

**AMENDMENT IN THE NATURE OF A SUBSTITUTE**  
**TO H.R. \_\_\_\_\_**  
**OFFERED BY M. \_\_\_\_\_**

Strike all after the enacting clause and insert the following:

**1 SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Preserving Telehealth,  
3 Hospital, and Ambulance Access Act”.

**4 TITLE I—PRESERVING PA-**  
**5 TIENTS’ ACCESS TO CARE IN**  
**6 THE HOME**

**7 SEC. 101. EXTENSION OF CERTAIN TELEHEALTH FLEXIBILI-**  
**8 TIES.**

9 (a) REMOVING GEOGRAPHIC REQUIREMENTS AND  
10 EXPANDING ORIGINATING SITES FOR TELEHEALTH  
11 SERVICES.—Section 1834(m) of the Social Security Act  
12 (42 U.S.C. 1395m(m)) is amended—

13 (1) in paragraph (2)(B)(iii), by striking “end-  
14 ing December 31, 2024” and inserting “ending De-  
15 cember 31, 2026”; and

16 (2) in paragraph (4)(C)(iii), by striking “ending  
17 on December 31, 2024” and inserting “ending on  
18 December 31, 2026”.

1 (b) EXPANDING PRACTITIONERS ELIGIBLE TO FUR-  
2 NISH TELEHEALTH SERVICES.—Section 1834(m)(4)(E)  
3 of the Social Security Act (42 U.S.C. 1395m(m)(4)(E))  
4 is amended by striking “ending on December 31, 2024”  
5 and inserting “ending on December 31, 2026”.

6 (c) EXTENDING TELEHEALTH SERVICES FOR FED-  
7 ERALLY QUALIFIED HEALTH CENTERS AND RURAL  
8 HEALTH CLINICS.—Section 1834(m)(8)(A) of the Social  
9 Security Act (42 U.S.C. 1395m(m)(8)(A)) is amended by  
10 striking “ending on December 31, 2024” and inserting  
11 “ending on December 31, 2026”.

12 (d) DELAYING THE IN-PERSON REQUIREMENTS  
13 UNDER MEDICARE FOR MENTAL HEALTH SERVICES  
14 FURNISHED THROUGH TELEHEALTH AND TELE-  
15 COMMUNICATIONS TECHNOLOGY.—

16 (1) DELAY IN REQUIREMENTS FOR MENTAL  
17 HEALTH SERVICES FURNISHED THROUGH TELE-  
18 HEALTH.—Section 1834(m)(7)(B)(i) of the Social  
19 Security Act (42 U.S.C. 1395m(m)(7)(B)(i)) is  
20 amended, in the matter preceding subclause (I), by  
21 striking “on or after” and all that follows through  
22 “described in section 1135(g)(1)(B))” and inserting  
23 “on or after January 1, 2027”.

24 (2) MENTAL HEALTH VISITS FURNISHED BY  
25 RURAL HEALTH CLINICS.—Section 1834(y)(2) of the

1 Social Security Act (42 U.S.C. 1395m(y)(2)) is  
2 amended by striking “January 1, 2025” and all that  
3 follows through the period at the end and inserting  
4 “January 1, 2027.”.

5 (3) MENTAL HEALTH VISITS FURNISHED BY  
6 FEDERALLY QUALIFIED HEALTH CENTERS.—Section  
7 1834(o)(4)(B) of the Social Security Act (42 U.S.C.  
8 1395m(o)(4)(B)) is amended by striking “January  
9 1, 2025” and all that follows through the period at  
10 the end and inserting “January 1, 2027.”.

11 (e) ALLOWING FOR THE FURNISHING OF AUDIO-  
12 ONLY TELEHEALTH SERVICES.—Section 1834(m)(9) of  
13 the Social Security Act (42 U.S.C. 1395m(m)(9)) is  
14 amended by striking “ending on December 31, 2024” and  
15 inserting “ending on December 31, 2026”.

16 (f) EXTENDING USE OF TELEHEALTH TO CONDUCT  
17 FACE-TO-FACE ENCOUNTER PRIOR TO RECERTIFICATION  
18 OF ELIGIBILITY FOR HOSPICE CARE.—Section  
19 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C.  
20 1395f(a)(7)(D)(i)(II)) is amended—

21 (1) by striking “ending on December 31, 2024”  
22 and inserting “ending on December 31, 2026”; and

23 (2) by inserting “, except that this subclause  
24 shall not apply in the case of such an encounter with  
25 an individual occurring on or after January 1, 2025,

1 if such individual is located in an area that is sub-  
2 ject to a moratorium on the enrollment of hospice  
3 programs under this title pursuant to section  
4 1866(j)(7), if such individual is receiving hospice  
5 care from a provider that is subject to enhanced  
6 oversight under this title pursuant to section  
7 1866(j)(3), or if such encounter is performed by a  
8 hospice physician or nurse practitioner who is not  
9 enrolled under section 1866(j) and is not an opt-out  
10 physician or practitioner (as defined in section  
11 1802(b)(6)(D))” before the semicolon.

12 (g) PROGRAM INSTRUCTION AUTHORITY.—The Sec-  
13 retary of Health and Human Services may implement the  
14 amendments made by this section through program in-  
15 struction or otherwise.

16 **SEC. 102. GUIDANCE ON FURNISHING SERVICES VIA TELE-**  
17 **HEALTH TO INDIVIDUALS WITH LIMITED**  
18 **ENGLISH PROFICIENCY.**

19 (a) IN GENERAL.—Not later than 1 year after the  
20 date of the enactment of this section, the Secretary of  
21 Health and Human Services, in consultation with 1 or  
22 more entities from each of the categories described in  
23 paragraphs (1) through (7) of subsection (b), shall issue  
24 and disseminate, or update and revise as applicable, guid-

1 ance for the entities described in such subsection on the  
2 following:

3 (1) Best practices on facilitating and inte-  
4 grating use of interpreters during a telemedicine ap-  
5 pointment.

6 (2) Best practices on providing accessible in-  
7 structions on how to access telecommunications sys-  
8 tems (as such term is used for purposes of section  
9 1834(m) of the Social Security Act (42 U.S.C.  
10 1395m(m)) for individuals with limited English pro-  
11 ficiency.

12 (3) Best practices on improving access to dig-  
13 ital patient portals for individuals with limited  
14 English proficiency.

