Florida, in Florida's Seventh Congressional District.

From a young age, Colonel Kittinger was fascinated by planes. He ended up dedicating his life to pushing the boundaries of aviation and advancing the understandings of high altitude and space exploration, inspiring many generations to come.

He joined the Air Force in 1949, where he flew experimental jets and participated in aerospace medical research. He was part of Project Excelsior, which researched high-altitude pilot bailouts to learn if humans could sustain the extended travel at space-like altitudes.

On August 16, 1960, he set the record for the highest parachute jump, jumping out of a gondola at 102,800 feet, completing the longest free fall at 4 minutes and 36 second airborne.

During the free fall, he also reached a maximum speed of 614 miles per hour, the fastest speed reached by a human at that time before deploying his parachute.

He was called to further service during the Vietnam war and flew 483 fighter plane missions. On his third tour in 1972, his plane was shot down, and he spent close to a year as a prisoner of war in the famed Hanoi Hilton, enduring torture.

His fighting spirit never wavered, Mr. Speaker. In fact, he titled his autobiography ''Come Up and Get Me.'' Back home, he dreamed of returning to the air, but this time via long-distance balloon travel.

Upon retiring from the Air Force in 1978, that dream later became a reality when he completed the first solo balloon flight across the Atlantic Ocean.

About his travel, he would state: Life is an adventure, and I am an adventurer.

Seventy-five years ago, he answered the call to service. May Colonel Kittinger's courage, resilience, and service inspire aviators, servicemembers, veterans, and all Americans.

It is a great privilege to sponsor this legislation to rename the main post office at 109 Live Oaks Boulevard in Casselberry, Florida, in honor of Colonel Joseph Kittinger.

I thank my colleagues in the Florida delegation for supporting this bill and request that all Members join us in passing it in honor of an American hero.

From one combat soldier to another, I want to take a moment to salute him and his service. Life is an adventure, Mr. Speaker. May we all be adventurers like Colonel Kittinger.

Mr. RASKIN. Mr. Speaker, I have no further speakers, and I yield back the balance of my time.

Mr. LATURNER. Mr. Speaker, I encourage my colleagues to support this bill, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kansas (Mr. LATURNER) that the House suspend the rules and pass the bill, H.R. 5867.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

□ 1445

CARDIOMYOPATHY HEALTH EDUCATION, AWARENESS, AND RESEARCH, AND AED TRAINING IN THE SCHOOLS ACT OF 2024

Mr. BUCSHON. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 6829) to amend the Public Health Service Act to authorize and support the creation and dissemination of cardiomyopathy education, awareness, and risk assessment materials and resources to identify more at-risk families, to authorize research and surveillance activities relating to cardiomyopathy, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 6829

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Cardiomyopathy Health Education, Awareness, and Research, and AED Training in the Schools Act of 2024'' or the ''HEARTS Act of 2024''.

SEC. 2. CARDIOMYOPATHY HEALTH EDUCATION, AWARENESS, AND RESEARCH, AND AED TRAINING IN SCHOOLS.

(a) AMENDMENT.—The Public Health Service Act is amended by inserting after section 312 (42 U.S.C. 244) the following:

''SEC. 312A. MATERIALS AND RESOURCES TO INCREASE EDUCATION AND AWARENESS OF CARDIOMYOPATHY AMONG SCHOOL ADMINISTRATORS, EDUCATORS, AND FAMILIES.

''(a) MATERIALS AND RESOURCES.—Not later than 18 months after the date of the enactment of the HEARTS Act of 2024, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop public education materials and resources to be disseminated to school administrators, educators, school health professionals, coaches, families, guardians, caregivers, and other appropriate individuals. The materials and resources shall include—

''(1) information on the signs, symptoms, and risk factors associated with high-risk cardiac conditions and genetic heart rhythm abnormalities that may cause sudden cardiac arrest in children, adolescents, and young adults, including—

''(A) cardiomyopathy;

''(B) long QT syndrome, Brugada syndrome, catecholaminergic polymorphic ventricular tachycardia, short QT syndrome, and Wolff-Parkinson-White syndrome; and

''(C) other high-risk cardiac conditions, as determined by the Secretary;

''(2) guidelines regarding the placement of automated external defibrillators in schools, early childhood education programs, and child care centers;

''(3) training information on automated external defibrillators and cardiopulmonary resuscitation; and

''(4) recommendations for how schools, early childhood education programs, and child care centers can develop and implement a cardiac emergency response plan.

