H.R. 5603, Access to Telehealth Services for Opioid Use Disorder;

H.R. 5605, Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act;

H.R. 5675, To amend title XVIII of the Social Security Act to require prescription drug plan sponsors under the Medicare program to establish drug management programs for at-risk beneficiaries;

H.R. 5684, Protecting Seniors from Opioid Abuse Act;

H.R. 5685, Medicare Opioid Safety Education Act;

H.R. 5686, Medicare Clear Health Options in Care for Enrollees (CHOICE) Act;

H.R. 5715, Strengthening Partnerships to Prevent Opioid Abuse Act;

H.R. 5716, Commit to Opioid Medical Prescriber Accountability and Safety for Seniors (COMPASS) Act;

H.R. 5796, Responsible Education Achieves Care and Healthy Outcomes for Users' Treatment (REACH OUT) Act of 2018;

H.R. 5798, Opioid Screening and Chronic Pain Management Alternatives for Seniors Act;

H.R. 5804, Post-Surgical Injections as an Opioid Alternative Act; and

H.R. 5809, Postoperative Opioid Prevention Act of 2018.

The Committee on Ways and Means takes this action with the mutual understanding that we do not waive any jurisdiction over the subject matter contained in this or similar legislation, and the Committee will be appropriately consulted and involved as the bill or similar legislation moves forward so that we may address any remaining issues that fall within our jurisdiction. The Committee also reserves the right to seek appointment of an appropriate number of conferees to any House-Senate conference involving this or similar legislation and requests your support for such a request.

Finally, I would appreciate your commitment to include this exchange of letters in the bill reports and the Congressional Record.

Sincerely,

KEVIN BRADY,
Chairman.

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

Mr. Speaker, I rise in support of H.R. 5590 sponsored by Representatives KINZINGER and CLARKE. I commend my colleagues for their hard work on this legislation.

We know that there is more that the Department of Health and Human Services needs to do to address the opioid crisis. We know that we need to do more not only to bring down opioid prescribing, but to expand access to medication-assisted treatment for opioid use disorders.

H.R. 5590 would direct the Secretary of HHS to examine potential obstacles to an effective response to the opioid crisis and issue recommendations for addressing them. It directs the Secretary to look at barriers to both wider use of nonopioid alternatives to manage pain, as well as therapies that treat opioid addiction.

Mr. Speaker, while this is an important bill, I want to underscore that it is incremental.

I also want to reiterate my continuing concern that while Democrats support working on a legislative package to address the opioid crisis, as we have over the course of the day-to-day and over the course of the past several weeks with our Republican colleagues, we must also assure that we first do no harm.

The Trump administration and Republican efforts to dismantle the Affordable Care Act would do serious harm to our healthcare system and to individuals suffering from opioid use disorders specifically.

For instance, the Trump administration continues to undermine the individual market by promoting junk insurance plans, such as short-term, limited duration health plans.

These plans would allow insurers to once again exclude individuals with preexisting conditions, such as opioid use disorder, and charge individuals more based on their health status. It would make coverage for individuals who need comprehensive health coverage, such as individuals with opioid use disorders, less affordable and accessible.

Moreover, apparently Republicans are not done with their efforts to repeal the ACA. Despite public backlash to repeal efforts last year and despite statements today expressing concern about the opioid crisis, news reports indicate that Republicans are once again planning to make another effort to try to repeal the Affordable Care Act.

The opioids package cannot be considered in a vacuum. Ongoing efforts to sabotage and repeal the ACA will not only reverse the gains that we make from these efforts today, but will inflict lasting harm to our healthcare system and our ability to fight the opioid crisis.

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

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

Ms. CLARKE of New York. Mr. Speaker, let me take this time to express my appreciation to Chairman WALDEN and Ranking Member PALLONE, for their leadership in addressing the opioid epidemic in the U.S. House of Representatives.

On April 24th of this year, I had the opportunity to work across the aisle in introducing bipartisan legislation with my Energy and Commerce colleague, Congressman ADAM KINZINGER of Illinois.

We were joined by two additional colleagues as original co-sponsors, who sit on the House Ways and Means Committee—Rep. DARRIN LAHOOD, my Republican colleague from Illinois and Rep. DANNY K. DAVIS, my CBC Colleague who hails from Illinois as well.

Our bill, The Opioid Addiction Action Plan of 2018, is a roadmap to not only abating the opioid epidemic, but to engaging industry to be innovative in the development of new pain management therapies.

There are many players and much is at stake.

According to the National Institutes of Drug Abuse, there are more than 115 opioid related deaths per day.

The CDC estimates that the economic burden of prescription opioid misuse is roughly $78.5 billion a year—and that's in the U.S. alone.

Since we know the enormity of this issue plaguing our country, passing H.R. 5590 would require that the Centers for Medicare and Medicaid Services (CMS) seeks stakeholder feedback as well as public comment, before producing an Opioid Addiction Act Plan report to Congress.

It is going to take all of us to tackle this national opioid epidemic.

And Mr. Speaker, with the opioid crisis at epic levels, government cannot do this alone.