15 (4) Best practices on integrating the use of  
16 video platforms that enable multi-person video calls  
17 furnished via a telecommunications system for pur-  
18 poses of providing interpretation during a telemedi-  
19 cine appointment for an individual with limited  
20 English proficiency.

21 (5) Best practices for providing patient mate-  
22 rials, communications, and instructions in multiple  
23 languages, including text message appointment re-  
24 minders and prescription information.

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

4 (1) Health information technology service pro-  
5 viders, including—

6 (A) electronic medical record companies;

7 (B) remote patient monitoring companies;

8 and

9 (C) telehealth or mobile health vendors and  
10 companies.

11 (2) Health care providers, including—

12 (A) physicians; and

13 (B) hospitals.

14 (3) Health insurers.

15 (4) Language service companies.

16 (5) Interpreter or translator professional asso-  
17 ciations.

18 (6) Health and language services quality certifi-  
19 cation organizations.

20 (7) Patient and consumer advocates, including  
21 such advocates that work with individuals with lim-  
22 ited English proficiency.

1 **SEC. 103. ESTABLISHMENT OF MODIFIER FOR RECERTIFI-**  
2 **CATIONS OF HOSPICE CARE ELIGIBILITY**  
3 **CONDUCTED THROUGH TELEHEALTH.**

4 Section 1814(a)(7)(D)(i)(II) of the Social Security  
5 Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)), as amended by sec-  
6 tion 101(f), is further amended by inserting “, provided  
7 that, in the case of such an encounter occurring on or  
8 after the date that is 2 years after the date of the enact-  
9 ment of the ‘Preserving Telehealth, Hospital, and Ambu-  
10 lance Access Act’, such physician or nurse practitioner in-  
11 cludes in any claim for such encounter one or more modi-  
12 fiers or codes specified by the Secretary to indicate that  
13 such encounter was furnished through telehealth” after  
14 “as determined appropriate by the Secretary”.

15 **SEC. 104. EXTENDING ACUTE HOSPITAL CARE AT HOME**  
16 **WAIVER FLEXIBILITIES.**

17 Section 1866G of the Social Security Act (42 U.S.C.  
18 1395cc-7) is amended—

19 (1) in subsection (a)(1), by striking “2024” and  
20 inserting “2029”; and

21 (2) in subsection (b)—

22 (A) in the header, by striking “STUDY AND  
23 REPORT” and inserting “STUDIES AND RE-  
24 PORTS”;

25 (B) in paragraph (1)—

1 (i) in the matter preceding subpara-  
2 graph (A), by striking “The Secretary”  
3 and inserting “Not later than September  
4 30, 2024, and again not later than Sep-  
5 tember 30, 2028, the Secretary”;

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

8 (iii) in clause (vii), by striking the pe-  
9 riod and inserting “; and”;

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

12 “(viii) in the case of the second study  
13 conducted under this paragraph, the qual-  
14 ity of care, outcomes, costs, quantity and  
15 intensity of services, and other relevant  
16 metrics between individuals who entered  
17 into the Acute Hospital Care at Home ini-  
18 tiative directly from an emergency depart-  
19 ment compared with individuals who en-  
20 tered into the Acute Hospital Care at  
21 Home initiative directly from an existing  
22 inpatient stay in a hospital.”; and

23 (C) in paragraph (2)—

24 (i) in the header, by striking “RE-  
25 PORT” and inserting “REPORTS”; and



1 (ii) by inserting “and again not later  
2 than September 30, 2028,” after “2024,”;  
3 and

4 (iii) by striking “on the study con-  
5 ducted under paragraph (1).” and insert-  
6 ing the following: “on—

7 “(A) with respect to the first report sub-  
8 mitted under this paragraph, the first study  
9 conducted under paragraph (1); and

10 “(B) with respect to the second report sub-  
11 mitted under this paragraph, the second study  
12 conducted under paragraph (1).”.

13 **SEC. 105. REPORT ON WEARABLE MEDICAL DEVICES.**

14 Not later than 18 months after the date of the enact-  
15 ment of this Act, the Comptroller General of the United  
16 States shall conduct a technology assessment of, and sub-  
17 mit to Congress a report on, the capabilities and limita-  
18 tions of wearable medical devices used to support clinical  
19 decision-making. Such report shall include a description  
20 of—

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

23 (2) an examination of the benefits and chal-  
24 lenges of artificial intelligence to augment such ca-  
25 pabilities; and

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

4 **SEC. 106. ENHANCING CERTAIN PROGRAM INTEGRITY RE-**  
5 **QUIREMENTS FOR DME UNDER MEDICARE.**

6           (a) **DURABLE MEDICAL EQUIPMENT.**—Section  
7 1834(a) of the Social Security Act (42 U.S.C. 1395m(a))  
8 is amended by adding at the end the following new para-  
9 graph:

10                   “(23) **MASTER LIST INCLUSION AND CLAIM RE-**  
11 **VIEW FOR CERTAIN ITEMS.**—

12                           “(A) **MASTER LIST INCLUSION.**—Begin-  
13                           ning January 1, 2027, for purposes of the Mas-  
14                           ter List described in section 414.234(b) of title  
15                           42, Code of Federal Regulations (or any suc-  
16                           cessor regulation), an item for which payment  
17                           may be made under this subsection shall be  
18                           treated as having aberrant billing patterns (as  
19                           such term is used for purposes of such section)  
20                           if the Secretary determines that, without ex-  
21                           planatory contributing factors (such as fur-  
22                           nishing emergent care services), a substantial  
23                           number of claims for such items under this sub-  
24                           section are from an ordering physician or prac-  
25                           titioner with whom the individual involved does

1 not have a prior relationship, as determined on  
2 the basis of claims.

3 “(B) CLAIM REVIEW.—With respect to  
4 items furnished on or after January 1, 2027  
5 that are included on the Master List pursuant  
6 to subparagraph (A), if such an item is not sub-  
7 ject to a determination of coverage in advance  
8 pursuant to paragraph (15)(C), the Secretary  
9 may conduct prepayment review of claims for  
10 payment for such item.”.

