118TH CONGRESS
1ST SESSION

S. _____

To amend titles XVIII and XIX of the Social Security Act to expand the mental health care workforce and services, reduce prescription drug costs, and extend certain expiring provisions under Medicare and Medicaid, and for other purposes.

IN THE SENATE OF THE UNITED STATES

_____

_____ introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To amend titles XVIII and XIX of the Social Security Act to expand the mental health care workforce and services, reduce prescription drug costs, and extend certain expiring provisions under Medicare and Medicaid, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "_____ Act of _____".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—EXPANDING MENTAL HEALTH CARE WORKFORCE AND SERVICES UNDER MEDICARE AND MEDICAID

Sec. 101. Expanding eligibility for incentives under the Medicare health professional shortage area bonus program to practitioners furnishing mental health and substance use disorder services.
Sec. 102. Improved access to mental health services under the Medicare program.
Sec. 103. Clarifying coverage of occupational therapy under the Medicare program.
Sec. 104. Medicare incentives for behavioral health integration with primary care.
Sec. 105. Establishment of Medicare incident to modifier for mental health services furnished through telehealth.
Sec. 106. Guidance on furnishing behavioral health services via telehealth to individuals with limited English proficiency under Medicare program.
Sec. 107. Ensuring timely communication regarding telehealth and interstate licensure requirements.
Sec. 108. Facilitating accessibility for behavioral health services furnished through telehealth.
Sec. 109. Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act.
Sec. 110. Guidance to States on strategies under Medicaid and CHIP to increase mental health and substance use disorder care provider capacity.
Sec. 111. Guidance to States on supporting mental health services and substance use disorder care for children and youth.
Sec. 112. Recurring analysis and publication of Medicaid health care data related to mental health services.
Sec. 113. Guidance to States on supporting mental health services or substance use disorder care integration with primary care in Medicaid and CHIP.
Sec. 114. Medicaid State option relating to inmates with a substance use disorder pending disposition of charges.

TITLE II—REDUCING PRESCRIPTION DRUG COSTS UNDER MEDICARE AND MEDICAID

Sec. 201. Assuring pharmacy access and choice for Medicare beneficiaries.
Sec. 202. Ensuring accurate payments to pharmacies under Medicaid.
Sec. 203. Protecting seniors from excessive cost-sharing for certain medicines.
Sec. 204. Requirements for PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA–PD plans that use formularies under part D of the Medicare program.

TITLE III—MEDICAID EXPIRING PROVISIONS

Sec. 301. Delaying certain disproportionate share hospital payment reductions under the Medicaid program.
Sec. 302. Extension of State option to provide medical assistance for certain individuals who are patients in certain institutions for mental diseases.

TITLE IV—MEDICARE EXPIRING PROVISIONS AND PROVIDER PAYMENT CHANGES

Sec. 401. Extension of funding for quality measure endorsement, input, and selection.
Sec. 402. Extension of funding outreach and assistance for low-income programs.
Sec. 403. Extension of the work geographic index floor under the Medicare program.
Sec. 404. Extending incentive payments for participation in eligible alternative payment models.
Sec. 405. Payment rates for durable medical equipment under the Medicare Program.
Sec. 406. Extending the independence at home medical practice demonstration program under the Medicare program.
Sec. 407. Increase in support for physicians and other professionals in adjusting to Medicare payment changes.
Sec. 408. Revised phase-in of Medicare clinical laboratory test payment changes.
Sec. 409. Extension of adjustment to calculation of hospice cap amount under Medicare.

TITLE V—OFFSETS

Sec. 501. Medicaid Improvement Fund.
Sec. 502. Medicare Improvement Fund.

TITLE I—EXPANDING MENTAL HEALTH CARE WORKFORCE AND SERVICES UNDER MEDICARE AND MEDICAID

SEC. 101. EXPANDING ELIGIBILITY FOR INCENTIVES UNDER THE MEDICARE HEALTH PROFESSIONAL SHORTAGE AREA BONUS PROGRAM TO PRACTITIONERS FURNISHING MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.

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

(1) by striking paragraph (1) and inserting the following new paragraph:

''(1) In the case of—

''(A) physicians' services (other than specified health services that are eligible for the additional payment under subparagraph (B)) furnished in a year to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of such year, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part; and

''(B) specified health services (as defined in paragraph (5)) furnished in a year to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under such

section 332(a)(1)(A)) as a mental health professional shortage area as identified by the Secretary prior to the beginning of such year, in addition to the amount otherwise paid under this part, there also shall be paid to the physician or applicable practitioner (as defined in paragraph (6)) (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from such Trust Fund an amount equal to 15 percent of the payment amount for the service under this part.'';

(2) in paragraph (2)—

(A) by striking ''in paragraph (1)'' and inserting ''in subparagraph (A) or (B) of paragraph (1)'';

(B) by inserting ''or, in the case of specified health services, the physician or applicable practitioner'' after ''physician'';

(3) in paragraph (3), by striking ''in paragraph (1)'' and inserting ''in subparagraph (A) or (B) of paragraph (1)'';

(4) in paragraph (4)—

(A) in subparagraph (B), by inserting ''or applicable practitioner'' after ''physician''; and

(B) in subparagraph (C), by inserting ''or applicable practitioner'' after ''physician''; and

(5) by adding at the end the following new paragraphs:

''(5) In this subsection, the term 'specified health services' means services otherwise covered under this part that are furnished on or after January 1, 2026, by a physician or an applicable practitioner to an individual—

''(A) for purposes of diagnosis, evaluation, or treatment of a mental health disorder, as determined by the Secretary; or

''(B) with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder, as determined by the Secretary.

''(6) In this subsection, the term 'applicable practitioner' means the following:

''(A) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)).

''(B) A clinical social worker (as defined in section 1861(hh)(1)).

''(C) A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)).

''(D) A marriage and family therapist (as defined in section 1861(lll)(2)).

''(E) A mental health counselor (as defined in section 1861(lll)(4)).''.

SEC. 102. IMPROVED ACCESS TO MENTAL HEALTH SERVICES UNDER THE MEDICARE PROGRAM.

(a) ACCESS TO CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.—

(1) EXCLUSION OF CLINICAL SOCIAL WORKER SERVICES FROM THE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(iii)) is amended by adding at the end the following new subclause:

''(VII) Clinical social worker services (as defined in section 1861(hh)(2)).''.

(2) CONFORMING AMENDMENT.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(b) ACCESS TO THE COMPLETE SCOPE OF CLINICAL SOCIAL WORKER SERVICES.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)), as amended by subsection (a)(2), is amended by striking ''for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital)'' and inserting '', including services for the diagnosis and treatment of mental illnesses or services for health behavior assessment and intervention (identified as of January 1, 2023, by HCPCS codes 96160 and 96161 (and any succeeding codes)), but not including services furnished to an inpatient of a hospital,''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2026.

SEC. 103. CLARIFYING COVERAGE OF OCCUPATIONAL THERAPY UNDER THE MEDICARE PROGRAM.

Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall use existing communication mechanisms to provide education and outreach to stakeholders about the Medicare Benefit Policy Manual with respect to occupational therapy services furnished to individuals under the Medicare program for the treatment of a substance use or men-

tal health disorder diagnosis using applicable Healthcare Common Procedure Coding System (HCPCS) codes.

SEC. 104. MEDICARE INCENTIVES FOR BEHAVIORAL HEALTH INTEGRATION WITH PRIMARY CARE.

(a) INCENTIVES.—

(1) IN GENERAL.—Section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) is amended by adding at the end the following new paragraph:

"(13) INCENTIVES FOR BEHAVIORAL HEALTH INTEGRATION.—

"(A) IN GENERAL.—For services described in subparagraph (B) that are furnished during 2026, 2027, or 2028, instead of the payment amount that would otherwise be determined under this section for such year, the payment amount shall be equal to the applicable percent (as defined in subparagraph (C)) of such payment amount for such year.

"(B) SERVICES DESCRIBED.—The services described in this subparagraph are services identified, as of January 1, 2023, by HCPCS codes 99484, 99492, 99493, 99494, and G2214 (and any successor or similar codes as determined appropriate by the Secretary).

"(C) APPLICABLE PERCENT.—In this paragraph, the term 'applicable percent' means, with respect to a service described in subparagraph (A), the following:

"(i) For services furnished during 2026 , 175 percent.

"(ii) For services furnished during 2027, 150 percent.

"(iii) For services furnished during 2028, 125 percent.".

(2) WAIVER OF BUDGET NEUTRALITY.—Section 1848(c)(2)(B)(iv) of such Act (42 U.S.C. 1395w–4(c)(2)(B)(iv)) is amended—

(A) in subclause (V), by striking "and" at the end;

(B) in subclause (VI), by striking the period at the end and inserting "; and" and

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

"(VII) the increase in payment amounts as a result of the application of subsection (b)(13) shall not be taken into account in applying clause (ii)(II) for 2026, 2027, or 2028.".

(b) TECHNICAL ASSISTANCE FOR THE ADOPTION OF BEHAVIORAL HEALTH INTEGRATION.—

(1) IN GENERAL.—Not later than January 1, 2025, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall enter into contracts or agreements with appropriate entities to offer technical assistance to primary care practices that are seeking to adopt behavioral health integration models in such practices.

(2) BEHAVIORAL HEALTH INTEGRATION MODELS.—For purposes of paragraph (1), behavioral health integration models include the Collaborative Care Model (with services identified as of January 1, 2023, by HCPCS codes 99492, 99493, 99494, and G2214 (and any successor codes)), the Primary Care Behavioral Health model (with services identified as of January 1, 2023, by HCPCS code 99484 (and any successor code)), and other models identified by the Secretary.

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

(4) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Secretary

for fiscal year 2024, out of any money in the Treasury not otherwise appropriated, $5,000,000, to remain available until expended, for purposes of carrying out this subsection.

SEC. 105. ESTABLISHMENT OF MEDICARE INCIDENT TO MODIFIER FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH.