That is why we are calling on all of our partners to aide in the fight against opioid addiction in our communities—for both addiction to prescription painkillers and addiction to synthetics, including heroin and fentanyl.

Overdose deaths that were once perceived as largely a rural white problem have now become widespread among black Americans in urban communities who are dying from horrific rates of fentanyl overdoses.

While white Americans die at greater rates of overdose deaths, overdose death rates have been steadily increasing among black Americans since 2011—at the time that fentanyl and heroin, as well as other synthetics began to climb.

One of the solutions to the ever-growing problem to the opioid crisis in the black community is access to addiction care treatment.

Traditionally, African Americans have had unequal access to quality health care in comparison to our white counterparts.

This legislation would also mandate improved data collection to better understand the opioid crisis.

H.R. 5590 directs the CMS to develop an Opioid Addiction Action Plan to address challenges for treatment of substance abuse disorders.

Additionally, this bill also identifies nonopioid pain management options and make considerations for Medicare and Medicaid coverage and reimbursement of medication-assisted treatment (MAT) for opioid use disorders.

In addition to making sure our communities have access to medication-assisted treatment, it is important that we help them in the event someone is in the midst of an overdose.

Mr. Speaker, we cannot leave those behind who need us most.

We are our brother's and our sister's keepers.

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. 5590, 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.

DR. TODD GRAHAM PAIN MANAGEMENT, TREATMENT, AND RECOVERY ACT OF 2018

Mrs. WALORSKI. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 6110) to amend title XVIII of the Social Security Act to provide for the review and adjustment of payments under the Medicare outpatient prospective payment system to avoid financial incentives to use opioids instead of non-opioid alternative treatments, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 6110

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 ''Dr. Todd Graham Pain Management, Treatment, and Recovery Act of 2018''.

SEC. 2. REVIEW AND ADJUSTMENT OF PAYMENTS UNDER THE MEDICARE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM TO AVOID FINANCIAL INCENTIVES TO USE OPIOIDS INSTEAD OF NON-OPIOID ALTERNATIVE TREATMENTS.

(a) OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

''(22) REVIEW AND REVISIONS OF PAYMENTS FOR NON-OPIOID ALTERNATIVE TREATMENTS.—

''(A) IN GENERAL.—With respect to payments made under this subsection for covered OPD services (or groups of services), including covered OPD services assigned to a comprehensive ambulatory payment classification, the Secretary—

''(i) shall, as soon as practicable, conduct a review (part of which may include a request for information) of payments for opioids and evidence-based non-opioid alternatives for pain management (including drugs and devices, nerve blocks, surgical injections, and neuromodulation) with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives;

''(ii) may, as the Secretary determines appropriate, conduct subsequent reviews of such payments; and

''(iii) shall consider the extent to which revisions under this subsection to such payments (such as the creation of additional groups of covered OPD services to classify separately those procedures that utilize opioids and non-opioid alternatives for pain management) would reduce payment incentives to use opioids instead of non-opioid alternatives for pain management.

''(B) PRIORITY.—In conducting the review under clause (i) of subparagraph (A) and considering revisions under clause (iii) of such subparagraph, the Secretary shall focus on covered OPD services (or groups of services) assigned to a comprehensive ambulatory payment classification, ambulatory payment classifications that primarily include surgical services, and other services determined by the Secretary which generally involve treatment for pain management.

''(C) REVISIONS.—If the Secretary identifies revisions to payments pursuant to subparagraph (A)(iii), the Secretary shall, as determined appropriate, begin making such revisions for services furnished on or after January 1, 2020. Revisions under the previous sentence shall be treated as adjustments for purposes of application of paragraph (9)(B).

''(D) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed to preclude the Secretary—

''(i) from conducting a demonstration before making the revisions described in subparagraph (C); or

''(ii) prior to implementation of this paragraph, from changing payments under this subsection for covered OPD services (or groups of services) which include opioids or non-opioid alternatives for pain management.''.

(b) AMBULATORY SURGICAL CENTERS.—Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

''(8) The Secretary shall conduct a similar type of review as required under paragraph (22) of section 1833(t)), including the second sentence of subparagraph (C) of such paragraph, to payment for services under this subsection, and make such revisions under this paragraph, in an appropriate manner (as determined by the Secretary).''.

SEC. 3. EXPANDING ACCESS UNDER THE MEDICARE PROGRAM TO ADDICTION TREATMENT IN FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1834(o) of the Social Security Act (42 U.S.C. 1395m(o)) is amended by adding at the end the following new paragraph:

''(3) ADDITIONAL PAYMENTS FOR CERTAIN FQHCS WITH PHYSICIANS OR OTHER PRACTITIONERS RECEIVING DATA 2000 WAIVERS.—

''(A) IN GENERAL.—In the case of a Federally qualified health center with respect to which, beginning on or after January 1, 2019, Federally-qualified health center services (as defined in section 1861(aa)(3)) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in subparagraph (C) the Secretary shall, subject to availability of funds under subparagraph (D), make a payment (at such time and in such manner as specified by the Secretary) to such Federally qualified health center after receiving and approving an application submitted by such Federally qualified health center under subparagraph (B). Such a payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in subparagraph (C)(ii). Such a payment may be made only one time with respect to each such physician or practitioner.