11 (b) REPORT ON IDENTIFYING CLINICAL DIAGNOSTIC  
12 LABORATORY TESTS AT HIGH RISK FOR FRAUD AND EF-  
13 FECTIVE MITIGATION MEASURES.—Not later than Janu-  
14 ary 1, 2026, the Inspector General of the Department of  
15 Health and Human Services shall submit to Congress a  
16 report assessing fraudulent claims for clinical diagnostic  
17 laboratory tests for which payment may be made under  
18 section 1834A of the Social Security Act (42 U.S.C.  
19 1395m–1) and effective tools for reducing such fraudulent  
20 claims. The report shall include—

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

1           (2) with respect to a clinical diagnostic labora-  
2           tory test identified under subparagraph (A) as being  
3           at high risk of fraudulent claims—

4                   (A) the amount payable under such section  
5           1834A with respect to such test;

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

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

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

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

22                   (A) an analysis of whether the Centers for  
23           Medicare & Medicaid Services can detect aber-  
24           rant billing patterns with respect to such tests  
25           in a timely manner;

1 (B) any strategies for identifying and mon-  
2 itoring the providers who are outliers with re-  
3 spect to the number of such tests that such pro-  
4 viders order; and

5 (C) targeted education efforts to mitigate  
6 improper billing for such tests.

7 **TITLE II—SUSTAINING ACCESS**  
8 **TO HOSPITAL AND EMER-**  
9 **GENCY SERVICES**

10 **SEC. 201. EXTENSION OF INCREASED INPATIENT HOSPITAL**  
11 **PAYMENT ADJUSTMENT FOR CERTAIN LOW-**  
12 **VOLUME HOSPITALS.**

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

15 (1) in subparagraph (B), by striking “during  
16 the portion of fiscal year 2025 beginning on January  
17 1, 2025, and ending on September 30, 2025, and”;

18 (2) in subparagraph (C)(i)—

19 (A) in the matter preceding subclause  
20 (I)—

21 (i) by striking “or portion of a fiscal  
22 year”; and

23 (ii) by striking “2024 and the portion  
24 of fiscal year 2025 beginning on October 1,

1                   2024, and ending on December 31, 2024”  
2                   and inserting “2025”;

3                   (B) in subclause (III), by striking “2024  
4                   and the portion of fiscal year 2025 beginning  
5                   on October 1, 2024, and ending on December  
6                   31, 2024” and inserting “2025”; and

7                   (C) in subclause (IV), by striking “the por-  
8                   tion of fiscal year 2025 beginning on January  
9                   1, 2025, and ending on September 30, 2025,  
10                  and”; and

11                  (3) in subparagraph (D)—

12                   (A) in the matter preceding clause (i), by  
13                   striking “2024 or during the portion of fiscal  
14                   year 2025 beginning on October 1, 2024, and  
15                   ending on December 31, 2024” and inserting  
16                   “2025”; and

17                   (B) in clause (ii), by striking “ 2024 and  
18                   the portion of fiscal year 2025 beginning on Oc-  
19                   tober 1, 2024, and ending on December 31,  
20                   2024” and inserting “2025”.

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

1 **SEC. 202. EXTENSION OF THE MEDICARE-DEPENDENT HOS-**  
2 **PITAL PROGRAM.**

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

6 (1) in clause (i), by striking “January 1, 2025”  
7 and inserting “October 1, 2025”; and

8 (2) in clause (ii)(II), by striking “January 1,  
9 2025” and inserting “October 1, 2025”.

10 (b) CONFORMING AMENDMENTS.—

11 (1) EXTENSION OF TARGET AMOUNT.—Section  
12 1886(b)(3)(D) of the Social Security Act (42 U.S.C.  
13 1395ww(b)(3)(D)) is amended—

14 (A) in the matter preceding clause (i), by  
15 striking “January 1, 2025” and inserting “Oc-  
16 tober 1, 2025”; and

17 (B) in clause (iv), by striking “2024 and  
18 the portion of fiscal year 2025 beginning on Oc-  
19 tober 1, 2024, and ending on December 31,  
20 2024” and inserting “2025”.

21 (2) PERMITTING HOSPITALS TO DECLINE RE-  
22 CLASSIFICATION.—Section 13501(e)(2) of the Omni-  
23 bus Budget Reconciliation Act of 1993 (42 U.S.C.  
24 1395ww note) is amended by striking “2024, or the  
25 portion of fiscal year 2025 beginning on October 1,

1 2024, and ending on December 31, 2024” and in-  
2 serting “2025”.

3 **SEC. 203. EXTENSION OF ADD-ON PAYMENTS FOR AMBU-**  
4 **LANCE SERVICES.**

5 (a) IN GENERAL.—Section 1834(l) of the Social Se-  
6 curity Act (42 U.S.C. 1395m(l)) is amended—

7 (1) in paragraph (12)(A), by striking “January  
8 1, 2025” and inserting “October 1, 2025”; and

9 (2) in paragraph (13), by striking “January 1,  
10 2025” in each place it appears and inserting “Octo-  
11 ber 1, 2025” in each such place.

12 (b) PROGRAM INSTRUCTION AUTHORITY.—Notwith-  
13 standing any other provision of law, the Secretary of  
14 Health and Human Services may implement the provisions  
15 of, including amendments made by, this section through  
16 program instruction or otherwise.

17 **TITLE III—OFFSETS**

18 **SEC. 301. REVISING PHASE-IN OF MEDICARE CLINICAL LAB-**  
19 **ORATORY TEST PAYMENT CHANGES.**

20 (a) REVISED PHASE-IN OF REDUCTIONS FROM PRI-  
21 VATE PAYOR RATE IMPLEMENTATION.—Section  
22 1834A(b)(3) of the Social Security Act (42 U.S.C.  
23 1395m–1(b)(3)) is amended—

24 (1) in subparagraph (A), by striking “2027”  
25 and inserting “2028”; and



1 (2) in subparagraph (B)—

2 (A) in clause (ii), by striking “2024” and  
3 inserting “2025”; and

4 (B) in clause (iii), by striking “2025  
5 through 2027” and inserting “2026 through  
6 2028”.

7 (b) REVISED REPORTING PERIOD FOR REPORTING  
8 OF PRIVATE SECTOR PAYMENT RATES FOR ESTABLISH-  
9 MENT OF MEDICARE PAYMENT RATES.—Section  
10 1834A(a)(1)(B) of the Social Security Act (42 U.S.C.  
11 1395m–1(a)(1)(B)) is amended—

12 (1) in clause (i), by striking “2024” and insert-  
13 ing “2025”; and

14 (2) in clause (ii), by striking “2025” each place  
15 it appears and inserting “2026”.

16 (c) IMPLEMENTATION.—The Secretary of Health and  
17 Human Services may implement the amendments made by  
18 this section by program instruction or otherwise.