Section 1834(m)(7) of the Social Security Act (42 U.S.C. 1395m(m)(7)) is amended by adding at the end the following new subparagraph:

''(C) ESTABLISHMENT OF INCIDENT TO MODIFIER FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH.—Not later than 2 years after the date of the enactment of this subparagraph, the Secretary shall establish requirements to include a code or modifier, as determined appropriate by the Secretary, on claims for mental health services furnished through telehealth under this paragraph that are furnished by auxiliary personnel (as defined in section 410.26(a)(1) of title 42, Code of Federal Regulations, or any successor regulation) and billed incident to a physician or practitioner's professional services.''.

SEC. 106. GUIDANCE ON FURNISHING BEHAVIORAL HEALTH SERVICES VIA TELEHEALTH TO INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY UNDER MEDICARE PROGRAM.

Not later than 1 year after the date of the enactment of this section, the Secretary of Health and Human Services shall issue and disseminate, or update and revise as applicable, guidance on the following:

(1) Best practices for providers to work with interpreters to furnish behavioral health services via video-based and audio-only telehealth, when video-based telehealth is not an option.

(2) Best practices on integrating the use of video platforms that enable multi-person video calls into behavioral health services furnished via telehealth.

(3) Best practices on teaching patients, especially those with limited English proficiency, to use video-based telehealth platforms.

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

SEC. 107. ENSURING TIMELY COMMUNICATION REGARDING TELEHEALTH AND INTERSTATE LICENSURE REQUIREMENTS.

The Secretary of Health and Human Services shall provide information—

(1) on licensure requirements for furnishing telehealth services under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.); and

(2) clarifying the extent to which licenses through an interstate license compact pathway can qualify as valid and full licenses for the purposes of meeting Federal licensure requirements under such titles.

SEC. 108. FACILITATING ACCESSIBILITY FOR BEHAVIORAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH.

The Secretary of Health and Human Services shall provide regular updates to guidance to facilitate the accessibility of behavioral health services furnished through telehealth for the visually and hearing impaired.

SEC. 109. REQUIRING ENHANCED & 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 network-based MA plan (as defined in paragraph (3)(C)), for plan year 2026 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 2026 and subsequent plan years, each MA organization offering a network-based MA plan shall, for each network-based MA 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 provider directory 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;

"(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; and

"(v) meet such other requirements as the Secretary may specify.

"(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 plan has an agreement for furnishing items and services covered under such plan such as name, specialty, contact information, primary office or facility address, avail-

ability, accommodations for people with disabilities, cultural and linguistic capabilities, and telehealth capabilities.

''(C) NETWORK-BASED MA PLAN DEFINED.—In this paragraph, the term 'network-based MA plan' means an MA plan that has a network of providers that contract or make arrangements with the MA organization offering the plan to furnish items and services covered under such plan.''.

(b) ACCOUNTABILITY FOR PROVIDER DIRECTORY ACCURACY.—

(1) COST SHARING FOR SERVICES FURNISHED BASED ON RELIANCE ON INCORRECT PROVIDER NETWORK INFORMATION.—Section 1852(d) of the Social Security Act (42 U.S.C. 1395w–22(d)) is amended by adding at the end the following new paragraph:

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

''(A) IN GENERAL.—For plan year 2026 and subsequent plan years, if an enrollee is furnished a covered item or service by a provider that is not participating in the network of a network-based MA plan (as defined in sub-

section (c)(3)(C)) 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, the MA organization offering such plan shall ensure that the enrollee is only responsible for the amount of cost sharing that would apply if such provider had been participating in the network of such plan.

''(B) NOTIFICATION REQUIREMENT.—For plan year 2026 and subsequent plan years, each MA organization that offers a network-based 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 network-based MA plan offered by the MA organization.; and

"(iii) notify enrollees of their cost-sharing protections under this paragraph in an explanation of benefits.".

(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, 2026, subject to subparagraph (C), a contract under this section with an MA organization shall require the organization, for each network-based MA plan (as defined in section 1852(c)(3)(C)) offered by the organization, to annually—

"(i) conduct an analysis of the accuracy of the provider directory of such plan (including provider types with high inaccuracy rates, such as providers specializing in mental health and substance use disorder treatment, as determined by the Secretary); and

''(ii) submit a report to the Secretary containing the results of such analysis and other information required by the Secretary.

''(B) CONSIDERATIONS.—In establishing requirements with respect to analysis and reporting under this paragraph, the Secretary shall take into account—

''(i) data sources maintained by MA organizations;

''(ii) publicly available data sets;

''(iii) the administrative burden on plans and providers; and

''(iv) the relative importance of certain directory information on enrollee ability to access to care.

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

''(D) TRANSPARENCY.—Beginning with plan years beginning on or after January 1, 2027, the Secretary shall post accuracy scores (as reported under subparagraph (A)), in a ma-

chine readable file, on the internet website of the Centers for Medicare & Medicaid Services.

''(E) IMPLEMENTATION.—The Secretary shall implement this paragraph through notice and comment rulemaking.''.

(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, 2027, information regarding the accuracy of the plan's provider directory (as reported under section 1857(e)(6)) 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, $1,000,000 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 study of the implementation of the amendments 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 protections required under section 1852(d)(7) of the Social Security Act, as added by paragraph (1);

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

(iii) provider response rates by plan verification methods; and

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

(B) REPORT.—Not later than January 15, 2031, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legisla-

tion 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 3 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 convene a public stakeholder meeting to receive public comments on 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 approaches for reducing administrative burden such as data standardization and best practices to maintain provider directory information.

(B) PARTICIPANTS.—The meeting under subparagraph (A) shall include representatives from the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Office of the National Coordinator for Health Information Technology, health care providers, companies that specialize in relevant

technologies, health insurers, and patient advocates.

(2) GUIDANCE.—Not later than 12 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 comments submitted 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 plans on how to work with providers to maintain the accuracy of provider directories of such plans and reduce provider and Medicare Advantage plan burden.

(B) Information on data sets and data sources with information that could be used by such plans to maintain accurate provider directories.

(C) Approaches for utilizing data sources maintained by MA organizations and publicly

available data sets to maintain accurate provider directories.

(D) Information for providers on when to update the National Plan and Provider Enumeration System.

(E) Information that may be useful for beneficiaries to assess plan networks when selecting a plan and accessing providers participating in plan networks during the plan year.

SEC. 110. GUIDANCE TO STATES ON STRATEGIES UNDER MEDICAID AND CHIP TO INCREASE MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE PROVIDER CAPACITY.

Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall issue guidance to States on strategies under Medicaid and the Children's Health Insurance Program (CHIP) to increase access to mental health and substance use disorder care providers that participate in Medicaid or CHIP, which may include education, training, recruitment, and retention of such providers, with a focus on improving the capacity of the mental health and substance use disorder care workforce in rural and underserved areas by increasing the number, type, and capacity of providers. Such guidance shall include, but not be limited to—

(1) best practices from States that have used Medicaid or CHIP waivers and authorities under titles XI, XIX, and XXI of such Act (42 U.S.C. 1301 et seq., 1396 et seq., 1397aa et seq.) for such purposes;

(2) best practices related to expanding the availability of community-based mental health and substance use disorder services under Medicaid and CHIP, including through the participation of paraprofessionals with behavioral health expertise, and review of State practices for leveraging paraprofessionals within State scope of practice requirements as well as State supervision requirements, such as peer support specialists and clinicians with baccalaureate degrees; and

(3) best practices related to financing, supporting, and expanding the education and training of providers of mental health and substance use disorder services to increase the workforce of such providers who participate in Medicaid and CHIP, including by supporting on-site training in the clinical setting and innovative public-private partnerships.

SEC. 111. GUIDANCE TO STATES ON SUPPORTING MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER CARE FOR CHILDREN AND YOUTH.

(a) GUIDANCE ON INCREASING THE AVAILABILITY AND PROVISION OF MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER CARE UNDER MEDICAID AND CHIP.—Not later than 12 months after the date of enactment of this Act, the Secretary shall issue guidance to States regarding opportunities to improve the availability and provision of mental health services and substance use disorder care through Medicaid and CHIP for children and youth. Such guidance shall address the following:

(1) The design and implementation of a continuum of benefits for children and youth with significant mental health conditions and substance use disorders covered by Medicaid and CHIP, including the role of EPSDT and what is required of States to ensure compliance with EPSDT.

(2) Strategies to facilitate access to mental health services and substance use disorder care under Medicaid and CHIP that are delivered in the home or in community-based settings for children and youth.

(3) Strategies to facilitate access to mental health services and substance use disorder care

under Medicaid and CHIP for children and youth who—

(A) are at risk for having a significant mental health condition or substance use disorder;

(B) have a significant mental health condition or substance use disorder; or

(C) have an intellectual or developmental disability.

(4) Strategies to promote screening for mental health and substance use disorder needs of children and youth, including children and youth provided, or at risk for needing, child welfare services, in coordination with providers, managed care organizations (as defined by the Secretary), prepaid inpatient health plans (as defined by the Secretary), prepaid ambulatory health plans (as defined by the Secretary), and schools (as defined by the Secretary).

(5) Strategies for supporting the provision of culturally competent, developmentally appropriate, and trauma-informed mental health services and substance use disorder care to children and youth.

(6) Strategies for providing early prevention, intervention, and screening services, including for children and youth at higher risk for having mental

health or substance use disorder needs, children and youth who do not have a mental health or substance use disorder diagnosis, children and youth provided, or at risk for needing, child welfare services, and children at risk of first episode psychosis.

(7) Best practices from State Medicaid and CHIP programs in expanding access to mental health services and substance use disorder care for children and youth, including children and youth that are part of underserved communities and children and youth with co-occurring intellectual disability or autism spectrum disorder.

(8) Strategies to coordinate services and funding provided under parts B and E of title IV of the Social Security Act (42 U.S.C. 621 et seq., 670 et seq.), and other funding sources at the discretion of the Secretary, with services for which Federal financial participation is available under Medicaid or CHIP, to support improved access to comprehensive mental health services and substance use disorder care for children and youth provided, or at risk for needing, child welfare services.

(b) CONSULTATION.—The Secretary shall consult with the Administrator of the Centers for Medicare & Medicaid Services, the Assistant Secretary for the Admin-

istration for Children and Families, the Assistant Secretary for Mental Health and Substance Use, and the Director of the Office of National Drug Control Policy with respect to the guidance issued under subsection (a).

