LANGEVIN to introduce H.R. 6042, which gives States an extra year to put in place their EVV systems and ensure stakeholder input. Home visits are a critical part of providing quality care to patients, many of whom have disabilities and rely on extra care in their homes.

H.R. 6042 will make sure that EVV can be implemented effectively. Thanks to hard work, the bill has changed a little bit working with Congresswoman DEGETTE, who came to me and said we want to make sure that we have stakeholder input. That is included in this version of the bill that is before us now. Her diligence in doing that has been very helpful, and I appreciate her efforts in that.

Mr. Speaker, I urge my colleagues to support this bipartisan bill to provide a simple fix for the benefit of improved accountability and patient care in State Medicaid programs.

Mr. Speaker, I reserve the balance of my time.

Mr. KENNEDY. Mr. Speaker, I yield such time as he may consume to the gentleman from Rhode Island (Mr. LANGEVIN).

Mr. LANGEVIN. Mr. Speaker, I thank the gentleman from Massachusetts for yielding.

Mr. Speaker, I rise in support of H.R. 6042, which will delay implementation of the Medicaid electronic visit verification system requirement by 1 year and promote stakeholder feedback as part of its implementation.

The Medicaid EVV system requirement under the landmark 21st Century Cures Act was established to ensure accurate billing and delivery of personal care services in the homes of Medicaid beneficiaries. We want to make sure that Medicaid patients are accurately getting the care that they received, that Medicaid is properly billed for those services, and that we do everything possible to wring fraud out of the system.

Unfortunately, the short implementation period, compounded by a delay in CMS guidance and a lack of stakeholder input, has presented significant challenges for affected populations, especially seniors and people with disabilities.

I am pleased to join my colleagues, Representative GUTHRIE and Representative DEGETTE, in supporting this important piece of legislation. I am glad to see that Representative GUTHRIE's bill largely mirrors the bipartisan, bicameral legislation I introduced to address this issue last month.

The collaboration and the inclusive approach it took to bring this bill to the floor is the same dynamic Medicaid beneficiaries, family caregivers, personal care and home health providers, and other stakeholders are hoping to see from CMS when the agency defines EVV system requirements so that States can design effective and thoughtful EVV programs.

Delaying implementation by 1 year and encouraging input from relevant stakeholders will be paramount to the success of the EVV programs and is a part of our enduring promise to protect vulnerable populations, people who would otherwise suffer from adverse outcomes should the policy be hastily implemented.

Mr. Speaker, I thank Mr. GUTHRIE, Congresswoman DEGETTE, Chairman WALDEN, Ranking Member PALLONE, and all those who had a hand in bringing this bill to the floor today for the opportunity to join in leading this important effort.

Mr. KENNEDY. Mr. Speaker, I want to commend the gentleman from Rhode Island for all of his work and dedication on this issue.

Mr. Speaker, I urge the House to support the bill, and I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield myself such time as I may consume to close.

Mr. Speaker, I didn't see my friend from Rhode Island on the floor when I was speaking earlier on Ms. DEGETTE and her work in this. He has been working really hard. I appreciate my friend from Rhode Island leading on this issue and us being able to work together and our staffs working together to make something very important like this. His input was very important on the stakeholder issue, as was Ms. DEGETTE's.

Mr. Speaker, I urge my colleagues to vote for the bill, and I yield back the balance of my time.

Ms. DEGETTE. Mr. Speaker, I would like to thank Representatives GUTHRIE and LANGEVIN for working with me on this very important bill, which addresses a national health care issue involving safety, efficiency and privacy affecting many of our constituents.

As most people who have been engaged in this matter know, the mental health portion of the 21st Century Cures Act—the overwhelmingly bipartisan biomedical reform bill that was signed into law in December 2016—included what is called electronic visit verification (EVV) provisions. These provisions require states to verify the provider, date, time and site of personal care and home health services.

They were meant to give patients the power to hold their providers accountable for delivering services when and where they are supposed to do so.

But given the delay by the Centers for Medicare and Medicaid Services (CMS) in getting guidance for implementation of the provisions to the states, and the way the agency ignored Congressional intent to involve stakeholders in the regulatory process, House members had to step in to try and right what the Executive Branch has done poorly in the past year and a half.