19 **SEC. 302. ARRANGEMENTS WITH PHARMACY BENEFIT MAN-**  
20 **AGERS WITH RESPECT TO PRESCRIPTION**  
21 **DRUG PLANS AND MA-PD PLANS.**

22 (a) IN GENERAL.—

23 (1) PRESCRIPTION DRUG PLANS.—Section  
24 1860D–12 of the Social Security Act (42 U.S.C.

1 1395w–112) is amended by adding at the end the  
2 following new subsection:

3 “(h) REQUIREMENTS RELATING TO PHARMACY BEN-  
4 EFIT MANAGERS.—For plan years beginning on or after  
5 January 1, 2027:

6 “(1) AGREEMENTS WITH PHARMACY BENEFIT  
7 MANAGERS.—Each contract entered into with a  
8 PDP sponsor under this part with respect to a pre-  
9 scription drug plan offered by such sponsor shall  
10 provide that any pharmacy benefit manager acting  
11 on behalf of such sponsor has a written agreement  
12 with the PDP sponsor under which the pharmacy  
13 benefit manager, and any affiliates of such phar-  
14 macy benefit manager, as applicable, agree to meet  
15 the following requirements:

16 “(A) NO INCOME OTHER THAN BONA FIDE  
17 SERVICE FEES.—

18 “(i) IN GENERAL.—The pharmacy  
19 benefit manager and any affiliate of such  
20 pharmacy benefit manager shall not derive  
21 any remuneration with respect to any serv-  
22 ices provided on behalf of any entity or in-  
23 dividual, in connection with the utilization  
24 of covered part D drugs, from any such en-

1           tity or individual other than bona fide serv-  
2           ice fees, subject to clauses (ii) and (iii).

3           “(ii) INCENTIVE PAYMENTS.—For the  
4           purposes of this subsection, an incentive  
5           payment paid by a PDP sponsor to a phar-  
6           macy benefit manager that is performing  
7           services on behalf of such sponsor shall be  
8           deemed a ‘bona fide service fee’(even if  
9           such payment does not otherwise meet the  
10          definition of such term under paragraph  
11          (7)(B)) if such payment is a flat dollar  
12          amount, is consistent with fair market  
13          value (as specified by the Secretary), is re-  
14          lated to services actually performed by the  
15          pharmacy benefit manager or affiliate of  
16          such pharmacy benefit manager, on behalf  
17          of the entity making such payment, in con-  
18          nection with the utilization of covered part  
19          D drugs, and meets additional require-  
20          ments, if any, as determined appropriate  
21          by the Secretary.

22          “(iii) CLARIFICATION ON REBATES  
23          AND DISCOUNTS USED TO LOWER COSTS  
24          FOR COVERED PART D DRUGS.—Rebates,  
25          discounts, and other price concessions re-

1           ceived by a pharmacy benefit manager or  
2           an affiliate of a pharmacy benefit manager  
3           from manufacturers, even if such price  
4           concessions are calculated as a percentage  
5           of a drug's price, shall not be considered a  
6           violation of the requirements of clause (i)  
7           if they are fully passed through to a PDP  
8           sponsor and are compliant with all regu-  
9           latory and subregulatory requirements re-  
10          lated to direct and indirect remuneration  
11          for manufacturer rebates under this part,  
12          including in cases where a PDP sponsor is  
13          acting as a pharmacy benefit manager on  
14          behalf of a prescription drug plan offered  
15          by such PDP sponsor.

16                   “(iv) EVALUATION OF REMUNERATION  
17                   ARRANGEMENTS.—Components of subsets  
18                   of remuneration arrangements (such as  
19                   fees or other forms of compensation paid  
20                   to or retained by the pharmacy benefit  
21                   manager or affiliate of such pharmacy ben-  
22                   efit manager), as determined appropriate  
23                   by the Secretary, between pharmacy ben-  
24                   efit managers or affiliates of such phar-  
25                   macy benefit managers, as applicable, and

1 other entities involved in the dispensing or  
2 utilization of covered part D drugs (includ-  
3 ing PDP sponsors, manufacturers, phar-  
4 macies, and other entities as determined  
5 appropriate by the Secretary) shall be sub-  
6 ject to review by the Secretary, in con-  
7 sultation with the Office of the Inspector  
8 General of the Department of Health and  
9 Human Services, as determined appro-  
10 priate by the Secretary. The Secretary, in  
11 consultation with the Office of the Inspec-  
12 tor General, shall review whether remu-  
13 nation under such arrangements is con-  
14 sistent with fair market value (as specified  
15 by the Secretary) through reviews and as-  
16 sessments of such remuneration, as deter-  
17 mined appropriate.

18 “(v) DISGORGEMENT.—The pharmacy  
19 benefit manager shall disgorge any remu-  
20 nation paid to such pharmacy benefit  
21 manager or an affiliate of such pharmacy  
22 benefit manager in violation of this sub-  
23 paragraph to the PDP sponsor.

24 “(vi) ADDITIONAL REQUIREMENTS.—  
25 The pharmacy benefit manager shall—

1                   “(I) enter into a written agree-  
2                   ment with any affiliate of such phar-  
3                   macy benefit manager, under which  
4                   the affiliate shall identify and disgorge  
5                   any remuneration described in clause  
6                   (v) to the pharmacy benefit manager;  
7                   and

8                   “(II) attest, subject to any re-  
9                   quirements determined appropriate by  
10                  the Secretary, that the pharmacy ben-  
11                  efit manager has entered into a writ-  
12                  ten agreement described in subclause  
13                  (I) with any relevant affiliate of the  
14                  pharmacy benefit manager.

