

ACCESS TO TELEHEALTH SERVICES FOR SUBSTANCE
USE DISORDERS ACT

JUNE 12, 2018.—Committed to the Committee of the Whole House on the State of
the Union and ordered to be printed

Mr. WALDEN, from the Committee on Energy and Commerce,
submitted the following

R E P O R T

[To accompany H.R. 5603]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 5603) to amend title XVIII of the Social Security Act to provide the Secretary of Health and Human Services authority to waive certain Medicare telehealth requirements in the case of certain treatment of an opioid use disorder or co-occurring mental health disorder, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

CONTENTS

	Page
Purpose and Summary	3
Background and Need for Legislation	3
Committee Action	3
Committee Votes	4
Oversight Findings and Recommendations	4
New Budget Authority, Entitlement Authority, and Tax Expenditures	4
Congressional Budget Office Estimate	4
Federal Mandates Statement	26
Statement of General Performance Goals and Objectives	26
Duplication of Federal Programs	26
Committee Cost Estimate	26
Earmark, Limited Tax Benefits, and Limited Tariff Benefits	27
Disclosure of Directed Rule Makings	27
Advisory Committee Statement	27
Applicability to Legislative Branch	27
Section-by-Section Analysis of the Legislation	27
Changes in Existing Law Made by the Bill, as Reported	27
Exchange of Letters with Additional Committees of Referral	96

The amendment are as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Access to Telehealth Services for Substance Use Disorders Act”.

SEC. 2. AUTHORITY NOT TO APPLY CERTAIN MEDICARE TELEHEALTH REQUIREMENTS IN THE CASE OF CERTAIN TREATMENT OF A SUBSTANCE USE DISORDER OR CO-OCCURRING MENTAL HEALTH DISORDER.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(1) in paragraph (2)(B)(i), by inserting “and paragraph (7)(E)” after “Subject to clause (ii)”; and

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

“(7) AUTHORITY NOT TO APPLY CERTAIN REQUIREMENTS IN THE CASE OF CERTAIN TREATMENT OF SUBSTANCE USE DISORDER OR CO-OCCURRING MENTAL HEALTH DISORDER.—

“(A) IN GENERAL.—For purposes of payment under this subsection, in the case of telehealth services described in subparagraph (C) furnished on or after January 1, 2020, to an eligible beneficiary (as defined in subparagraph (F)) for the treatment of a substance use disorder or a mental health disorder that is co-occurring with a substance use disorder, the Secretary is authorized to, through rulemaking, not apply any of the requirements described in subparagraph (B).

“(B) REQUIREMENTS DESCRIBED.—For purposes of this paragraph, the requirements described in this subparagraph are any of the following:

“(i) Qualifications for an originating site under paragraph (4)(C)(ii).

“(ii) Geographic limitations under paragraph (4)(C)(i).

“(C) TELEHEALTH SERVICES DESCRIBED.—For purposes of this paragraph, the telehealth services described in this subparagraph are services that are both telehealth services and identified by the Secretary, through rulemaking, as services that are the most commonly furnished (as defined by the Secretary) under this part to individuals diagnosed with a substance use disorder or a mental health disorder that is co-occurring with a substance use disorder.

“(D) CLARIFICATION.—Nothing in this paragraph shall be construed as limiting or otherwise affecting the authority of the Secretary to limit or eliminate the non-application pursuant to this paragraph of any of the requirements under subparagraph (B).

“(E) TREATMENT OF ORIGINATING SITE FACILITY FEE.—No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (B) for which payment is made under this subsection by reason of the non-application of a requirement described in subparagraph (B) pursuant to this paragraph if payment for such service would not otherwise be permitted under this subsection if such requirement were applied.

“(F) ELIGIBLE BENEFICIARY DEFINED.—For purposes of this paragraph, the term ‘eligible beneficiary’ means an individual who—

“(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under this part;

“(ii) has a diagnosis for a substance use disorder; and

“(iii) meets such other criteria as the Secretary determines appropriate.

“(G) REPORT.—Not later than 5 years after the date of the enactment of this paragraph, the Secretary shall submit to Congress a report on the impact of any non-application under this paragraph of any of the requirements described in subparagraph (B) on

“(i) the utilization of health care services related to substance use disorder, such as behavioral health services and emergency department visits; and

“(ii) health outcomes related to substance use disorder, such as substance use overdose deaths.

“(H) FUNDING.—For purposes of carrying out this paragraph, in addition to funds otherwise available, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of \$3,000,000 to the Centers for Medicare & Medicaid Services Program Management Account to remain available until expended.

“(8) RULE OF CONSTRUCTION.—Nothing in this subsection may be construed as waiving requirements under this title to comply with applicable State law, including State licensure requirements.”.

Amend the title so as to read:

A bill to amend title XVIII of the Social Security Act to provide the Secretary of Health and Human Services authority not to apply certain Medicare telehealth requirements in the case of certain treatment of a substance use disorder or co-occurring mental health disorder.

PURPOSE AND SUMMARY

H.R. 5603, Access to Telehealth Services for Opioid Use Disorders, was introduced on April 24, 2018, by Rep. Doris Matsui (D-CA), Rep. Tony Cardenas (D-CA), and Rep. Bill Johnson (R-OH). The bill would require the Centers for Medicare and Medicaid Services (CMS) to expand the use of telehealth services in treating substance use disorder in the Medicare program.

BACKGROUND AND NEED FOR LEGISLATION

The Medicare program serves as the healthcare coverage provider to over 58 million beneficiaries. This number is projected to rise to over 80 million by 2030. In serving the over age 65 population, Medicare accounts for a large share of total opioid prescriptions. In 2016, one out of every three beneficiaries was prescribed an opioid through Medicare Part D. In total, this equates to almost 80 million prescriptions and \$4 billion in Medicare Part D spending. While many Medicare beneficiaries with serious pain-related conditions are being properly prescribed opioids, there is mounting evidence of opioid misuse in the Medicare system. As more seniors and individuals with disabilities come into the program, the challenges of fraud, misuse, and abuse will only increase.

This bill seeks to expand the use of telehealth services for treating substance use disorder by giving the Secretary of the Department of Health and Human Services the flexibility to lift the rural and originating site requirements for telehealth services for the treatment of substance use disorders and co-occurring mental health disorders.

COMMITTEE ACTION

On April 11 and 12, 2018, the Subcommittee on Health held a hearing entitled “Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients” to review legislation related to the opioid epidemic. The Subcommittee received testimony from:

- Kimberly Brandt, Principal Deputy Administrator for Operations, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services;
- Michael Botticelli, Executive Director, Grayken Center for Addiction, Boston Medical Center;
- Toby Douglas, Senior Vice President, Medicaid Solutions, Centene Corporation;
- David Guth, CEO, Centerstone;
- John Kravitz, CIO, Geisinger Health System; and,
- Sam Srivastava, CEO, Magellan Health.

On April 25, 2018, the Subcommittee on Health met in open markup session and forwarded a discussion draft, entitled “Use of Telehealth to Treat Opioid Use Disorder,” without amendment, to the full Committee by a voice vote. On May 17, 2018, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 5603, as amended, favorable reported to the House by a voice vote. H.R. 5603 was similar to the discussion draft forwarded by the Subcommittee.

COMMITTEE VOTES

Clause 3(b) of rule XIII requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 5603 reported.

OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 2(b)(1) of rule X and clause 3(c)(1) of rule XIII, the Committee held a hearing and made findings that are reflected in this report.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Pursuant to clause 3(c)(2) of rule XIII, the Committee finds that H.R. 5603 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 6, 2018.

Hon. GREG WALDEN,
*Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed document with cost estimates for the opioid-related legislation ordered to be reported on May 9 and May 17, 2018.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Tom Bradley and Chad Chirico.

Sincerely,

MARK P. HADLEY
(For Keith Hall, Director).

Enclosure.

