

(b) DEFINITIONS.—In this section:

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

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

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

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

SEC. 6215. MEDICATION-INDUCED MOVEMENT DISORDER OUTREACH AND EDUCATION.

Not later than January 1, 2028, the Secretary of Health and Human Services shall use existing communications mechanisms to provide education and outreach to physicians and appropriate non-physician practitioners participating under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) with respect to periodic screening for medication-induced movement disorders that are associated with the treatment of mental health disorders in at-risk patients, as well as resources related to clinical guidelines and best practices for furnishing such screening services through telehealth. Such education and outreach shall include information on how to account for such screening services in evaluation and management code selection. The Secretary shall, to the extent practicable, seek input from relevant stakeholders to inform such education and outreach. Such education and outreach may also address other relevant screening services furnished through telehealth, as the Secretary determines appropriate.

SEC. 6216. REPORT ON WEARABLE MEDICAL DEVICES.

Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a technology assessment of, and submit to Congress a report on, the capabilities and limita-

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

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

(2) an examination of the benefits and challenges of artificial intelligence to augment such capabilities; and

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

SEC. 6217. EXTENSION OF TEMPORARY INCLUSION OF AUTHORIZED ORAL ANTIVIRAL DRUGS AS COVERED PART D DRUGS.

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

SEC. 6218. EXTENSION OF ADJUSTMENT TO CALCULATION OF HOSPICE CAP AMOUNT UNDER MEDICARE.

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

(1) in clause (ii), by striking ''2033'' and inserting ''2035''; and

(2) in clause (iii), by striking ''2033'' and inserting ''2035''.

SEC. 6219. ADJUSTMENTS TO MEDICARE PART D COST-SHARING REDUCTIONS FOR LOW-INCOME INDIVIDUALS.

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

(1) in paragraph (1)(D)(ii), by striking ''that does not exceed $1 for'' and all that follows through the period at the end and inserting ″that does not exceed— ''

''(I) for a plan year before 2028—

''(aa) for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1927(k)(7)(A)(i)), $1 or, if less, the copayment amount applicable to an individual under clause (iii); and

''(bb) for any other drug, $3 or, if less, the copayment amount applicable to an individual under clause (iii); and

"(II) for plan year 2028 and each subsequent plan year—

"(aa) for a generic drug, $0;

"(bb) for a preferred drug that is a multiple source drug (as defined in section 1927(k)(7)(A)(i)), the dollar amount applied under this clause for such a drug for the preceding plan year, increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such preceding year, or, if less, the copayment amount applicable to an individual under clause (iii); and

"(cc) for a drug not described in either item (aa) or (bb), the dollar amount applied under this clause for such a drug for the preceding plan year, increased in the manner specified in item (bb), or, if less, the co-

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

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

(2) in paragraph (4)(A)(ii), by inserting ''(before 2028)'' after ''a subsequent year''.

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

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

(1) in paragraph (1)(C)—

(A) by striking ''plan, and any'' and inserting ''plan, any''; and

(B) by inserting the following before the period: '', and, in the case of a specified MA plan (as defined in paragraph (3)(C)), for plan year 2028 and subsequent plan years, the information described in paragraph (3)(B)''; and

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

''(3) PROVIDER DIRECTORY ACCURACY.—

''(A) IN GENERAL.—For plan year 2028 and subsequent plan years, each MA organization offering a specified MA plan (as defined in subparagraph (C)) shall, for each such plan offered by the organization—

''(i) maintain, on a publicly available internet website, an accurate provider directory that includes the information described in subparagraph (B);

''(ii) not less frequently than once every 90 days (or, in the case of a hospital or any other facility determined appropriate by the Secretary, at a lesser frequency specified by the Secretary but in no case less frequently than once every 12 months), verify the provider directory information of each provider listed in such directory and, if applicable, update such information;

''(iii) if the organization is unable to verify such information with respect to a provider, include in such directory an indication that the information of such provider may not be up to date; and

''(iv) remove a provider from such directory within 5 business days if the organization determines that the provider is no longer a provider participating in the network of such plan.

''(B) PROVIDER DIRECTORY INFORMATION.—The information described in this subparagraph is information enrollees may need to access covered benefits from a provider with which such organization offering such plan has an agreement for furnishing items and services covered under such plan, such as name, specialty, contact information, primary office or facility addresses where items or services are furnished, whether the provider is accepting new patients, accommodations for people with disabilities, cultural and linguistic capabilities, and telehealth capabilities.

''(C) SPECIFIED MA PLAN.—In this paragraph, the term 'specified MA plan' means—

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

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

ards under subsection (d)(4), in whole or in part, through entering into contracts or agreements as provided for under subparagraph (B) of such subsection.''.

(b) ACCOUNTABILITY FOR PROVIDER DIRECTORY ACCURACY.—

(1) COST SHARING FOR SERVICES FURNISHED BASED ON RELIANCE ON INCORRECT PROVIDER DIRECTORY INFORMATION.—Section 1852(d) of the Social Security Act (42 U.S.C. 1395w–22(d)) is amended—

(A) in paragraph (1)(C)—

(i) in clause (ii), by striking ''or'' at the end;

(ii) in clause (iii), by striking the semicolon at the end and inserting '', or''; and

(iii) by adding at the end the following new clause:

''(iv) for plan year 2028 and subsequent plan years, in the case of a specified MA plan (as defined in subsection (c)(3)(C)), the services were furnished by a provider that was not participating in the network of such plan but was listed in the

provider directory of such plan on the date on which the appointment was made, as described in paragraph (7)(A);''; and

(B) by adding at the end the following new paragraph:

''(7) COST SHARING FOR SERVICES FURNISHED BASED ON RELIANCE ON INCORRECT PROVIDER DIRECTORY INFORMATION.—

''(A) IN GENERAL.—For plan year 2028 and subsequent plan years, if an enrollee in a specified MA plan (as defined in subsection (c)(3)(C)) is furnished an item or service by a provider that is not participating in the network of such plan but is listed in the provider directory of such plan (as required to be provided to an enrollee pursuant to subsection (c)(1)(C)) on the date on which the appointment is made, and if such item or service would otherwise be covered under such plan if furnished by a provider that is participating in the network of such plan, the MA organization offering such plan shall ensure that the enrollee is only responsible for the lesser of—

''(i) the amount of cost sharing that would apply if such provider had been participating in the network of such plan; or

''(ii) the amount of cost sharing that would otherwise apply (without regard to this subparagraph).

''(B) NOTIFICATION REQUIREMENT.—For plan year 2028 and subsequent plan years, each MA organization that offers a specified MA plan shall—

''(i) notify enrollees of their cost-sharing protections under this paragraph and make such notifications, to the extent practicable, by not later than the first day of an annual, coordinated election period under section 1851(e)(3) with respect to a year;

''(ii) include information regarding such cost-sharing protections in the provider directory of each specified MA plan offered by the MA organization.; and

''(iii) notify enrollees of their cost-sharing protections under this paragraph in the first explanation of benefits issued in a plan year.''.

(2) REQUIRED PROVIDER DIRECTORY ACCURACY ANALYSIS AND REPORTS.—

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

''(6) PROVIDER DIRECTORY ACCURACY ANALYSIS AND REPORTS.—

''(A) IN GENERAL.—Beginning with plan years beginning on or after January 1, 2028, subject to subparagraph (C), a contract under this section with an MA organization shall require the organization, for each specified MA plan (as defined in section 1852(c)(3)(C)) offered by the organization, to annually do the following:

''(i) Conduct an analysis estimating the accuracy of the provider directory information of such plan using a random sample of providers included in such provider directory as follows:

''(I) Such a random sample shall include a random sample of each specialty of providers with a high inaccuracy rate of provider directory infor-

mation relative to other specialties of providers, as determined by the Secretary.

''(II) For purposes of subclause (I), one type of specialty may be providers specializing in mental health or substance use disorder treatment.

''(ii) Submit to the Secretary a report containing the results of the analysis conducted under clause (i), including an accuracy score for such provider directory information (as determined using a plan verification method specified by the Secretary under subparagraph (B)(i)).

''(B) DETERMINATION OF ACCURACY SCORE.—

''(i) IN GENERAL.—The Secretary shall specify plan verification methods, such as using telephonic verification or other approaches using data sources maintained by an MA organization or using publicly available data sets, that MA organizations may use for estimating accuracy scores of the provider directory information

of specified MA plans offered by such organizations.

''(ii) ACCURACY SCORE METHODOLOGY.—With respect to each such method specified by the Secretary as described in clause (i), the Secretary shall specify a methodology for MA organizations to use in estimating such accuracy scores. Each such methodology shall take into account the administrative burden on plans and providers and the relative importance of certain provider directory information on enrollee ability to access care.

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

''(D) TRANSPARENCY.—Beginning with plan years beginning on or after January 1, 2029, the Secretary shall post accuracy scores (as reported under subparagraph (A)(ii)), in a machine readable file, on an internet website maintained by the Centers for Medicare & Medicaid Services.''.

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

''(F) PROVIDER DIRECTORY.—Beginning with plan years beginning on or after January 1, 2029, in the case of a specified MA plan (as defined in section 1852(c)(3)(C)), the accuracy score of the plan's provider directory (as reported under section 1857(e)(6)(A)(ii)) listed prominently on the plan's provider directory.''.