15                  “(B) TRANSPARENCY REGARDING GUARAN-  
16                  TEES AND COST PERFORMANCE EVALUA-  
17                  TIONS.—The pharmacy benefit manager shall—

18                         “(i) define, interpret, and apply, in a  
19                         fully transparent and consistent manner  
20                         for purposes of calculating or otherwise  
21                         evaluating pharmacy benefit manager per-  
22                         formance against pricing guarantees or  
23                         similar cost performance measurements re-  
24                         lated to rebates, discounts, price conces-  
25                         sions, or net costs, terms such as—

1                   “(I) ‘generic drug’, in a manner  
2                   consistent with the definition of the  
3                   term under section 423.4 of title 42,  
4                   Code of Federal Regulations, or a suc-  
5                   cessor regulation;

6                   “(II) ‘brand name drug’, in a  
7                   manner consistent with the definition  
8                   of the term under section 423.4 of  
9                   title 42, Code of Federal Regulations,  
10                  or a successor regulation;

11                  “(III) ‘specialty drug’;

12                  “(IV) ‘rebate’; and

13                  “(V) ‘discount’;

14                  “(ii) identify any drugs, claims, or  
15                  price concessions excluded from any pric-  
16                  ing guarantee or other cost performance  
17                  calculation or evaluation in a clear and  
18                  consistent manner; and

19                  “(iii) where a pricing guarantee or  
20                  other cost performance measure is based  
21                  on a pricing benchmark other than the  
22                  wholesale acquisition cost (as defined in  
23                  section 1847A(e)(6)(B)) of a drug, cal-  
24                  culate and provide a wholesale acquisition  
25                  cost-based equivalent to the pricing guar-

1           antee or other cost performance measure  
2           in the written agreement.

3           “(C) PROVISION OF INFORMATION.—

4                   “(i) IN GENERAL.—Not later than  
5           July 1 of each year, beginning in 2027, the  
6           pharmacy benefit manager shall submit to  
7           the PDP sponsor, and to the Secretary, a  
8           report, in accordance with this subpara-  
9           graph, and shall make such report avail-  
10          able to such sponsor at no cost to such  
11          sponsor in a format specified by the Sec-  
12          retary under paragraph (5). Each such re-  
13          port shall include, with respect to such  
14          PDP sponsor and each plan offered by  
15          such sponsor, the following information  
16          with respect to the previous plan year:

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

20                           “(aa) the brand name, ge-  
21                           neric or non-proprietary name,  
22                           and National Drug Code;

23                           “(bb) the number of plan  
24                           enrollees for whom the drug was  
25                           dispensed, the total number of



1 prescription claims for the drug  
2 (including original prescriptions  
3 and refills, counted as separate  
4 claims), and the total number of  
5 dosage units of the drug dis-  
6 pensed;

7 “(cc) the number of pre-  
8 scription claims described in item  
9 (bb) by each type of dispensing  
10 channel through which the drug  
11 was dispensed, including retail,  
12 mail order, specialty pharmacy,  
13 long term care pharmacy, home  
14 infusion pharmacy, or other types  
15 of pharmacies or providers;

16 “(dd) the average wholesale  
17 acquisition cost, listed as cost per  
18 day’s supply, cost per dosage  
19 unit, and cost per typical course  
20 of treatment (as applicable);

21 “(ee) the average wholesale  
22 price for the drug, listed as cost  
23 per day’s supply, cost per dosage  
24 unit, and cost per typical course  
25 of treatment (as applicable);

1                   “(ff) the total out-of-pocket  
2                   spending by plan enrollees on  
3                   such drug after application of  
4                   any benefits under the plan, in-  
5                   cluding plan enrollee spending  
6                   through copayments, coinsurance,  
7                   and deductibles;

8                   “(gg) total rebates paid by  
9                   the manufacturer on the drug as  
10                  reported under the Detailed DIR  
11                  Report (or any successor report)  
12                  submitted by such sponsor to the  
13                  Centers for Medicare & Medicaid  
14                  Services;

15                  “(hh) all other direct or in-  
16                  direct remuneration on the drug  
17                  as reported under the Detailed  
18                  DIR Report (or any successor re-  
19                  port) submitted by such sponsor  
20                  to the Centers for Medicare &  
21                  Medicaid Services;

22                  “(ii) the average pharmacy  
23                  reimbursement amount paid by  
24                  the plan for the drug in the ag-  
25                  gregate and disaggregated by dis-

1 dispensing channel identified in item  
2 (cc);

3 “(jj) the average National  
4 Average Drug Acquisition Cost  
5 (NADAC); and

6 “(kk) total manufacturer-de-  
7 rived revenue, inclusive of bona  
8 fide service fees, attributable to  
9 the drug and retained by the  
10 pharmacy benefit manager and  
11 any affiliate of such pharmacy  
12 benefit manager.

13 “(II) In the case of a pharmacy  
14 benefit manager that has an affiliate  
15 that is a retail, mail order, or spe-  
16 cialty pharmacy, with respect to drugs  
17 covered by such plan that were dis-  
18 pensed, the following information:

19 “(aa) The percentage of  
20 total prescriptions that were dis-  
21 pensed by pharmacies that are an  
22 affiliate of the pharmacy benefit  
23 manager for each drug.

24 “(bb) The interquartile  
25 range of the total combined costs

1 paid by the plan and plan enroll-  
2 ees, per dosage unit, per course  
3 of treatment, per 30-day supply,  
4 and per 90-day supply for each  
5 drug dispensed by pharmacies  
6 that are not an affiliate of the  
7 pharmacy benefit manager and  
8 that are included in the phar-  
9 macy network of such plan.

10 “(cc) The interquartile  
11 range of the total combined costs  
12 paid by the plan and plan enroll-  
13 ees, per dosage unit, per course  
14 of treatment, per 30-day supply,  
15 and per 90-day supply for each  
16 drug dispensed by pharmacies  
17 that are an affiliate of the phar-  
18 macy benefit manager and that  
19 are included in the pharmacy  
20 network of such plan.

21 “(dd) The lowest total com-  
22 bined cost paid by the plan and  
23 plan enrollees, per dosage unit,  
24 per course of treatment, per 30-  
25 day supply, and per 90-day sup-

1                   ply, for each drug that is avail-  
2                   able from any pharmacy included  
3                   in the pharmacy network of such  
4                   plan.

5                   “(ee) The difference between  
6                   the average acquisition cost of  
7                   the affiliate, such as a pharmacy  
8                   or other entity that acquires pre-  
9                   scription drugs, that initially ac-  
10                  quires the drug and the amount  
11                  reported under subclause (I)(jj)  
12                  for each drug.

13                  “(ff) A list inclusive of the  
14                  brand name, generic or non-pro-  
15                  prietary name, and National  
16                  Drug Code of covered part D  
17                  drugs subject to an agreement  
18                  with a covered entity under sec-  
19                  tion 340B of the Public Health  
20                  Service Act for which the phar-  
21                  macy benefit manager or an affil-  
22                  iate of the pharmacy benefit  
23                  manager had a contract or other  
24                  arrangement with such a covered

1 entity in the service area of such  
2 plan.