(c) DEFINITIONS.—In this section:

(1) EPSDT.—The term ''EPSDT'' means early and periodic screening, diagnostic, and treatment services under Medicaid in accordance with sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act (42 U.S.C. 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)).

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

(3) STATE.—The term ''State'' has the meaning given that term 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.

SEC. 112. RECURRING ANALYSIS AND PUBLICATION OF MEDICAID HEALTH CARE DATA RELATED TO MENTAL HEALTH SERVICES.

(a) IN GENERAL.—The Secretary, on a biennial basis, shall link, analyze, and publish on a publicly available website Medicaid data reported by States through the Transformed Medicaid Statistical Information System (T–MSIS) (or a successor system) relating to mental health

services provided to individuals enrolled in Medicaid. Such enrollee information shall be de-identified of any personally identifying information, shall adhere to privacy standards established by the Department of Health and Human Services, and shall be aggregated to protect the privacy of enrollees, as necessary. Each publication of such analysis shall include for each State available data for the following measures:

(1) The number and percentage of individuals enrolled in the State Medicaid plan or waiver of such plan in each of the major enrollment categories (as defined in a letter, to be made publicly available on the website of the Medicaid and CHIP Payment and Access Commission, from the Medicaid and CHIP Payment and Access Commission to the Secretary) who have been diagnosed with a mental health condition and whether such individuals are enrolled under the State Medicaid plan or waiver of such plan, including the specific waiver authority under which they are enrolled, to the extent available.

(2) A list of the mental health treatment services by each major type of service, such as counseling, intensive home-based services, intensive care coordination, crisis services tailored to children and youth, youth peer support services, family-to-family

support, inpatient hospitalization, and other appropriate services as identified by the Secretary, for which beneficiaries in each State received at least 1 service under the State Medicaid plan or a waiver of such plan.

(3) The number and percentage of individuals with a substance use disorder diagnosis enrolled in the State Medicaid plan or waiver of such plan who received services for a mental health condition under such plan or waiver by each major type of service specified under paragraph (2) within each major setting type, such as outpatient, inpatient, residential, and other home-based and community-based settings.

(4) The number of services provided under the State Medicaid plan or waiver of such plan per individual with a mental health diagnosis enrolled in such plan or waiver for each major type of service specified under paragraph (2).

(5) The number and percentage of individuals enrolled in the State Medicaid plan or waiver by major enrollment category, who received mental health services through—

(A) a Medicaid managed care entity (as defined in section 1932(a)(1)(B) of the Social

Security Act (42 U.S.C. 1396u–2(a)(1)(B))), including the number of such individuals who received such assistance through a prepaid inpatient health plan (as defined by the Secretary) or a prepaid ambulatory health plan (as defined by the Secretary);

(B) a fee-for-service payment model; or

(C) an alternative payment model, to the extent available.

(6) The number and percentage of individuals with a mental health diagnosis who received mental health services in an outpatient or home-based and community-based setting after receiving services in an inpatient or residential setting and the number of services received by such individuals in the outpatient or home-based and community-based setting.

(7) The number and percentage of inpatient admissions in which services for a mental health condition were provided to an individual enrolled in the State Medicaid plan or a waiver of such plan that occurred within 30 days after discharge from a hospital or inpatient facility in which services for a mental health condition previously were provided to such individual, disaggregated by type of facility, to the extent such information is available.

(8) The number of emergency department visits by an individual enrolled in the State Medicaid plan or a waiver of such plan for treatment of a mental health condition within 7 days of such individual being discharged from a hospital inpatient facility in which services for a mental health condition were provided, or from a mental health facility, an independent psychiatric wing of acute care hospital, or an intermediate care facility for individuals with intellectual disabilities, disaggregated by type of facility, to the extent such information is available.

(9) The number and percentage of individuals enrolled in the State Medicaid plan or a waiver of such plan—

(A) who received an assessment to diagnose a mental health condition; and

(B) the number of mental health services provided to individuals described in subparagraph (A) in the 30 days post-assessment.

(10) Prescription National Drug Code codes, fill dates, and number of days supply of any covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act (42 U.S.C. 1396r-8(k)(2)) to treat a mental health condition that were dispensed to an individual enrolled in the State Medicaid plan

or waiver with an episode described in paragraph (7) or (8) during any period that occurs after the individual's discharge date defined in paragraph (7) or (8) (as applicable), and before the admission date applicable under paragraph (7) or the date of the emergency department visit applicable under paragraph (8).

(b) PUBLICATION.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary shall make publicly available the first analysis required by subsection (a).

(2) USE OF T–MSIS DATA.—The report required under paragraph (1) and updates required under paragraph (3) shall—

(A) use data and definitions from the Transformed Medicaid Statistical Information System (''T–MSIS'') (or a successor system) data set that is no more than 12 months old on the date that the report or update is published; and

(B) as appropriate, include a description with respect to each State of the quality and completeness of the data and caveats describing the limitations of the data reported to the Sec-

retary by the State that is sufficient to communicate the appropriate uses for the information.

(3) REVISED PUBLICATION.—Not later than 3 years after the date of enactment of this Act, the Secretary shall publish a revised publication of the analysis required by subsection (a) that allows for a research-ready and publicly accessible interface of the publication that is developed after consultation with stakeholders on the usability of the data contained in the publication.

(c) MAKING PERMANENT THE REQUIREMENT TO ANNUALLY UPDATE THE SUD DATA BOOK.—Section 1015 of the SUPPORT for Patients and Communities Act (Public Law 115–271) is amended—

(1) in subsection (a)(3), by striking ''through 2024''; and

(2) in subsection (b), by adding at the end the following new paragraph:

''(4) PUBLICATION OF DATA.—

''(A) IN GENERAL.—The Secretary shall publish in the Federal Register a system of records notice that modifies the system of records notice required under paragraph (1) to provide that—

"(i) the data specified in paragraph (2) shall be published on a publicly available website; and

"(ii) such data shall be de-identified of any personally identifying information, shall adhere to privacy standards established by the Department of Health and Human Services, and shall be aggregated to protect the privacy of enrollees, as necessary.

"(B) INITIATION OF MODIFIED DATA-SHARING ACTIVITIES.—Not later than [January 1, 2025,] the Secretary shall initiate the data sharing activities outlined in the notice required under paragraph (1), as modified pursuant to this paragraph.".

(d) DEFINITIONS.—In this section:

(1) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(2) STATE.—The term "State" has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of title XIX of such Act.

SEC. 113. GUIDANCE TO STATES ON SUPPORTING MENTAL HEALTH SERVICES OR SUBSTANCE USE DISORDER CARE INTEGRATION WITH PRIMARY CARE IN MEDICAID AND CHIP.

(a) ANALYSIS REGARDING CARE INTEGRATION.—Not later than 18 months after the date of enactment of this Act, the Secretary shall conduct an analysis of Medicaid and CHIP regarding clinical outcomes among different models of integration of mental health services or substance use disorder care within the primary care setting. Such analysis shall—

(1) consider different models for how mental health services or substance use disorder care is delivered and integrated within the primary care setting, including when providers operating in an integrated model are physically located in the same practice or building, when at least 1 provider in an integrated care model is available via telehealth, and when primary care, mental health, or substance use disorder care providers seek education and consultation from other providers through electronic modalities; and

(2) evaluate—

(A) the use of different payment methodologies, such as bundled payments and value-based payment arrangements; and

(B) the use and quality of services to coordinate care, including but not limited to case management, care coordination, enhanced care coordination, and enhanced care management, for mental health services and for substance use disorder care.

(b) GUIDANCE.—Not later than 12 months after the Secretary completes the analysis required under subsection (a), the Secretary shall issue guidance to States on supporting integration of mental health services or substance use disorder care with primary care under Medicaid and CHIP. Such guidance shall be informed by the analysis required under subsection (a) and, at minimum, shall do the following:

(1) Provide an overview of State options for adopting and expanding value-based payment arrangements and alternative payment models, including accountable care organizations and other shared savings programs, that integrate mental health services or substance use disorder care with primary care.

(2) Describe opportunities for States to use and align existing authorities and resources to finance integration of mental health services or substance use disorder care with primary care, including with

respect to the use of electronic health records in mental health care settings and in substance use disorder care settings.

(3) Describe strategies to support integration of mental health services or substance use disorder care with primary care through the use of non-clinical professionals and paraprofessionals, including trained peer support specialists.

(4) Provide examples of specific strategies and models designed to support integration of mental health services or substance use disorder care with primary care for differing age groups, including children and youth, and individuals over the age of 65.

(5) Describe options for assessing the clinical outcomes of differing models and strategies for integration of mental health services or substance use disorder care with primary care.

(c) INTEGRATION OF MENTAL HEALTH SERVICES OR SUBSTANCE USE DISORDER CARE WITH PRIMARY CARE.—For purposes of subsections (a) and (b), integration of mental health services or substance use disorder care with primary care may include (and shall not be limited to, including when furnished via telehealth, when appropriate)—

(1) adherence to the collaborative care model or primary care behavioral health model for behavioral health integration;

(2) use of behavioral health integration models primarily intended for pediatric populations with non-severe mental health needs that are focused on prevention and early detection and intervention methods through a multidisciplinary collaborative behavioral health team approach co-managed with primary care, to include same-day access to family-focused mental health treatment services;

(3) having mental health providers or substance use disorder providers physically co-located in a primary care setting with same-day visit availability;

(4) implementing or maintaining enhanced care coordination or targeted case management which includes regular interactions between and within care teams;

(5) providing mental health or substance use disorder screening and follow-up assessments, interventions, or services within the same practice or facility as a primary care or physical service setting;

(6) the use of assertive community treatment that is integrated with or facilitated by a primary care practice; and

(7) delivery of integrated primary care and mental health services or substance use disorder care in the home or in community-based settings for individuals who choose and are able to receive care in such settings, as authorized under subsections (b), (c), (i), (j), and (k) of section 1915 of the Social Security Act (42 U.S.C. 1396n), under a waiver under section 1115 of such Act (42 U.S.C. 1315), or under section 1937, 1945, or 1945A of such Act (42 U.S.C. 1396u–7, 1396w–4, 1396w–4a).