Opioid Legislation

Summary: On May 9 and May 17, 2018, the House Committee on Energy and Commerce ordered 59 bills to be reported related to

the nation's response to the opioid epidemic. Generally, the bills would:

- Provide grants to facilities and providers that treat people with substance use disorders,
- Direct various agencies within the Department of Health and Human Services (HHS) to explore nonopioid approaches to treating pain and to educate providers about those alternatives,
- Modify requirements under Medicaid and Medicare for prescribing controlled substances,
- Expand Medicaid coverage for substance abuse treatment, and
- Direct the Food and Drug Administration (FDA) to modify its oversight of opioid drugs and other medications that are used to manage pain.

Because of the large number of related bills ordered reported by the Committee, CBO is publishing a single comprehensive document that includes estimates for each piece of legislation.

CBO estimates that enacting 20 of the bills would affect direct spending, and 2 of the bills would affect revenues; therefore, pay-as-you-go procedures apply for those bills.

CBO estimates that enacting H.R. 4998, the Health Insurance for Former Foster Youth Act, would increase net direct spending by more than \$2.5 billion and on-budget deficits by more than \$5 billion in at least one of the four consecutive 10-year periods beginning in 2029. None of the remaining 58 bills included in this estimate would increase net direct spending by more than \$2.5 billion or on-budget deficits by more than \$5 billion in any of the four consecutive 10-year periods beginning in 2029.

One of the bills reviewed for this document, H.R. 5795, would impose both intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the costs of those mandates on public and private entities would fall below the thresholds in UMRA (\$80 million and \$160 million, respectively, in 2018, adjusted annually for inflation). Five bills, H.R. 5228, H.R. 5333, H.R. 5554, H.R. 5687, and H.R. 5811, would impose private-sector mandates as defined in UMRA. CBO estimates that the costs of the mandates in three of the bills (H.R. 5333, H.R. 5554, and H.R. 5811) would not exceed the UMRA threshold for private entities. Because CBO is uncertain how federal agencies would implement new authority granted in the other two bills, H.R. 5228 and H.R. 5687, CBO cannot determine whether the costs of those mandates would exceed the UMRA threshold.

Estimated cost to the Federal Government: The estimates in this document do not include the effects of interactions among the bills. If all 59 bills were combined and enacted as one piece of legislation, the budgetary effects would be different from the sum of the estimates in this document, although CBO expects that any such differences would be small. The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), 750 (administration of justice), and 800 (general government).

Basis of estimate: For this estimate, CBO assumes that all of the legislation will be enacted late in 2018 and that authorized and estimated amounts will be appropriated each year. Outlays for discre-

tionary programs are estimated based on historical spending patterns for similar programs.

Uncertainty

CBO aims to produce estimates that generally reflect the middle of a range of the most likely budgetary outcomes that would result if the legislation was enacted. Because data on the utilization of mental health and substance abuse treatment under Medicaid and Medicare is scarce, CBO cannot precisely predict how patients or providers would respond to some policy changes or what budgetary effects would result. In addition, several of the bills would give the Department of Health and Human Services (HHS) considerable latitude in designing and implementing policies. Budgetary effects could differ from those provided in CBO's analyses depending on those decisions.

Direct spending and revenues

Table 1 lists the 22 bills of the 59 ordered to be reported that would affect direct spending or revenues.

TABLE 1.—ESTIMATED CHANGES IN MANDATORY SPENDING AND REVENUES

By fiscal year, in millions of dollars—

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019– 2023	2019–2028
INCREASES OR DECREASES (–) IN DIRECT SPENDING													
Legislation Primarily Affecting Medicaid:													
H.R. 1925, At-Risk Youth Medicaid Protection Act of 2017	0	*	5	5	5	10	10	10	10	10	10	25	75
H.R. 4998, Health Insurance for Former Foster Youth Act	0	0	0	0	0	*	10	21	33	46	61	*	171
H.R. 5477, Rural Development of Opioid Capacity Services Act	0	13	35	58	68	83	27	9	3	3	3	256	301
H.R. 5583, a bill to amend title XI of the Social Security Act to require States to annually report on certain adult health quality measures, and for other purposes	0	*	*	*	*	*	*	*	*	*	*	*	*
H.R. 5797, IMD CARE Act	0	38	158	251	265	279	0	0	0	0	0	991	991
H.R. 5799, Medicaid DRUG Improvement Act ^a	0	*	*	1	1	1	1	1	1	1	1	2	5
H.R. 5801, Medicaid Providers Are Required To Note Experiences in Record Systems to Help In-Need Patients (PARTNERSHIP) Act ^a	0	*	*	*	*	*	*	*	*	*	*	*	*
H.R. 5808, Medicaid Pharmaceutical Home Act of 2018 ^a	0	*	-1	-1	-1	-1	-2	-2	-2	-2	-2	-4	-13
H.R. 5810, Medicaid Health HOME Act	0	94	58	62	56	52	48	43	38	32	25	323	509
Legislation Primarily Affecting Medicare:													
H.R. 3528, Every Prescription Conveyed Securely Act	0	0	0	-24	-35	-33	-30	-33	-32	-31	-32	-92	-250
H.R. 4841, Standardizing Electronic Prior Authorization for Safe Prescribing Act of 2018	0	0	0	*	*	*	*	*	*	*	*	*	*
H.R. 5603, Access to Telehealth Services for Opioid Use Disorders Act	0	2	*	*	*	1	1	1	2	2	2	3	11
H.R. 5605, Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act	0	0	0	15	26	24	23	23	10	1	*	65	122
H.R. 5675, a bill 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	0	0	0	-6	-7	-7	-7	-8	-9	-9	-11	-20	-64
H.R. 5684, Protecting Seniors From Opioid Abuse Act	0	0	0	*	*	*	*	*	*	*	*	*	*
H.R. 5796, Responsible Education Achieves Care and Healthy Outcomes for Users' Treatment Act of 2018	0	10	25	50	10	5	0	0	0	0	0	100	100
H.R. 5798, Opioid Screening and Chronic Pain Management Alternatives for Seniors Act	0	0	*	1	1	1	1	1	1	1	1	2	5
H.R. 5804, Post-Surgical Injections as an Opioid Alternative Act ^a	0	0	0	25	30	25	10	5	0	0	0	100	115
H.R. 5809, Postoperative Opioid Prevention Act of 2018	0	0	0	0	10	15	20	25	30	35	45	25	180
Legislation Primarily Affecting the Food and Drug Administration:													

TABLE 1.—ESTIMATED CHANGES IN MANDATORY SPENDING AND REVENUES—Continued

	By fiscal year, in millions of dollars—												
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019– 2023	2019–2028
H.R. 5333, Over-the-Counter Monograph Safety, Innovation, and Reform Act of 2018 ^a	0	0	*	*	*	*	*	*	*	*	*	*	*
H.R. 5752, Stop Illicit Drug Importation Act of 2018	0	*	*	*	*	*	*	*	*	*	*	*	*
INCREASES OR DECREASES (–) IN REVENUES ^b	0	*	*	*	*	*	*	*	*	*	*	*	*

Annual amounts may not sum to totals because of rounding. * = between –\$500,000 and \$500,000. Budget authority is equivalent to outlays.

^aThis bill also would affect spending subject to appropriation.

^bOne additional bill, H.R. 5228, the Stop Counterfeit Drugs by Regulating and Enhancing Enforcement Now Act, would have a negligible effect on revenues.

Legislation Primarily Affecting Medicaid. The following nine bills would affect direct spending for the Medicaid program.

H.R. 1925, the At-Risk Youth Medicaid Protection Act of 2017, would require states to suspend, rather than terminate, Medicaid eligibility for juvenile enrollees (generally under 21 years of age) who become inmates of public correctional institutions. States also would have to redetermine those enrollees' Medicaid eligibility before their release and restore their coverage upon release if they qualify for the program. States would be required to process Medicaid applications submitted by or on behalf of juveniles in public correctional institutions who were not enrolled in Medicaid before becoming inmates and ensure that Medicaid coverage is provided when they are released if they are found to be eligible. On the basis of an analysis of juvenile incarceration trends and of the per enrollee spending for Medicaid foster care children, who have a similar health profile to incarcerated juveniles, CBO estimates that implementing the bill would cost \$75 million over the 2019–2028 period.