''(B) APPLICATION.—In order to receive a payment described in subparagraph (A), a Federally-qualified health center shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A Federally-qualified health center may apply for such a payment for each physician or practitioner described in subparagraph (A) furnishing services described in such subparagraph at such center.

''(C) REQUIREMENTS.—For purposes of subparagraph (A), the requirements described in this subparagraph, with respect to a physician or practitioner, are the following:

''(i) The physician or practitioner is employed by or working under contract with a Federally qualified health center described in subparagraph (A) that submits an application under subparagraph (B).

''(ii) The physician or practitioner first receives a waiver under section 303(g) of the Controlled Substances Acton or after January 1, 2019.

''(D) FUNDING.—For purposes of making payments under this paragraph, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $6,000,000, which shall remain available until expended.''.

(b) RURAL HEALTH CLINIC.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

(1) by redesignating the subsection (z) relating to medical review of spinal subluxation services as subsection (aa); and

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

''(bb) ADDITIONAL PAYMENTS FOR CERTAIN RURAL HEALTH CLINICS WITH PHYSICIANS OR PRACTITIONERS RECEIVING DATA 2000 WAIVERS.—

''(1) IN GENERAL.—In the case of a rural health clinic with respect to which, beginning on or after January 1, 2019, rural health clinic services (as defined in section 1861(aa)(1)) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in paragraph (3), the Secretary shall, subject to availability of funds under paragraph (4), make a payment (at such time and in such manner as specified by the Secretary) to such rural health clinic after receiving and approving an application described in paragraph (2). Such payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in paragraph (3)(B). Such payment may be made only one time with respect to each such physician or practitioner.

''(2) APPLICATION.—In order to receive a payment described in paragraph (1), a rural health clinic shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A rural health clinic may apply for such a payment for each physician or practitioner described in paragraph (1) furnishing services described in such paragraph at such clinic.

''(3) REQUIREMENTS.—For purposes of paragraph (1), the requirements described in this paragraph, with respect to a physician or practitioner, are the following:

''(A) The physician or practitioner is employed by or working under contract with a rural health clinic described in paragraph (1) that submits an application under paragraph (2).

''(B) The physician or practitioner first receives a waiver under section 303(g) of the Controlled Substances Acton or after January 1, 2019.

''(4) FUNDING.—For purposes of making payments under this subsection, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $2,000,000, which shall remain available until expended.''.

SEC. 4. STUDYING THE AVAILABILITY OF SUPPLEMENTAL BENEFITS DESIGNED TO TREAT OR PREVENT SUBSTANCE USE DISORDERS UNDER MEDICARE ADVANTAGE PLANS.

(a) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to Congress a report on the availability of supplemental health care benefits (as described in section 1852(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–22(a)(3)(A))) designed to treat or prevent substance use disorders under Medicare Advantage plans offered under part C of title XVIII of such Act. Such report shall include the analysis described in subsection (c) and any differences in the availability of such benefits under specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of such Act (42 U.S.C. 1395w–28(b)(6))) offered to individuals entitled to medical assistance under title XIX of such Act and other such Medicare Advantage plans.

(b) CONSULTATION.—The Secretary shall develop the report described in subsection (a) in consultation with relevant stakeholders, including—

(1) individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act;

(2) entities who advocate on behalf of such individuals;

(3) Medicare Advantage organizations;

(4) pharmacy benefit managers; and

(5) providers of services and suppliers (as such terms are defined in section 1861 of such Act (42 U.S.C. 1395x)).

(c) CONTENTS.—The report described in subsection (a) shall include an analysis on the following:

(1) The extent to which plans described in such subsection offer supplemental health care benefits relating to coverage of—

(A) medication-assisted treatments for opioid use, substance use disorder counseling, peer recovery support services, or other forms of substance use disorder treatments (whether furnished in an inpatient or outpatient setting); and

(B) non-opioid alternatives for the treatment of pain.

(2) Challenges associated with such plans offering supplemental health care benefits relating to coverage of items and services described in subparagraph (A) or (B) of paragraph (1).

(3) The impact, if any, of increasing the applicable rebate percentage determined under section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) for plans offering such benefits relating to such coverage would have on the availability of such benefits relating to such coverage offered under Medicare Advantage plans.

(4) Potential ways to improve upon such coverage or to incentivize such plans to offer additional supplemental health care benefits relating to such coverage.

SEC. 5. CLINICAL PSYCHOLOGIST SERVICES MODELS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION; GAO STUDY AND REPORT.

(a) CMI MODELS.—Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B) is amended by adding at the end the following new clauses:

''(xxv) Supporting ways to familiarize individuals with the availability of coverage under part B of title XVIII for qualified psychologist services (as defined in section 1861(ii)).

''(xxvi) Exploring ways to avoid unnecessary hospitalizations or emergency department visits for mental and behavioral health services (such as for treating depression) through use of a 24-hour, 7-day a week help line that may inform individuals about the availability of treatment options, including the availability of qualified psychologist services (as defined in section 1861(ii)).''.