The bill before you today grants a one-year delay in implementation of the EVV requirements. It also requires CMS to involve stakeholders both in the planning and throughout the implementation of the EVV requirements to ensure that the privacy and civil rights of consumers are protected.

This bill ensures that administrative and financial burdens on service providers are neither onerous nor duplicative and that states are able to design and implement their EVV programs in a thoughtful, deliberative manner. It also affords CMS the opportunity to hear from beneficiaries enrolled in self-directed plans about the challenges EVV could present for them.

This legislation will also help foster a comprehensive and transparent process that carefully balances the serious privacy concerns of consumers and caregivers, the administrative and financial concerns of providers and states, and EVV's goals of patient control and fraud prevention.

Mr. Speaker, if properly implemented EVV has potential to ensure that high-quality services are delivered when and where needed, while also reducing the potential for waste and fraud. This legislation will require CMS to follow a proper stakeholder engagement process, in order to ensure that the policy is implemented correctly. It will also allow each state greater opportunity to ensure that its EVV programs are best suited to individuals' specific needs.

I strongly urge all members to support this bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 6042, 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 PROVIDERS ARE REQUIRED TO NOTE EXPERIENCES IN RECORD SYSTEMS TO HELP IN-NEED PATIENTS ACT

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5801) to amend title XIX of the Social Security Act to provide for requirements under the Medicaid program relating to the use of qualified prescription drug monitoring programs and prescribing certain controlled substances, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5801

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 ''Medicaid Providers Are Required To Note Experiences in Record Systems to Help In-need Patients Act'' or the ''Medicaid PARTNERSHIP Act''.

SEC. 2. MEDICAID PROVIDERS ARE REQUIRED TO NOTE EXPERIENCES IN RECORD SYSTEMS TO HELP IN-NEED PATIENTS.

(a) REQUIREMENTS UNDER THE MEDICAID PROGRAM RELATING TO QUALIFIED PRESCRIPTION DRUG MONITORING PROGRAMS AND PRESCRIBING CERTAIN CONTROLLED SUBSTANCES.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1943 the following new section:

''SEC. 1944. REQUIREMENTS RELATING TO QUALIFIED PRESCRIPTION DRUG MONITORING PROGRAMS AND PRESCRIBING CERTAIN CONTROLLED SUBSTANCES.

''(a) IN GENERAL.—Beginning October 1, 2021, a State shall, subject to subsection (d),

require each covered provider to check, in accordance with such timing, manner, and form as specified by the State, the prescription drug history of a covered individual being treated by the covered provider through a qualified prescription drug monitoring program described in subsection (b) before prescribing to such individual a controlled substance.

''(b) QUALIFIED PRESCRIPTION DRUG MONITORING PROGRAM DESCRIBED.—A qualified prescription drug monitoring program described in this subsection is, with respect to a State, a prescription drug monitoring program administered by the State that, at a minimum, satisfies each of the following criteria:

''(1) The program facilitates access by a covered provider to, at a minimum, the following information with respect to a covered individual, in as close to real-time as possible:

''(A) Information regarding the prescription drug history of a covered individual with respect to controlled substances.

''(B) The number and type of controlled substances prescribed to and filled for the covered individual during at least the most recent 12-month period.

''(C) The name, location, and contact information (or other identifying number selected by the State, such as a national provider identifier issued by the National Plan and Provider Enumeration System of the Centers for Medicare & Medicaid Services) of each covered provider who prescribed a controlled substance to the covered individual during at least the most recent 12-month period.

''(2) The program facilitates the integration of information described in paragraph (1) into the workflow of a covered provider, which may include the electronic system the covered provider uses to prescribe controlled substances.