(d) DEFINITIONS.—In this section:

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

(2) STATE.—The term ''State'' has the meaning given that term 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.

SEC. 114. MEDICAID STATE OPTION RELATING TO INMATES WITH A SUBSTANCE USE DISORDER PENDING DISPOSITION OF CHARGES.

(a) STATE OPTION.—

(1) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(A) in the subdivision (A) following the last numbered paragraph of subsection (a), by

inserting ''subject to subsection (jj),'' before ''any such payments''; and

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

''(jj) STATE OPTION TO PROVIDE MEDICAL ASSISTANCE TO CERTAIN INMATES WITH A SUBSTANCE USE DISORDER PENDING DISPOSITION OF CHARGES.—

''(1) IN GENERAL.—Subject to paragraph (2), a State may elect to provide, and, notwithstanding the subdivision (A) following the last numbered paragraph of subsection (a), receive Federal financial participation for, medical assistance for an individual who—

''(A) is an inmate of a public institution (as defined in section 1902(nn)(3)) pending disposition of charges; and

''(B) has been diagnosed with a substance use disorder.

''(2) LIMITATION; CONDITIONS.—

''(A) LIMITATION.—A State may only receive Federal financial participation for medical assistance provided to an individual described in paragraph (1) during the 7-day period that begins on the first day that the individual is an inmate of a public institution.

"(B) CONDITIONS.—A State may only receive Federal financial participation for medical assistance provided to an individual described in paragraph (1) if—

"(i) the State has elected to not terminate eligibility for medical assistance under the State plan for individuals on the basis that they are inmates of public institutions (but may suspend coverage during the period an individual is such an inmate); and

"(ii) the diagnosis that the covered individual has a substance use disorder is made while the individual is an inmate of the public institution by a licensed medical professional using a standardized screening and assessment model approved by the Secretary.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2026.

(b) TECHNICAL CORRECTION AND CONFORMING AMENDMENTS.—

(1) TECHNICAL CORRECTION.—Section 5122(a)(1) of the Consolidated Appropriations Act,

2023 (Public Law 117–328) is amended by striking ''after'' and all that follows through the period at the end and inserting ''after 'or in the case of an eligible juvenile described in section 1902(a)(84)(D) with respect to the screenings, diagnostic services, referrals, and targeted case management services required under such section'.''.

(2) OTHER CONFORMING AMENDMENTS.—

(A) Section 1902(nn)(3) of the Social Security Act (42 U.S.C. 1396a(nn)(3)), is amended by striking ''following'' and all that follows through ''section 1905(a)'' and inserting ''following the last numbered paragraph of section 1905(a)''.

(B) The fifth sentence of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by striking ''paragraph (30)'' and inserting ''the last numbered paragraph''.

TITLE II—REDUCING PRESCRIPTION DRUG COSTS UNDER MEDICARE AND MEDICAID

SEC. 201. 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 amend-

ed 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.—For plan years beginning on or after January 1, 2028, 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 2027, 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 January 1, 2025, 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, 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 determined appropriate by the Secretary.''.

(b) TREATMENT OF ESSENTIAL RETAIL PHARMACIES.—Section 1860D–4(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–104(b)(1)(C)) is amended by adding at the end the following new clause:

"(v) ESSENTIAL RETAIL PHARMACIES.—

"(I) IN GENERAL.—For plan years beginning on or after January 1, 2028, a PDP sponsor of a prescription drug plan that has preferred pharmacies in its network shall contract with, as preferred pharmacies in such plan's network, at least—

"(aa) 80 percent of essential retail pharmacies (as defined in subclause (III)) in such plan's service area that are independent community pharmacies (as defined in subclause (V)(bb)); and

"(bb) 50 percent of essential retail pharmacies in such plan's service area not described in item (aa).

"(II) TOTAL REIMBURSEMENT FOR ESSENTIAL RETAIL PHARMACIES

THAT ARE INDEPENDENT COMMUNITY PHARMACIES.—For plan years beginning on or after January 1, 2028, total reimbursement (as defined in subclause (V)(dd)) paid by a PDP sponsor to an essential retail pharmacy that is an independent community pharmacy for a covered part D drug shall not be lower than—

"(aa) in the case where National Average Drug Acquisition Cost information for such drug for retail community pharmacies or applicable non-retail community pharmacies has been available under section 1927(f) for at least one full plan year—

"(AA) if such information is available for such drug for retail community pharmacies, the average National Average Drug Acquisition Cost for such drug for retail community pharmacies for the most recent plan

year for which such information is available;

"(BB) in the case where such information for retail community pharmacies is not available, the average National Average Drug Acquisition Cost for such drug for applicable non-retail pharmacies for the most recent plan year for which such information is available;

"(bb) in the case where National Average Drug Acquisition Cost information for such drug under section 1927(f) is not available for retail community pharmacies or applicable non-retail pharmacies, the wholesale acquisition cost (as defined in section 1847A(c)(6)(B)) for such drug; and

"(cc) in the case where National Average Drug Acquisition

Cost information under section 1927(f) is available for such drug and ending on the date such survey information has been available for such drug but has not been available for a full plan year—

''(AA) the most recent National Average Drug Acquisition Cost for such drug for retail community pharmacies, if available; or

''(BB) if the information specified in subitem (AA) is not available, the most recent National Average Drug Acquisition Cost for such drug for applicable non-retail pharmacies.

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

"(aa) is not an affiliate of a pharmacy benefit manager or PDP sponsor;

"(bb) is located in a medically underserved area (as designated pursuant to section 330(b)(3)(A) of the Public Health Service Act); and

"(cc) is designated as an essential retail pharmacy by the Secretary for such plan year under subclause (IV).

"(IV) DESIGNATION OF ESSENTIAL RETAIL PHARMACIES.—

"(aa) IN GENERAL.—For each plan year (beginning with plan year 2028), the Secretary shall designate pharmacies that meet the requirements specified in items (aa) and (bb) of subclause (III) as essential retail pharmacies, in accordance with this subclause.

"(bb) REQUIRED SUBMISSIONS FROM PDP SPONSORS.—

For each plan year beginning with plan year 2028, each PDP sponsor offering a prescription drug plan shall submit to the Secretary, for the purposes of determining retail pharmacies that do not meet the requirement specified in item (aa) of subclause (III), a list of any retail pharmacy that is an affiliate of such sponsor, subject to time, manner, and form requirements established by the Secretary.

''(cc) PUBLICATION.—Not later than one month prior to the start of each plan year (beginning with plan year 2028), the Secretary shall list, on a publicly available website of the Centers for Medicare & Medicaid Services, all pharmacies designated as essential retail pharmacies for such plan year.

''(dd) REVOCATION OF DESIGNATION.—In the case where,

during a plan year, the Secretary determines that a pharmacy no longer meets the requirements for designation as an essential retail pharmacy, the Secretary may revoke such designation for such pharmacy, as determined appropriate by the Secretary.

''(V) OTHER DEFINITIONS.—In this clause:

''(aa) AFFILIATE.—The term 'affiliate' means any entity that is owned by, controlled by, or related under a common ownership structure with a pharmacy benefit manager or PDP sponsor or that acts as a contractor or agent to such pharmacy benefit manager or PDP sponsor, if such contractor or agent performs any of the functions described in item (cc).

''(bb) INDEPENDENT COMMUNITY PHARMACY.—The term 'independent community phar-

macy' means a retail pharmacy that has fewer than 4 locations and is not affiliated with any person or entity other than its owners.

"(cc) 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 processing 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 identifies itself as a 'pharmacy benefit manager'.

"(dd) TOTAL REIMBURSEMENT.—The term 'total reimbursement' means, with respect to a covered part D drug, the negotiated price (as defined in section 1860D–2(d)(1)(B)) plus any incentive payments paid by the PDP sponsor to such essential retail pharmacy that is an independent community pharmacy net of any fees, pharmacy price concessions, discounts, or any other forms of remuneration paid by such pharmacy and furnished by such PDP sponsor under section 1860D–2(f)(4).".

(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 AND ESSENTIAL RETAIL PHARMACY PROTECTIONS.—

"(i) ALLEGATION SUBMISSION PROCESS.—

"(I) IN GENERAL.—Not later than January 1, 2028, the Secretary shall establish a process through which a pharmacy may submit an allegation of a violation by a PDP sponsor offering a prescription drug plan of—

"(aa) the standards for reasonable and relevant contract terms and conditions under subparagraph (A)(ii); or

"(bb) the requirements for total reimbursement for essential retail pharmacies that are inde-

pendent community pharmacies under subparagraph (C)(v)(II).

"(II) FREQUENCY OF SUBMISSION.—

"(aa) VIOLATIONS OF REASONABLE AND RELEVANT CONTRACT TERMS AND CONDITIONS.—The allegation submission process under this clause shall allow pharmacies to submit any allegations of violations described in item (aa) of subclause (I) not more frequently than once per plan year per contract between a pharmacy and a PDP sponsor. Such submissions shall be separate from any submissions under item (bb) and may include multiple allegations of such violations.

"(bb) VIOLATIONS OF ESSENTIAL RETAIL PHARMACY PROTECTIONS.—The allegation submission process under this clause shall allow essential retail phar-

macies that are independent community pharmacies to submit any allegations of violations described in item (bb) of subclause (I) once per calendar quarter. Such submissions shall be separate from any submissions under item (aa) and may include multiple allegations of such violations.

"(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 docu-

ments or materials to the Secretary for the purpose of submitting an allegation or providing evidence for such an allegation under this clause.

"(IV) STANDARDIZED TEMPLATE.—The Secretary shall establish separate standardized templates for pharmacies to use for the submission of allegations described in items (aa) and (bb) of subclause (I). Each 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.

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

''(iii) ENFORCEMENT.—

''(I) REASONABLE AND RELEVANT CONTRACT TERMS AND CONDITIONS.—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), the Secretary shall use existing authorities under sections 1857(g) and 1860D–12(b)(3)(E) to impose civil

monetary penalties or take other enforcement actions.