(b) GAO STUDY AND REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a study, and submit to Congress a report, on mental and behavioral health services under the Medicare program under title XVIII of the Social Security Act, including an examination of the following:

(1) Information about services furnished by psychiatrists, clinical psychologists, and other professionals.

(2) Information about ways that Medicare beneficiaries familiarize themselves about the availability of Medicare payment for qualified psychologist services (as defined in section 1861(ii) of the Social Security Act (42 U.S.C. 1395x(ii)) and ways that the provision of such information could be improved.

SEC. 6. PAIN MANAGEMENT STUDY.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall conduct a study analyzing best practices as well as payment and coverage for pain management services under title XVIII of the Social Security Act and submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report containing options for revising payment to providers and suppliers of services and coverage related to the use of multi-disciplinary, evidence-based, non-opioid treatments for acute and chronic pain management for individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act. The Secretary shall make such report available on the public website of the Centers for Medicare & Medicaid Services.

(b) CONSULTATION.—In developing the report described in subsection (a), the Secretary shall consult with—

(1) relevant agencies within the Department of Health and Human Services;

(2) licensed and practicing osteopathic and allopathic physicians, behavioral health practitioners, physician assistants, nurse practitioners, dentists, pharmacists, and other providers of health services;

(3) providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x));

(4) substance abuse and mental health professional organizations;

(5) pain management professional organizations and advocacy entities, including individuals who personally suffer chronic pain;

(6) medical professional organizations and medical specialty organizations;

(7) licensed health care providers who furnish alternative pain management services;

(8) organizations with expertise in the development of innovative medical technologies for pain management;

(9) beneficiary advocacy organizations; and

(10) other organizations with expertise in the assessment, diagnosis, treatment, and management of pain, as determined appropriate by the Secretary.

(c) CONTENTS.—The report described in subsection (a) shall include the following:

(1) An analysis of payment and coverage under title XVIII of the Social Security Act with respect to the following:

(A) Evidence-based treatments and technologies for chronic or acute pain, including such treatments that are covered, not covered, or have limited coverage under such title.

(B) Evidence-based treatments and technologies that monitor substance use withdrawal and prevent overdoses of opioids.

(C) Evidence-based treatments and technologies that treat substance use disorders.

(D) Items and services furnished by practitioners through a multi-disciplinary treatment model for pain management, including the patient-centered medical home.

(E) Medical devices, non-opioid based drugs, and other therapies (including interventional and integrative pain therapies) approved or cleared by the Food and Drug Administration for the treatment of pain.

(F) Items and services furnished to beneficiaries with psychiatric disorders, substance use disorders, or who are at risk of suicide, or have comorbidities and require consultation or management of pain with one or more specialists in pain management, mental health, or addiction treatment.

(2) An evaluation of the following:

(A) Barriers inhibiting individuals entitled to benefits under part A or enrolled under part B of such title from accessing treatments and technologies described in subparagraphs (A) through (F) of paragraph (1).

(B) Costs and benefits associated with potential expansion of coverage under such title to include items and services not covered under such title that may be used for the treatment of pain, such as acupuncture, therapeutic massage, and items and services furnished by integrated pain management programs.

(C) Pain management guidance published by the Federal Government that may be relevant to coverage determinations or other coverage requirements under title XVIII of the Social Security Act.

(3) An assessment of all guidance published by the Department of Health and Human Services on or after January 1, 2016, relating to the prescribing of opioids. Such assessment shall consider incorporating into such guidance relevant elements of the ''Va/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain'' published in February 2017 by the Department of Veterans Affairs and Department of Defense, including adoption of elements of the Department of Defense and Veterans Administration pain rating scale.

(4) The options described in subsection (d).

(5) The impact analysis described in subsection (e).

(d) OPTIONS.—The options described in this subsection are, with respect to individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act, legislative and administrative options for accomplishing the following:

(1) Improving coverage of and payment for pain management therapies without the use of opioids, including interventional pain therapies, and options to augment opioid therapy with other clinical and complementary, integrative health services to minimize the risk of substance use disorder, including in a hospital setting.

(2) Improving coverage of and payment for medical devices and non-opioid based pharmacological and non-pharmacological therapies approved or cleared by the Food and Drug Administration for the treatment of pain as an alternative or augment to opioid therapy.

(3) Improving and disseminating treatment strategies for beneficiaries with psychiatric disorders, substance use disorders, or who are at risk of suicide, and treatment strategies to address health disparities related to opioid use and opioid abuse treatment.

(4) Improving and disseminating treatment strategies for beneficiaries with comorbidities who require a consultation or comanagement of pain with one or more specialists in pain management, mental health, or addiction treatment, including in a hospital setting.

(5) Educating providers on risks of coadministration of opioids and other drugs, particularly benzodiazepines.

(6) Ensuring appropriate case management for beneficiaries who transition between inpatient and outpatient hospital settings, or between opioid therapy to non-opioid therapy, which may include the use of care transition plans.

(7) Expanding outreach activities designed to educate providers of services and suppliers under the Medicare program and individuals entitled to benefits under part A or under part B of such title on alternative, non-opioid therapies to manage and treat acute and chronic pain.

(8) Creating a beneficiary education tool on alternatives to opioids for chronic pain management.