''(b) DISSEMINATION OF MATERIALS AND RESOURCES.—Not later than 30 months after the date of the enactment of the HEARTS Act of 2024, the Secretary shall disseminate the materials and resources developed under subsection (a) in accordance with the following:

''(1) DISTRIBUTION BY STATE EDUCATIONAL AGENCIES.—The Secretary shall make available such materials and resources to State educational agencies to distribute—

''(A) to school administrators, educators, school health professionals, coaches, families, guardians, caregivers, and other appropriate individuals, the information developed under subsection (a)(1);

''(B) to parents, guardians, or other caregivers, the cardiomyopathy risk assessment developed pursuant to section 312B(b)(1); and

''(C) to school administrators, educators, school health professionals, and coaches—

''(i) the guidelines described in subsection (a)(2);

''(ii) the training information described in subsection (a)(3); and

''(iii) the recommendations described in subsection (a)(4).

''(2) DISSEMINATION TO HEALTH DEPARTMENTS AND PROFESSIONALS.—The Secretary shall make available the materials and resources developed under subsection (a) to State and local health departments, pediatricians, hospitals, and other health professionals, such as nurses and first responders.

''(3) POSTING ON WEBSITE.—

''(A) CDC.—

''(i) IN GENERAL.—The Secretary, through the Director, shall post the materials and resources developed under subsection (a) on the public Internet website of the Centers for Disease Control and Prevention.

''(ii) ADDITIONAL INFORMATION.—The Director is encouraged to maintain on such public Internet website such additional information regarding cardiomyopathy as deemed appropriate by the Director.

''(B) STATE EDUCATIONAL AGENCIES.—State educational agencies are encouraged to create public Internet webpages dedicated to cardiomyopathy and post the materials and resources developed under subsection (a) on such webpages.

''(c) DEFINITIONS.—In this section:

''(1) The term 'cardiomyopathy' means a heart disease that affects the heart's muscle (myocardium)—

''(A) the symptoms of which may vary from case to case, including—

''(i) cases in which no symptoms are present (asymptomatic); and

''(ii) cases in which there are symptoms of a progressive condition that may result from an impaired ability of the heart to pump blood, such as fatigue, irregular heartbeats (arrhythmia), heart failure, and, potentially, sudden cardiac death; and

''(B) the recognized types of which include dilated, hypertrophic, restrictive, arrhythmogenic right ventricular dysplasia, and left ventricular non-compaction.

''(2) The term 'Director' means the Director of the Centers for Disease Control and Prevention.

''(3) The terms 'early childhood education program', 'elementary school', and 'secondary school' have the meanings given to those terms in section 8101 of the Elementary and Secondary Education Act of 1965.

''(4) The term 'school administrator' means a principal, director, manager, or other supervisor or leader within an elementary school, secondary school, State-based early childhood education program, or child care center.

''(5) The term 'school health professional' means a health professional serving at an elementary school, secondary school, State-based early childhood education program, or child care center.

"SEC. 312B. ACTIVITIES RELATING TO CARDIOMYOPATHY.

''(a) REPORT ON CDC NATIONAL CARDIOMYOPATHY ACTIVITIES.—

''(1) IN GENERAL.—Not later than 18 months after the date of the enactment of the HEARTS Act of 2024, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall submit to Congress a report on findings generated from existing activities conducted by the Centers for Disease Control and Prevention to improve the understanding of the prevalence and epidemiology of cardiomyopathy across the lifespan, from birth to adulthood, with particular interest in the following:

''(A) The natural history of individuals with cardiomyopathy, in both the pediatric and adult population.

''(B) Estimates of cardiomyopathy-related emergency department visits and hospitalizations, in both the pediatric and adult population.

''(2) PUBLIC ACCESS.—Subject to paragraph (3), the report submitted under this subsection shall be made available to the public.