H.R. 4998, the Health Insurance for Former Foster Youth Act, would require states to provide Medicaid coverage to adults up to age 25 who had aged out of foster care in any state. Under current law, such coverage is mandatory only if the former foster care youth has aged out in the state in which the individual applies for coverage. The policy also would apply to former foster children who had been in foster care upon turning 14 years of age but subsequently left foster care to enter into a legal guardianship with a kinship caregiver. The provisions would take effect respect for foster youth who turn 18 on or after January 1, 2023. On the basis of spending for Medicaid foster care children and data from the Census Bureau regarding annual migration rates between states, CBO estimates that implementing the bill would cost \$171 million over the 2019–2028 period.

H.R. 5477, the Rural Development of Opioid Capacity Services Act, would direct the Secretary of HHS to conduct a five-year demonstration to increase the number and ability of providers participating in Medicaid to provide treatment for substance use disorders. On the basis of an analysis of federal and state spending for treatment of substance use disorders and the prevalence of such disorders, CBO estimates that enacting the bill would increase direct spending by \$301 million over the 2019–2028 period.

H.R. 5583, a bill to amend title XI of the Social Security Act to require States to annually report on certain adult health quality measures, and for other purposes, would require states to include behavioral health indicators in their annual reports on the quality of care under Medicaid. Although the bill would add a requirement for states, CBO estimates that its enactment would not have a significant budgetary effect because most states have systems in place for reporting such measures to the federal government.

H.R. 5797, the IMD CARE Act, would expand Medicaid coverage for people with opioid use disorder who are in institutions for mental disease (IMDs) for up to 30 days per year. Under a current-law policy known as the IMD exclusion, the federal government generally does not make matching payments to state Medicaid programs for most services provided by IMDs to adults between the ages of 21 and 64. Recent administrative changes have made fed-

eral financing for IMDs available in limited circumstances, but the statutory prohibition remains in place. CBO analyzed several data sets, primarily those collected by the Substance Abuse and Mental Health Services Administration (SAMHSA), to estimate current federal spending under Medicaid for IMD services and to estimate spending under H.R. 5797. Using that analysis, CBO estimates that enacting H.R. 5797 would increase direct spending by \$991 million over the 2019–2028 period.

H.R. 5799, the Medicaid DRUG Improvement Act, would require state Medicaid programs to implement additional reviews of opioid prescriptions, monitor concurrent prescribing of opioids and certain other drugs, and monitor use of antipsychotic drugs by children. CBO estimates that the bill would increase direct spending by \$5 million over the 2019–2028 period to cover the administrative costs of complying with those requirements. On the basis of stakeholder feedback, CBO expects that the bill would not have a significant effect on Medicaid spending for prescription drugs because many of the bill's requirements would duplicate current efforts to curb opioid and antipsychotic drug use. (If enacted, H.R. 5799 also would affect spending subject to appropriation; CBO has not completed an estimate of that amount.)

H.R. 5801, the Medicaid Providers Are Required To Note Experiences in Record Systems to Help In-Need Patients (PARTNERSHIP) Act, would require providers who are permitted to prescribe controlled substances and who participate in Medicaid to query prescription drug monitoring programs (PDMPs) before prescribing controlled substances to Medicaid patients. PDMPs are statewide electronic databases that collect data on controlled substances dispensed in the state. The bill also would require PDMPs to comply with certain data and system criteria, and it would provide additional federal matching funds to certain states to help cover administrative costs. On the basis of a literature review and stakeholder feedback, CBO estimates that the net budgetary effect of enacting H.R. 5801 would be insignificant. Costs for states to come into compliance with the systems and administrative requirements would be roughly offset by savings from small reductions in the number of controlled substances paid for by Medicaid under the proposal. (If enacted, H.R. 5801 also would affect spending subject to appropriation; CBO has not completed an estimate of that amount.)

H.R. 5808, the Medicaid Pharmaceutical Home Act of 2018, would require state Medicaid programs to operate pharmacy programs that would identify people at high risk of abusing controlled substances and require those patients to use a limited number of providers and pharmacies. Although nearly all state Medicaid programs currently meet such a requirement, a small number of high-risk Medicaid beneficiaries are not now monitored. Based on an analysis of information about similar state and federal programs, CBO estimates that net Medicaid spending under the bill would decrease by \$13 million over the 2019–2028 period. That amount represents a small increase in administrative costs and a small reduction in the number of controlled substances paid for by Medicaid under the proposal. (If enacted, H.R. 5808 also would affect spending subject to appropriation; CBO has not completed an estimate of that amount.)

H.R. 5810, the Medicaid Health HOME Act, would allow states to receive six months of enhanced federal Medicaid funding for programs that coordinate care for people with substance use disorders. Based on enrollment and spending data from states that currently participate in Medicaid’s Health Homes program, CBO estimates that the expansion would cost approximately \$469 million over the 2019–2028 period. The bill also would require states to cover all FDA-approved drugs used in medication-assisted treatment for five years, although states could seek a waiver from that requirement. (Medication-assisted treatment combines behavioral therapy and pharmaceutical treatment for substance use disorders.) Under current law, states already cover most FDA-approved drugs used in such programs in some capacity, although a few exclude methadone dispensed by opioid treatment programs. CBO estimates that a small share of those states would begin to cover methadone if this bill was enacted at a federal cost of about \$39 million over the 2019–2028 period. In sum, CBO estimates that the enacting H.R. 5810 would increase direct spending by \$509 million over the 2019–2028 period.

Legislation Primarily Affecting Medicare. The following ten bills would affect direct spending for the Medicare program.

H.R. 3528, the Every Prescription Conveyed Securely Act, would require prescriptions for controlled substances covered under Medicare Part D to be transmitted electronically, starting on January 1, 2021. Based on CBO’s analysis of prescription drug spending, spending for controlled substances is a small share of total drug spending. CBO also assumes a small share of those prescriptions would not be filed because they are not converted to an electronic format. Therefore, CBO expects that enacting H.R. 3528 would reduce the number of prescriptions filled and estimates that Medicare spending would be reduced by \$250 million over the 2019–2028 period.

H.R. 4841, the Standardizing Electronic Prior Authorization for Safe Prescribing Act of 2018, would require health care professionals to submit prior authorization requests electronically, starting on January 1, 2021, for drugs covered under Medicare Part D. Taking into account that many prescribers already use electronic methods to submit such requests, CBO estimates that enacting H.R. 4841 would not significantly affect direct spending for Part D.

H.R. 5603, the Access to Telehealth Services for Opioid Use Disorders Act, would permit the Secretary of HHS to lift current geographic and other restrictions on coverage of telehealth services under Medicare for treatment of substance use disorders or co-occurring mental health disorders. Under the bill, the Secretary of HHS would be directed to encourage other payers to coordinate payments for opioid use disorder treatments and to evaluate the extent to which the demonstration reduces hospitalizations, increases the use of medication-assisted treatments, and improves the health outcomes of individuals with opioid use disorders during and after the demonstration. Based on current use of Medicare telehealth services for treatment of substance use disorders, CBO estimates that expanding that coverage would increase direct spending by \$11 million over the 2019–2028 period.

H.R. 5605, the Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act, would establish a five-year demonstra-

tion program to increase access to treatment for opioid use disorder. The demonstration would provide incentive payments and funding for care management services based on criteria such as patient engagement, use of evidence-based treatments, and treatment length and intensity. Under the bill, the Secretary of HHS would be directed to encourage other payers to coordinate payments for opioid use disorder treatments and to evaluate the extent to which the demonstration reduces hospitalizations, increases the use of medication-assisted treatments, and improves the health outcomes of individuals with opioid use disorders during and after the demonstration. Based on historical utilization of opioid use disorder treatments and projected spending on incentive payments and care management fees, CBO estimates that increased use of treatment services and the demonstration's incentive payments would increase direct spending by \$122 million over the 2019–2028 period.

H.R. 5675, a bill 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, would require Part D prescription drug plans to provide drug management programs for Medicare beneficiaries who are at risk for prescription drug abuse. (Under current law, Part D plans are permitted but not required to establish such programs as of 2019.) Based on an analysis of the number of plans currently providing those programs, CBO estimates that enacting H.R. 5675 would lower federal spending by \$64 million over the 2019–2028 period by reducing the number of prescriptions filled and Medicare's payments for controlled substances.