A qualified prescription drug monitoring program described in this subsection, with respect to a State, may have in place, in accordance with applicable State and Federal law, a data sharing agreement with the State Medicaid program that allows the medical director and pharmacy director of such program (and any designee of such a director who reports directly to such director) to access the information described in paragraph (1) in an electronic format. The State Medicaid program under this title may facilitate reasonable and limited access, as determined by the State and ensuring documented beneficiary protections regarding the use of such data, to such qualified prescription drug monitoring program for the medical director or pharmacy director of any managed care entity (as defined under section 1932(a)(1)(B)) that has a contract with the State under section 1903(m) or under section 1905(t)(3), or the medical director or pharmacy director of any entity has a contract to manage the pharmaceutical benefit with respect to individuals enrolled in the State plan (or waiver of the State plan). All applicable State and Federal security and privacy laws shall apply to the directors or designees of such directors of any State Medicaid program or entity accessing a qualified prescription drug monitoring program under this section.

''(c) APPLICATION OF PRIVACY RULES CLARIFICATION.—The Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), related to the sharing of data under subsection (b) in the same manner as the Secretary is required under subparagraph (J) of section 1860D–4(c)(5) to clarify privacy requirements related to the sharing of data described in such subparagraph.

''(d) ENSURING ACCESS.—In order to ensure reasonable access to health care, the Secretary shall waive the application of the requirement under subsection (a), with respect to a State, in the case of natural disasters and similar situations, and in the case of the provision of emergency services (as defined for purposes of section 1860D–4(c)(5)(D)(ii)(II)).

''(e) REPORTS.—

''(1) STATE REPORTS.—Each State shall include in the annual report submitted to the Secretary under section 1927(g)(3)(D), beginning with such reports submitted for 2023, information including, at a minimum, the following information for the most recent 12-month period:

''(A) The percentage of covered providers (as determined pursuant to a process established by the State) who checked the prescription drug history of a covered individual through a qualified prescription drug monitoring program described in subsection (b) before prescribing to such individual a controlled substance.

''(B) Aggregate trends with respect to prescribing controlled substances such as—

''(i) the quantity of daily morphine milligram equivalents prescribed for controlled substances;

''(ii) the number and quantity of daily morphine milligram equivalents prescribed for controlled substances per covered individual; and

''(iii) the types of controlled substances prescribed, including the dates of such prescriptions, the supplies authorized (including the duration of such supplies), and the period of validity of such prescriptions, in different populations (such as individuals who are elderly, individuals with disabilities, and individuals who are enrolled under both this title and title XVIII).

''(C) Whether or not the State requires (and a detailed explanation as to why the State does or does not require) pharmacists to check the prescription drug history of a covered individual through a qualified drug management program before dispensing a controlled substance to such individual.

''(2) REPORT BY CMS.—Not later than October 1, 2023, the Administrator of the Centers for Medicare & Medicaid Services shall publish on the publicly available website of the Centers for Medicare & Medicaid Services a report including the following information:

''(A) Guidance for States on how States can increase the percentage of covered providers who use qualified prescription drug monitoring programs described in subsection (b).

''(B) Best practices for how States and covered providers should use such qualified prescription drug monitoring programs to reduce the occurrence of abuse of controlled substances.

''(f) INCREASE TO FEDERAL MATCHING RATE FOR CERTAIN EXPENDITURES RELATING TO QUALIFIED PRESCRIPTION DRUG MANAGEMENT PROGRAMS.—The Secretary shall increase the Federal medical assistance percentage or Federal matching rate that would otherwise apply to a State under section 1903(a) for a calendar quarter occurring during the period beginning October 1, 2018, and ending September 30, 2021, for expenditures by the State for activities under the State plan (or waiver of the State plan) to implement a prescription drug management program that satisfies the criteria described in paragraphs (1) and (2) of subsection (b) if the State (in this subsection referred to as the 'administering State') has in place agreements with all States that are contiguous to such administering State that, when combined, enable covered providers in all such contiguous States to access, through the prescription drug management program, the information that is described in subsection (b)(1) of covered individuals of such administering State and that covered providers in such administering State are able to access through such program. In no case shall an increase under this subsection result in a Federal medical assistance percentage or Federal matching rate that exceeds 100 percent.

''(g) RULE OF CONSTRUCTION.—Nothing in this section prevents a State from requiring pharmacists to check the prescription drug history of covered individuals through a qualified drug management program before dispensing controlled substances to such individuals.