''(3) PRIVACY PROTECTIONS.—The Secretary shall ensure that this subsection is carried out in a manner that complies with all applicable privacy laws under Federal and State law.

''(b) IMPROVING RISK ASSESSMENTS FOR INDIVIDUALS WITH CARDIOMYOPATHY.—

''(1) IN GENERAL.—The Secretary shall develop and make publicly available a cardiomyopathy risk assessment for health care providers and individuals. Such risk assessment shall, at a minimum, include the following:

''(A) Background information on the prevalence, incidence, and health impact of cardiomyopathy, including all forms of cardiomyopathy and their effects on pediatric, adolescent, and adult individuals.

''(B) A worksheet with variables and conditions for an individual or health care provider to use in assessing whether an individual is at risk for cardiomyopathy.

''(C) A worksheet with variables and stages of progression for an individual or health care provider to use in assessing whether and to what extent cardiomyopathy has progressed in an individual.

''(D) Guidelines on cardiomyopathy screenings for individuals who are at risk for, or have a family history of, cardiomyopathy.

''(2) STAKEHOLDER INPUT.—In carrying out paragraph (1), the Director of the Centers for Disease Control and Prevention shall seek input from external stakeholders including—

''(A) representatives from national patient advocacy organizations expert in all forms of cardiomyopathy;

''(B) representatives from medical professional societies that specialize in the care of adults and pediatrics with cardiomyopathy; and

''(C) representatives from other relevant Federal agencies.

''(c) DEFINITION.—In this section, the term 'cardiomyopathy' has the meaning given to such term in section 312A.

"SEC. 312C. CARDIOMYOPATHY RESEARCH.

''(a) IN GENERAL.—The Secretary, in consultation with the Director of the National Institutes of Health, may expand and coordinate research and related activities of the National Institutes of Health with respect to cardiomyopathy, which may include research with respect to—

''(1) causation of cardiomyopathy, including genetic causes and molecular biomarkers;

''(2) long-term health outcomes in individuals with cardiomyopathy, including infants, children, teenagers, adults, and elderly individuals; and

''(3) studies using longitudinal data and retrospective analysis to identify effective treatments and outcomes for individuals with cardiomyopathy.

''(b) NONDUPLICATION.—The Secretary shall ensure that any research and activities related to cardiomyopathy under this section do not unnecessarily duplicate activities, programs, or efforts of other agencies and offices within the Department of Health and Human Services.

''(c) NIH REPORT.—Not later than 18 months after the date of the enactment of the HEARTS Act of 2024, the Secretary, in consultation with the Director of the National Institutes of Health, shall submit to Congress a report—

''(1) outlining the ongoing research efforts of the National Institutes of Health regarding cardiomyopathy; and

''(2) identifying—

''(A) a research agenda regarding adult forms of cardiomyopathy;

''(B) plans for researching cardiomyopathy affecting the pediatric population; and

''(C) the areas of greatest need for such research.

''(d) CARDIOMYOPATHY DEFINED.—In this section, the term 'cardiomyopathy' has the meaning given to such term in section 312A.

"SEC. 312D. PROMOTING STUDENT ACCESS TO AEDS AND CPR.

''(a) IN GENERAL.—The Secretary may award grants to eligible entities to develop and implement a comprehensive program to promote student access to automated external defibrillators (in this section referred to as 'AEDs') and cardiopulmonary resuscitation (in this section referred to as 'CPR') in public elementary schools and secondary schools.

''(b) USE OF FUNDS.—An eligible entity receiving a grant under subsection (a) may use funds received through such grant to carry out any of the following activities:

''(1) Developing and providing comprehensive materials to establish AED and CPR programs in public elementary schools and secondary schools.

''(2) Providing support for CPR and AED training programs in such schools for students, staff, and related sports volunteers.

''(3) Providing support for developing a cardiac emergency response plan within such schools.

''(4) Purchasing AEDs that have been approved under section 515 of the Federal Food, Drug, and Cosmetic Act, cleared under section 510(k) of such Act, or classified under section 513(f)(2) of such Act.