"(II) ESSENTIAL RETAIL PHARMACY PROTECTIONS.—In the case where the Secretary determines that a PDP sponsor offering a prescription drug plan has violated the requirements for total reimbursement for essential retail pharmacies that are independent community pharmacies under subparagraph (C)(v)(II), the Secretary shall—

"(aa) if the amount of total reimbursement paid by the sponsor to an essential retail pharmacy that is an independent community pharmacy for a covered part D drug was less than the amount of total reimbursement required to be paid to the pharmacy under subparagraph (C)(v)(II) for such drug, require the PDP sponsor to pay to the pharmacy an amount equal to

the difference between such amounts; and

''(bb) use existing authorities under section 1857(g) and 1860D–12(b)(3)(E) to impose civil monetary penalties or take other enforcement actions.

''(III) 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).

''(iv) DEFINITIONS.—In this subparagraph, the terms 'essential retail pharmacy', 'independent community pharmacy', and 'total reimbursement' have the meaning given those terms in subparagraph (C)(v).''.

(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—

''(i) the standards for reasonable and relevant contract terms and conditions under subparagraph (A)(ii) of section 1860D–4(b)(1); or

''(ii) the requirements for total reimbursement for essential retail pharmacies that are independent community pharmacies under subparagraph (C)(v)(II) 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 AND ESSENTIAL RETAIL PHARMACY PROTECTIONS.—

(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 AND ESSENTIAL RETAIL PHARMACY PROTECTIONS.—For plan years beginning on or after January 1, 2028, 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 subclause (I) or (II) of section 1860D–4(b)(1)(F)(iii) as a result of a violation described in such subclause (I) or (II) 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 AND CONDITIONS AND ESSENTIAL RETAIL PHARMACY PROTECTIONS.—For plan years beginning on or after January 1, 2028, section 1860D–12(b)(9).".

(e) 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, $250,000,000 for fiscal year 2024, to remain available until expended, to carry out the amendment made by this section.

SEC. 202. ENSURING ACCURATE PAYMENTS TO PHARMACIES UNDER MEDICAID.

(a) IN GENERAL.—Section 1927(f) of the Social Security Act (42 U.S.C. 1396r–8(f)) is amended—

(1) in paragraph (1)(A)—

(A) by redesignating clause (ii) as clause (iii); and

(B) by striking ''and'' after the semicolon at the end of clause (i) and all that precedes it through ''(1)'' and inserting the following:

''(1) DETERMINING PHARMACY ACTUAL ACQUISITION COSTS.—The Secretary shall conduct a survey of retail community pharmacy drug prices and applicable non-retail pharmacy drug prices to determine national average drug acquisition cost benchmarks as follows:

''(A) USE OF VENDOR.—The Secretary may contract services for—

''(i) with respect to retail community pharmacies, the determination of retail survey prices of the national average drug acquisition cost for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available) based on a monthly survey of such pharmacies;

''(ii) with respect to applicable non-retail pharmacies—

''(I) the determination of survey prices, separate from the survey prices described in clause (i), of the non-retail national average drug acquisition cost for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available) based on a monthly survey of such pharmacies; and

''(II) at the discretion of the Secretary, for each type of applicable non-retail pharmacy (as identified pursuant to the type indicators established by the Secretary under subsection (k)(12)(B)(ii)), the determination of survey prices, separate from the survey prices described in clause (i) or subclause (I) of this clause, of the national average drug acquisition cost for such type of pharmacy for covered outpatient drugs that represent a nationwide average of con-

sumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available) based on a monthly survey of such pharmacies; and'';

(2) in subparagraph (D) of paragraph (1), by striking clauses (ii) and (iii) and inserting the following:

''(ii) The vendor must update the Secretary no less often than monthly on the survey prices for covered outpatient drugs.

''(iii) The vendor must differentiate, in collecting and reporting survey data, the relevant pharmacy type indicator for all cost information collected, including whether a pharmacy is owned by, operated by, or otherwise affiliated with a pharmacy benefit manager and whether a pharmacy is a retail community pharmacy or an applicable non-retail pharmacy, and, in the case of an applicable non-retail pharmacy, which type of applicable non-retail pharmacy (as identified pursuant to the type

indicators established by the Secretary under subsection (k)(12)(B)(ii)) it is.'';

(3) by adding at the end of paragraph (1) the following:

''(F) SURVEY REPORTING.—In order to meet the requirement of section 1902(a)(54), a State shall require that any retail community pharmacy or applicable non-retail pharmacy in the State that receives any payment, reimbursement, administrative fee, discount, or rebate related to the dispensing of covered outpatient drugs to individuals receiving benefits under this title, regardless of whether such payment, reimbursement, administrative fee, discount, or rebate is received from the State or a managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D)) directly or from a pharmacy benefit manager or another entity that has a contract with the State or a managed care entity or other specified entity (as so defined), shall respond to surveys conducted under this paragraph.

''(G) SURVEY INFORMATION.—Information on national drug acquisition prices obtained under this paragraph shall be made publicly

available and shall include at least the following:

"(i) The monthly response rate to the survey including a list of pharmacies not in compliance with subparagraph (F).

"(ii) The sampling frame and number of pharmacies sampled monthly.

"(iii) Information on price concessions to the pharmacy, including discounts, rebates, and other price concessions, to the extent that such information may be publicly released and has been collected by the Secretary as part of the survey.

"(H) PENALTIES.—The Secretary, in consultation with the Office of the Inspector General of the Department of Health and Human Services, shall enforce the provisions of this paragraph with respect to a pharmacy through the establishment of appropriate civil monetary penalties, which may be assessed with respect to each violation or survey non-response, and with respect to each non-compliant pharmacy (including a pharmacy that is part of a chain), until compliance with this paragraph has been completed. The provisions of section 1128A

(other than subsections (a) and (b)) shall apply to a civil money penalty under the preceding sentence in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).

''(I) LIMITATION ON USE OF APPLICABLE NON-RETAIL PHARMACY PRICING INFORMATION.—No State shall use pricing information reported by applicable non-retail pharmacies under paragraph (1)(A)(ii) to develop or inform reimbursement rates for retail community pharmacies.'';

(4) in paragraph (2)—

(A) in subparagraph (A), by inserting '', including payment rates under managed care entities or other specified entities (as such terms are defined in section 1903(m)(9)(D)),'' after ''under this title''; and

(B) in subparagraph (B), by inserting ''and the basis for such dispensing fees'' before the semicolon;

(5) by redesignating paragraph (4) as paragraph (5);

(6) by inserting after paragraph (3) the following new paragraph:

"(4) OVERSIGHT.—

"(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct periodic studies of the survey data reported under this subsection, as appropriate, including with respect to substantial variations in acquisition costs or other applicable costs, as well as with respect to how internal transfer prices and related party transactions may influence the costs reported by pharmacies affiliated with pharmacy benefit managers, wholesalers, distributors, and other entities that acquire covered outpatient drugs relative to costs reported by pharmacies not affiliated with such entities. The Inspector General shall provide periodic updates to Congress on the results of such studies, as appropriate, in a manner that does not disclose trade secrets or other proprietary information.

"(B) APPROPRIATION.—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, $5,000,000 for fiscal year 2024, to

remain available until expended, to carry out this paragraph.''; and

(7) in paragraph (5), as so redesignated, by inserting '', and $9,000,000 for fiscal year 2024 and each fiscal year thereafter,'' after ''2010''.

(b) DEFINITIONS.—Section 1927(k) of the Social Security Act (42 U.S.C. 1396r–8(k)) is amended by adding the following—

''(12) APPLICABLE NON-RETAIL PHARMACY.—

''(A) IN GENERAL.—The term 'applicable non-retail pharmacy' means a pharmacy that is licensed as a pharmacy by the State and that is not a retail community pharmacy, including a pharmacy that dispenses prescription medications to patients primarily through mail and specialty pharmacies. Such term does not include nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or low dispensing pharmacies (as defined by the Secretary).

''(B) IDENTIFICATION OF APPLICABLE NON-RETAIL PHARMACIES.—

''(i) IN GENERAL.—For purposes of subsection (f), the Secretary shall, not

later than January 1, 2026, in consultation with stakeholders as appropriate, issue guidance specifying pharmacies that meet the definition of applicable non-retail pharmacies and that will, beginning January 1, 2027, be subject to the survey requirements under subsection (f)(1).

''(ii) INCLUSION OF PHARMACY TYPE INDICATORS.—The guidance promulgated under clause (i) shall include pharmacy type indicators to distinguish between different types of applicable non-retail pharmacies, such as pharmacies that dispense prescriptions primarily through the mail and pharmacies that dispense prescriptions that require special handling or distribution. An applicable non-retail pharmacy may be identified through multiple pharmacy type indicators.

''(13) 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 State, managed care entity or other specified entity (as such terms are defined in

section 1903(m)(9)(D)), or manages the prescription drug benefits provided by such State, managed care entity, or other specified entity, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the managing of appeals or grievances related to the prescription drug benefits, contracting with pharmacies, controlling the cost of covered outpatient drugs, or the provision of services related thereto. Such term includes any person or entity that carries out 1 or more of the activities described in the preceding sentence, irrespective of whether such person or entity calls itself a 'pharmacy benefit manager'.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the first day of the first quarter that begins on or after the date that is 18 months after the date of enactment of this Act.

SEC. 203. PROTECTING SENIORS FROM EXCESSIVE COST-SHARING FOR CERTAIN MEDICINES.

Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102) is amended—

(1) in subsection (b)—

(A) in paragraph (2)(A), in the matter preceding clause (i), by striking ''and (9)'' and inserting '', (9), (10), and (11)''; and

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

''(10) TYING COST-SHARING TO NET PRICE FOR CERTAIN MEDICATIONS.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2028, for costs above the annual deductible specified in paragraph (1) and below the annual out-of-pocket threshold specified in paragraph (4), any coinsurance amount for a discount-eligible drug that is included on the plan's formulary and subject to coinsurance rather than a copayment shall be calculated based on the net price of such discount-eligible drug.

''(B) REPORTING TO THE SECRETARY.—For plan years beginning on or after January 1, 2028, a PDP sponsor of a prescription drug plan and an MA organization offering an MA–PD plan shall annually submit to the Secretary, in a form and manner determined appropriate by the Secretary—

"(i) approximate price concessions and net prices for each discount-eligible drug; and

"(ii) a written explanation of the methodology used to calculate such approximate price concessions and net prices.