(C) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $4,000,000 for fiscal year 2026, to remain available until expended, to carry out the amendments made by this paragraph.

(3) GAO STUDY AND REPORT.—

(A) ANALYSIS.—The Comptroller General of the United States (in this paragraph referred to as the ''Comptroller General'') shall conduct a study of the implementation of the amend-

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

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

(ii) the trends in provider directory information accuracy scores submitted to the Secretary of Health and Human Services under section 1857(e)(6)(A)(ii) of the Social Security Act (as added by paragraph (2)(A)), both overall and among providers specializing in mental health or substance use disorder treatment;

(iii) provider response rates by plan verification methods;

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

(v) other items determined appropriate by the Comptroller General.

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

study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) GUIDANCE ON MAINTAINING ACCURATE PROVIDER DIRECTORIES.—

(1) STAKEHOLDER MEETING.—

(A) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall hold a public meeting to receive input on approaches for maintaining accurate provider directories for Medicare Advantage plans under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.), including input on approaches for reducing administrative burden, such as data standardization, and best practices to maintain accurate provider directory information.

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

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

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

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

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

Medicare Advantage organizations to maintain accurate provider directories.

(C) Approaches for utilizing data sources maintained by Medicare Advantage organizations and publicly available data sets to maintain accurate provider directories.

(D) Information that may be useful to include in provider directories for Medicare beneficiaries to use in assessing plan networks when selecting a plan and accessing providers participating in plan networks during the plan year.

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

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

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

(1) in subsection (s)(2)—

(A) by striking the semicolon at the end of subparagraph (JJ) and inserting ''; and''; and

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

''(KK) multi-cancer early detection screening tests (as defined in subsection (nnn));''; and

(2) by adding at the end the following new subsection:

''(nnn) MULTI-CANCER EARLY DETECTION SCREENING TESTS.—

''(1) IN GENERAL.—The term 'multi-cancer early detection screening test' means a test furnished to an individual for the concurrent detection of multiple cancer types across multiple organ sites on or after January 1, 2029, that—

''(A) is cleared under section 510(k), classified under section 513(f)(2), or approved under section 515 of the Federal Food, Drug, and Cosmetic Act;

''(B) is—

''(i) a genomic sequencing blood or blood product test that includes the analysis of cell-free nucleic acids; or

''(ii) a test based on samples of biological material that provide results com-

parable to those obtained with a test described in clause (i), as determined by the Secretary; and

''(C) the Secretary determines is—

''(i) reasonable and necessary for the prevention or early detection of an illness or disability; and

''(ii) appropriate for individuals entitled to benefits under part A or enrolled under part B.

''(2) NCD PROCESS.—In making determinations under paragraph (1)(C) regarding the coverage of a new test, the Secretary shall use the process for making national coverage determinations (as defined in section 1869(f)(1)(B)) under this title.''.

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

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

''(aa) PAYMENT AND STANDARDS FOR MULTI-CANCER EARLY DETECTION SCREENING TESTS.—

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

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

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

"(i) the amount described in subparagraph (A); or

"(ii) the payment amount determined for such test under section 1834A.

"(2) LIMITATIONS.—

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

"(i) such individual—

"(I) is under 50 years of age; or

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

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

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

"(i) for 2029, 65 years of age; and

"(ii) for a succeeding year, the age specified in this subparagraph for the preceding year, increased by 1 year.

"(C) STANDARDS FOLLOWING USPSTF RATING OF A OR B.—In the case of a multi-cancer early detection screening test that is recommended with a grade of A or B by the United States Preventive Services Task Force, beginning on the date on which coverage for such test is provided pursuant to section 1861(ddd)(1), the preceding provisions of this paragraph shall not apply.".

(2) CONFORMING AMENDMENTS.—

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

(i) in subsection (a)—

(I) in paragraph (1)(D)(i)(I), by striking "section 1834(d)(1)" and inserting "subsection (d)(1) or (aa) of section 1834"; and

(II) in paragraph (2)(D)(i)(I), by striking ''section 1834(d)(1)'' and inserting ''subsection (d)(1) or (aa) of section 1834''; and

(ii) in subsection (h)(1)(A), by striking ''section 1834(d)(1)'' and inserting ''subsections (d)(1) and (aa) of section 1834''.

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

(i) by striking ''or additional preventive services'' and inserting '', additional preventive services''; and

(ii) by inserting '', or multi-cancer early detection screening tests (as defined in section 1861(nnn))'' after ''(as described in section 1861(ddd)(1))''.

(c) RULE OF CONSTRUCTION RELATING TO OTHER CANCER SCREENING TESTS.—Nothing in this section, including the amendments made by this section, shall be construed—

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

cial Security Act for other cancer screening tests covered under such title, such as screening tests for breast, cervical, colorectal, lung, or prostate cancer; or

(2) in the case of an individual who undergoes another cancer screening test, to affect coverage under such part for a multi-cancer early detection screening test or the use of such a test as a diagnostic or confirmatory test for a result of the other cancer screening test.

(d) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $2,000,000 for fiscal year 2026, to remain available until expended, to carry out this section.

SEC. 6222. MEDICARE COVERAGE OF EXTERNAL INFUSION PUMPS AND NON-SELF-ADMINISTRABLE HOME INFUSION DRUGS.

(a) IN GENERAL.—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by adding at the end the following new sentence: ''Beginning with the first calendar quarter beginning on or after the date that is 1 year after the date of the enactment of this sentence, an external infusion pump and associated home in-

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

''(1) The prescribing information approved by the Food and Drug Administration for the home infusion drug associated with the pump instructs that the drug should be administered by or under the supervision of a health care professional.

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

''(3) The prescribing information described in paragraph (1) instructs that the drug should be infused at least 12 times per year—

''(A) intravenously or subcutaneously; or

''(B) at infusion rates that the Secretary determines would require the use of an external infusion pump.''.

(b) COST SHARING NOTIFICATION.—The Secretary of Health and Human Services shall ensure that patients are notified of the cost sharing for electing home infusion therapy compared to other applicable settings of care for the furnishing of infusion drugs under the Medicare program.

SEC. 6223. ASSURING PHARMACY ACCESS AND CHOICE FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Section 1860D–4(b)(1) of the Social Security Act (42 U.S.C. 1395w–104(b)(1)) is amended by striking subparagraph (A) and inserting the following:

"(A) IN GENERAL.—

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

"(ii) CONTRACT TERMS AND CONDITIONS.—

"(I) IN GENERAL.—Notwithstanding any other provision of law, for plan years beginning on or after

January 1, 2029, in accordance with clause (i), contract terms and conditions offered by such PDP sponsor shall be reasonable and relevant according to standards established by the Secretary under subclause (II).

''(II) STANDARDS.—Not later than the first Monday in April of 2028, the Secretary shall establish standards for reasonable and relevant contract terms and conditions for purposes of this clause.

''(III) REQUEST FOR INFORMATION.—Not later than April 1, 2027, for purposes of establishing the standards under subclause (II), the Secretary shall issue a request for information to seek input on trends in prescription drug plan and network pharmacy contract terms and conditions, current prescription drug plan and network pharmacy contracting practices, whether pharmacy reimbursement and dispensing fees paid by PDP sponsors to network pharmacies

sufficiently cover the ingredient and operational costs of such pharmacies, the use and application of pharmacy quality measures by PDP sponsors for network pharmacies, PDP sponsor restrictions or limitations on the dispensing of covered part D drugs by network pharmacies (or any subsets of such pharmacies), PDP sponsor auditing practices for network pharmacies, areas in current regulations or program guidance related to contracting between prescription drug plans and network pharmacies requiring clarification or additional specificity, factors for consideration in determining the reasonableness and relevance of contract terms and conditions between prescription drug plans and network pharmacies, and other issues as determined appropriate by the Secretary.''.

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

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

"(e) ESSENTIAL RETAIL PHARMACIES.—

"(1) IN GENERAL.—With respect to plan years beginning on or after January 1, 2028, the Secretary shall publish reports, at least once every 2 years until 2034, and periodically thereafter, that provide information, to the extent feasible, on—

"(A) trends in ingredient cost reimbursement, dispensing fees, incentive payments and other fees paid by PDP sponsors offering prescription drug plans and MA organizations offering MA–PD plans under this part to essential retail pharmacies (as defined in paragraph (2)) with respect to the dispensing of covered part D drugs, including a comparison of such trends between essential retail pharmacies and pharmacies that are not essential retail pharmacies;

"(B) trends in amounts paid to PDP sponsors offering prescription drug plans and MA organizations offering MA–PD plans under this part by essential retail pharmacies with respect to the dispensing of covered part D drugs, including a comparison of such trends between

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

''(C) trends in essential retail pharmacy participation in pharmacy networks and preferred pharmacy networks for prescription drug plans offered by PDP sponsors and MA–PD plans offered by MA organizations under this part, including a comparison of such trends between essential retail pharmacies and pharmacies that are not essential retail pharmacies;

''(D) trends in the number of essential retail pharmacies, including variation in such trends by geographic region or other factors;

''(E) a comparison of cost-sharing for covered part D drugs dispensed by essential retail pharmacies that are network pharmacies for prescription drug plans offered by PDP sponsors and MA–PD plans offered by MA organizations under this part and cost-sharing for covered part D drugs dispensed by other network pharmacies for such plans located in similar geographic areas that are not essential retail pharmacies;

''(F) a comparison of the volume of covered part D drugs dispensed by essential retail

pharmacies that are network pharmacies for prescription drug plans offered by PDP sponsors and MA–PD plans offered by MA organizations under this part and such volume of dispensing by network pharmacies for such plans located in similar geographic areas that are not essential retail pharmacies, including information on any patterns or trends in such comparison specific to certain types of covered part D drugs, such as generic drugs or drugs specified as specialty drugs by a PDP sponsor under a prescription drug plan or an MA organization under an MA–PD plan; and

''(G) a comparison of the information described in subparagraphs (A) through (F) between essential retail pharmacies that are network pharmacies for prescription drug plans offered by PDP sponsors under this part and essential retail pharmacies that are network pharmacies for MA–PD plans offered by MA organizations under this part.