''(5) Purchasing necessary AED batteries and performing necessary AED maintenance (such as by replacing AED pads) in accordance with the labeling of the AED involved.

''(6) Replacing old and outdated AED and CPR equipment, machinery, and educational materials.

''(c) ELIGIBILITY; APPLICATION.—To be eligible for a grant under subsection (a), an entity shall—

''(1) be a local educational agency (including a public charter school operating as a local educational agency under State law), in consultation with a qualified health care entity; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may reasonably require.

''(d) DEFINITIONS.—In this section:

''(1) ESEA TERMS.—The terms 'elementary school', 'local educational agency', and 'secondary school' have the meanings given such terms in section 8101 of the Elementary and Secondary Education Act of 1965.

''(2) QUALIFIED HEALTH CARE ENTITY.—The term 'qualified health care entity' means a health care entity that—

''(A) is—

''(i) a public entity; or

''(ii) an organization that is described in section 501(c) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code;

''(B) demonstrates an ability to develop, train, and implement a comprehensive program to promote student access to defibrillation in public elementary and secondary schools; and

''(C) is qualified in providing technical assistance in AED and CPR training.''.

(b) NO ADDITIONAL FUNDS.—No additional funds are authorized to be appropriated to carry out sections 312A, 312B, 312C, and 312D of the Public Health Service Act, as inserted by subsection (a).

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Indiana (Mr. BUCSHON) and the gentleman from New Jersey (Mr. PALLONE) each will control 20 minutes.

The Chair recognizes the gentleman from Indiana.

GENERAL LEAVE

Mr. BUCSHON. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material into the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

Mr. BUCSHON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 6829, the Cardiomyopathy Health Education, Awareness, and Research, and AED Training in the Schools Act, or the HEARTS Act, of 2024, led by Committee on Energy and Commerce Ranking Member FRANK PALLONE.

In the United States, more than 30,000 children are diagnosed with some form of cardiomyopathy, and more than 2,000 children and adolescents die from a sudden cardiac event each year.

Research and experience have shown that immediate use of an automated external defibrillator, or AED, for short, or CPR can double or triple an individual's chance of survival.

The HEARTS Act of 2024 would authorize and support programs to coordinate related research, promote access to AEDs and CPR training, and raise public awareness of cardiomyopathy within schools, local health departments, and communities.

Mr. Speaker, I encourage my colleagues to support this bill, and I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise to speak in support of H.R. 6829, the HEARTS Act. I am proud to have sponsored this legislation, which is inspired by two New Jersey families who each tragically lost a child to sudden cardiac arrest during high school sporting events.

Sadly, more than 2,000 children and adolescents die this way, unfortunately, every single year, and the bill aims to prevent future deaths of cardiac arrest by preparing schools to respond to cardiac emergencies when they occur.

It directs the Secretary of Health and Human Services to develop guidelines on the placement of automated external defibrillators, or AEDs, in schools and to provide resources to help schools create and implement cardiac emergency response plans.

The legislation also supports CPR education and training among students, school personnel, coaches, and volunteers. It would also support the development of cardiac emergency response plans, which, along with AEDs and CPR, are integral to a coordinated, immediate, and effective response in the crucial minutes between the time when a victim collapses and when emergency medical services arrive.

The HEARTS Act will raise awareness about the causes of sudden cardiac arrest and ensure schools are more prepared to deal with cardiac emergencies so we can save lives. This legislation has the support of the American Heart Association and the Smart Heart Coalition, among others.

It is my hope the Senate will consider this legislation and restore the authorization level, which we reluctantly were required to remove in order to get this bill before us today to comply with the Speaker's CutGo protocol. The Speaker's protocol, in my opinion, is arbitrary, selectively enforced, and ill-advised because it hampers our ability to address the pressing public health issues of the day.

I am disappointed that although the bill as originally written was cleared in committee on a bipartisan basis with the funding authorization, the House Republican leadership reversed course and determined before floor consideration that it was not in compliance with the Speaker's protocol.

We are, nonetheless, moving forward today because we believe it is imperative to move this policy forward for the parents and student athletes who have suffered from this sudden cardiac arrest, and I remain committed to ensuring the enduring success of this program and to seek funding for it.