(e) IMPACT ANALYSIS.—The impact analysis described in this subsection consists of an analysis of any potential effects implementing the options described in subsection (d) would have—

(1) on expenditures under the Medicare program; and

(2) on preventing or reducing opioid addiction for individuals receiving benefits under the Medicare program.

SEC. 7. SUSPENSION OF PAYMENTS BY MEDICARE PRESCRIPTION DRUG PLANS AND MA–PD PLANS PENDING INVESTIGATIONS OF CREDIBLE ALLEGATIONS OF FRAUD BY PHARMACIES.

(a) IN GENERAL.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

''(7) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD BY PHARMACIES.—

''(A) IN GENERAL.—The provisions of section 1862(o) shall apply with respect to a PDP sponsor with a contract under this part,

a pharmacy, and payments to such pharmacy under this part in the same manner as such provisions apply with respect to the Secretary, a provider of services or supplier, and payments to such provider of services or supplier under this title.

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of a PDP sponsor to conduct postpayment review.''.

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

''(D) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD BY PHARMACIES.—Section 1860D–12(b)(7).''.

(c) CONFORMING AMENDMENT.—Section 1862(o)(3) of the Social Security Act (42 U.S.C. 1395y(o)(3)) is amended by inserting '', section 1860D–12(b)(7) (including as applied pursuant to section 1857(f)(3)(D)),'' after ''this subsection''.

(d) CLARIFICATION RELATING TO CREDIBLE ALLEGATION OF FRAUD.—Section 1862(o) of the Social Security Act (42 U.S.C. 1395y(o)) is amended by adding at the end the following new paragraph:

''(4) CREDIBLE ALLEGATION OF FRAUD.—In carrying out this subsection, section 1860D–12(b)(7) (including as applied pursuant to section 1857(f)(3)(D)), and section 1903(i)(2)(C), a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for a credible allegation of fraud.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2020.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Indiana (Mrs. WALORSKI) and the gentlewoman from California (Ms. JUDY CHU) each will control 20 minutes.

The Chair recognizes the gentlewoman from Indiana.

GENERAL LEAVE

Mrs. WALORSKI. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 6110, currently under consideration.

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

There was no objection.

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

Mr. Speaker, I rise today in support of H.R. 6110, the Dr. Todd Graham Pain Management, Treatment, and Recovery Act.

Solving the opioid epidemic requires everyone to work together at all levels, from the Federal Government down to those on the front lines of this fight.

My legislation focuses on increasing access to pain management alternatives that do not involve opioids and improving recovery treatment options for those suffering from opioid use disorder.

Additionally, my legislation contains the following provisions that will also be vital in overcoming this crisis: H.R. 5778, the Promoting Outpatient Access to Non-Opioid Treatments Act introduced by Representative KENNY MARCHANT and Health Subcommittee Ranking Member SANDER LEVIN, which requires the Secretary of Health and Human Services, or HHS, to require payments made to hospital outpatient departments and ambulatory surgery centers to ensure there are no financial incentives to use opioids over nonopioid alternatives; H.R. 5769, the Expanding Access to Treatment Act introduced by Representatives KEITH ROTHFUS and DANNY DAVIS, which provides payments to federally qualified health centers and rural health clinics to offset the cost of their providers receiving training so they are able to provide medication-assisted treatment that will help individuals recover from opioid use disorder; H.R. 5725, the Benefit Evaluation of Safe Treatment Act introduced by Health Subcommittee Chairman PETER ROSKAM and Representatives LINDA SÁNCHEZ, JOHN SHIMKUS, and RAUL RUIZ, which directs the Secretary of HHS to evaluate the extent to which MA plans offer medication-assisted treatments and cover nonopioid alternative treatments not otherwise covered under a Medicare fee for service as part of a supplemental benefit; and H.R. 5790, the Medicare Nurse Hotline Act introduced by Representatives KRISTI NOEM and JUDY CHU, which directs the Secretary of HHS to educate patients on the availability of psychologist services and explore the use of hotlines to reduce unnecessary hospitalizations and Medicare.

The bill is named after my friend Dr. Todd Graham. He was a double board certified physician in both physical medicine and rehabilitation and pain medicine who lived and worked in my district in northern Indiana.

Last year, he was senselessly murdered after refusing to prescribe an opioid to a patient.

Dr. Graham prided himself on serving his patients in a friendly and caring fashion. He treated each person individually, taking the time to offer specific steps to treat their issues.

One day last year, he had an interaction with a patient demanding opioids, a situation that has become disturbingly all too common. He stood firm in refusing to write a prescription for her, but her husband, who was also there, became increasingly angry throughout that visit. Two hours after they left his office, the husband returned and murdered him in cold blood.

Dr. Graham's loss has been a heavy blow, but his legacy of compassion and enthusiasm lives on through his wife, Julie; their two daughters; and their son, who plans to follow in his father's footsteps.

We are lucky to have the Graham family with us here today to witness the passage of this important bill.

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

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, June 8, 2018.

Hon. GREG WALDEN,
Chairman, Committee on Energy and Commerce, Washington, DC.