''(2) DEFINITION OF ESSENTIAL RETAIL PHARMACY.—In this subsection, the term 'essential retail pharmacy' means, with respect to a plan year, a retail pharmacy that—

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

''(B) is located in—

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

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

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

''(3) LIST OF ESSENTIAL RETAIL PHARMACIES.—

''(A) PUBLICATION OF LIST OF ESSENTIAL RETAIL PHARMACIES.—For each plan year (beginning with plan year 2028), the Secretary shall publish, on a publicly available internet website of the Centers for Medicare & Medicaid Services, a list of retail pharmacies that meet the criteria described in subparagraphs (A) and (B) of paragraph (2) to be considered an essential retail pharmacy.

''(B) REQUIRED SUBMISSIONS FROM PDP SPONSORS.—For each plan year (beginning

with plan year 2028), each PDP sponsor offering a prescription drug plan and each MA organization offering an MA–PD plan shall submit to the Secretary, for the purposes of determining retail pharmacies that meet the criterion specified in subparagraph (A) of paragraph (2), a list of retail pharmacies that are affiliates of such sponsor or organization, or are affiliates of a pharmacy benefit manager acting on behalf of such sponsor or organization, at a time, and in a form and manner, specified by the Secretary.

''(C) REPORTING BY PDP SPONSORS AND MA ORGANIZATIONS.—For each plan year beginning with plan year 2027, each PDP sponsor offering a prescription drug plan and each MA organization offering an MA–PD plan under this part shall submit to the Secretary information on incentive payments and other fees paid by such sponsor or organization to pharmacies, insofar as any such payments or fees are not otherwise reported, at a time, and in a form and manner, specified by the Secretary.

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

implement this paragraph by program instruction or otherwise.

''(E) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this paragraph.

''(4) DEFINITION OF AFFILIATE; PHARMACY BENEFIT MANAGER.—In this subsection, the terms 'affiliate' and 'pharmacy benefit manager' have the meaning given those terms in section 1860D–12(h)(7).''.

(c) ENFORCEMENT.—

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

''(F) ENFORCEMENT OF STANDARDS FOR REASONABLE AND RELEVANT CONTRACT TERMS AND CONDITIONS.—

''(i) ALLEGATION SUBMISSION PROCESS.—

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

Secretary an allegation of a violation by a PDP sponsor offering a prescription drug plan of the standards for reasonable and relevant contract terms and conditions under subparagraph (A)(ii), or of subclause (VIII) of this clause.

''(II) FREQUENCY OF SUBMISSION.—

''(aa) IN GENERAL.—Except as provided in item (bb), the allegation submission process under this clause shall allow pharmacies to submit any allegations of violations described in subclause (I) not more frequently than once per plan year per contract between a pharmacy and a PDP sponsor.

''(bb) ALLEGATIONS RELATING TO CONTRACT MODIFICATIONS.—In the case where a contract between a pharmacy and a PDP sponsor is modified following the submission of allega-

tions by a pharmacy with respect to such contract and plan year, the allegation submission process under this clause shall allow such pharmacy to submit an additional allegation related to those modifications with respect to such contract and plan year.

''(III) ACCESS TO RELEVANT DOCUMENTS AND MATERIALS.—A PDP sponsor subject to an allegation under this clause—

''(aa) shall provide documents or materials, as specified by the Secretary, including contract offers made by such sponsor to such pharmacy or correspondence related to such offers, to the Secretary at a time, and in a form and manner, specified by the Secretary; and

''(bb) shall not prohibit or otherwise limit the ability of a pharmacy to submit such documents or materials to the Sec-

retary for the purpose of submitting an allegation or providing evidence for such an allegation under this clause.

''(IV) STANDARDIZED TEMPLATE.—The Secretary shall establish a standardized template for pharmacies to use for the submission of allegations described in subclause (I). Such template shall require that the submission include a certification by the pharmacy that the information included is accurate, complete, and true to the best of the knowledge, information, and belief of such pharmacy.

''(V) PREVENTING FRIVOLOUS ALLEGATIONS.—In the case where the Secretary determines that a pharmacy has submitted frivolous allegations under this clause on a routine basis, the Secretary may temporarily prohibit such pharmacy from using the allegation submission process under this clause, as determined appropriate by the Secretary.

"(VI) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Allegations submitted under this clause shall be exempt from disclosure under section 552 of title 5, United States Code.

"(VII) RULE OF CONSTRUCTION.—Nothing in this clause shall be construed as limiting the ability of a pharmacy to pursue other legal actions or remedies, consistent with applicable Federal or State law, with respect to a potential violation of a requirement described in this subparagraph.

"(VIII) ANTI-RETALIATION AND ANTI-COERCION.—Consistent with applicable Federal or State law, a PDP sponsor shall not—

"(aa) retaliate against a pharmacy for submitting any allegations under this clause; or

"(bb) coerce, intimidate, threaten, or interfere with the

ability of a pharmacy to submit any such allegations.

"(ii) INVESTIGATION.—The Secretary shall investigate, as determined appropriate by the Secretary, allegations submitted pursuant to clause (i).

"(iii) ENFORCEMENT.—

"(I) IN GENERAL.—In the case where the Secretary determines that a PDP sponsor offering a prescription drug plan has violated the standards for reasonable and relevant contract terms and conditions under subparagraph (A)(ii) or the provisions of clause (i)(VIII) of this subparagraph, the Secretary may use authorities under sections 1857(g) and 1860D–12(b)(3)(E) to impose civil monetary penalties or other intermediate sanctions.

"(II) APPLICATION OF CIVIL MONETARY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil monetary penalty under this

clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

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

(A) in subparagraph (J), by striking ''or'' after the semicolon;

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

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

''(K) fails to comply with the standards for reasonable and relevant contract terms and conditions under subparagraph (A)(ii) of section 1860D–4(b)(1) or violates the provisions of subparagraph (F)(i)(VIII) of such section; or'';

(D) in subparagraph (L), as redesignated by subparagraph (B), by striking ''through (J)'' and inserting ''through (K)''; and

(E) in the flush matter following subparagraph (L), as so redesignated, by striking ''subparagraphs (A) through (K)'' and inserting ''subparagraphs (A) through (L)''.

(d) ACCOUNTABILITY OF PHARMACY BENEFIT MANAGERS FOR VIOLATIONS OF REASONABLE AND RELEVANT CONTRACT TERMS AND CONDITIONS.—

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

''(9) ACCOUNTABILITY OF PHARMACY BENEFIT MANAGERS FOR VIOLATIONS OF REASONABLE AND RELEVANT CONTRACT TERMS AND CONDITIONS.—For plan years beginning on or after January 1, 2029, each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that any pharmacy benefit manager acting on behalf of such sponsor has a written agreement with the PDP sponsor under which the pharmacy benefit manager agrees to reimburse the PDP sponsor for any amounts paid by such sponsor under section 1860D–4(b)(1)(F)(iii)(I) to the Secretary as a result of a violation described in such section if such violation is related to a responsibility delegated to the pharmacy benefit manager by such PDP sponsor.''.

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

amended by adding at the end the following new subparagraph:

"(F) ACCOUNTABILITY OF PHARMACY BENEFIT MANAGERS FOR VIOLATIONS OF REASONABLE AND RELEVANT CONTRACT TERMS.—For plan years beginning on or after January 1, 2029, section 1860D–12(b)(9).".

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

"(f) BIENNIAL REPORT ON ENFORCEMENT AND OVERSIGHT OF PHARMACY ACCESS REQUIREMENTS.—

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

"(2) LIMITATION.—A report under paragraph (1) shall not disclose—

"(A) identifiable information about individuals or entities unless such information is otherwise publicly available; or

"(B) trade secrets with respect to any entities.".

(f) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $188,000,000 for fiscal year 2026, to remain available until expended, to carry out this section.

SEC. 6224. MODERNIZING AND ENSURING PBM ACCOUNTABILITY.

(a) IN GENERAL.—

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

"(h) REQUIREMENTS RELATING TO PHARMACY BENEFIT MANAGERS.—For plan years beginning on or after January 1, 2028:

"(1) AGREEMENTS WITH PHARMACY BENEFIT MANAGERS.—Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall

provide that any pharmacy benefit manager acting on behalf of such sponsor has a written agreement with the PDP sponsor under which the pharmacy benefit manager, and any affiliates of such pharmacy benefit manager, as applicable, agree to meet the following requirements:

"(A) NO INCOME OTHER THAN BONA FIDE SERVICE FEES.—

"(i) IN GENERAL.—The pharmacy benefit manager and any affiliate of such pharmacy benefit manager shall not derive any remuneration with respect to any services provided on behalf of any entity or individual, in connection with the utilization of covered part D drugs, from any such entity or individual other than bona fide service fees, subject to clauses (ii) and (iii).

