

To the office of U.S. Representative Alma S. Adams

Re: HR 10414 (119th Congress), Community Health Worker Access Act • Latest action (2026-09-16): Referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

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Community Health Worker Pilot and Cost Control Act

The measure, as described from the official record: The bill seeks to make it easier for people to get preventive care and practical local health support from trusted community health workers.

THE PROPOSAL

Congress may act only under its listed powers, with limits on spending, respect for states, and fair process for those it pays. Article I, Section 8, Clause 1 allows spending for the general welfare but demands responsible limits. The Tenth Amendment leaves health regulation to states unless they choose to join a federal program. Fifth Amendment Due Process requires clear rules and fair review before payment is denied. This proposal follows those limits.

The strongest objection is that prevention needs a permanent open-ended benefit to work. The answer is that an uncapped promise risks waste and state control, while a capped voluntary test would prove what helps patients before Congress commits more funds.

The Community Health Worker Pilot Act would create a five-year voluntary pilot to test coverage of community health services. The official summary states the original would cover these services under Medicare and open a state option under Medicaid with a higher federal match. This proposal keeps that goal but makes it narrower, capped, and measured before Congress decides whether to continue it.

Under the pilot, Medicare would cover preventive visits, health screenings, home education visits, and referrals to care when given by a qualified community health agency under a written needs plan. Qualified agencies would include nonprofits, federally qualified health centers, and similar groups that hire workers with lived ties to the areas served and meet clear training, background check, and supervision standards. Payment would be tied to documented visits and results, not open-ended claims.

State participation in Medicaid would be fully voluntary. A participating state could cover the same defined services and receive a temporarily higher federal matching rate of five percentage points for those services only, within the overall five-year cap. States would keep control over which agencies qualify, how workers are supervised, and how services fit state health plans.

Strong taxpayer protections would apply. Total federal spending for the pilot would be capped, with yearly public reports on costs, health results, and improper payments. The Inspector General would audit claims. Agencies could seek fair and prompt review of denied payments. After five years the pilot and the added match would end unless Congress reviews the results and passes a new law.

OPERATIVE PROVISIONS (VFA PROPOSAL)

Effective Date	Pilot coverage would begin for services furnished on or after January 1, 2028.
Enforcement Mechanism	The Centers for Medicare and Medicaid Services would pay only qualified agencies that meet worker standards and report results, with audits, repayment for improper claims, and a new fair review process for denied claims.
Funding Amount	Capped at \$1.5 billion in total federal funds over five years for the Medicare pilot and the added Medicaid match funds combined.
Funding Source	Federal funds would come from amounts already provided for Medicare and Medicaid, subject to annual spending laws, with no new tax.
Oversight Body	The Centers for Medicare and Medicaid Services would run the program, with yearly reports to Congress and review by the Department of Health and Human Services Office of Inspector General.
Sunset Years	5 years

CONSTITUTIONAL BASIS

- Article I, Section 8, Clause 1
- Tenth Amendment
- Fifth Amendment Due Process

Concerns with the measure as written:

- Open-ended Medicare coverage and a higher Medicaid matching rate could expand federal spending without a stated limit, which raises issues under Article I, Section 8, Clause 1 and its demand for responsible use of funds.
 - Allowing broad services tied to social needs could blur federal and state roles unless participation stays voluntary for states, as the Tenth Amendment requires.
 - Payment rules for new worker groups need clear standards and fair review of denials so providers receive due process under Fifth Amendment Due Process.
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WHY BOTH SIDES CAN BACK IT (VFA'S ASSESSMENT)

VFA assesses this draft honors Democratic priorities by expanding preventive care and support for trusted local health workers in underserved areas, and honors Republican priorities by adding clear cost caps, state choice, work standards, and a firm sunset with outside review before any extension.

Strongest objection, and the answer: The strongest objection is that prevention needs a permanent open-ended benefit to work. The answer is that an uncapped promise risks waste and state control, while a capped voluntary test would prove what helps patients before Congress commits more funds.

CHECK BEFORE RELYING ON THIS

Basis: The Congress.gov summary of H.R. 10414 in the 119th Congress states the title, that it would provide Medicare coverage of community health services through qualifying agencies, and that it would let state Medicaid programs cover these services with a higher federal matching rate, with referral to committees as the latest action.

The official summary does not give the full bill text, current Medicare or Medicaid eligibility rules, appeal rights, labor standards, cost effects, or vote outlook, so those facts remain unverified and readers should check the full bill text and current law at the official source before relying on them.

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