H.R. 5684, the Protecting Seniors From Opioid Abuse Act, would expand medication therapy management programs under Medicare Part D to include beneficiaries who are at risk for prescription drug abuse. Because relatively few beneficiaries would be affected by this bill, CBO estimates that its enactment would not significantly affect direct spending for Part D.

H.R. 5796, the Responsible Education Achieves Care and Healthy Outcomes for Users' Treatment Act of 2018, would allow the Secretary of HHS to award grants to certain organizations that provide technical assistance and education to high-volume prescribers of opioids. The bill would appropriate \$100 million for fiscal year 2019. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5796 would cost \$100 million over the 2019–2028 period.

H.R. 5798, the Opioid Screening and Chronic Pain Management Alternatives for Seniors Act, would add an assessment of current opioid prescriptions and screening for opioid use disorder to the Welcome to Medicare Initial Preventive Physical Examination. Based on historical use of the examinations and pain management alternatives, CBO expects that enacting the bill would increase use of pain management services and estimates that direct spending would increase by \$5 million over the 2019–2028 period.

H.R. 5804, the Post-Surgical Injections as an Opioid Alternative Act, would freeze the Medicare payment rate for certain analgesic injections provided in ambulatory surgical centers (ASCs). (For injections identified by specific billing codes, Medicare would pay the 2016 rate, which is higher than the current rate, during the 2020–2024 period.) Based on current utilization in the ASC setting, CBO

estimates that enacting the legislation would increase direct spending by about \$115 million over the 2019–2028 period. (If enacted, H.R. 5804 also would affect spending subject to appropriation; see Table 3.)

H.R. 5809, the Postoperative Opioid Prevention Act of 2018, would create an additional payment under Medicare for nonopioid analgesics. Under current law, certain new drugs and devices may receive an additional payment—separate from the bundled payment for a surgical procedure—in outpatient hospital departments and ambulatory surgical centers. The bill would allow nonopioid analgesics to qualify for a five-year period of additional payments. Based on its assessment of current spending for analgesics and on the probability of new nonopioid analgesics coming to market, CBO estimates that H.R. 5809 would increase direct spending by about \$180 million over the 2019–2028 period.

Legislation Primarily Affecting the Food and Drug Administration. One bill related to the FDA would affect direct spending.

H.R. 5333, the Over-the-Counter Monograph Safety, Innovation, and Reform Act of 2018, would change the way that the FDA regulates the marketing of over-the-counter (OTC) medicines, and it would authorize that agency to grant 18 months of exclusive market protection for certain qualifying OTC drugs, thus delaying the entry of other versions of the same qualifying OTC product. Medicaid currently provides some coverage for OTC medicines, but only if a medicine is the least costly alternative in its drug class. On the basis of stakeholder feedback, CBO expects that delaying the availability of additional OTC versions of a drug would not significantly affect the average net price paid by Medicaid. As a result, CBO estimates that enacting H.R. 5333 would have a negligible effect on the federal budget. (If enacted, H.R. 5333 also would affect spending subject to appropriation; see Table 3.)

Legislation with Revenue Effects. Two bills would affect revenues. However, CBO estimates that one bill, H.R. 5228, the Stop Counterfeit Drugs by Regulating and Enhancing Enforcement Now Act, would have only a negligible effect.

H.R. 5752, the Stop Illicit Drug Importation Act of 2018, would amend the Federal Food, Drug, and Cosmetic Act (FDCA) to strengthen the FDA’s seizure powers and enhance its authority to detain, refuse, seize, or destroy illegal products offered for import. The legislation would subject more people to debarment under the FDCA and thus increase the potential for violations, and subsequently, the assessment of civil penalties, which are recorded in the budget as revenues. CBO estimates that those collections would result in an insignificant increase in revenues. Because H.R. 5752 would prohibit the importation of drugs that are in the process of being scheduled, it also could reduce amounts collected in customs duties. CBO anticipates that the result would be a negligible decrease in revenues. With those results taken together, CBO estimates, enacting H.R. 5752 would generate an insignificant net increase in revenues over the 2019–2028 period.

Spending subject to appropriation

For this document, CBO has grouped bills with spending that would be subject to appropriation into four general categories:

- Bills that would have no budgetary effect,

- Bills with provisions that would authorize specified amounts to be appropriated (see Table 2),
- Bills with provisions for which CBO has estimated an authorization of appropriations (see Table 3), and
- Bills with provisions that would affect spending subject to appropriation for which CBO has not yet completed an estimate.

No Budgetary Effect. CBO estimates that 6 of the 59 bills would have no effect on direct spending, revenues, or spending subject to appropriation.

H.R. 3192, the CHIP Mental Health Parity Act, would require all Children’s Health Insurance Program (CHIP) plans to cover mental health and substance abuse treatment. In addition, states would not be allowed to impose financial or utilization limits on mental health treatment that are lower than limits placed on physical health treatment. Based on information from the Centers for Medicare and Medicaid Services, CBO estimates that enacting the bill would have no budgetary effect because all CHIP enrollees are already in plans that meet those requirements.

H.R. 3331, a bill to amend title XI of the Social Security Act to promote testing of incentive payments for behavioral health providers for adoption and use of certified electronic health record technology, would give the Center for Medicare and Medicaid Innovation (CMMI) explicit authorization to test a program offering incentive payments to behavioral health providers that adopt and use certified electronic health record technology. Because it is already clear to CMMI that it has that authority, CBO estimates that enacting the legislation would not affect federal spending.

H.R. 5202, the Ensuring Patient Access to Substance Use Disorder Treatments Act of 2018, would clarify permission for pharmacists to deliver controlled substances to providers under certain circumstances. Because this provision would codify current practice, CBO estimates that H.R. 5202 would not affect direct spending or revenues during the 2019–2028 period.

H.R. 5685, the Medicare Opioid Safety Education Act of 2018, would require the Secretary of HHS to include information on opioid use, pain management, and nonopioid pain management treatments in future editions of *Medicare & You*, the program’s handbook for beneficiaries, starting on January 1, 2019. Because H.R. 5685 would add information to an existing administrative document, CBO estimates that enacting the bill would have no budgetary effect.

H.R. 5686, the Medicare Clear Health Options in Care for Enrollees Act of 2018, would require prescription drug plans that provide coverage under Medicare Part D to furnish information to beneficiaries about the risks of opioid use and the availability of alternative treatments for pain. CBO estimates that enacting the bill would not affect direct spending because the required activities would not impose significant administrative costs.

H.R. 5716, the Commit to Opioid Medical Prescriber Accountability and Safety for Seniors Act, would require the Secretary of HHS on an annual basis to identify high prescribers of opioids and furnish them with information about proper prescribing methods. Because HHS already has the capacity to meet those requirements,

CBO estimates that enacting that provision would not impose additional administrative costs on the agency.

Specified Authorizations. Table 2 lists the ten bills that would authorize specified amounts to be appropriated over the 2019–2023 period. Spending from those authorized amounts would be subject to appropriation.