"(ii) INCENTIVE PAYMENTS.—For the purposes of this subsection, an incentive payment (as determined by the Secretary) paid by a PDP sponsor to a pharmacy benefit manager or an affiliate of a pharmacy benefit manager that is performing services on behalf of such sponsor shall be deemed a 'bona fide service fee' (even if

such payment does not otherwise meet the definition of such term under paragraph (7)(B)) if such payment is a flat dollar amount, is consistent with fair market value (as specified by the Secretary), is related to services actually performed by the pharmacy benefit manager or affiliate of such pharmacy benefit manager, on behalf of the PDP sponsor making such payment, in connection with the utilization of covered part D drugs, and meets additional requirements, if any, as determined appropriate by the Secretary.

''(iii) CLARIFICATION ON REBATES AND DISCOUNTS USED TO LOWER COSTS FOR COVERED PART D DRUGS.—Rebates, discounts, and other price concessions received by a pharmacy benefit manager or an affiliate of a pharmacy benefit manager from manufacturers, even if such price concessions are calculated as a percentage of a drug's price, shall not be considered a violation of the requirements of clause (i) if they are fully passed through to a PDP sponsor and are compliant with all regu-

latory and subregulatory requirements related to direct and indirect remuneration for manufacturer rebates, discounts, and other price concessions under this part, including in cases where a PDP sponsor is acting as a pharmacy benefit manager on behalf of a prescription drug plan offered by such PDP sponsor.

''(iv) EVALUATION OF REMUNERATION ARRANGEMENTS.—Components of subsets of remuneration arrangements (such as fees or other forms of compensation paid to or retained by the pharmacy benefit manager or affiliate of such pharmacy benefit manager), as determined appropriate by the Secretary, between pharmacy benefit managers or affiliates of such pharmacy benefit managers, as applicable, and other entities involved in the dispensing or utilization of covered part D drugs (including PDP sponsors, manufacturers, pharmacies, and other entities as determined appropriate by the Secretary) shall be subject to review by the Secretary, in consultation with the Office of the Inspector

General of the Department of Health and Human Services, as determined appropriate by the Secretary. The Secretary, in consultation with the Office of the Inspector General, shall review whether remuneration under such arrangements is consistent with fair market value (as specified by the Secretary) through reviews and assessments of such remuneration, as determined appropriate.

''(v) DISGORGEMENT.—The pharmacy benefit manager shall disgorge any remuneration paid to such pharmacy benefit manager or an affiliate of such pharmacy benefit manager in violation of this subparagraph to the PDP sponsor.

''(vi) ADDITIONAL REQUIREMENTS.—The pharmacy benefit manager shall—

''(I) enter into a written agreement with any affiliate of such pharmacy benefit manager, under which the affiliate shall identify and disgorge any remuneration described in clause (v) to the pharmacy benefit manager; and

''(II) attest, subject to any requirements determined appropriate by the Secretary, that the pharmacy benefit manager has entered into a written agreement described in subclause (I) with any affiliate of the pharmacy benefit manager.

''(B) TRANSPARENCY REGARDING GUARANTEES AND COST PERFORMANCE EVALUATIONS.—The pharmacy benefit manager shall—

''(i) define, interpret, and apply, in a fully transparent and consistent manner for purposes of calculating or otherwise evaluating pharmacy benefit manager performance against pricing guarantees or similar cost performance measurements related to rebates, discounts, price concessions, or net costs, terms such as—

''(I) 'generic drug', in a manner consistent with the definition of the term under section 423.4 of title 42, Code of Federal Regulations, or a successor regulation;

''(II) 'brand name drug', in a manner consistent with the definition

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

"(III) 'specialty drug';

"(IV) 'rebate'; and

"(V) 'discount';

"(ii) identify any drugs, claims, or price concessions excluded from any pricing guarantee or other cost performance measure in a clear and consistent manner; and

"(iii) where a pricing guarantee or other cost performance measure is based on a pricing benchmark other than the wholesale acquisition cost (as defined in section 1847A(c)(6)(B)) of a drug, calculate and provide a wholesale acquisition cost-based equivalent to the pricing guarantee or other cost performance measure.

"(C) PROVISION OF INFORMATION.—

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

graph, and shall make such report available to such sponsor at no cost to such sponsor in a format specified by the Secretary under paragraph (5). Each such report shall include, with respect to such PDP sponsor and each plan offered by such sponsor, the following information with respect to the previous plan year:

''(I) A list of all drugs covered by the plan that were dispensed including, with respect to each such drug—

''(aa) the brand name, generic or non-proprietary name, and National Drug Code;

''(bb) the number of plan enrollees for whom the drug was dispensed, the total number of prescription claims for the drug (including original prescriptions and refills, counted as separate claims), and the total number of dosage units of the drug dispensed;

''(cc) the number of prescription claims described in item

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

''(dd) the average wholesale acquisition cost, listed as cost per day's supply, cost per dosage unit, and cost per typical course of treatment (as applicable);

''(ee) the average wholesale price for the drug, listed as price per day's supply, price per dosage unit, and price per typical course of treatment (as applicable);

''(ff) the total out-of-pocket spending by plan enrollees on such drug after application of any benefits under the plan, including plan enrollee spending through copayments, coinsurance, and deductibles;

"(gg) total rebates paid by the manufacturer on the drug as reported under the Detailed DIR Report (or any successor report) submitted by such sponsor to the Centers for Medicare & Medicaid Services;

"(hh) all other direct or indirect remuneration on the drug as reported under the Detailed DIR Report (or any successor report) submitted by such sponsor to the Centers for Medicare & Medicaid Services;

"(ii) the average pharmacy reimbursement amount paid by the plan for the drug in the aggregate and disaggregated by dispensing channel identified in item (cc);

"(jj) the average National Average Drug Acquisition Cost (NADAC); and

"(kk) total manufacturer-derived revenue, inclusive of bona

fide service fees, attributable to the drug and retained by the pharmacy benefit manager and any affiliate of such pharmacy benefit manager.

''(II) In the case of a pharmacy benefit manager that has an affiliate that is a retail, mail order, or specialty pharmacy, with respect to drugs covered by such plan that were dispensed, the following information:

''(aa) The percentage of total prescriptions that were dispensed by pharmacies that are an affiliate of the pharmacy benefit manager for each drug.

''(bb) The interquartile range of the total combined costs paid by the plan and plan enrollees, per dosage unit, per course of treatment, per 30-day supply, and per 90-day supply for each drug dispensed by pharmacies that are not an affiliate of the pharmacy benefit manager and

that are included in the pharmacy network of such plan.

''(cc) The interquartile range of the total combined costs paid by the plan and plan enrollees, per dosage unit, per course of treatment, per 30-day supply, and per 90-day supply for each drug dispensed by pharmacies that are an affiliate of the pharmacy benefit manager and that are included in the pharmacy network of such plan.

''(dd) The lowest total combined cost paid by the plan and plan enrollees, per dosage unit, per course of treatment, per 30-day supply, and per 90-day supply, for each drug that is available from any pharmacy included in the pharmacy network of such plan.

''(ee) The difference between the average acquisition cost of the affiliate, such as a pharmacy

or other entity that acquires prescription drugs, that initially acquires the drug and the amount reported under subclause (I)(jj) for each drug.

''(ff) A list inclusive of the brand name, generic or non-proprietary name, and National Drug Code of covered part D drugs subject to an agreement with a covered entity under section 340B of the Public Health Service Act for which the pharmacy benefit manager or an affiliate of the pharmacy benefit manager had a contract or other arrangement with such a covered entity in the service area of such plan.

''(III) Where a drug approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (referred to in this subclause as the 'listed drug') is covered by the plan, the following information:

''(aa) A list of currently marketed generic drugs approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act pursuant to an application that references such listed drug that are not covered by the plan, are covered on the same formulary tier or a formulary tier typically associated with higher cost-sharing than the listed drug, or are subject to utilization management that the listed drug is not subject to.

''(bb) The estimated average beneficiary cost-sharing under the plan for a 30-day supply of the listed drug.

''(cc) Where a generic drug listed under item (aa) is on a formulary tier typically associated with higher cost-sharing than the listed drug, the estimated average cost-sharing that a beneficiary would have paid for a 30-

day supply of each of the generic drugs described in item (aa), had the plan provided coverage for such drugs on the same formulary tier as the listed drug.

''(dd) A written justification for providing more favorable coverage of the listed drug than the generic drugs described in item (aa).

''(ee) The number of currently marketed generic drugs approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act pursuant to an application that references such listed drug.

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

''(aa) A list of currently marketed biosimilar biological products licensed under section 351(k) of the Public Health

Service Act pursuant to an application that refers to such reference product that are not covered by the plan, are covered on the same formulary tier or a formulary tier typically associated with higher cost-sharing than the reference product, or are subject to utilization management that the reference product is not subject to.

''(bb) The estimated average beneficiary cost-sharing under the plan for a 30-day supply of the reference product.

''(cc) Where a biosimilar biological product listed under item (aa) is on a formulary tier typically associated with higher cost-sharing than the reference product, the estimated average cost-sharing that a beneficiary would have paid for a 30-day supply of each of the biosimilar biological products described in item (aa),

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

''(dd) A written justification for providing more favorable coverage of the reference product than the biosimilar biological products described in item (aa).