DEAR CHAIRMAN WALDEN: I write to you regarding several opioid bills the Committee on Ways and Means ordered favorably reported to address the opioid epidemic. The following bills were also referred to the Committee on Energy and Commerce.

I ask that the Committee on Energy and Commerce waive formal consideration of the following bills so that they may proceed expeditiously to the House Floor:

H.R. 5774, Combatting Opioid Abuse for Care in Hospitals (COACH) Act;

H.R. 5775, Providing Reliable Options for Patients and Educations Resources (PROPER) Act;

H.R. 5776, Medicare and Opioid Safe Treatment (MOST) Act;

H.R. 5773, Preventing Addition for Susceptible Seniors (PASS) Act;

H.R. 5676, Stop Excessive Narcotics in our Retirement (SENIOR) Communities Protection Act; and

H.R. 5723, Expanding Oversight of Opioid Prescribing and Payment Act.

I acknowledge that by waiving formal consideration of the bills, the Committee on Energy and Commerce is in no way waiving its jurisdiction over the subject matter contained in those provisions of the bills that fall within your Rule X jurisdiction. I would support your effort to seek appointment of an appropriate number of conferees on any House-Senate conference involving this legislation.

I will include a copy of our letters in the Congressional Record during consideration of this legislation on the House floor.

Sincerely,

KEVIN BRADY,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, June 8, 2018.

Hon. KEVIN BRADY,
Chairman, Committee on Ways and Means, Washington, DC.

DEAR CHAIRMAN BRADY: Thank you for your letter regarding the following bills, which were also referred to the Committee on Energy and Commerce:

H.R. 5774, Combatting Opioid Abuse for Care in Hospitals (COACH) Act;

H.R. 5775, Providing Reliable Options for Patients and Educations Resources (PROPER) Act;

H.R. 5776, Medicare and Opioid Safe Treatment (MOST) Act;

H.R. 5773, Preventing Addition for Susceptible Seniors (PASS) Act;

H.R. 5676, Stop Excessive Narcotics in our Retirement (SENIOR) Communities Protection Act; and

H.R. 5723, Expanding Oversight of Opioid Prescribing and Payment Act.

I wanted to notify you that the Committee will forgo action on these bills so that they may proceed expeditiously to the House floor.

I appreciate your acknowledgment that by forgoing formal consideration of these bills, the Committee on Energy and Commerce is in no way waiving its jurisdiction over the subject matter contained in those provisions of the bills that fall within its Rule X jurisdiction. I also appreciate your offer to support the Committee's request for the appointment of conferees in the event of a House-Senate conference involving this legislation.

Thank you for your assistance on this matter.

Sincerely,

GREG WALDEN,
Chairman.

Ms. JUDY CHU of California. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, according to the Centers for Disease Control and Prevention, more than 42,000 Americans died from opioid-related drug overdoses in 2016. That is five times more than the overdose rate in 1999.

As we have heard from countless Members in this Chamber, there is no congressional district that hasn't been impacted by the opioid crisis. No town or city is immune from the devastating impact of addiction, and I hope that the steps we take today are the first of many to address the needs of our communities.

The Substance Abuse and Mental Health Services Administration, or SAMHSA, estimated that in 2016, 11.8 million Americans over the age of 12 had misused opioids in the past year and 3.8 million were currently misusing prescription pain relievers.

But while we are seeing news reports of the devastating toll this crisis is taking on our Nation's young people, it is important to note that our seniors are also suffering. From 2005 to 2014, individuals 65 years and older experienced an 85 percent cumulative increase in opioid-related inpatient stays and a 112 percent cumulative increase in emergency department visits, the largest increase of any age group.

Compared to other age groups, individuals 65 and older have the highest rate of opioid-related inpatient stays in 13 States, including my home State of California.

This crisis is especially acute for the nonelderly Medicare population. In 2015, nonelderly Medicare beneficiaries, or those who qualify on the basis of disability, had opioid utilization rates more than twice that of elderly beneficiaries.

The bill before us, H.R. 6110, contains numerous provisions aimed at improving access to treatment for Medicare beneficiaries suffering from opioid use disorders, including access to nondrug opioid alternatives.

While every alternative will not work for every person, when dealing with a crisis of this magnitude, I believe that we must use every tool in the toolbox.

This bill contains two bipartisan provisions I authored with my colleagues on the Ways and Means Committee.

Mr. Speaker, I thank the gentlewoman from Indiana (Mrs. WALORSKI) for working with me on language that would direct CMS to study barriers to patient access to nondrug alternatives for opioids in chronic care settings.

Studies conducted by the NIH have concluded that alternative treatments, like acupuncture, can be effective in treating conditions like chronic pain. This issue is very important to me, because I have been working to expand access to acupuncture since I first arrived in the California State legislature many years ago. I have heard firsthand what a difference acupuncture can make in the lives of patients.

I remember very clearly when I heard the testimony of a woman who had severe back pain, but did not want invasive surgery and risk possible addiction to morphine.

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Instead, she sought acupuncture, and it worked for her. She avoided the risks associated with surgery and certain pain medications.

Furthermore, we know access to physical and occupational therapy also helps alleviate pain and eliminates the need for an opioid prescription.