TABLE 2.—ESTIMATED SPENDING SUBJECT TO APPROPRIATION FOR BILLS WITH SPECIFIED AUTHORIZATIONS

	By fiscal year, in millions of dollars—						
	2018	2019	2020	2021	2022	2023	2019–2023
INCREASES IN SPENDING SUBJECT TO APPROPRIATION							
H.R. 4684, Ensuring Access to Quality Sober Living Act:							
Authorization Level	0	3	0	0	0	0	3
Estimated Outlays	0	1	2	*	*	*	3
H.R. 5102, Substance Use Disorder Workforce Loan Repayment Act of 2018:							
Authorization Level	0	25	25	25	25	25	125
Estimated Outlays	0	9	19	23	25	25	100
H.R. 5176, Preventing Overdoses While in Emergency Rooms Act of 2018:							
Authorization Level	0	50	0	0	0	0	50
Estimated Outlays	0	16	26	6	2	1	50
H.R. 5197, Alternatives to Opioids (ALTO) in the Emergency Department Act:							
Authorization Level	0	10	10	10	0	0	30
Estimated Outlays	0	3	8	10	7	2	30
H.R. 5261, Treatment, Education, and Community Help to Combat Addiction Act of 2018:							
Authorization Level	0	4	4	4	4	4	20
Estimated Outlays	0	1	3	4	4	4	16
H.R. 5327, Comprehensive Opioid Recovery Centers Act of 2018:							
Authorization Level	0	10	10	10	10	10	50
Estimated Outlays	0	3	8	10	10	10	41
H.R. 5329, Poison Center Network Enhancement Act of 2018:							
Authorization Level	0	30	30	30	30	30	151
Estimated Outlays	0	12	25	29	29	29	125
H.R. 5353, Eliminating Opioid-Related Infectious Diseases Act of 2018:							
Authorization Level	0	40	40	40	40	40	200
Estimated Outlays	0	15	34	38	39	40	166
H.R. 5580, Surveillance and Testing of Opioids to Prevent Fentanyl Deaths Act of 2018:							
Authorization Level	30	30	30	30	30	0	120
Estimated Outlays	0	11	25	29	29	19	113
H.R. 5587, Peer Support Communities of Recovery Act:							
Authorization Level	0	15	15	15	15	15	75
Estimated Outlays	0	5	13	14	15	15	62

Annual amounts may not sum to totals because of rounding. * = between zero and \$500,000.

H.R. 4684, the Ensuring Access to Quality Sober Living Act, would direct the Secretary of HHS to develop and disseminate best practices for organizations that operate housing designed for people recovering from substance use disorders. The bill would authorize a total of \$3 million over the 2019–2021 period for that purpose. Based on historical spending patterns for similar activities, CBO estimates that implementing *H.R. 4684* would cost \$3 million over the 2019–2023 period.

H.R. 5102, the Substance Use Disorder Workforce Loan Repayment Act of 2018, would establish a loan repayment program for

mental health professionals who practice in areas with few mental health providers or with high rates of death from overdose and would authorize \$25 million per year over the 2019–2028 period for that purpose. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5102 would cost \$100 million over the 2019–2023 period; the remaining amounts would be spent in years after 2023.

H.R. 5176, the Preventing Overdoses While in Emergency Rooms Act of 2018, would require the Secretary of HHS to develop protocols and a grant program for health care providers to address the needs of people who survive a drug overdose, and it would authorize \$50 million in 2019 for that purpose. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5176 would cost \$50 million over the 2019–2023 period.

H.R. 5197, the Alternatives to Opioids (ALTO) in the Emergency Department Act, would direct the Secretary of HHS to carry out a demonstration program for hospitals and emergency departments to develop alternative protocols for pain management that limit the use of opioids and would authorize \$10 million annually in grants for fiscal years 2019 through 2021. Based on historical spending patterns for similar programs, CBO estimates that implementing H.R. 5197 would cost \$30 million over the 2019–2023 period.

H.R. 5261, the Treatment, Education, and Community Help to Combat Addiction Act of 2018, would direct the Secretary of HHS to designate regional centers of excellence to improve the training of health professionals who treat substance use disorders. The bill would authorize \$4 million annually for grants to those programs over the 2019–2023 period. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5261 would cost \$16 million over the 2019–2023 period; the remaining amounts would be spent in years after 2023.

H.R. 5327, the Comprehensive Opioid Recovery Centers Act of 2018, would direct the Secretary of HHS to award grants to at least 10 providers that offer treatment services for people with opioid use disorder, and it would authorize \$10 million per year over the 2019–2023 period for that purpose. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5327 would cost \$41 million over the 2019–2023 period; the remaining amounts would be spent in years after 2023.

H.R. 5329, the Poison Center Network Enhancement Act of 2018, would reauthorize the poison control center toll-free number, national media campaign, and grant program under the Public Health Service Act. Among other actions, H.R. 5329 would increase the share of poison control center funding that could be provided by federal grants. The bill would authorize a total of about \$30 million per year over the 2019–2023 period. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5329 would cost \$125 million over the 2019–2023 period; the remaining amounts would be spent in years after 2023.

H.R. 5353, the Eliminating Opioid Related Infectious Diseases Act of 2018, would amend the Public Health Service Act by broadening the focus of surveillance and education programs from preventing and treating hepatitis C virus to preventing and treating infections associated with injection drug use. It would authorize

\$40 million per year over 2019–2023 period for that purpose. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5353 would cost \$166 million over the 2019–2023 period; the remaining amounts would be spent in years after 2023.

H.R. 5580, the Surveillance and Testing of Opioids to Prevent Fentanyl Deaths Act of 2018, would establish a grant program for public health laboratories that conduct testing for fentanyl and other synthetic opioids. It also would direct the Centers for Disease Control and Prevention to expand its drug surveillance program, with a particular focus on collecting data on fentanyl. The bill would authorize a total of \$30 million per year over the 2018–2022 period for those activities. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5580 would cost \$113 million over the 2019–2023 period; the remaining amounts would be spent in years after 2023.

H.R. 5587, Peer Support Communities of Recovery Act, would direct the Secretary of HHS to award grants to nonprofit organizations that support community-based, peer-delivered support, including technical support for the establishment of recovery community organizations, independent, nonprofit groups led by people in recovery and their families. The bill would authorize \$15 million per year for the 2019–2023 period. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5587 would cost \$62 million over the 2019–2023 period; the remaining amounts would be spent in years after 2023.

Estimated Authorizations. Table 3 shows CBO’s estimates of the appropriations that would be necessary to implement 19 of the bills. Spending would be subject to appropriation of those amounts.

H.R. 449, the Synthetic Drug Awareness Act of 2018, would require the Surgeon General to report to the Congress on the health effects of synthetic psychoactive drugs on children between the ages of 12 and 18. Based on spending patterns for similar activities, CBO estimates that implementing H.R. 449 would cost approximately \$1 million over the 2019–2023 period.

H.R. 4005, the Medicaid Reentry Act, would direct the Secretary of HHS to convene a group of stakeholders to develop and report to the Congress on best practices for addressing issues related to health care faced by those returning from incarceration to their communities. The bill also would require the Secretary to issue a letter to state Medicaid directors about relevant demonstration projects. Based on an analysis of anticipated workload, CBO estimates that implementing H.R. 4005 would cost less than \$500,000 over the 2018–2023 period.

H.R. 4275, the Empowering Pharmacists in the Fight Against Opioid Abuse Act, would require the Secretary of HHS to develop and disseminate materials for training pharmacists, health care practitioners, and the public about the circumstances under which a pharmacist may decline to fill a prescription. Based on historical spending patterns for similar activities, CBO estimates that costs to the federal government for the development and distribution of those materials would not be significant.