''(ee) The number of currently marketed biosimilar biological products licensed under section 351(k) of the Public Health Service Act, pursuant to an application that refers to such reference product.

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

''(VI) The total amount retained by the pharmacy benefit manager or an affiliate of such pharmacy benefit manager in revenue related to utilization of covered part D drugs under

that plan, inclusive of bona fide service fees.

''(VII) The total spending on covered part D drugs net of rebates, fees, discounts, or other direct and indirect remuneration by the plan.

''(VIII) An explanation of any benefit design parameters under such plan that encourage plan enrollees to fill prescriptions at pharmacies that are an affiliate of such pharmacy benefit manager, such as mail and specialty home delivery programs, and retail and mail auto-refill programs.

''(IX) The following information:

''(aa) A list of all brokers, consultants, advisors, and auditors that receive compensation from the pharmacy benefit manager or an affiliate of such pharmacy benefit manager for referrals, consulting, auditing, or other services offered to PDP sponsors related to pharmacy benefit management services.

''(bb) The amount of compensation provided by such pharmacy benefit manager or affiliate to each such broker, consultant, advisor, and auditor.

''(cc) The methodology for calculating the amount of compensation provided by such pharmacy benefit manager or affiliate, for each such broker, consultant, advisor, and auditor.

''(X) A list of all affiliates of the pharmacy benefit manager.

''(XI) A summary document submitted in a standardized template developed by the Secretary that includes such information described in subclauses (I) through (X).

''(ii) WRITTEN EXPLANATION OF CONTRACTS OR AGREEMENTS WITH MANUFACTURERS.—

''(I) IN GENERAL.—The pharmacy benefit manager shall, not later than 30 days after the finalization of any contract or agreement between

such pharmacy benefit manager or an affiliate of such pharmacy benefit manager and a manufacturer (or subsidiary, agent, or entity affiliated with such manufacturer) that makes rebates, discounts, payments, or other financial incentives related to one or more covered part D drugs or other prescription drugs, as applicable, of the manufacturer directly or indirectly contingent upon coverage, formulary placement, or utilization management conditions on any other covered part D drugs or other prescription drugs, as applicable, submit to the PDP sponsor a written explanation of such contract or agreement.

''(II) REQUIREMENTS.—A written explanation under subclause (I) shall—

''(aa) include the manufacturer subject to the contract or agreement, all covered part D drugs and other prescription drugs, as applicable, subject to

the contract or agreement and the manufacturers of such drugs, and a high-level description of the terms of such contract or agreement and how such terms apply to such drugs; and

''(bb) be certified by the Chief Executive Officer, Chief Financial Officer, or General Counsel of such pharmacy benefit manager, or affiliate of such pharmacy benefit manager, as applicable, or an individual delegated with the authority to sign on behalf of one of these officers, who reports directly to the officer.

''(III) DEFINITION OF OTHER PRESCRIPTION DRUGS.—For purposes of this clause, the term 'other prescription drugs' means prescription drugs covered as supplemental benefits under this part or prescription drugs paid outside of this part.

''(D) AUDIT RIGHTS.—

"(i) IN GENERAL.—Not less than once a year, at the request of the PDP sponsor, the pharmacy benefit manager shall allow for an audit of the pharmacy benefit manager to ensure compliance with all terms and conditions under the written agreement described in this paragraph and the accuracy of information reported under subparagraph (C).

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

"(iii) PROVISION OF INFORMATION.—The pharmacy benefit manager shall make available to such auditor all records, data, contracts, and other information necessary to confirm the accuracy of information reported under subparagraph (C), subject to reasonable restrictions on how such information must be reported to prevent redisclosure of such information.

"(iv) TIMING.—The pharmacy benefit manager must provide information under

clause (iii) and other information, data, and records relevant to the audit to such auditor within 6 months of the initiation of the audit and respond to requests for additional information from such auditor within 30 days after the request for additional information.

''(v) INFORMATION FROM AFFILIATES.—The pharmacy benefit manager shall be responsible for providing to such auditor information required to be reported under subparagraph (C) or under clause (iii) of this subparagraph that is owned or held by an affiliate of such pharmacy benefit manager.

''(2) ENFORCEMENT.—

''(A) IN GENERAL.—Each PDP sponsor shall—

''(i) disgorge to the Secretary any amounts disgorged to the PDP sponsor by a pharmacy benefit manager under paragraph (1)(A)(v);

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

such pharmacy benefit manager, that such pharmacy benefit manager or affiliate reimburse the PDP sponsor for any civil money penalty imposed on the PDP sponsor as a result of the failure of the pharmacy benefit manager or affiliate to meet the requirements of paragraph (1) that are applicable to the pharmacy benefit manager or affiliate under the agreement; and

''(iii) require, in a written agreement with any such pharmacy benefit manager acting on behalf of such sponsor or affiliate of such pharmacy benefit manager, that such pharmacy benefit manager or affiliate be subject to punitive remedies for breach of contract for failure to comply with the requirements applicable under paragraph (1).

''(B) REPORTING OF ALLEGED VIOLATIONS.—The Secretary shall make available and maintain a mechanism for manufacturers, PDP sponsors, pharmacies, and other entities that have contractual relationships with pharmacy benefit managers or affiliates of such pharmacy benefit managers to report, on a confidential

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

''(C) ANTI-RETALIATION AND ANTI-COERCION.—Consistent with applicable Federal or State law, a PDP sponsor shall not—

''(i) retaliate against an individual or entity for reporting an alleged violation under subparagraph (B); or

''(ii) coerce, intimidate, threaten, or interfere with the ability of an individual or entity to report any such alleged violations.

''(3) CERTIFICATION OF COMPLIANCE.—

''(A) IN GENERAL.—Each PDP sponsor shall furnish to the Secretary (at a time and in a manner specified by the Secretary) an annual certification of compliance with this subsection, as well as such information as the Secretary determines necessary to carry out this subsection.

''(B) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

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

''(A) prohibiting flat dispensing fees or reimbursement or payment for ingredient costs (including customary, industry-standard discounts directly related to drug acquisition that are retained by pharmacies or wholesalers) to entities that acquire or dispense prescription drugs; or

''(B) modifying regulatory requirements or sub-regulatory program instruction or guidance related to pharmacy payment, reimbursement, or dispensing fees.

''(5) STANDARD FORMATS.—

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

''(B) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

''(6) CONFIDENTIALITY.—

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

or a pharmacy under this subsection that is not otherwise publicly available or available for purchase shall not be disclosed by the Secretary or a PDP sponsor receiving the information, except that the Secretary may disclose the information for the following purposes:

''(i) As the Secretary determines necessary to carry out this part.

''(ii) To permit the Comptroller General to review the information provided.

''(iii) To permit the Director of the Congressional Budget Office to review the information provided.

''(iv) To permit the Executive Director of the Medicare Payment Advisory Commission to review the information provided.

''(v) To the Attorney General for the purposes of conducting oversight and enforcement under this title.

''(vi) To the Inspector General of the Department of Health and Human Services in accordance with its authorities under the Inspector General Act of 1978

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

''(B) RESTRICTION ON USE OF INFORMATION.—The Secretary, the Comptroller General, the Director of the Congressional Budget Office, and the Executive Director of the Medicare Payment Advisory Commission shall not report on or disclose information disclosed pursuant to subparagraph (A) to the public in a manner that would identify—

''(i) a specific pharmacy benefit manager, affiliate, pharmacy, manufacturer, wholesaler, PDP sponsor, or plan; or

''(ii) contract prices, rebates, discounts, or other remuneration for specific drugs in a manner that may allow the identification of specific contracting parties or of such specific drugs.

''(7) DEFINITIONS.—For purposes of this subsection:

''(A) AFFILIATE.—The term 'affiliate' means, with respect to any pharmacy benefit manager or PDP sponsor, any entity that, directly or indirectly—

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

"(ii) acts as a contractor, principal, or agent to such pharmacy benefit manager or PDP sponsor, insofar as such contractor, principal, or agent performs any of the functions described under subparagraph (C).

"(B) BONA FIDE SERVICE FEE.—The term 'bona fide service fee' means a fee that is reflective of the fair market value (as specified by the Secretary, through notice and comment rulemaking) for a bona fide, itemized service actually performed on behalf of an entity, that the entity would otherwise perform (or contract for) in the absence of the service arrangement and that is not passed on in whole or in part to a client or customer, whether or not the entity takes title to the drug. Such fee must be a flat dollar amount and shall not be directly or indirectly based on, or contingent upon—

"(i) drug price, such as wholesale acquisition cost or drug benchmark price (such as average wholesale price);

"(ii) the amount of discounts, rebates, fees, or other direct or indirect remuneration with respect to covered part D drugs dispensed to enrollees in a prescription drug plan, except as permitted pursuant to paragraph (1)(A)(ii);

"(iii) coverage or formulary placement decisions or the volume or value of any referrals or business generated between the parties to the arrangement; or

"(iv) any other amounts or methodologies prohibited by the Secretary.