''(h) DEFINITIONS.—In this section:

''(1) CONTROLLED SUBSTANCE.—The term 'controlled substance' means a drug that is included in schedule II of section 202(c) of the Controlled Substances Act and, at the option of the State involved, a drug included in schedule III or IV of such section.

''(2) COVERED INDIVIDUAL.—The term 'covered individual' means, with respect to a State, an individual who is enrolled in the State plan (or under a waiver of such plan). Such term does not include an individual who—

''(A) is receiving—

''(i) hospice or palliative care; or

''(ii) treatment for cancer;

''(B) is a resident of a long-term care facility, of a facility described in section 1905(d), or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

''(C) the State elects to treat as exempted from such term.

''(3) COVERED PROVIDER.—

''(A) IN GENERAL.—The term 'covered provider' means, subject to subparagraph (B), with respect to a State, a health care provider who is participating under the State plan (or waiver of the State plan) and licensed, registered, or otherwise permitted by the State to prescribe a controlled substance (or the designee of such provider).

''(B) EXCEPTIONS.—

''(i) IN GENERAL.—Beginning October 1, 2021, for purposes of this section, such term does not include a health care provider included in any type of health care provider determined by the Secretary to be exempt from application of this section under clause (ii).

''(ii) EXCEPTIONS PROCESS.—Not later than October 1, 2020, the Secretary, after consultation with the National Association of Medicaid Directors, national health care provider associations, Medicaid beneficiary advocates, and advocates for individuals with rare diseases, shall determine, based on such consultations, the types of health care providers (if any) that should be exempted from the definition of the term 'covered provider' for purposes of this section.''.

(b) GUIDANCE.—Not later than October 1, 2019, the Administrator of the Centers for Medicare & Medicaid Services, in consultation with the Director of the Centers for Disease Control and Prevention, shall issue guidance on best practices on the uses of prescription drug monitoring programs required of prescribers and on protecting the privacy of Medicaid beneficiary information maintained in and accessed through prescription drug monitoring programs.

(c) DEVELOPMENT OF MODEL STATE PRACTICES.—

(1) IN GENERAL.—Not later than October 1, 2020, the Secretary of Health and Human Services shall develop and publish model practices to assist State Medicaid program operations in identifying and implementing strategies to utilize data sharing agreements

described in the matter following paragraph (2) of section 1944(b) of the Social Security Act, as added by subsection (a), for the following purposes:

(A) Monitoring and preventing fraud, waste, and abuse.

(B) Improving health care for individuals enrolled in a State plan under title XIX of such Act (or waiver of such plan) who—

(i) transition in and out of coverage under such title;

(ii) may have sources of health care coverage in addition to coverage under such title; or

(iii) pay for prescription drugs with cash.

(C) Any other purposes specified by the Secretary.

(2) ELEMENTS OF MODEL PRACTICES.—The model practices described in paragraph (1)—

(A) shall include strategies for assisting States in allowing the medical director or pharmacy director (or designees of such a director) of managed care organizations or pharmaceutical benefit managers to access information with respect to all covered individuals served by such managed care organizations or pharmaceutical benefit managers to access as a single data set, in an electronic format; and

(B) shall include any appropriate beneficiary protections and privacy guidelines.

(3) CONSULTATION.—In developing model practices under this subsection, the Secretary shall consult with the National Association of Medicaid Directors, managed care entities (as defined in section 1932(a)(1)(B) of the Social Security Act) with contracts with States pursuant to section 1903(m) of such Act, pharmaceutical benefit managers, physicians and other health care providers, beneficiary advocates, and individuals with expertise in health care technology related to prescription drug monitoring programs and electronic health records.

(d) REPORT BY COMPTROLLER GENERAL.—Not later than October 1, 2020, the Comptroller General of the United States shall issue a report examining the operation of prescription drug monitoring programs administered by States, including data security and access standards used by such programs.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Kentucky (Mr. GUTHRIE) and the gentleman from Massachusetts (Mr. KENNEDY) each will control 20 minutes.

The Chair recognizes the gentleman from Kentucky.

GENERAL LEAVE

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

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

There was no objection.