TABLE 3.—ESTIMATED SPENDING SUBJECT TO APPROPRIATION FOR BILLS WITH ESTIMATED AUTHORIZATIONS

	By fiscal year, in millions of dollars—						
	2018	2019	2020	2021	2022	2023	2019–2023
INCREASES IN SPENDING SUBJECT TO APPROPRIATION							
H.R. 449, Synthetic Drug Awareness Act of 2018:							
Estimated Authorization Level	0	*	*	*	0	0	1
Estimated Outlays	0	*	*	*	0	0	1
H.R. 4005, Medicaid Reentry Act:							
Estimated Authorization Level	*	*	0	0	0	0	*
Estimated Outlays	*	*	0	0	0	0	*
H.R. 4275, Empowering Pharmacists in the Fight Against Opioid Abuse Act:							
Estimated Authorization Level	0	*	*	*	*	*	*
Estimated Outlays	0	*	*	*	*	*	*
H.R. 5009, Jessie’s Law:							
Estimated Authorization Level	0	*	*	*	*	*	*
Estimated Outlays	0	*	*	*	*	*	*
H.R. 5041, Safe Disposal of Unused Medication Act:							
Estimated Authorization Level	0	*	*	*	*	*	*
Estimated Outlays	0	*	*	*	*	*	*
H.R. 5272, Reinforcing Evidence-Based Standards Under Law in Treating Substance Abuse Act of 2018:							
Estimated Authorization Level	0	1	1	1	1	1	4
Estimated Outlays	0	1	1	1	1	1	4
H.R. 5333, Over-the-Counter Monograph Safety, Innovation, and Reform Act of 2018: ^a							
Food and Drug Administration:							
Collections from fees:							
Estimated Authorization Level	0	–22	–22	–26	–35	–42	–147
Estimated Outlays	0	–22	–22	–26	–35	–42	–147
Spending of fees:							
Estimated Authorization Level	0	22	22	26	35	42	147
Estimated Outlays	0	6	17	30	44	41	137
Net effect on FDA:							
Estimated Authorization Level	0	0	0	0	0	0	0
Estimated Outlays	0	–17	–6	4	9	*	–10
Government Accountability Office:							
Estimated Authorization Level	0	0	0	0	0	*	*
Estimated Outlays	0	0	0	0	0	*	*
Total, H.R. 5333:							
Estimated Authorization Level	0	0	0	0	0	*	*
Estimated Outlays	0	–17	–6	4	9	*	–10
H.R. 5473, Better Pain Management Through Better Data Act of 2018:							
Estimated Authorization Level	0	*	*	*	*	0	1
Estimated Outlays	0	*	*	*	*	*	1
H.R. 5483, Special Registration for Telemedicine Clarification Act of 2018:							
Estimated Authorization Level	0	*	*	*	*	*	*
Estimated Outlays	0	*	*	*	*	*	*
H.R. 5554, Animal Drug and Animal Generic Drug User Fee Amendments of 2018:							
Collections from fees:							
Animal drug fees	0	–30	–31	–32	–33	–34	–159
Generic animal drug fees	0	–18	–19	–19	–20	–21	–97
Total, Estimated Authorization Level	0	–49	–50	–51	–53	–55	–257
Total, Estimated Outlays	0	–49	–50	–51	–53	–55	–257
Spending of fees:							
Animal drug fees	0	30	31	32	33	34	159
Generic animal drug fees	0	18	19	19	20	21	97
Total, Estimated Authorization Level	0	49	50	51	53	55	257
Total, Estimated Outlays	0	39	47	51	52	54	243

TABLE 3.—ESTIMATED SPENDING SUBJECT TO APPROPRIATION FOR BILLS WITH ESTIMATED AUTHORIZATIONS—Continued

	By fiscal year, in millions of dollars—						
	2018	2019	2020	2021	2022	2023	2019–2023
Net changes in fees:							
Estimated Authorization Level	0	0	0	0	0	0	0
Estimated Outlays	0	–10	–3	*	*	*	–14
Other effects:							
Estimated Authorization Level	0	3	1	1	1	1	6
Estimated Outlays	0	2	1	1	1	1	6
Total, H.R. 5554:							
Estimated Authorization Level	0	3	1	1	1	1	6
Estimated Outlays	0	–8	–2	1	*	*	–8
H.R. 5582, Abuse Deterrent Access Act of 2018:							
Estimated Authorization Level	0	0	*	0	0	0	*
Estimated Outlays	0	0	*	0	0	0	*
H.R. 5590, Opioid Addiction Action Plan Act:							
Estimated Authorization Level	*	*	*	*	*	*	2
Estimated Outlays	*	*	*	*	*	*	2
H.R. 5687, Securing Opioids and Unused Narcotics with Deliberate Disposal and Packaging Act of 2018:							
Estimated Authorization Level	0	*	*	*	*	*	*
Estimated Outlays	0	*	*	*	*	*	*
H.R. 5715, Strengthening Partnerships to Prevent Opioid Abuse Act:							
Estimated Authorization Level	0	2	2	2	2	2	9
Estimated Outlays	0	2	2	2	2	2	9
H.R. 5789, a bill to require the Secretary of Health and Human Services to issue guidance to improve care for infants with neonatal abstinence syndrome and their mothers, and to require the Comptroller General of the United States to conduct a study on gaps in Medicaid coverage for pregnant and postpartum women with substance use disorder:							
Estimated Authorization Level	0	2	0	0	0	0	2
Estimated Outlays	0	2	0	0	0	0	2
H.R. 5795, Overdose Prevention and Patient Safety Act:							
Estimated Authorization Level	0	1	0	0	0	0	1
Estimated Outlays	0	1	0	0	0	0	1
H.R. 5800, Medicaid IMD ADDITIONAL INFO Act:							
Estimated Authorization Level	0	1	0	0	0	0	1
Estimated Outlays	0	*	*	0	0	0	1
H.R. 5804, Post-Surgical Injections as an Opioid Alternative Act: ^a							
Estimated Authorization Level	0	0	0	0	1	1	1
Estimated Outlays	0	0	0	0	1	1	1
H.R. 5811, a bill to amend the Federal Food, Drug, and Cosmetic Act with respect to postapproval study requirements for certain controlled substances, and for other purposes:							
Estimated Authorization Level	0	*	*	*	*	*	*
Estimated Outlays	0	*	*	*	*	*	*

Annual amounts may not sum to totals because of rounding. * = between –\$500,000 and \$500,000.
^aThis bill also would affect mandatory spending (see Table 1).

H.R. 5009, Jessie’s Law, would require HHS, in collaboration with outside experts, to develop best practices for displaying information about opioid use disorder in a patient’s medical record. HHS also would be required to develop and disseminate written materials annually to health care providers about what disclosures could be made while still complying with federal laws that govern health care privacy. Based on spending patterns for similar activities, CBO estimates that implementing H.R. 5009 would have an insignificant effect on spending over the 2019–2023 period.

H.R. 5041, the Safe Disposal of Unused Medication Act, would require hospice programs to have written policies and procedures for the disposal of controlled substances after a patient's death. Certain licensed employees of hospice programs would be permitted to assist in the disposal of controlled substances that were lawfully dispensed. Using information from the Department of Justice (DOJ), CBO estimates that implementing the bill would cost less than \$500,000 over the 2019–2023 period.

H.R. 5272, the Reinforcing Evidence-Based Standards Under Law in Treating Substance Abuse Act of 2018, would require the newly established National Mental Health and Substance Use Policy Laboratory to issue guidance to applicants for SAMHSA grants that support evidence-based practices. Using information from HHS about the historical cost of similar activities, CBO estimates that enacting this bill would cost approximately \$4 million over the 2019–2023 period.

H.R. 5333, the Over-the-Counter Monograph Safety, Innovation, and Reform Act of 2018, would change the FDA's oversight of the commercial marketing of OTC medicines and authorize the collection and spending of fees through 2023 to cover the costs of expediting the FDA's administrative procedures for certain regulatory activities relating to OTC products. Under H.R. 5333, CBO estimates, the FDA would assess about \$147 million in fees over the 2019–2023 period that could be collected and made available for obligation only to the extent and in the amounts provided in advance in appropriation acts. Because the FDA could spend those fees, CBO estimates that the estimated budget authority for collections and spending would offset each other exactly in each year, although CBO expects that spending initially would lag behind collections. Assuming appropriation action consistent with the bill, CBO estimates that implementing H.R. 5333 would reduce net discretionary outlays by \$10 million over the 2019–2023 period, primarily because of that lag. The bill also would require the Government Accountability Office to study exclusive market protections for certain qualifying OTC drugs authorized by the bill—a provision that CBO estimates would cost less than \$500,000. (If enacted, H.R. 5333 also would affect mandatory spending; see Table 1.)

H.R. 5473, the Better Pain Management Through Better Data Act of 2018, would require that the FDA conduct a public meeting and issue guidance to industry addressing data collection and labeling for medical products that reduce pain while enabling the reduction, replacement, or avoidance of oral opioids. Using information from the agency, CBO estimates that implementing H.R. 5473 would cost about \$1 million over the 2019–2023 period.

H.R. 5483, the Special Registration for Telemedicine Clarification Act of 2018, would direct DOJ, within one year of the bill's enactment, to issue regulations concerning the practice of telemedicine (for remote diagnosis and treatment of patients). Using information from DOJ, CBO estimates that implementing the bill would cost less than \$500,000 over the 2019–2023 period.