"(C) PHARMACY BENEFIT MANAGER.—The term 'pharmacy benefit manager' means any person or entity that, either directly or through an intermediary, acts as a price negotiator or group purchaser on behalf of a PDP sponsor or prescription drug plan, or manages the prescription drug benefits provided by such sponsor or plan, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the proc-

essing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered part D drugs, or the provision of related services. Such term includes any person or entity that carries out one or more of the activities described in the preceding sentence, irrespective of whether such person or entity calls itself a 'pharmacy benefit manager'.''.

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

''(G) REQUIREMENTS RELATING TO PHARMACY BENEFIT MANAGERS.—For plan years beginning on or after January 1, 2028, section 1860D–12(h).''.

(3) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this subsection.

(4) FUNDING.—

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

Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $113,000,000 for fiscal year 2026, to remain available until expended, to carry out this subsection.

(B) OIG.—In addition to amounts otherwise available, there is appropriated to the Inspector General of the Department of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $20,000,000 for fiscal year 2026, to remain available until expended, to carry out this subsection.

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

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the ''Comptroller General'') shall conduct a study describing the use of compensation and payment structures related to a prescription drug's price within the retail prescription drug supply chain in part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.). Such study shall summarize information from Federal agencies and industry ex-

perts, to the extent available, with respect to the following:

(A) The type, magnitude, other features (such as the pricing benchmarks used), and prevalence of compensation and payment structures related to a prescription drug's price, such as calculating fee amounts as a percentage of a prescription drug's price, between intermediaries in the prescription drug supply chain, including—

(i) pharmacy benefit managers;

(ii) PDP sponsors offering prescription drug plans and Medicare Advantage organizations offering MA–PD plans;

(iii) drug wholesalers;

(iv) pharmacies;

(v) manufacturers;

(vi) pharmacy services administrative organizations;

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

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

PD plans regarding pharmacy benefits; or

(II) review PDP sponsor and Medicare Advantage organization contracts with pharmacy benefit managers; and

(viii) other service providers that contract with any of the entities described in clauses (i) through (vii) that may use price-related compensation and payment structures, such as rebate aggregators (or other entities that negotiate or process price concessions on behalf of pharmacy benefit managers, plan sponsors, or pharmacies).

(B) The primary business models and compensation structures for each category of intermediary described in subparagraph (A).

(C) Variation in price-related compensation structures between affiliated entities (such as entities with common ownership, either full or partial, and subsidiary relationships) and unaffiliated entities.

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

scription drug price-related compensation structures, such as the potential for fees or other payments set as a percentage of a prescription drug's price to advantage formulary selection, distribution, or purchasing of prescription drugs with higher prices.

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

(F) The effects of drug price-related compensation structures and alternative compensation structures on Federal health care programs and program beneficiaries, including with respect to cost-sharing, premiums, Federal outlays, biosimilar and generic drug adoption and utilization, drug shortage risks, and the potential for fees set as a percentage of a drug's price to advantage the formulary selection, distribution, or purchasing of drugs with higher prices.

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

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

(c) MEDPAC REPORTS ON AGREEMENTS WITH PHARMACY BENEFIT MANAGERS WITH RESPECT TO PRESCRIPTION DRUG PLANS AND MA-PD PLANS.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall submit to Congress the following reports:

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

(i) a description of trends and patterns, including relevant averages, totals,

and other figures for the types of information submitted;

(ii) an analysis of any differences in agreements and their effects on plan enrollee out-of-pocket spending and average pharmacy reimbursement, and other impacts; and

(iii) any recommendations the Commission determines appropriate.

(B) FINAL REPORT.—Not later than 2 years after the date on which the Commission submits the initial report under subparagraph (A), a report describing any changes with respect to the information described in subparagraph (A) over time, together with any recommendations the Commission determines appropriate.

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

SEC. 6225. REQUIRING A SEPARATE IDENTIFICATION NUMBER AND AN ATTESTATION FOR EACH OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.

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

''(23) USE OF UNIQUE HEALTH IDENTIFIERS; ATTESTATION.—

''(A) IN GENERAL.—No payment may be made under this subsection (or under an applicable payment system pursuant to paragraph (21)) for items and services furnished on or after January 1, 2028, by an off-campus outpatient department of a provider (as defined in subparagraph (C)) unless—

''(i) such department has obtained, and such items and services are billed under, a National Provider Identifier that is separate from such identifier for such provider;

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

compliant with the requirements described in section 413.65 of title 42, Code of Federal Regulations (or a successor regulation), which, until the Secretary establishes the process described in subparagraph (B), may include an attestation submitted in accordance with paragraph (b)(3) of such section (as in effect on the date of enactment of this paragraph); and

''(iii) after such provider has submitted an attestation under clause (ii), such provider has submitted a subsequent attestation within the timeframe specified by the Secretary.

''(B) PROCESS FOR SUBMISSION AND REVIEW.—

''(i) IN GENERAL.—The Secretary shall, through notice and comment rulemaking, establish a process for each provider with an off-campus outpatient department of a provider to submit an initial and subsequent attestation pursuant to clauses (ii) and (iii), respectively, of subparagraph (A), and for the Secretary to review each such attestation and determine,

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

''(ii) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2026, out of any amounts in the Treasury not otherwise appropriated, $20,000,000, to remain available until expended, for purposes of carrying out this subparagraph.

''(C) OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER DEFINED.—For purposes of this paragraph, the term 'off-campus outpatient department of a provider' means a department of a provider (as defined in section 413.65 of title 42, Code of Federal Regulations, or any successor regulation) that is not located—

''(i) on the campus (as defined in such section) of such provider; or

"(ii) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section).".

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

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

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

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

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

(1) in subparagraph (A), by striking "2028" and inserting "2029"; and

(2) in subparagraph (B)—

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

and ending on January 30, 2026'' and inserting ''2026''; and

(B) in clause (iii), by striking ''the period beginning on January 31, 2026, and ending on December 31, 2026, and for each of 2027 and 2028'' and inserting ''each of 2027 through 2029''.

(b) REVISED DATA COLLECTION PERIOD FOR REPORTING OF PRIVATE SECTOR PAYMENT RATES FOR ESTABLISHMENT OF MEDICARE PAYMENT RATES.—Section 1834A(a)(4)(B) of the Social Security Act (42 U.S.C. 1395m–1(a)(4)(B)) is amended by striking ''2019'' each place it appears and inserting ''2025'' in each such place.

(c) REVISED REPORTING PERIOD FOR REPORTING OF PRIVATE SECTOR PAYMENT RATES FOR ESTABLISHMENT OF MEDICARE PAYMENT RATES.—Section 1834A(a)(1)(B) of the Social Security Act (42 U.S.C. 1395m–1(a)(1)(B)) is amended—

(1) in clause (i), by striking ''January 31'' and inserting ''April 30''; and

(2) in clause (ii), by striking ''February 1, 2026, and ending April 30, 2026'' and inserting ''May 1, 2026, and ending July 31, 2026''.

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

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

SEC. 6227. MEDICARE SEQUESTRATION.

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

(1) in subparagraph (D), by striking ''such that,'' and all that follows and inserting ''such that the payment reduction shall be 2.0 percent for such fiscal year.''; and

(2) by adding at the end the following:

''(F) On the date on which the President submits the budget under section 1105 of title 31, United States Code, for fiscal year 2033, the President shall order a sequestration of payments for the Medicare programs specified in section 256(d), effective upon issuance, such that, notwithstanding the 2 percent limit specified in subparagraph (A) for such payments—

''(i) with respect to the first 5 months in which such order is effective for such fiscal year, the payment reduction shall be 2.0 percent; and

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

year, the payment reduction shall be 0 percent.''.

SEC. 6228. MEDICARE IMPROVEMENT FUND.

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

TITLE III—HUMAN SERVICES

SEC. 6301. SEXUAL RISK AVOIDANCE EDUCATION EXTENSION.

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

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026'' and inserting ''2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026''; and

(ii) by striking ''fiscal year 2026'' and inserting ''fiscal year 2027''; and

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) by striking ''through 2025'' and inserting ''through 2026''; and

(II) by striking ''fiscal year 2026'' each place it appears and inserting ''fiscal year 2027''; and

(ii) in subparagraph (B)(i), by striking ''2026'' and inserting ''2027''; and

(2) in subsection (f)(1) by striking ''2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2025'' and inserting ''2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2026''.

SEC. 6302. PERSONAL RESPONSIBILITY EDUCATION EXTENSION.

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

(1) in subsection (a)(1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ''2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026'' and inserting ''2026, and for the period beginning on October

1, 2026, and ending on December 31, 2026''; and

(B) in subparagraph (B)(i), by striking ''fiscal years 2024 and 2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026'' and inserting ''fiscal years 2025 and 2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026'';

(2) in subsection (c)(3), by striking ''2026'' and inserting ''2027''; and

(3) in subsection (f), by striking ''2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2025'' and inserting ''2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2026''.

SEC. 6303. EXTENSION OF FUNDING FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

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

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

(2) in clause (ix), by striking ''October 1, 2025, and ending on January 30, 2026, an amount equal to the pro rata portion of the amount appropriated for fiscal year 2025'' and inserting ''October 1, 2026, and ending on December 31, 2026, an amount equal to the pro rata portion of the amount appropriated for fiscal year 2026''.

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

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

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.

(a) EXTENSION FOR COMMUNITY HEALTH CENTERS.—Section 10503(b)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(1)) is amended by striking subparagraphs (H), (I), (J), and (K) and inserting the following:

''(H) $4,236,712,328 for fiscal year 2024;

''(I) $4,295,287,671 for fiscal year 2025;

''(J) $4,600,000,000 for fiscal year 2026; and

''(K) $1,159,452,055 for the period beginning on October 1, 2026, and ending on December 31, 2026; and''.