3 “(III) Where a drug approved  
4 under section 505(c) of the Federal  
5 Food, Drug, and Cosmetic Act (re-  
6 ferred to in this subclause as the ‘list-  
7 ed drug’) is covered by the plan, the  
8 following information:

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

23 “(bb) The estimated average  
24 beneficiary cost-sharing under

1 the plan for a 30-day supply of  
2 the listed drug.

3 “(cc) Where a generic drug  
4 listed under item (aa) is on a for-  
5 mulary tier typically associated  
6 with higher cost-sharing than the  
7 listed drug, the estimated aver-  
8 age cost-sharing that a bene-  
9 ficiary would have paid for a 30-  
10 day supply of each of the generic  
11 drugs described in item (aa), had  
12 the plan provided coverage for  
13 such drugs on the same for-  
14 mulary tier as the listed drug.

15 “(dd) A written justification  
16 for providing more favorable cov-  
17 erage of the listed drug than the  
18 generic drugs described in item  
19 (aa).

20 “(ee) The number of cur-  
21 rently marketed generic drugs  
22 approved under section 505(j) of  
23 the Federal Food, Drug, and  
24 Cosmetic Act pursuant to an ap-

1 application that references such  
2 listed drug.

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

7 “(aa) A list of currently  
8 marketed biosimilar biological  
9 products licensed under section  
10 351(k) of the Public Health  
11 Service Act pursuant to an appli-  
12 cation that refers to such ref-  
13 erence product that are not cov-  
14 ered by the plan, are covered on  
15 the same formulary tier or a for-  
16 mulary tier typically associated  
17 with higher cost-sharing than the  
18 reference product, or are subject  
19 to utilization management that  
20 the reference product is not sub-  
21 ject to.

22 “(bb) The estimated average  
23 beneficiary cost-sharing under  
24 the plan for a 30-day supply of  
25 the reference product.



1                   “(cc) Where a biosimilar bi-  
2                   ological product listed under item  
3                   (aa) is on a formulary tier typi-  
4                   cally associated with higher cost-  
5                   sharing than the listed drug, the  
6                   estimated average cost-sharing  
7                   that a beneficiary would have  
8                   paid for a 30-day supply of each  
9                   of the biosimilar biological prod-  
10                  ucts described in item (aa), had  
11                  the plan provided coverage for  
12                  such products on the same for-  
13                  mulary tier as the reference prod-  
14                  uct.

15                  “(dd) A written justification  
16                  for providing more favorable cov-  
17                  erage of the reference product  
18                  than the biosimilar biological  
19                  product described in item (aa).

20                  “(ee) The number of cur-  
21                  rently marketed biosimilar bio-  
22                  logical products licensed under  
23                  section 351(k) of the Public  
24                  Health Service Act, pursuant to

1 an application that refers to such  
2 reference product.

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

7 “(VI) The total amount retained  
8 by the pharmacy benefit manager or  
9 an affiliate of such pharmacy benefit  
10 manager in revenue related to utiliza-  
11 tion of covered part D drugs under  
12 that plan, inclusive of bona fide serv-  
13 ice fees.

14 “(VII) The total spending on cov-  
15 ered part D drugs net of rebates, fees,  
16 discounts, or other direct and indirect  
17 remuneration by the plan.

18 “(VIII) An explanation of any  
19 benefit design parameters under such  
20 plan that encourage plan enrollees to  
21 fill prescriptions at pharmacies that  
22 are an affiliate of such pharmacy ben-  
23 efit manager, such as mail and spe-  
24 cialty home delivery programs, and re-  
25 tail and mail auto-refill programs.

1 “(IX) The following information:  
2 “(aa) A list of all brokers,  
3 consultants, advisors, and audi-  
4 tors that receive compensation  
5 from the pharmacy benefit man-  
6 ager or an affiliate of such phar-  
7 macy benefit manager for refer-  
8 rals, consulting, auditing, or  
9 other services offered to PDP  
10 sponsors related to pharmacy  
11 benefit management services.  
12 “(bb) The amount of com-  
13 pensation provided by such phar-  
14 macy benefit manager or affiliate  
15 to each such broker, consultant,  
16 advisor, and auditor.  
17 “(cc) The methodology for  
18 calculating the amount of com-  
19 pensation provided by such phar-  
20 macy benefit manager or affil-  
21 iate, for each such broker, con-  
22 sultant, advisor, and auditor.  
23 “(X) A list of all affiliates of the  
24 pharmacy benefit manager.

1                   “(XI) A summary document sub-  
2                   mitted in a standardized template de-  
3                   veloped by the Secretary that includes  
4                   such information described in sub-  
5                   clauses (I) through (X).

6                   “(ii) WRITTEN EXPLANATION OF CON-  
7                   TRACTS OR AGREEMENTS WITH DRUG  
8                   MANUFACTURERS.—

9                   “(I) IN GENERAL.—The phar-  
10                  macy benefit manager shall, not later  
11                  than 30 days after the finalization of  
12                  any contract or agreement between  
13                  such pharmacy benefit manager or an  
14                  affiliate of such pharmacy benefit  
15                  manager and a drug manufacturer (or  
16                  subsidiary, agent, or entity affiliated  
17                  with such drug manufacturer) that  
18                  makes rebates, discounts, payments,  
19                  or other financial incentives related to  
20                  one or more covered part D drugs or  
21                  other prescription drugs, as applica-  
22                  ble, of the manufacturer directly or  
23                  indirectly contingent upon coverage,  
24                  formulary placement, or utilization  
25                  management conditions on any other

1 covered part D drugs or other pre-  
2 scription drugs, as applicable, submit  
3 to the PDP sponsor a written expla-  
4 nation of such contract or agreement.

5 “(II) REQUIREMENTS.—A writ-  
6 ten explanation under subclause (I)  
7 shall—

8 “(aa) include the manufac-  
9 turer subject to the contract or  
10 agreement, all covered part D  
11 drugs and other prescription  
12 drugs, as applicable, subject to  
13 the contract or agreement and  
14 the manufacturers of such drugs,  
15 and a high-level description of  
16 the terms of such contract or  
17 agreement and how such terms  
18 apply to such drugs; and

19 “(bb) be certified by the  
20 Chief Executive Officer, Chief Fi-  
21 nancial Officer, or General Coun-  
22 sel of such pharmacy benefit  
23 manager, or affiliate of such  
24 pharmacy benefit manager, as  
25 applicable, or an individual dele-

1 gated with the authority to sign  
2 on behalf of one of these officers,  
3 who reports directly to the offi-  
4 cer.