"(C) REQUIREMENTS FOR APPROXIMATE PRICE CONCESSIONS.—

"(i) IN GENERAL.—Approximate price concessions submitted under subparagraph (B) shall comply with—

"(I) the drug-specific threshold under clause (ii) for the applicable plan year; and

"(II) the aggregate threshold under clause (iii) for the applicable plan year.

"(ii) THRESHOLDS.—

"(I) PLAN YEARS 2028 THROUGH 2032.—For plan years 2028 through 2032—

"(aa) the drug-specific threshold is 20 percent; and

"(bb) the aggregate threshold is 15 percent.

"(II) SUBSEQUENT PLAN YEARS.—

"(aa) IN GENERAL.—For plan years beginning with 2033, the Secretary may, as determined appropriate by the Secretary, adjust the drug-specific and aggregate thresholds under this clause.

"(bb) CONSIDERATIONS.—In making any such adjustments, the Secretary may consider historical variations in expected and actual manufacturer price concessions for covered part D drugs, factors that may result in manufacturer price concession uncertainty or variation in a given plan year, PDP sponsor and MA organization behavioral responses, effects of precise manufacturer price concession disclosures, beneficiary out-of-pocket costs, expenditures under this part, and other factors deter-

mined appropriate by the Secretary.

"(cc) REQUIREMENTS.—In making any such adjustments, the Secretary shall ensure that the aggregate threshold for an applicable plan year is lower than the drug-specific threshold for such applicable plan year.

"(dd) PUBLICATION.—The Secretary shall publish any adjustments to the drug-specific and aggregate thresholds under this clause no later than the first Monday of April of the year before the start of the plan year for which such adjusted thresholds are applicable.

"(D) PUBLICATION OF DISCOUNT-ELIGIBLE DRUGS.—Not later than 15 months before the start of each plan year (beginning with plan year 2028), the Secretary shall publish on a publicly available website a list of the discount-eligible drugs that apply with respect to such

plan year (as determined by the Secretary under subparagraph (F)(iv)).

"(E) ENFORCEMENT.—

"(i) MONITORING COMPLIANCE.—The Secretary, in consultation with the Office of the Inspector General, shall conduct periodic audits of prescription drug plans and MA–PD plans to monitor compliance with the requirements under this paragraph. All information reported by a PDP sponsor or MA organization under this paragraph may be subject to audit by the Secretary and the Office of the Inspector General.

"(ii) PENALTIES.—

"(I) IN GENERAL.—A PDP sponsor or an MA organization that violates the requirements under this paragraph may be subject to civil monetary penalties, consistent with sections 1857(g) and 1860D–12(b)(3)(E), as determined appropriate by the Secretary.

"(II) APPLICATION.—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).

''(F) DEFINITIONS.—In this paragraph:

''(i) ACTUAL PRICE CONCESSIONS.—The term 'actual price concessions' means, with respect to a covered part D drug, the amount of manufacturer price concessions that the PDP sponsor or MA organization reports for such drug in the Detailed DIR Report (or successor report) for the applicable plan year.

''(ii) AGGREGATE THRESHOLD.—The term 'aggregate threshold' means the maximum percentage by which the total approximate price concessions for all discount-eligible drugs may vary from the total actual manufacturer price concessions for all such discount-eligible drugs as reported in the Detailed DIR Report (or successor report) for the applicable plan year.

''(iii) APPROXIMATE PRICE CONCESSIONS.—The term 'approximate price con-

cessions' means, with respect to a covered part D drug, the amount of price concessions from manufacturers that the PDP sponsor or MA organization estimates it will receive with respect to an applicable plan year, subject to the thresholds established under subparagraph (C)(ii), and reflected in the net price.

''(iv) DISCOUNT-ELIGIBLE DRUG.—

''(I) IN GENERAL.—The term 'discount-eligible drug' means a covered part D drug (other than a covered part D drug described in paragraph (8) or (9))—

''(aa) that is in an applicable category or class described in subclause (II); and

''(bb) for which the aggregate manufacturer price concessions received by PDP sponsors and MA organizations (or pharmacy benefit managers acting on behalf of such sponsors or organizations) for such drug are equal to or exceed 50 percent of

aggregate gross covered prescription drug costs for such drug in the most recent plan year for which data is available, as determined by the Secretary based on previous submissions of Detailed DIR Reports (or successor reports) or other relevant reporting from PDP sponsors or MA organizations.

''(II) APPLICABLE CATEGORY OR CLASS.—The applicable categories and classes described in this subclause are the following, as specified by the United States Pharmacopeia:

''(aa) Anti-inflammatories (Inhaled Corticosteroids).

''(bb) Bronchodilators, Anticholinergic.

''(cc) Bronchodilators, Sympathomimetic.

''(dd) Respiratory tract agents.

''(ee) Anticoagulants.

''(ff) Cardiovascular agents.

"(v) DRUG-SPECIFIC THRESHOLD.—The term 'drug-specific threshold' means the maximum percentage by which approximate price concessions with respect to a discount-eligible drug may vary from the actual manufacturer price concessions for such drug, as reported in the Detailed DIR Report (or successor report) for the applicable plan year.

"(vi) NET PRICE.—The term 'net price' means, with respect to a covered part D drug, the negotiated price of such drug, net of all approximate price concessions (estimated on an average per-unit basis, as needed) not already reflected in the negotiated price for the applicable plan year.

"(vii) MANUFACTURER PRICE CONCESSIONS.—The term 'manufacturer price concessions' means, with respect to a covered part D drug, rebates that the PDP sponsor or MA organization receives from manufacturers.

"(G) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44,

United States Code, shall not apply to any data collection undertaken by the Secretary under this paragraph.

"(11) LIMITING COST-SHARING TO NET PRICE.—

"(A) IN GENERAL.—For plan years beginning on or after January 1, 2028, the cost-sharing (for costs above the annual deductible specified in paragraph (1)) for a covered part D drug (other than a covered part D drug described in paragraph (8) or (9)) shall not exceed the negotiated price for such covered part D drug net of all price concessions (as defined in paragraph (10)(F)(v)), as reported in the Detailed DIR Report (or successor report) for the applicable plan year.

"(B) ENFORCEMENT.—

"(i) MONITORING COMPLIANCE.—The Secretary shall monitor compliance with the requirements under subparagraph (A) on an ongoing basis, including through periodic audits.

"(ii) RETROACTIVE PENALTIES.—

"(I) IN GENERAL.—A PDP sponsor or an MA organization that vio-

lates the requirements under subparagraph (A) may be subject to civil monetary penalties, consistent with sections 1857(g) and 1860D–12(b)(3)(E), as determined appropriate by the Secretary. The Secretary may impose such penalties retroactively upon review of the Detailed DIR Report (or any successor report) with respect to a given plan year.

''(II) APPLICATION.—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).''; and

(2) in subsection (c), by adding at the end the following new paragraphs:

''(7) TYING COST-SHARING TO NET PRICE FOR CERTAIN DRUGS.—The coverage is provided in accordance with subsection (b)(10).

"(8) LIMITING COST-SHARING TO NET PRICE.—The coverage is provided in accordance with subsection (b)(11).".

SEC. 204. REQUIREMENTS FOR PDP SPONSORS OF PRESCRIPTION DRUG PLANS AND MEDICARE ADVANTAGE ORGANIZATIONS OFFERING MA–PD PLANS THAT USE FORMULARIES UNDER PART D OF THE MEDICARE PROGRAM.

(a) REQUIREMENTS.—

(1) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended by adding at the end the following new subparagraph:

"(J) FORMULARY REQUIREMENTS RELATED TO HIGH-DISCOUNT BIOSIMILARS.—

"(i) REQUIREMENTS.—With respect to a plan year beginning on or after January 1, 2026, the following shall apply:

"(I) FOR PLANS THAT COVER A PART D REFERENCE BIOLOGIC.—If the formulary includes a part D reference biologic, and at least one high-discount biosimilar for such biologic is currently licensed and marketed, then the plan shall include on its formulary

at least one such high-discount biosimilar—

"(aa) on a different formulary tier and with lower cost-sharing than such part D reference biologic; and

"(bb) without utilization management policies (such as step therapy, prior authorization, or quantity limits) that are more restrictive than the utilization management policies applied to such part D reference biologic.

"(II) FOR PLANS THAT COVER LOWER DISCOUNT BIOSIMILARS.—If the formulary includes at least one lower discount biosimilar for a part D reference biologic, and at least one high-discount biosimilar for such biologic is currently licensed and marketed, then the plan shall include on its formulary at least one such high-discount biosimilar—

"(aa) on a different formulary tier and with lower cost-

sharing than every lower discount biosimilar for such biologic on such formulary; and

''(bb) with less restrictive (or equivalent) utilization management policies (such as step therapy, prior authorization, or quantity limits), if any such policies are applied, than are applied to any lower discount biosimilar for such biologic on such formulary.

''(III) CLARIFICATION ON LOWEST COST-SHARING TIER.—In the case of a plan that covers a part D reference biologic or a lower discount biosimilar on the lowest cost-sharing tier of the formulary or with the most preferred status for such formulary, then the plan shall be deemed to be in compliance with the requirements specified under subclauses (I)(aa) and (II)(aa) if such plan also covers a high-discount biosimilar for such bio-

logic on such a tier or with such preferred status, as applicable.

''(ii) PUBLICATION OF BIANNUAL HIGH-DISCOUNT BIOSIMILAR LIST AND CERTAIN AVERAGE WHOLESALE ACQUISITION COST INFORMATION.—On a biannual basis, beginning July 1, 2025, the Secretary shall publish, on a publicly accessible website of the Centers for Medicare & Medicaid Services, in a form and manner determined appropriate by the Secretary, the following:

''(I) A high-discount biosimilar list based on the most recent average wholesale acquisition cost calculation period for which data is available, as determined by the Secretary. Such list shall specify each high-discount biosimilar and each lower discount biosimilar with respect to each part D reference biologic for which at least one part D biosimilar biological product has been licensed and is currently marketed, as of the last day of the average wholesale acquisition cost cal-

culation period used by the Secretary as the basis for such list.

"(II) The average wholesale acquisition cost for each such reference part D biologic, lower discount biosimilar, and high-discount biosimilar.