By asking CMS to examine where barriers to these alternatives exist, we can open the door to more treatment alternatives for beneficiaries.

I am also proud that this bill includes a provision I authored with the gentlewoman from North Dakota (Mrs. NOEM) to address the need for more psychologists in the Medicare program. This bill would direct the Centers for Medicare and Medicaid Innovation to examine ways for beneficiaries to familiarize themselves with coverage for psychologist services and request a study from the General Accountability Office on the viability of mental and behavioral health services in the Medicare program.

As one of only two psychologists in Congress, I firmly believe that expanding access to psychologist services in Medicare is one of the most important things we can do to improve the mental health of our senior population.

We know that those who suffer from depression or other mental health disorders are particularly vulnerable to addiction. For those who have already taken the incredibly difficult step of seeking treatment, we need to ensure that they have access to the full range of mental health professionals who can support them on the journey to recovery.

H.R. 6110 also contains a number of provisions from my colleagues on the Ways and Means Committee. Congress Members LEVIN and MARCHANT authored a provision to review certain Medicare payments in outpatient settings to determine whether there are financial incentives in the Medicare program to use or prescribe opioids instead of evidence-based, nonopioid alternatives.

Next, the legislation includes a provision introduced by Congress Members SANCHEZ and ROSKAM that would direct the Secretary of HHS to evaluate the extent to which Medicare Advantage programs offer medication-assisted treatment, or MAT, and cover nonopioid alternative treatments not otherwise covered under traditional Medicare as part of a supplemental benefit.

Finally, this bill would also include a provision from Congress Members DANNY DAVIS and ROTHFUS that would provide grants to federally qualified centers and rural health clinics to help offset the cost of training providers to become certified in dispensing medications for opioid abuse dependence.

While the provisions in the bills before us this afternoon will certainly move us in the right direction, we cannot stop here. For example, the Medicaid program pays for the majority of mental health and substance abuse treatments in this country and, yet, we see multiple attempts by Republicans over the past 4 years to slash this program.

We must maintain protections for those with preexisting conditions so that those who sought treatment for their addiction disorders are not punished for trying to get sober.

We must maintain the progress we have made with the Affordable Care Act and work together to bring down the premiums for American families so that, should they need coverage for mental health counseling or substance abuse treatment, no one is shut out because of how much money they make or what State they live in.

So I hope that today represents the first step, and I hope my colleagues on the other side of the aisle will continue to work with us to invest in prevention, treatment, and recovery efforts all across the country.

I encourage my colleagues to support this legislation, and I reserve the balance of my time.

Mrs. WALORSKI. Mr. Speaker, having no other speakers, I reserve the balance of my time.

Ms. JUDY CHU of California. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I am encouraged to see my colleagues on the other side of the aisle turn their attention to this critical issue. But this is not a new problem, and the coverage expansions under the Affordable Care Act have been among the most significant steps the Federal Government has taken to stem the tide of the opioid crisis. And yet, Republicans in Congress and President Trump have actively worked to repeal this landmark law.

The Medicaid expansion and the increased coverage under the individual market have provided millions of Americans access to health insurance, and research has shown that Medicaid expansion States have seen a greater reduction in deaths from opioids than nonexpansion States.

Again, Medicaid is the biggest payer for substance use disorder treatment in this country. We simply can't afford to go back.

As we discuss this crisis today and in the week to come, we must broaden our understanding of the ways in which we, as a Nation, approach chronic pain. That is exactly what H.R. 6110 does.

While there will always be patients who have a legitimate need for these medications, we need to look beyond a system where an opioid prescription is

the automatic default. This means we need to look to alternative methods of treating pain, whether it be acupuncture or physical therapy or a medical device. It means we must examine existing policies that may have inadvertently incentivized opioid prescribing practices.

But as much as we look forward, we must also address the crisis in front of us. So I am thrilled to see provisions in this bill that would study Medicare Advantage plans already doing groundbreaking work in substance abuse disorder treatment.

I am also glad to see that this bill provides direct resources to the front lines in the form of grants for federally qualified health centers to provide additional training for our providers.

I hope that, in the future, we will work to expand access to alternatives, both within the Medicare program and in the broader population, and ensure that no matter where someone lives or what kind of insurance coverage they have, they are able to seek treatment.

I urge my colleagues to support H.R. 6110, and I yield back the balance of my time.

Mrs. WALORSKI. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, this epidemic knows no boundaries. Opioid abuse continues to devastate families and communities all over this country. As we continue to work toward commonsense solutions to the opioid epidemic, this bipartisan legislation will help break down barriers to nonopioid treatments and give healthcare providers better tools to prevent addiction and to assist in recovery.

I want to thank Chairman BRADY for all of his hard work, as well as my friend Ms. JUDY CHU of California, who helped develop and introduce this bill.

I urge 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 gentlewoman from Indiana (Mrs. WALORSKI) that the House suspend the rules and pass the bill, H.R. 6110.

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.