(b) EXTENSION FOR THE NATIONAL HEALTH SERVICE CORPS.—Section 10503(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(2)) is amended by striking subparagraphs (I), (J), (K), and (L) and inserting the following:

''(I) $341,208,605 for fiscal year 2024;

"(J) $349,736,600 for fiscal year 2025;

"(K) $350,000,000 for fiscal year 2026; and

"(L) $88,219,178 for the period beginning on October 1, 2026, and ending on December 31, 2026.".

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

"(D) $168,915,878 for fiscal year 2024;

"(E) $181,563,574 for fiscal year 2025;

"(F) $225,000,000 for fiscal year 2026;

"(G) $250,000,000 for fiscal year 2027;

"(H) $275,000,000 for fiscal year 2028; and

"(I) $300,000,000 for fiscal year 2029.".

(d) APPLICATION OF PROVISIONS.—Amounts appropriated pursuant to the amendments made by this section shall be subject to the requirements contained in Public Law 118–47 for funds for programs authorized under sections 330 through 340 of the Public Health Service Act (42 U.S.C. 254b et seq.).

(e) CONFORMING AMENDMENTS.—Section 3014(h)(4) of title 18, United States Code, is amended by striking ''and section 6101(d) of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026'' and inserting ''section 6101(d) of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, and section 6401(d) of the Consolidated Appropriations Act, 2026''.

SEC. 6402. EXTENSION OF SPECIAL DIABETES PROGRAMS.

(a) EXTENSION OF SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)) is amended by striking subparagraphs (E), (F), (G), and (H) and inserting the following:

''(E) $155,619,196 for fiscal year 2024, to remain available until expended;

''(F) $159,228,188 for fiscal year 2025, to remain available until expended;

''(G) $200,000,000 for fiscal year 2026, to remain available until expended; and

''(H) $50,410,959 for the period beginning on October 1, 2026, and ending on December 31, 2026, to remain available until expended.''.

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

"(E) $155,619,196 for fiscal year 2024, to remain available until expended;

"(F) $159,228,188 for fiscal year 2025, to remain available until expended;

"(G) $200,000,000 for fiscal year 2026, to remain available until expended; and

"(H) $50,410,959 for the period beginning on October 1, 2026, and ending on December 31, 2026, to remain available until expended.".

SEC. 6403. EXTENSION OF NATIONAL HEALTH SECURITY PROGRAMS.

(a) Section 319(e)(8) of the Public Health Service Act (42 U.S.C. 247d(e)(8)) is amended by striking "January 30, 2026" and inserting "December 31, 2026".

(b) Section 319L(e)(1)(D) of the Public Health Service Act (42 U.S.C. 247d–7e(e)(1)(D)) is amended by striking "January 30, 2026" and inserting "December 31, 2026".

(c) Section 319L–1(b) of the Public Health Service Act (42 U.S.C. 247d–7f(b)) is amended by striking ''January 30, 2026'' and inserting ''December 31, 2026''.

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

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

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

(g) Section 2812(c)(4)(B) of the Public Health Service Act (42 U.S.C. 300hh–11(c)(4)(B)) is amended by striking ''January 30, 2026'' and inserting ''December 31, 2026''.

SEC. 6404. NO SURPRISES ACT IMPLEMENTATION.

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

(1) in paragraph (1), by striking ''January 30, 2026'' and inserting ''December 31, 2026''; and

(2) in paragraph (2)—

(A) by striking ''$14,000,000'' and inserting ''$42,100,000''; and

(B) by striking ''January 30, 2026'' and inserting ''December 31, 2026''.

Subtitle B—World Trade Center Health Program

SEC. 6411. 9/11 RESPONDER AND SURVIVOR HEALTH FUNDING CORRECTIONS.

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

(1) in clause (x), by striking ''; and'' and inserting a semicolon;

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

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

''(xi) for each of fiscal years 2026 through 2040—

''(I) the amount determined under this subparagraph for the previous fiscal year multiplied by 1.07; multiplied by

''(II) the ratio of—

''(aa) the total number of individuals enrolled in the AC Program on July 1 of such previous fiscal year; to

''(bb) the total number of individuals so enrolled on July 1 of the fiscal year prior to such previous fiscal year; and''.

(b) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall conduct an assessment of anticipated budget authority and outlays of the World Trade Center Health Program (referred to in this subsection as the ''Program'') through the duration of the Program and submit a report summarizing such assessment to—

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

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

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

(D) the Committee on Energy and Commerce and the Committee on the Budget of the House of Representatives.

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

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

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

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

(i) such projected authority and expenditures resulting from application of section 3351(a)(2)(A) of the Public Health Service Act (42 U.S.C. 300mm–61(a)(2)(A)), as amended by subsection (a); and

(ii) such projected authority and expenditures that would result if such section were amended so that the formula under clause (xi) of such section, as amended by subsection (a), were to be extended through fiscal year 2090; and

(D) any recommendations of the Secretary to make changes to the formula under such section 3351(a)(2)(A), as so amended, to fully offset anticipated Program expenditures through fiscal year 2090.

(c) TECHNICAL AMENDMENTS.—Title XXIII of the Public Health Service Act (42 U.S.C. 300mm et seq.) is amended—

(1) in section 3352(d) (42 U.S.C. 300mm–62(d)), by striking ''Any amounts'' and inserting ''Any unobligated amounts'';

(2) in section 3353(d) (42 U.S.C. 300mm–63(d)), by striking ''Any amounts'' and inserting ''Any unobligated amounts''; and

(3) in section 3354(d) (42 U.S.C. 300mm–64(d)), by striking ''Any amounts'' and inserting ''Any unobligated amounts''.

TITLE V—PUBLIC HEALTH PROGRAMS

SEC. 6501. PREVENTING MATERNAL DEATHS.

(a) MATERNAL MORTALITY REVIEW COMMITTEES.—Section 317K(d) of the Public Health Service Act (42 U.S.C. 247b–12(d)) is amended—

(1) in paragraph (1)(A), by inserting ''(including obstetricians and gynecologists)'' after ''clinical specialties''; and

(2) in paragraph (3)(A)(i)—

(A) in subclause (I), by striking ''as applicable'' and inserting ''if available''; and

(B) in subclause (III), by striking '', as appropriate'' and inserting ''and coordinating with individuals responsible for certifying deaths to improve the collection and quality of death record reports, including by amending errors and missing or incomplete information to cause-of-death information on a death certificate, as appropriate''.

(b) MATERNAL MORTALITY.—Section 317K of the Public Health Service Act (42 U.S.C. 247b–12) is amended—

(1) by redesignating subsections (e) and (f) as subsections (f) and (g), respectively; and

(2) by inserting after subsection (d) the following:

''(e) BEST PRACTICES RELATING TO THE PREVENTION OF MATERNAL MORTALITY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease

Control and Prevention, shall, in consultation with the Administrator of the Health Resources and Services Administration, identify and disseminate to health care providers, relevant professional societies, and perinatal quality collaboratives, best practices related to preventing maternal morbidity and mortality, taking into consideration any relevant findings from other Federal maternal health programs.

''(2) FREQUENCY.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall disseminate the best practices referred to in paragraph (1) not less than once per fiscal year.''.

(c) AUTHORIZATION OF APPROPRIATIONS.—Subsection (g) of section 317K of the Public Health Service Act (42 U.S.C. 247b–12), as redesignated by subsection (b)(1), is amended by striking ''$58,000,000 for each of fiscal years 2019 through 2023'' and inserting ''$100,000,000 for each of fiscal years 2026 through 2030''.

SEC. 6502. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK.

Section 372 of the Public Health Service Act (42 U.S.C. 274) is amended—

(1) in subsection (b)(2)—

(A) by moving the margins of subparagraphs (M) through (O) 2 ems to the left;

(B) in subparagraph (A)—

(i) in clause (i), by striking ‘‘, and’’ and inserting ‘‘; and’’; and

(ii) in clause (ii), by striking the comma at the end and inserting a semicolon;

(C) in subparagraph (C), by striking ‘‘twenty-four-hour telephone service’’ and inserting ‘‘24-hour telephone or information technology service’’;

(D) in each of subparagraphs (B) through (M), by striking the comma at the end and inserting a semicolon;

(E) in subparagraph (N), by striking ‘‘transportation, and’’ and inserting ‘‘transportation;’’;

(F) in subparagraph (O), by striking the period and inserting a semicolon; and

(G) by adding at the end the following:

‘‘(P) encourage the integration of electronic health records systems through application programming interfaces (or successor technologies) among hospitals, organ procurement organizations, and

transplant centers, including the use of automated electronic hospital referrals and the grant of remote, electronic access to hospital electronic health records of potential donors by organ procurement organizations, in a manner that complies with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, at part 160 of title 45, Code of Federal Regulations, and subparts A, C, and E of part 164 of such title (or any successor regulations); and

''(Q) consider establishing a dashboard to display the number of transplants performed, the types of transplants performed, the number and types of organs that entered the Organ Procurement and Transplantation Network system and failed to be transplanted, and other appropriate statistics, which should be updated more frequently than annually.''; and

(2) by adding at the end the following:

''(d) REGISTRATION FEES.—

''(1) IN GENERAL.—The Secretary may collect registration fees from any member of the Organ Procurement and Transplantation Network for each transplant candidate such member places on the list described in subsection (b)(2)(A)(i). Such registra-

tion fees shall be collected and distributed only to support the operation of the Organ Procurement and Transplantation Network. Such registration fees are authorized to remain available until expended.