"(iii) CALCULATION OF AVERAGE WHOLESALE ACQUISITION COST.—For purposes of this subparagraph, the Secretary shall calculate the average wholesale acquisition cost of a covered part D drug in accordance with the following:

"(I) Except as provided in subclause (II), for purposes of determining the average wholesale acquisition cost of a part D reference biologic or a biosimilar biological product, the Secretary shall calculate the volume-weighted monthly average wholesale acquisition cost for such product over the most recent 6-month period for which data is available.

"(II) For purposes of determining the average wholesale acquisition cost of a part D reference bio-

logic or a biosimilar biological product first licensed or marketed during the most recent 6-month period for which data is available, the Secretary shall calculate the average wholesale acquisition cost for such biologic or product based on the average wholesale acquisition cost for such biologic or product for those months for which data is available.

''(iv) ESTIMATED NET PRICE EXCEPTION.—

''(I) IN GENERAL.—An exception to the requirements under clause (i) shall apply to a plan that, as determined by the Secretary under subclause (II), at the time of submission of an application for an exception (or for a renewal of such an exception) under this clause—

''(aa) includes on its formulary a part D reference biologic with an estimated net price that is lower than the average wholesale acquisition cost of

every high-discount biosimilar for such biologic included in the most recently published biannual high-discount biosimilar list; and

''(bb) does not include on its formulary a part D reference biologic, but does include on its formulary at least one lower discount biosimilar that is placed on the lowest cost-sharing tier or has the most preferred formulary status under such plan and has an estimated net price that is lower than the average wholesale acquisition cost of every high-discount biosimilar for such part D reference biologic included in the most recently published biannual high-discount biosimilar list.

''(II) APPLICATION PROCESS.—The Secretary shall establish a process under which a PDP sponsor or an MA organization may submit an application to the Secretary requesting

an exception under subclause (I) or a renewal of such an exception.

''(III) COMPLIANCE.—A submission of an application under subclause (II) may be subject to audit by the Secretary, as determined appropriate.

''(IV) DETERMINATIONS.—After receiving a submission of an application under this clause, the Secretary shall make a determination as to whether the exception under subclause (I) is applicable. The Secretary shall notify a PDP sponsor or an MA organization of such determination within 60 days after the publication of the biannual high-discount biosimilar list. The Secretary may, as determined appropriate and to the extent feasible, establish a process for a sponsor or organization that has received a rejection of an application under this clause to apply for reconsideration of such application.

''(V) REPORTING.—With respect to plan year 2026 and each subse-

quent plan year, the Secretary shall publish, on a publicly available website of the Centers for Medicare & Medicaid Services, the following information related to the exception under subclause (I):

"(aa) The total number of applications submitted by PDP sponsors or MA organizations seeking such exceptions.

"(bb) The total number of such applications that are accepted.

"(cc) The total number of such applications that are rejected.

"(v) ENFORCEMENT.—

"(I) PENALTIES.—

"(aa) IN GENERAL.—Subject to subclause (II), in the case where the Secretary determines that a PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan has violated the require-

ments under this subparagraph, including by not including a high-discount biosimilar on its formulary, not including a high-discount biosimilar on an appropriate cost-sharing tier, or submitting false or misleading information to the Secretary when applying for the exception established under clause (iv), the Secretary may use existing authorities under sections 1857(g) and 1860D–12(b)(3)(E) to impose civil monetary penalties or take other enforcement actions, as determined appropriate by the Secretary.

''(bb) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to any civil monetary penalties imposed under this subclause in the same manner as such provisions apply to a

penalty or proceeding under section 1128A(a).

''(II) GRACE PERIOD FOR COMPLIANCE.—A PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan shall have until the date that is 90 days after the publication of each biannual high-discount biosimilar list to make any formulary changes necessary to be in compliance with the requirements of clause (i)

''(III) CLARIFICATION OF MID-YEAR FORMULARY CHANGE FLEXIBILITIES FOR COMPLIANCE PURPOSES.—

''(aa) IN GENERAL.—The PDP sponsor may, for purposes of complying with the requirements of clause (i), change the preferred or tiered cost-sharing status of a part D reference biologic or a lower discount biosimilar for such biologic if such sponsor adds (before or at the

same time) to the formulary one or more high-discount biosimilars for such biologic at the same or a higher preferred status or to the same or lower cost-sharing tier, as that of such biologic or such lower discount biosimilar prior to such change.

''(bb) OVERSIGHT.—The Secretary may, as determined appropriate, establish requirements and procedures with respect to formulary changes under item (aa). Such changes shall be subject to review or reversal by the Secretary, as determined appropriate, based on the application of such requirements and procedures.

''(cc) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to limit the ability of the Secretary to establish or modify requirements with respect to formularies for plans

under this part, consistent with other provisions of law.

''(vi) CONFIDENTIALITY.—The Secretary, in accordance with requirements and standards determined appropriate by the Secretary, shall provide for the confidentiality of any trade secrets or other proprietary information contained in information received by the Secretary under this subparagraph.

''(vii) DEFINITIONS.—In this subparagraph:

''(I) AVERAGE WHOLESALE ACQUISITION COST.—The term 'average wholesale acquisition cost' means, with respect to a covered part D drug, the volume-weighted monthly average wholesale acquisition cost during the average wholesale acquisition cost calculation period used by the Secretary to establish the biannual high-discount biosimilar list.

''(II) AVERAGE WHOLESALE ACQUISITION COST CALCULATION PERIOD.—The term 'average wholesale

acquisition cost calculation period' means the 6-month period used by the Secretary to calculate the average wholesale acquisition costs of relevant covered part D drugs under clause (iii) for the purposes of developing the biannual high-discount biosimilar list.

''(III) BIANNUAL HIGH-DISCOUNT BIOSIMILAR LIST.—The term 'biannual high-discount biosimilar list' means the list of high-discount biosimilars with respect to each part D reference biologic, as determined by the Secretary and published on a biannual basis under clause (ii).

''(IV) BIOSIMILAR BIOLOGICAL PRODUCT.—The term 'biosimilar biological product' has the meaning given that term in section 1847A(c)(6)(H)).

''(V) BIOSIMILAR DISCOUNT THRESHOLD PERCENT.—

''(aa) IN GENERAL.—Subject to item (bb), the term 'biosimilar discount threshold percent' is 45 percent.

"(bb) DISCRETIONARY INCREASE TO THRESHOLD PERCENT.—

"(AA) IN GENERAL.—Subject to subitems (BB) and (CC), for plan years beginning with 2030, the Secretary may increase the biosimilar discount threshold percent applicable under this subclause during the preceding year.

"(BB) TIMING FOR ADJUSTMENTS.—If the Secretary elects to increase the biosimilar discount threshold percent pursuant to subitem (AA) with respect to a plan year, the Secretary shall publish, on a publicly available website of the Centers for Medicare & Medicaid Services, such increased biosimilar discount threshold percent not later than the

first Monday in April of the plan year preceding such plan year.

''(CC) LIMITATIONS ON ADJUSTMENTS.—The Secretary shall not increase the biosimilar discount threshold percent under subitem (AA) by more than 5 percentage points from one plan year to the next.

''(VI) ESTIMATED NET PRICE.—The term 'estimated net price' means the average wholesale acquisition cost of a covered part D drug, net of all manufacturer rebates that are received or expected to be received by the plan (or pharmacy benefit manager on behalf of such plan) for such drug that are not already reflected in the average wholesale acquisition cost, as evidenced by the submission of any documents or materials required by the Secretary, and by any consultation

determined appropriate by the Secretary.

''(VII) HIGH-DISCOUNT BIOSIMILAR.—The term 'high-discount biosimilar' means a part D biosimilar biological product with an average wholesale acquisition cost that is lower than the average wholesale acquisition cost of the part D reference biologic for such biosimilar biological product by at least the biosimilar discount threshold percent, as determined under subclause (V) and published under clause (ii).

''(VIII) LOWER DISCOUNT BIOSIMILAR.—The term 'lower discount biosimilar' means a part D biosimilar biological product that is not a high-discount biosimilar.

''(IX) PART D BIOSIMILAR BIOLOGICAL PRODUCT.—The term 'part D biosimilar biological product' means a covered part D drug that is a biosimilar biological product.

"(X) PART D REFERENCE BIOLOGIC.—The term 'part D reference biologic' means a covered part D drug that is the reference biological product (as defined in section 1847A(c)(6)(I)) for at least one high-discount biosimilar or lower discount biosimilar.

"(XI) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given that term in section 1847A(c)(6)(B).".

(2) CONFORMING AMENDMENTS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)), as amended by section 201(c)(2), is amended—

(A) in subparagraph (K), by striking "or" after the semicolon;

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

(C) by inserting after subparagraph (K) the following new subparagraph:

"(L) fails to comply with—

"(i) the standards for reasonable and relevant contract terms and conditions

under subparagraph (A)(ii) of section 1860D–4(b)(1); or

''(ii) the requirements for total reimbursement for essential retail pharmacies that are independent community pharmacies under subparagraph (C)(v)(II) of such section; or'';

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

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

(b) ADMINISTRATION.—

(1) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may, with respect to plan years 2026 through 2028, implement the amendment made by subsection (a) by program instruction or otherwise.

(2) NON-APPLICATION OF THE PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly referred to as the ''Paperwork Reduction Act of 1995''), shall not apply to the

implementation of the amendments made by subsection (a).

TITLE III—MEDICAID EXPIRING PROVISIONS

SEC. 301. DELAYING CERTAIN DISPROPORTIONATE SHARE HOSPITAL PAYMENT REDUCTIONS UNDER THE MEDICAID PROGRAM.

Section 1923(f)(7)(A) of the Social Security Act (42 U.S.C. 1396r–4(f)(7)(A)), as amended by section 2341 of title III of division B of the Continuing Appropriations Act, 2024 and Other Extensions Act (Public Law 118–15), is further amended—

(1) in clause (i)—

(A) in the matter preceding subclause (I), by striking ''For the period beginning'' and all that follows through ''2027'' and inserting ''For each of fiscal years 2026 and 2027''; and

(B) in subclauses (I) and (II), by striking ''or period'' each place it appears; and

(2) in clause (ii), by striking ''for the period beginning'' and all that follows through ''2027'' and inserting ''for each of fiscal years 2026 and 2027''.