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

Mr. Speaker, this bill, cosponsored by myself, Representative GRIFFITH, Representative FITZPATRICK, and Representative BLACKBURN, requires Medicaid providers to check the prescription drug history of a beneficiary through a qualified prescription drug monitoring program, or PDMP, before prescribing a schedule II controlled substance. This is a crucial step in helping us get a grip on the crisis we are facing.

Currently, 49 States have a PDMP program, and the final State, Missouri, has begun creating a PDMP program. However, only 13 States require the prescribers check the patient's prescribing history prior to prescribing controlled substances, despite the fact that studies show that mandatory PDMP access laws are effective in reducing prescription drug abuse and, in particular, opioid abuse.

For example, evidence from New York suggests that PDMPs are associated with a 75 percent decrease in the number of beneficiaries who got a prescription drug from more than one prescriber and dispenser. Implementation of Florida's PDMP was associated with a 25 percent decrease in mortality related to oxycodone.

Both the current and past administrations have noted that PDMPs should be leveraged in the opioid crisis and are most effective when they are used by all clinicians.

This bill requires that States have a qualified PDMP by October 1, 2021, and provides enhanced matching funds from fiscal years 2018 to 2021 for States to establish data-sharing agreements with bordering States.

Finally, the bill requires CMS to publish best practices for how States and covered providers can use PDMPs to reduce the abuse of controlled substances.

Medicaid patients are especially vulnerable to being harmed by the opioid epidemic. This bill is an important step and one that I believe will help us address the scourge that is the opioid crisis.

Mr. Speaker, I thank Mr. GRIFFITH for his leadership on this issue, which has been invaluable.

Mr. Speaker, I reserve the balance of my time.

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

Mr. Speaker, I rise to speak on H.R. 5801, the Medicaid PARTNERSHIP Act.

This legislation requires Medicaid providers to have a program that requires providers to check a qualified prescription drug monitoring program, a PDMP, before prescribing a schedule II controlled substance and encourages integration of the PDMP into a provider's clinical work flow.

Today, Mr. Speaker, more than 30 States have some form of mandated provider PDMP check. This legislation would require all Medicaid programs to have such a policy in place.

Integrating PDMPs with Medicaid is a critical tool in this crisis for our providers to be able to prevent opioid addiction.

Research has demonstrated that these types of mandates can encourage registration and use of a State's PDMP by providers. That is why I support investing in our PDMPs so that they are good realtime systems that our providers can actually check easily.

Importantly, this legislation preserves the ability of States to work with providers to design a mandate that best meets the needs of all involved.

State flexibility and proper financing of our PDMPs is critical to achieving the intent of this legislation, which, if enacted, I will closely monitor going forward.

Mr. Speaker, I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I urge my colleagues to vote for this bill, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. GIANFORTE). The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 5801, 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.

OPIOID ADDICTION ACTION PLAN ACT

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5590) to require the Secretary of Health and Human Services to provide for an action plan on recommendations for changes under Medicare and Medicaid to prevent opioids addictions and enhance access to medication-assisted treatment, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5590

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 ''Opioid Addiction Action Plan Act''.

SEC. 2. ACTION PLAN ON RECOMMENDATIONS FOR CHANGES UNDER MEDICARE AND MEDICAID TO PREVENT OPIOIDS ADDICTIONS AND ENHANCE ACCESS TO MEDICATION-ASSISTED TREATMENT.

(a) IN GENERAL.—Not later than January 1, 2019, the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in collaboration with the Pain Management Best Practices Inter-Agency Task Force convened under section 101(b) of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–198), shall develop an action plan that provides recommendations described in subsection (b).

(b) ACTION PLAN COMPONENTS.—Recommendations described in this subsection are, based on an examination by the Secretary of potential obstacles to an effective response to the opioid crisis, recommendations, as determined appropriate by the Secretary, on the following:

(1) Recommendations on changes to the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act that would enhance coverage and payment under such programs of all medication-assisted treatment approved by the Food and Drug Administration for the treatment of opioid addiction and other therapies that manage chronic and acute pain and treat and minimize risk of opioid addiction, including recommendations on changes to the Medicare prospective payment system for hospital inpatient department services under section 1886(d) of