''(2) COLLECTION.—The Secretary may collect the registration fees under paragraph (1) directly or through awards made under subsection (b)(1)(A).

''(3) DISTRIBUTION.—Any amounts collected under this subsection shall—

''(A) be credited to the currently applicable appropriation, account, or fund of the Department of Health and Human Services as discretionary offsetting collections; and

''(B) be available, only to the extent and in the amounts provided in advance in appropriations Acts, to distribute such fees among awardees described in subsection (b)(1)(A).

''(4) TRANSPARENCY.—The Secretary shall—

''(A) promptly post on the website of the Organ Procurement and Transplantation Network—

''(i) the amount of registration fees collected under this subsection from each member of the Organ Procurement and Transplantation Network; and

"(ii) a list of activities such fees are used to support; and

"(B) update the information posted pursuant to subparagraph (A), as applicable for each calendar quarter for which fees are collected under paragraph (1).

"(5) GAO REVIEW.—Not later than 2 years after the date of enactment of this subsection, the Comptroller General of the United States shall, to the extent data are available—

"(A) conduct a review concerning the activities under this subsection; and

"(B) submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives, a report on such review, including related recommendations, as applicable.

"(6) SUNSET.—The authority to collect registration fees under paragraph (1) shall expire on the date that is 3 years after the date of enactment of the Consolidated Appropriations Act, 2026.".

SEC. 6503. HONOR OUR LIVING DONORS.

(a) NO CONSIDERATION OF INCOME OF ORGAN RECIPIENT.—Section 377 of the Public Health Service Act (42 U.S.C. 274f) is amended—

(1) by redesignating subsections (c) through (f) as subsections (d) through (g), respectively;

(2) by inserting after subsection (b) the following:

''(c) NO CONSIDERATION OF INCOME OF ORGAN RECIPIENT.—The recipient of a grant under this section, in providing reimbursement to a donating individual through such grant, shall not give any consideration to the income of the organ recipient.''; and

(3) in subsection (f), as so redesignated—

(A) in paragraph (1), by striking ''subsection (c)(1)'' and inserting ''subsection (d)(1)''; and

(B) in paragraph (2), by striking ''subsection (c)(2)'' and inserting ''subsection (d)(2)''.

(b) REMOVAL OF EXPECTATION OF PAYMENTS BY ORGAN RECIPIENTS.—Section 377(e) of the Public Health Service Act (42 U.S.C. 274f(e)), as redesignated by subsection (a)(1), is amended—

(1) in paragraph (1), by adding ''or'' at the end;

(2) in paragraph (2), by striking ''; or'' and inserting a period; and

(3) by striking paragraph (3).

(c) ANNUAL REPORT.—Section 377 of the Public Health Service Act (42 U.S.C. 274f), as amended by subsections (a) and (b), is amended by adding at the end the following:

''(h) ANNUAL REPORT.—Not later than December 31 of each year, beginning in fiscal year 2027, the Secretary shall—

''(1) prepare, submit to the Congress, and make public a report on whether grants under this section provided adequate funding during the preceding fiscal year to reimburse all donating individuals participating in the grant program under this section for all qualifying expenses; and

''(2) include in each such report—

''(A) the estimated number of all donating individuals participating in the grant program under this section who did not receive reimbursement for all qualifying expenses during the preceding fiscal year; and

''(B) the total amount of funding that is estimated to be necessary to fully reimburse all donating individuals participating in the grant

program under this section for all qualifying expenses.''.

SEC. 6504. PROGRAM FOR PEDIATRIC STUDIES OF DRUGS.

Section 409I(d)(1) of the Public Health Service Act (42 U.S.C. 284m(d)(1)) is amended by striking ''section,'' and all that follows through the period at the end and inserting ''section, $25,000,000 for each of fiscal years 2026 through 2028.''.

SEC. 6505. SICKLE CELL DISEASE PREVENTION AND TREATMENT.

(a) IN GENERAL.—Section 1106(b) of the Public Health Service Act (42 U.S.C. 300b–5(b)) is amended—

(1) in paragraph (1)(A)(iii), by striking ''prevention and treatment of sickle cell disease'' and inserting ''treatment of sickle cell disease and the prevention and treatment of complications of sickle cell disease'';

(2) in paragraph (2)(D), by striking ''prevention and treatment of sickle cell disease'' and inserting ''treatment of sickle cell disease and the prevention and treatment of complications of sickle cell disease'';

(3) in paragraph (3)—

(A) in subparagraph (A), by striking ''enter into a contract with'' and inserting

''make a grant to, or enter into a contract or cooperative agreement with,''; and

(B) in subparagraph (B), in each of clauses (ii) and (iii), by striking ''prevention and treatment of sickle cell disease'' and inserting ''treatment of sickle cell disease and the prevention and treatment of complications of sickle cell disease''; and

(4) in paragraph (6), by striking ''$4,455,000 for each of fiscal years 2019 through 2023'' and inserting ''$8,205,000 for each of fiscal years 2026 through 2030''.

(b) SENSE OF CONGRESS.—It is the sense of Congress that further research should be undertaken to expand the understanding of the causes of, and to find cures for, heritable blood disorders, including sickle cell disease.

SEC. 6506. LIFESPAN RESPITE CARE.

(a) DEFINITION OF FAMILY CAREGIVER.—Section 2901(5) of the Public Health Service Act (42 U.S.C. 300ii(5)) is amended by striking ''unpaid adult'' and inserting ''unpaid individual''.

(b) FUNDING.—Section 2905 of the Public Health Service Act (42 U.S.C. 300ii–4) is amended by striking ''fiscal years 2020 through fiscal year 2024'' and inserting ''fiscal years 2026 through 2030''.

SEC. 6507. PREEMIE.

(a) RESEARCH RELATING TO PRETERM LABOR AND DELIVERY AND THE CARE, TREATMENT, AND OUTCOMES OF PRETERM AND LOW BIRTHWEIGHT INFANTS.—

(1) IN GENERAL.—Section 3(e) of the Prematurity Research Expansion and Education for Mothers who deliver Infants Early Act (42 U.S.C. 247b–4f(e)) is amended by striking ''fiscal years 2019 through 2023'' and inserting ''fiscal years 2026 through 2030''.

(2) TECHNICAL CORRECTION.—Effective as if included in the enactment of the PREEMIE Reauthorization Act of 2018 (Public Law 115–328), section 2 of such Act is amended, in the matter preceding paragraph (1), by striking ''Section 2'' and inserting ''Section 3''.

(b) INTERAGENCY WORKING GROUP.—Section 5(a) of the PREEMIE Reauthorization Act of 2018 (Public Law 115–328) is amended by striking ''The Secretary of Health and Human Services, in collaboration with other departments, as appropriate, may establish'' and inserting ''Not later than 18 months after the date of the enactment of the Consolidated Appropriations Act, 2026, the Secretary of Health and Human Services, in collaboration with other departments, as appropriate, shall establish''.

(c) STUDY ON PRETERM BIRTHS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall enter into appropriate arrangements with the National Academies of Sciences, Engineering, and Medicine under which the National Academies shall—

(A) not later than 30 days after the date of enactment of this Act, convene a committee of experts in maternal health to study premature births in the United States; and

(B) upon completion of the study under subparagraph (A)—

(i) approve by consensus a report on the results of such study;

(ii) include in such report—

(I) an assessment of each of the topics listed in paragraph (2);

(II) the analysis required by paragraph (3); and

(III) the raw data used to develop such report; and

(iii) not later than 24 months after the date of enactment of this Act, transmit such report to—

(I) the Secretary of Health and Human Services;

(II) the Committee on Energy and Commerce of the House of Representatives; and

(III) the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate.

(2) ASSESSMENT TOPICS.—The topics listed in this subsection are each of the following:

(A) The financial costs of premature birth to society, including—

(i) an analysis of stays in neonatal intensive care units and the cost of such stays;

(ii) long-term costs of stays in such units to society and the family involved post-discharge; and

(iii) health care costs for families post-discharge from such units (such as medications, therapeutic services, co-payments for visits, and specialty equipment).

(B) The factors that impact preterm birth rates.

(C) Opportunities for earlier detection of premature birth risk factors, including—

(i) opportunities to improve maternal and infant health; and

(ii) opportunities for public health programs to provide support and resources for parents in-hospital, in non-hospital settings, and post-discharge.

(3) ANALYSIS.—The analysis required by this subsection is an analysis of—

(A) targeted research strategies to develop effective drugs, treatments, or interventions to bring at-risk pregnancies to term;

(B) State and other programs' best practices with respect to reducing premature birth rates; and

(C) precision medicine and preventative care approaches starting early in the life course (including during pregnancy) with a focus on behavioral and biological influences on premature birth, child health, and the trajectory of such approaches into adulthood.

SEC. 6508. DR. LORNA BREEN HEALTH CARE PROVIDER PROTECTION.

(a) DISSEMINATION OF BEST PRACTICES.—Section 2 of the Dr. Lorna Breen Health Care Provider Protection