H.R. 5554, the Animal Drug and Animal Generic Drug User Fee Amendments of 2018, would authorize the FDA to collect and spend fees to cover the cost of expedited approval for the development and marketing of certain drugs for use in animals. The legislation would extend through fiscal year 2023, and make several changes

to, the FDA's existing approval processes and fee programs for brand-name and generic veterinary drugs, which expire at the end of fiscal year 2018. CBO estimates that implementing H.R. 5554 would reduce net discretionary outlays by \$8 million over the 2019–2023 period, primarily because the spending of fees lags somewhat behind their collection.

Fees authorized under the bill would supplement funds appropriated to cover the FDA's cost of reviewing certain applications and investigational submissions for brand-name and generic drugs for use in animals. Those fees could be collected and made available for obligation only to the extent and in the amounts provided in advance in appropriation acts. Under H.R. 5554, CBO estimates, the FDA would assess about \$257 million in fees over the 2019–2023 period. Because the FDA could spend those funds, CBO estimates that budget authority for collections and spending would offset each other exactly in each year. CBO estimates that the delay between collecting and spending fees under the reauthorized programs would reduce net discretionary outlays by \$14 million over the 2019–2023 period, assuming appropriation actions consistent with the bill.

Enacting H.R. 5554 would increase the FDA's workload because the legislation would expand eligibility for conditional approval for certain drugs. The agency's administrative costs also would increase because of regulatory activities required by a provision concerning petitions for additives intended for use in animal food. H.R. 5554 also would require the FDA to publish guidance or produce regulations on a range of topics, transmit a report to the Congress, and hold public meetings. CBO expects that the costs associated with those activities would not be covered by fees, and it estimates that implementing such provisions would cost \$6 million over the 2019–2023 period.

H.R. 5582, the Abuse Deterrent Access Act of 2018, would require the Secretary of HHS to report to the Congress on existing barriers to access to "abuse-deterrent opioid formulations" by Medicare Part C and D beneficiaries. Such formulations make the drugs more difficult to dissolve for injection, for example, and thus can impede their abuse. Assuming the availability of appropriated funds and based on historical spending patterns for similar activities, CBO estimates that implementing the legislation would cost less than \$500,000 over the 2019–2023 period.

H.R. 5590, the Opioid Addiction Action Plan Act, would require the Secretary of HHS to develop an action plan by January 1, 2019, for increasing access to medication-assisted treatment among Medicare and Medicaid enrollees. The bill also would require HHS to convene a stakeholder meeting and issue a request for information within three months of enactment, and to submit a report to the Congress by June 1, 2019. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5590 would cost approximately \$2 million over the 2019–2023 period.

H.R. 5687, the Securing Opioids and Unused Narcotics with Deliberate Disposal and Packaging Act of 2018, would permit the FDA to require certain packaging and disposal technologies, controls, or measures to mitigate the risk of abuse and misuse of drugs. Based on information from the FDA, CBO estimates that implementing H.R. 5687 would not significantly affect spending over the 2019–

2023 period. This bill would also require that the GAO study the effectiveness and use of packaging technologies for controlled substances—a provision that CBO estimates would cost less than \$500,000.

H.R. 5715, the Strengthening Partnerships to Prevent Opioid Abuse Act, would require the Secretary of HHS to establish a secure Internet portal to allow HHS, Medicare Advantage plans, and Medicare Part D plans to exchange information about fraud, waste, and abuse among providers and suppliers no later than two years after enactment. H.R. 5715 also would require organizations with Medicare Advantage contracts to submit information on investigations related to providers suspected of prescribing large volumes of opioids through a process established by the Secretary no later than January 2021. Based on historical spending patterns for similar activities, CBO estimates that implementing H.R. 5715 would cost approximately \$9 million over the 2019–2023 period.

H.R. 5789, a bill to require the Secretary of Health and Human Services to issue guidance to improve care for infants with neonatal abstinence syndrome and their mothers, and to require the Comptroller General of the United States to conduct a study on gaps in Medicaid coverage for pregnant and postpartum women with substance use disorder, would direct the Secretary of HHS to issue guidance to states on best practices under Medicaid and CHIP for treating infants with neonatal abstinence syndrome. H.R. 5789 also would direct the Government Accountability Office to study Medicaid coverage for pregnant and postpartum women with substance use disorders. Based on information from HHS and historical spending patterns for similar activities, CBO estimates that enacting H.R. 5789 would cost approximately \$2 million over the 2019–2023 period.

H.R. 5795, the Overdose Prevention and Patient Safety Act, would amend the Public Health Service Act so that requirements pertaining to the confidentiality and disclosure of medical records relating to substance use disorders align with the provisions of the Health Insurance Portability and Accountability Act of 1996. The bill would require the Office of the Secretary of HHS to issue regulations prohibiting discrimination based on data disclosed from such medical records, to issue regulations requiring covered entities to provide written notice of privacy practices, and to develop model training programs and materials for health care providers and patients and their families. Based on spending patterns for similar activities, CBO estimates that implementing H.R. 5795 would cost approximately \$1 million over the 2019–2023 period.

H.R. 5800, Medicaid IMD ADDITIONAL INFO Act, would direct the Medicaid and CHIP Payment and Access Commission to study institutions for mental diseases in a representative sample of states. Based on information from the commission about the cost of similar work, CBO estimates that implementing H.R. 5800 would cost about \$1 million over the 2019–2023 period.

H.R. 5804, the Post-Surgical Injections as an Opioid Alternative Act, would freeze the Medicare payment rate for certain analgesic injections provided in ambulatory surgical centers. The bill also would mandate two studies of Medicare coding and payments arising from enactment of this legislation. Based on the cost of similar activities, CBO estimates that those reports would cost \$1 million

over the 2019–2023 period. (If enacted, H.R. 5804 also would affect mandatory spending; see Table 1.)

H.R. 5811, a bill to amend the Federal Food, Drug, and Cosmetic Act with respect to postapproval study requirements for certain controlled substances, and for other purposes, would allow the FDA to require that pharmaceutical manufacturers study certain drugs after they are approved to assess any potential reduction in those drugs' effectiveness for the conditions of use prescribed, recommended, or suggested in labeling. CBO anticipates that implementing H.R. 5811 would not significantly affect the FDA's costs over the 2019–2023 period.

Other Authorizations. The following nine bills would increase authorization levels, but CBO has not completed estimates of amounts. All authorizations would be subject to future appropriation action.

- H.R. 4284, Indexing Narcotics, Fentanyl, and Opioids Act of 2017
- H.R. 5002, Advancing Cutting Edge Research Act
- H.R. 5228, Stop Counterfeit Drugs by Regulating and Enhancing Enforcement Now Act (see Table 1 for an estimate of the revenue effects of H.R. 5228)
- H.R. 5752, Stop Illicit Drug Importation Act of 2018 (see Table 1 for an estimate of the revenue effects of H.R. 5752)
- H.R. 5799, Medicaid DRUG Improvement Act (see Table 1 for an estimate of the direct spending effects of H.R. 5799)
- H.R. 5801, Medicaid Providers and Pharmacists Are Required to Note Experiences in Record Systems to Help In-Need Patients (PARTNERSHIP) Act (see Table 1 for an estimate of the direct spending effects of H.R. 5801)
- H.R. 5806, 21st Century Tools for Pain and Addiction Treatments Act
- H.R. 5808, Medicaid Pharmaceutical Home Act of 2018 (see Table 1 for an estimate of the direct spending effects of H.R. 5808)
- H.R. 5812, Creating Opportunities that Necessitate New and Enhanced Connections That Improve Opioid Navigation Strategies Act (CONNECTIONS) Act

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. Twenty-two of the bills discussed in this document contain direct spending or revenues and are subject to pay-as-you-go procedures. Details about the amount of direct spending and revenues in those bills can be found in Table 1.

Increase in long-term direct spending and deficits: CBO estimates that enacting H.R. 4998, the Health Insurance for Former Foster Youth Act, would increase net direct spending by more than \$2.5 billion and on-budget deficits by more than \$5 billion in at least one of the four consecutive 10-year periods beginning in 2029.

CBO estimates that none of the remaining 58 bills included in this estimate would increase net direct spending by more than \$2.5 billion or on-budget deficits by more than \$5 billion in any of the four consecutive 10-year periods beginning in 2029.