5 “(III) DEFINITION OF OTHER  
6 PRESCRIPTION DRUGS.—For purposes  
7 of this clause, the term ‘other pre-  
8 scription drugs’ means prescription  
9 drugs covered as supplemental bene-  
10 fits under this part or prescription  
11 drugs paid outside of this part.

12 “(D) AUDIT RIGHTS.—

13 “(i) IN GENERAL.—Not less than once  
14 a year, at the request of the PDP sponsor,  
15 the pharmacy benefit manager shall allow  
16 for an audit of the pharmacy benefit man-  
17 ager to ensure compliance with all terms  
18 and conditions under the written agree-  
19 ment and the accuracy of information re-  
20 ported under subparagraph (C).

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

1                   “(iii) PROVISION OF INFORMATION.—

2                   The pharmacy benefit manager shall make  
3                   available to such auditor all records, data,  
4                   contracts, and other information necessary  
5                   to confirm the accuracy of information  
6                   provided under subparagraph (C), subject  
7                   to reasonable restrictions on how such in-  
8                   formation must be reported to prevent re-  
9                   disclosure of such information.

10                   “(iv) TIMING.—The pharmacy benefit  
11                   manager must provide information under  
12                   clause (iii) and other information, data,  
13                   and records relevant to the audit to such  
14                   auditor within 6 months of the initiation of  
15                   the audit and respond to requests for addi-  
16                   tional information from such auditor with-  
17                   in 30 days after the request for additional  
18                   information.

19                   “(v) INFORMATION FROM AFFILI-  
20                   ATES.—The pharmacy benefit manager  
21                   shall be responsible for providing to such  
22                   auditor information required to be reported  
23                   under subparagraph (C) that is owned or  
24                   held by an affiliate of such pharmacy ben-  
25                   efit manager.

1           “(2) ENFORCEMENT.—

2                   “(A) IN GENERAL.—Each PDP sponsor  
3 shall—

4                           “(i) disgorge to the Secretary any  
5 amounts disgorged to the PDP sponsor by  
6 a pharmacy benefit manager under para-  
7 graph (1)(A)(v);

8                           “(ii) require, in a written agreement  
9 with any pharmacy benefit manager acting  
10 on behalf of such sponsor or affiliate of  
11 such pharmacy benefit manager, that such  
12 pharmacy benefit manager or affiliate re-  
13 imburse the PDP sponsor for any civil  
14 money penalty imposed on the PDP spon-  
15 sor as a result of the failure of the phar-  
16 macy benefit manager or affiliate to meet  
17 the requirements of paragraph (1) that are  
18 applicable to the pharmacy benefit man-  
19 ager or affiliate under the agreement; and

20                           “(iii) require, in a written agreement  
21 with any such pharmacy benefit manager  
22 acting on behalf of such sponsor or affil-  
23 iate of such pharmacy benefit manager,  
24 that such pharmacy benefit manager or af-  
25 filiate be subject to punitive remedies for



1 breach of contract for failure to comply  
2 with the requirements applicable under  
3 paragraph (1).

4 “(B) REPORTING OF ALLEGED VIOLA-  
5 TIONS.—The Secretary shall make available and  
6 maintain a mechanism for manufacturers, PDP  
7 sponsors, pharmacies, and other entities that  
8 have contractual relationships with pharmacy  
9 benefit managers or affiliates of such pharmacy  
10 benefit managers to report, on a confidential  
11 basis, alleged violations of paragraph (1)(A) or  
12 subparagraph (C).

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

16 “(i) retaliate against an individual or  
17 entity for reporting an alleged violation  
18 under subparagraph (B); or

19 “(ii) coerce, intimidate, threaten, or  
20 interfere with the ability of an individual  
21 or entity to report any such alleged viola-  
22 tions.

23 “(3) CERTIFICATION OF COMPLIANCE.—

24 “(A) IN GENERAL.—Each PDP sponsor  
25 shall furnish to the Secretary (in a time and

1 manner specified by the Secretary) an annual  
2 certification of compliance with this subsection,  
3 as well as such information as the Secretary de-  
4 termines necessary to carry out this subsection.

5 “(B) IMPLEMENTATION.—Notwithstanding  
6 any other provision of law, the Secretary may  
7 implement this paragraph by program instruc-  
8 tion or otherwise.

9 “(4) RULE OF CONSTRUCTION.—Nothing in  
10 this subsection shall be construed as prohibiting pay-  
11 ments related to reimbursement for ingredient costs  
12 to any entity that acquires prescription drugs, such  
13 as a pharmacy or wholesaler.

14 “(5) STANDARD FORMATS.—

15 “(A) IN GENERAL.—Not later than June  
16 1, 2026, the Secretary shall specify standard,  
17 machine-readable formats for pharmacy benefit  
18 managers to submit annual reports required  
19 under paragraph (1)(C)(i).

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

24 “(6) CONFIDENTIALITY.—

1           “(A) IN GENERAL.—Information disclosed  
2           by a pharmacy benefit manager, an affiliate of  
3           a pharmacy benefit manager, a PDP sponsor,  
4           or a pharmacy under this subsection that is not  
5           otherwise publicly available or available for pur-  
6           chase shall not be disclosed by the Secretary or  
7           a PDP sponsor receiving the information, ex-  
8           cept that the Secretary may disclose the infor-  
9           mation for the following purposes:

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

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

14                   “(iii) To permit the Director of the  
15                   Congressional Budget Office to review the  
16                   information provided.

17                   “(iv) To permit the Executive Direc-  
18                   tor of the Medicare Payment Advisory  
19                   Commission to review the information pro-  
20                   vided.

21                   “(v) To the Attorney General for the  
22                   purposes of conducting oversight and en-  
23                   forcement under this title.

24                   “(vi) To the Inspector General of the  
25                   Department of Health and Human Serv-

1           ices in accordance with its authorities  
2           under the Inspector General Act of 1978  
3           (section 406 of title 5, United States  
4           Code), and other applicable statutes.

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

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

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

21          “(7) DEFINITIONS.—For purposes of this sub-  
22          section:

23                 “(A) AFFILIATE.—The term ‘affiliate’  
24                 means any entity that is owned by, controlled  
25                 by, or related under a common ownership struc-

1           ture with a pharmacy benefit manager or PDP  
2           sponsor, or that acts as a contractor or agent  
3           to such pharmacy benefit manager or PDP  
4           sponsor, insofar as such contractor or agent  
5           performs any of the functions described under  
6           subparagraph (C).