I thank Chair RODGERS for working closely with me on the legislation, as well as the New Jersey families who shared their stories with me and have advocated tirelessly for safer cardiac health and resources in our schools.

Mr. Speaker, I urge strong support for the bill, and I thank all the members of our committee for reporting this bill out on a bipartisan basis. It is important for our kids.

Mr. Speaker, I ask everyone to vote in support of the bill, and I yield back the balance of my time.

Mr. BUCSHON. Mr. Speaker, in closing, I encourage a ''yes'' vote on this bill, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Indiana (Mr. BUCSHON) that the House suspend the rules and pass the bill, H.R. 6829, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

MEDICAID STATE PLAN REQUIREMENT FOR DETERMINING RESIDENCY OF MILITARY FAMILIES

Mr. BUCSHON. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 8108) to amend title XIX of the Social Security Act to add a Medicaid State plan requirement with respect to the determination of residency of certain individuals serving in the Armed Forces, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 8108

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

SECTION 1. MEDICAID STATE PLAN REQUIREMENT FOR DETERMINING RESIDENCY AND COVERAGE FOR MILITARY FAMILIES.

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

(1) in subsection (a)—

(A) in paragraph (86), by striking ''and'' at the end;

(B) in paragraph (87), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (87) the following new paragraph:

''(88) beginning January 1, 2028, provide, with respect to an active duty relocated individual (as defined in subsection (uu)(1))—

''(A) that, in determining eligibility for medical assistance under the State plan (or waiver of such plan), the relocation described in such subsection is deemed to be a temporary absence for purposes of section 435.403(j)(3) of title 42, Code of Federal Regulations (or any successor regulation);

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

''(i) the State completes an assessment and renders a decision with respect to the eligibility of such individual to receive the relevant home and community-based services at the time a slot for such services becomes available and, in the case such decision is a denial of such eligibility, such individual has exhausted the individual's opportunity for a fair hearing in accordance with paragraph (3); or

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

''(C) payment for medical assistance furnished under the State plan (or a waiver of the plan) to such active duty relocated individual in the temporary relocation State (as referred to in subsection (uu)(1)) in accordance with such guidance as the Secretary may issue to ensure access to such assistance.''; and

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

''(uu) ACTIVE DUTY RELOCATED INDIVIDUAL; HOME AND COMMUNITY-BASED SERVICES WAITING LIST.—For purposes of subsection (a)(88) and this subsection:

''(1) ACTIVE DUTY RELOCATED INDIVIDUAL.—The term 'active duty relocated individual' means an individual enrolled under the State plan (or waiver of such plan)—

''(A) who—

''(i) is a member of the Armed Forces engaged in active duty service and is temporarily relocated (as specified by the Secretary) to another State (in this subsection referred to as the 'temporary relocation State') by reason of such service;

''(ii) at any point during the preceding 1-year period, was such a member so engaged in such service and was temporarily relocated to the temporary relocation State by reason of such service, but is no longer so engaged in such service (including by reason of retirement from such service); or

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

''(B) who—

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

''(ii) if the State maintains a home and community-based services waiting list, was on such home and community-based services waiting list at the time of such relocation.

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

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Indiana (Mr. BUCSHON) and the gentleman from New Jersey (Mr. PALLONE) each will control 20 minutes.

The Chair recognizes the gentleman from Indiana.

GENERAL LEAVE

Mr. BUCSHON. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material into the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

Mr. BUCSHON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank Mrs. KIGGANS for bringing forth such an important solution for our military families.

H.R. 8108 would ensure that military families can maintain access to essential care when they are required to move States for Active Duty.

According to the Medicaid and CHIP Payment Access Commission, as many as 867,000 Medicaid enrollees have primary insurance through TRICARE, including as many as 220,000 children.

In most instances, servicemembers rely on TRICARE as their insurer to cover most of their needs, but for individuals who also have a disability—take, for example, a military family with a child with a disability—Medicaid will often step in to cover additional care, like home and community-based services. Those services help with daily living activities and are essential to keeping people with disabilities healthy and independent in their communities.

Unfortunately, many State Medicaid programs limit access to home and