COMBATING OPIOID ABUSE FOR CARE IN HOSPITALS ACT OF 2018

Mrs. WALORSKI. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5774) to require the Secretary of Health and Human Services to develop guidance on pain management and opioid use disorder prevention for hospitals receiving payment under part A of the Medicare program, provide for opioid quality measures development, and provide for a technical expert panel on reducing surgical setting opioid use and data collection on perioperative opioid use, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5774

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 ''Combating Opioid Abuse for Care in Hospitals Act of 2018'' or the ''COACH Act of 2018''.

SEC. 2. DEVELOPING GUIDANCE ON PAIN MANAGEMENT AND OPIOID USE DISORDER PREVENTION FOR HOSPITALS RECEIVING PAYMENT UNDER PART A OF THE MEDICARE PROGRAM.

(a) IN GENERAL.—Not later than January 1, 2019, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop and publish on the public website of the Centers for Medicare & Medicaid Services guidance for hospitals receiving payment under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) on pain management strategies and opioid use disorder prevention strategies with respect to individuals entitled to benefits under such part.

(b) CONSULTATION.—In developing the guidance described in subsection (a), the Secretary shall consult with relevant stakeholders, including—

(1) medical professional organizations;

(2) providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x));

(3) health care consumers or groups representing such consumers; and

(4) other entities determined appropriate by the Secretary.

(c) CONTENTS.—The guidance described in subsection (a) shall include, with respect to hospitals and individuals described in such subsection, the following:

(1) Best practices regarding evidence-based screening and practitioner education initiatives relating to screening and treatment protocols for opioid use disorder, including—

(A) methods to identify such individuals at-risk of opioid use disorder, including risk stratification;

(B) ways to prevent, recognize, and treat opioid overdoses; and

(C) resources available to such individuals, such as opioid treatment programs, peer support groups, and other recovery programs.

(2) Best practices for such hospitals to educate practitioners furnishing items and services at such hospital with respect to pain management and substance use disorders, including education on—

(A) the adverse effects of prolonged opioid use;

(B) non-opioid, evidence-based, non-pharmacological pain management treatments;

(C) monitoring programs for individuals who have been prescribed opioids; and

(D) the prescribing of naloxone along with an initial opioid prescription.

(3) Best practices for such hospitals to make such individuals aware of the risks associated with opioid use (which may include use of the notification template described in paragraph (4)).

(4) A notification template developed by the Secretary, for use as appropriate, for such individuals who are prescribed an opioid that—

(A) explains the risks and side effects associated with opioid use (including the risks of addiction and overdose) and the importance of adhering to the prescribed treatment regimen, avoiding medications that may have an adverse interaction with such opioid, and storing such opioid safely and securely;

(B) highlights multimodal and evidence-based non-opioid alternatives for pain management;

(C) encourages such individuals to talk to their health care providers about such alternatives;

(D) provides for a method (through signature or otherwise) for such an individual, or person acting on such individual's behalf, to acknowledge receipt of such notification template;

(E) is worded in an easily understandable manner and made available in multiple languages determined appropriate by the Secretary; and

(F) includes any other information determined appropriate by the Secretary.

(5) Best practices for such hospital to track opioid prescribing trends by practitioners furnishing items and services at such hospital, including—

(A) ways for such hospital to establish target levels, taking into account the specialties of such practitioners and the geographic area in which such hospital is located, with respect to opioids prescribed by such practitioners;

(B) guidance on checking the medical records of such individuals against information included in prescription drug monitoring programs;

(C) strategies to reduce long-term opioid prescriptions; and

(D) methods to identify such practitioners who may be over-prescribing opioids.

(6) Other information the Secretary determines appropriate, including any such information from the Opioid Safety Initiative established by the Department of Veterans Affairs or the Opioid Overdose Prevention Toolkit published by the Substance Abuse and Mental Health Services Administration.

SEC. 3. REQUIRING THE REVIEW OF QUALITY MEASURES RELATING TO OPIOIDS AND OPIOID USE DISORDER TREATMENTS FURNISHED UNDER THE MEDICARE PROGRAM AND OTHER FEDERAL HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1890A of the Social Security Act (42 U.S.C. 1395aaa–1) is amended by adding at the end the following new subsection:

''(g) TECHNICAL EXPERT PANEL REVIEW OF OPIOID AND OPIOID USE DISORDER QUALITY MEASURES.—

''(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall establish a technical expert panel for purposes of reviewing quality measures relating to opioids and opioid use disorders, including care, prevention, diagnosis, health outcomes, and treatment furnished to individuals with opioid use disorders. The Secretary may use the entity with a contract under section 1890(a) and amend such contract as necessary to provide for the establishment of such technical expert panel.

''(2) REVIEW AND ASSESSMENT.—Not later than 1 year after the date the technical expert panel described in paragraph (1) is established (and periodically thereafter as the Secretary determines appropriate), the technical expert panel shall—

''(A) review quality measures that relate to opioids and opioid use disorders, including existing measures and those under development;

''(B) identify gaps in areas of quality measurement that relate to opioids and opioid use disorders, and identify measure development priorities for such measure gaps; and

''(C) make recommendations to the Secretary on quality measures with respect to opioids and opioid use disorders for purposes of improving care, prevention, diagnosis, health outcomes, and treatment, including recommendations for revisions of such measures, need for development of new measures, and recommendations for including such