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

19                 “(i) drug price, such as wholesale ac-  
20                 quisition cost or drug benchmark price  
21                 (such as average wholesale price);

22                 “(ii) the amount of discounts, rebates,  
23                 fees, or other direct or indirect remunera-  
24                 tion with respect to covered part D drugs  
25                 dispensed to enrollees in a prescription

1 drug plan, except as permitted pursuant to  
2 paragraph (1)(A)(ii);

3 “(iii) coverage or formulary placement  
4 decisions or the volume or value of any re-  
5 ferrals or business generated between the  
6 parties to the arrangement; or

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

9 “(C) PHARMACY BENEFIT MANAGER.—The  
10 term ‘pharmacy benefit manager’ means any  
11 person or entity that, either directly or through  
12 an intermediary, acts as a price negotiator or  
13 group purchaser on behalf of a PDP sponsor or  
14 prescription drug plan, or manages the pre-  
15 scription drug benefits provided by such spon-  
16 sor or plan, including the processing and pay-  
17 ment of claims for prescription drugs, the per-  
18 formance of drug utilization review, the proc-  
19 essing of drug prior authorization requests, the  
20 adjudication of appeals or grievances related to  
21 the prescription drug benefit, contracting with  
22 network pharmacies, controlling the cost of cov-  
23 ered part D drugs, or the provision of related  
24 services. Such term includes any person or enti-  
25 ty that carries out one or more of the activities

1 described in the preceding sentence, irrespective  
2 of whether such person or entity calls itself a  
3 ‘pharmacy benefit manager’.”.

4 (2) MA–PD PLANS.—Section 1857(f)(3) of the  
5 Social Security Act (42 U.S.C. 1395w–27(f)(3)) is  
6 amended by adding at the end the following new  
7 subparagraph:

8 “(F) REQUIREMENTS RELATING TO PHAR-  
9 MACY BENEFIT MANAGERS.—For plan years be-  
10 ginning on or after January 1, 2027, section  
11 1860D–12(h).”.

12 (3) NONAPPLICATION OF PAPERWORK REDUC-  
13 TION ACT.—Chapter 35 of title 44, United States  
14 Code, shall not apply to the implementation of this  
15 subsection.

16 (4) FUNDING.—

17 (A) SECRETARY.—In addition to amounts  
18 otherwise available, there is appropriated to the  
19 Centers for Medicare & Medicaid Services Pro-  
20 gram Management Account, out of any money  
21 in the Treasury not otherwise appropriated,  
22 \$113,000,000 for fiscal year 2025, to remain  
23 available until expended, to carry out this sub-  
24 section.

1 (B) OIG.—In addition to amounts other-  
2 wise available, there is appropriated to the In-  
3 spector General of the Department of Health  
4 and Human Services, out of any money in the  
5 Treasury not otherwise appropriated,  
6 \$20,000,000 for fiscal year 2025, to remain  
7 available until expended, to carry out this sub-  
8 section.

9 (b) GAO STUDY AND REPORT ON CERTAIN REPORT-  
10 ING REQUIREMENTS.—

11 (1) STUDY.—The Comptroller General of the  
12 United States (in this subsection referred to as the  
13 “Comptroller General”) shall conduct a study on  
14 Federal and State reporting requirements for health  
15 plans and pharmacy benefit managers related to the  
16 transparency of prescription drug costs and prices.  
17 Such study shall include an analysis of the following:

18 (A) Federal statutory and regulatory re-  
19 porting requirements for health plans and phar-  
20 macy benefit managers related to prescription  
21 drug costs and prices.

22 (B) Selected States’ statutory and regu-  
23 latory reporting requirements for health plans  
24 and pharmacy benefit managers related to pre-  
25 scription drug costs and prices.



1 (C) The extent to which the statutory and  
2 regulatory reporting requirements identified in  
3 subparagraphs (A) and (B) overlap and con-  
4 flict.

5 (D) The resources required by health plans  
6 and pharmacy benefit managers to comply with  
7 the reporting requirements described in sub-  
8 paragraphs (A) and (B).

9 (E) Other items determined appropriate by  
10 the Comptroller General.

11 (2) REPORT.—Not later than 2 years after the  
12 date on which information is first required to be re-  
13 ported under section 1860D–12(h)(1)(C) of the So-  
14 cial Security Act, as added by subsection (a)(1), the  
15 Comptroller General shall submit to Congress a re-  
16 port containing the results of the study conducted  
17 under paragraph (1), together with recommenda-  
18 tions for legislation and administrative actions that  
19 would streamline and reduce the burden associated  
20 with the reporting requirements for health plans and  
21 pharmacy benefit managers described in paragraph  
22 (1).

23 (c) MEDPAC REPORTS ON AGREEMENTS WITH  
24 PHARMACY BENEFIT MANAGERS WITH RESPECT TO PRE-  
25 SCRIPTIION DRUG PLANS AND MA–PD PLANS.—The

1 Medicare Payment Advisory Commission shall submit to  
2 Congress the following reports:

3 (1) Not later than March 31, 2028, a report re-  
4 garding agreements with pharmacy benefit managers  
5 with respect to prescription drug plans and MA–PD  
6 plans. Such report shall include—

7 (A) a description of trends and patterns,  
8 including relevant averages, totals, and other  
9 figures for each of the types of information sub-  
10 mitted;

11 (B) an analysis of any differences in agree-  
12 ments and their effects on plan enrollee out-of-  
13 pocket spending and average pharmacy reim-  
14 bursement, and any other impacts; and

15 (C) any recommendations the Commission  
16 determines appropriate.

17 (2) Not later than March 31, 2030, a report de-  
18 scribing any changes with respect to the information  
19 described in paragraph (1) over time, together with  
20 any recommendations the Commission determines  
21 appropriate.

1 **SEC. 303. EXTENDING THE ADJUSTMENT TO THE CALCULA-**  
2 **TION OF HOSPICE CAP AMOUNTS UNDER THE**  
3 **MEDICARE PROGRAM.**

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

6 (1) in clause (ii), by striking “2033” and in-  
7 serring “2034”; and

8 (2) in clause (iii), by striking “2033” and in-  
9 serring “2034”.