SEC. 302. EXTENSION OF STATE OPTION TO PROVIDE MEDICAL ASSISTANCE FOR CERTAIN INDIVIDUALS WHO ARE PATIENTS IN CERTAIN INSTITUTIONS FOR MENTAL DISEASES.

(a) MAKING PERMANENT STATE PLAN AMENDMENT OPTION TO PROVIDE MEDICAL ASSISTANCE FOR CERTAIN INDIVIDUALS WHO ARE PATIENTS IN CERTAIN INSTITUTIONS FOR MENTAL DISEASES.—Section 1915(l)(1) of the Social Security Act (42 U.S.C. 1396n(l)(1)) is amended by striking ''With respect to calendar quarters beginning during the period beginning October 1, 2019, and ending September 30, 2023,'' and inserting ''With respect to calendar quarters beginning on or after October 1, 2019,''.

(b) MAINTENANCE OF EFFORT REVISION.—Section 1915(l)(3) of the Social Security Act (42 U.S.C. 1396n(l)(3)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking ''other than under this title''; and

(B) in clause (i), by striking ''or, if higher,'' and all that follows through ''in accordance with this subsection''; and

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

"(D) APPLICATION OF MAINTENANCE OF EFFORT REQUIREMENTS TO CERTAIN STATES.—In the case of a State with a State plan amendment in effect as of September 30, 2023, for the 1-year period beginning on the date of enactment of this subparagraph, the provisions of subparagraph (A) shall be applied as if the amendments to that subparagraph made by the [*insert short title of Act*] had never been made.".

(c) ADDITIONAL REQUIREMENTS.—

(1) IN GENERAL.—Section 1915(l)(4) of the Social Security Act (42 U.S.C. 1396n(l)(4)) is amended—

(A) in subparagraph (A), by striking "through (D)" and inserting "through (F)";

(B) in subparagraph (D), by adding at and below clause (ii)(II), the following flush sentence:

"With respect to calendar quarters beginning on or after October 1, 2025, the State shall have in place evidence-based, substance use disorder-specific individual placement criteria and utilization management approaches to ensure placement of an eligible individual in an appro-

priate level of care and, prior to the approval of a State plan amendment for which approval is sought on or after such date, shall notify the Secretary of how the State will ensure that the requirements of clauses (i) and (ii) will be met.''; and

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

''(E) REVIEW PROCESS.—With respect to calendar quarters beginning on or after October 1, 2025, the State shall have in place a process to review the compliance of eligible institutions for mental diseases with nationally recognized, evidence-based, substance use disorder-specific program standards specified by the State.''.

(2) ONE-TIME ASSESSMENT.—Section 1915(l)(4) of the Social Security Act (42 U.S.C. 1396n(l)(4)), as amended by paragraph (1), is further amended by adding at the end the following new subparagraph:

''(F) ASSESSMENT.—

''(i) IN GENERAL.—The State shall, not later than 12 months after the approval of a State plan amendment described in this subsection (or, in the case

such State has such an amendment approved as of September 30, 2023, not later than 12 months after the date of enactment of this subparagraph), commence an assessment of—

"(I) the availability for individuals enrolled under a State plan under this title (or waiver of such plan) of treatment in—

"(aa) each level of care described in clause (i) of subparagraph (C); and

"(bb) each level of care described in clause (ii) of subparagraph (C) at which the State provides medical assistance; and

"(II) the availability of medication-assisted treatment and medically supervised withdrawal management services for such individuals.

"(ii) REQUIRED COMPLETION.—The State shall complete the assessment described in clause (i) not later than 12 months after the date the State commences such assessment.".

(3) CLARIFICATION OF LEVELS OF CARE.—Section 1915(l)(7)(A) of the Social Security Act (42 U.S.C. 1396n(l)(7)(A)) is amended by inserting ''(or any successor publication)'' before the period.

TITLE IV—MEDICARE EXPIRING PROVISIONS AND PROVIDER PAYMENT CHANGES

SEC. 401. 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 $20,000,000'' and inserting ''$20,000,000''; and

(B) by inserting the following before the period at the end: '', and $20,000,000 for fiscal year 2024''; and

(2) in the third sentence, by striking ''and 2023'' and inserting ''2023, and 2024''.

SEC. 402. 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), as amended by section 3306

of the Patient Protection and Affordable Care Act (Public Law 111–148), section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112–240), section 1110 of the Pathway for SGR Reform Act of 2013 (Public Law 113–67), section 110 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93), section 208 of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), section 50207 of division E of the Bipartisan Budget Act of 2018 (Public Law 115–123), section 1402 of division B of the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (Public Law 116–59), section 1402 of division B of the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (Public Law 116–69), section 103 of division N of the Further Consolidated Appropriations Act, 2020 (Public Law 116–94), section 3803 of the CARES Act (Public Law 116–136), section 2203 of the Continuing Appropriations Act, 2021 and Other Extensions Act (Public Law 116–159), section 1102 of the Further Continuing Appropriations Act, 2021, and Other Extensions Act (Public Law 116–215), and section 103 of division CC of the Consolidated Appropriations Act, 2021 (Public Law 116–260), is amended—

(1) in the matter preceding clause (i), by striking ''Centers for Medicare & Medicaid Services Pro-

gram Management Account'' and inserting ''Administration for Community Living'';

(2) in clause (xii), by striking ''and'' at the end;

(3) in clause (xiii), by striking the period at the end and inserting ''; and''; and

(4) by inserting after clause (xiii) the following new clause:

''(xiv) for fiscal year 2024, $15,000,000.''.

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

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

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

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

''(xiv) for fiscal year 2024, $15,000,000.''.

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

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

(2) in clause (xiii), by striking the comma at the end and inserting ''; and''; and

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

"(xiv) for fiscal year 2024, $5,000,000.".

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

(1) in clause (xii), by striking "and" at the end;

(2) in clause (xiii), by striking the period at the end and inserting "; and"; and

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

"(xiv) for fiscal year 2024, $15,000,000.".

SEC. 403. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR UNDER THE MEDICARE PROGRAM.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking "January 1, 2024" and inserting "January 1, 2025".

SEC. 404. 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 striking ''with 2025'' and inserting ''with 2026''; and

(B) by inserting '', or, with respect to 2026, 1.75 percent'' after ''3.5 percent''.

(2) in paragraph (2)—

(A) in subparagraph (B)—

(i) in the header, by striking ''2025'' and inserting ''2026''; and

(ii) in the matter preceding clause (i), by striking ''2025'' and inserting ''2026'';

(B) in subparagraph (C)—

(i) in the header, by striking ''2026'' and inserting ''2027''; and

(ii) in the matter preceding clause (i), by striking ''2026'' and inserting ''2027''; and

(C) in subparagraph (D), by striking ''and 2025'' and inserting ''2025, and 2026''; and

(3) in paragraph (4)(B), by inserting '', or, with respect to 2026, 1.75 percent'' after ''3.5 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 striking ''2025'' and inserting ''2026''; and

(2) in subclause (III), by striking ''2026'' and inserting ''2027''.

SEC. 405. PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT UNDER THE MEDICARE PROGRAM.

(a) AREAS OTHER THAN RURAL AND NONCONTIGUOUS AREAS.—The Secretary shall implement section 414.210(g)(9)(v) of title 42, Code of Federal Regulations (or any successor regulation), to apply the transition rule described in the first sentence of such section to all applicable items and services furnished in areas other than rural or noncontiguous areas (as such terms are defined for purposes of such section) through December 31, 2024.

(b) ALL AREAS.—The Secretary shall not implement section 414.210(g)(9)(vi) of title 42, Code of Federal Regulations (or any successor regulation) until January 1, 2025.

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

SEC. 406. EXTENDING THE INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1866E of the Social Security Act (42 U.S.C. 1395cc–5) is amended—

(1) in subsection (e)—

(A) in paragraph (1), by striking ''10-year'' and inserting ''12-year''; and

(B) in paragraph (5)—

(i) in the second sentence, by striking ''tenth'' and inserting ''twelfth''; and

(ii) in the third sentence, by striking ''tenth'' and inserting ''twelfth''; and

(2) in subsection (h), by striking ''and $9,000,000 for fiscal year 2021'' and inserting '', $9,000,000 for fiscal year 2021, and $3,000,000 for fiscal year 2024''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of Public Law 111–148.

SEC. 407. INCREASE IN SUPPORT FOR PHYSICIANS AND OTHER PROFESSIONALS IN ADJUSTING TO MEDICARE PAYMENT CHANGES.

Section 1848(t)(1)(D) of the Social Security Act (42 U.S.C. 1395w–4(t)(1)(D)) is amended by striking ''1.25 percent'' and inserting ''2.5 percent''.

SEC. 408. REVISED 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 ''through 2026'' and inserting ''through 2027''; and

(2) in subparagraph (B)—

(A) in clause (ii), by striking ''through 2023'' and inserting ''through 2024''; and

(B) in clause (iii), by striking ''2024 through 2026'' and inserting ''2025 through 2027''.

(b) 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 ''December 31, 2023'' and inserting ''December 31, 2024''; and

(2) in clause (ii)—

(A) by striking ''January 1, 2024'' and inserting ''January 1, 2025''; and

(B) by striking ''March 31, 2024'' and inserting ''March 31, 2025''.

SEC. 409. 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 ''2032'' and inserting ''2033''; and

(2) in clause (iii), by striking ''2032'' and inserting ''2033''.

TITLE V—OFFSETS

SEC. 501. MEDICAID IMPROVEMENT FUND.

Section 1941(b)(3)(A) of the Social Security Act (42 U.S.C. 1396w–1(b)(3)(A)), as amended by section 2342 of the Continuing Appropriations Act, 2024 and Other Extensions Act (Public Law 118–15), is amended by striking ''$6,357,117,810'' and inserting **[**''$_____''**]**.

SEC. 502. MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''during and after fiscal year 2022, $180,000,000'' and inserting the following: ''during and after—

''(A) fiscal year 2022, $180,000,000; and

''(B) fiscal year 2024, **[**$570,000,000**]**''.