Mandates: One of the 59 bills included in this document, H.R. 5795, would impose both intergovernmental and private-sector

mandates as defined in UMRA. CBO estimates that the costs of that bill's mandates on public and private entities would fall below UMRA's thresholds (\$80 million and \$160 million, respectively, for public- and private-sector entities in 2018, adjusted annually for inflation).

In addition, five bills would impose private-sector mandates as defined in UMRA. CBO estimates that the costs of the mandates in three of those bills (H.R. 5333, H.R. 5554, and H.R. 5811) would fall below the UMRA threshold. Because CBO does not know how federal agencies would implement new authority granted in the other two of those five bills, H.R. 5228 and 5687, CBO cannot determine whether the costs of their mandates would exceed the threshold.

For large entitlement grant programs, including Medicaid and CHIP, UMRA defines an increase in the stringency of conditions on states or localities as an intergovernmental mandate if the affected governments lack authority to offset those costs while continuing to provide required services. Because states possess significant flexibility to alter their responsibilities within Medicaid and CHIP, the requirements imposed by various bills in the markup on state administration of those programs would not constitute mandates as defined in UMRA.

Mandates Affecting Public and Private Entities

H.R. 5795, the Overdose Prevention and Patient Safety Act, would impose intergovernmental and private-sector mandates by requiring entities that provide treatment for substance use disorders to notify patients of their privacy rights and also to notify patients in the event that the confidentiality of their records is breached. In certain circumstances, H.R. 5795 also would prohibit public and private entities from denying entry to treatment on the basis of information in patient health records. Those requirements would either supplant or narrowly expand responsibilities under existing law, and compliance with them would not impose significant additional costs. CBO estimates that the costs of the mandates would fall below the annual thresholds established in UMRA.

Mandates Affecting Private Entities

Five bills included in this document would impose private-sector mandates:

H.R. 5228, the Stop Counterfeit Drugs by Regulating and Enhancing Enforcement Now Act, would require drug distributors to cease distributing any drug that the Secretary of HHS determines might present an imminent or substantial hazard to public health. CBO cannot determine what drugs could be subject to such an order nor can it determine how private entities would respond. Consequently, CBO cannot determine whether the aggregate cost of the mandate would exceed the annual threshold for private-sector mandates.

H.R. 5333, the Over-the-Counter Monograph Safety, Innovation, and Reform Act of 2018, would require developers and manufacturers of OTC drugs to pay certain fees to the FDA. CBO estimates that about \$30 million would be collected each year, on average, for a total of \$147 million over the 2019–2023 period. Those amounts

would not exceed the annual threshold for private-sector mandates in any year during that period.

H.R. 5554, the Animal Drug and Animal Generic Drug User Fee Amendments of 2018, would require developers and manufacturers of brand-name and generic veterinary drugs to pay application, product, establishment, and sponsor fees to the FDA. CBO estimates that about \$51 million would be collected annually, on average, for a total of \$257 million over the 2019–2023 period. Those amounts would not exceed the annual threshold for private-sector mandates in any year during that period.

H.R. 5687, the Securing Opioids and Unused Narcotics with Deliberate Disposal and Packaging Act of 2018, would permit the Secretary of HHS to require drug developers and manufacturers to implement new packaging and disposal technology for certain drugs. Based on information from the agency, CBO expects that the Secretary would use the new regulatory authority provided in the bill; however, it is uncertain how or when those requirements would be implemented. Consequently, CBO cannot determine whether the aggregate cost of the mandate would exceed the annual threshold for private entities.

H.R. 5811, a bill to amend the Federal Food, Drug, and Cosmetic Act with respect to postapproval study requirements for certain controlled substances, and for other purposes, would expand an existing mandate that requires drug developers to conduct postapproval studies or clinical trials for certain drugs. Under current law, in certain instances, the FDA can require studies or clinical trials after a drug has been approved. H.R. 5811 would permit the FDA to use that authority if the reduction in a drug's effectiveness meant that its benefits no longer outweighed its costs. CBO estimates that the incremental cost of the mandate would fall below the annual threshold established in UMRA because of the small number of drugs affected and the narrow expansion of the authority that exists under current law.

None of the remaining 53 bills included in this document would impose an intergovernmental or private-sector mandate.

Previous CBO estimate: On June 6, 2018, CBO issued an estimate for seven opioid-related bills ordered reported by the House Committee on Ways and Means on May 16, 2018. Two of those bills contain provisions that are identical or similar to the legislation ordered reported by the Committee on Energy and Commerce, and for those provisions, CBO's estimates are the same.

In particular, five bills listed in this estimate contain provisions that are identical or similar to those in several sections of H.R. 5773, the Preventing Addiction for Susceptible Seniors Act of 2018:

- H.R. 5675, which would require prescription drug plans to implement drug management programs, is identical to section 2 of H.R. 5773.
- H.R. 4841, regarding electronic prior authorization for prescriptions under Medicare's Part D, is similar to section 3 of H.R. 5773.
- H.R. 5715, which would mandate the creation of a new Internet portal to allow various stakeholders to exchange information, is identical to section 4 of H.R. 5773.
- H.R. 5684, which would expand medication therapy management, is the same as section 5 of H.R. 5773.

- H.R. 5716, regarding prescriber notification, is identical to section 6 of H.R. 5773.

In addition, in this estimate, a provision related to Medicare beneficiary education in H.R. 5686, the Medicare Clear Health Options in Care for Enrollees Act of 2018, is the same as a provision in section 2 of H.R. 5775, the Providing Reliable Options for Patients and Educational Resources Act of 2018, in CBO's estimate for the Committee on Ways and Means.

Estimate prepared by: Federal Costs: Rebecca Yip (Centers for Disease Control and Prevention), Mark Grabowicz (Drug Enforcement Agency), Julia Christensen, Ellen Werble (Food and Drug Administration), Emily King, Andrea Noda, Lisa Ramirez-Branum, Robert Stewart (Medicaid and Children's Health Insurance Program), Philippa Haven, Lara Robillard, Colin Yee, Rebecca Yip (Medicare), Philippa Haven (National Institutes of Health), Alice Burns, Andrea Noda (Office of the Secretary of the Department of Health and Human Services), Philippa Haven, Lori Housman, Emily King (Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration); Federal Revenues: Jacob Fabian, Peter Huether, and Cecilia Pastrone; Fact Checking: Zachary Byrum and Kate Kelly; Mandates: Andrew Laughlin.

Estimate reviewed by: Tom Bradley, Chief, Health Systems and Medicare Cost Estimates Unit; Chad M. Chirico, Chief, Low-Income Health Programs and Prescription Drugs Cost Estimates Unit; Sarah Masi, Special Assistant for Health; Susan Willie, Chief, Mandates Unit; Leo Lex, Deputy Assistant Director for Budget Analysis; Theresa A. Gullo, Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is work with eligible entities, including Quality Improvement Organizations, to instruct CMS to evaluate the utilization of telehealth services in treating substance use disorder.

DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 5603 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111-139 or the most recent Catalog of Federal Domestic Assistance.

COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 5603 contains no earmarks, limited tax benefits, or limited tariff benefits.

DISCLOSURE OF DIRECTED RULE MAKINGS

Pursuant to section 3(i) of H. Res. 5, the Committee finds that H.R. 5603 contains no directed rule makings.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 provides that the Act may be cited as the “Access to Telehealth Services for Substance Use Disorders Act.”

Section 2. Authority not to apply certain Medicare telehealth requirements in the case of certain treatment of a substance use disorder or co-occurring mental health disorder

Section 2 the Secretary is authorized to expand the utilization of telehealth services for the treatment of substance use disorder by waiving certain qualifications for an originating site and geographic limitations.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * *

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) GENERAL RULE FOR PAYMENT.—

(A) IN GENERAL.—With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, payment shall be made in the frequency specified in paragraphs (2) through (7) and in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) PAYMENT BASIS.—Subject to subparagraph (F)(i), the payment basis described in this subparagraph is the lesser of—

- (i) the actual charge for the item, or
- (ii) the payment amount recognized under paragraphs (2) through (7) of this subsection for the item; except that clause (i) shall not apply if the covered item is furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(C) EXCLUSIVE PAYMENT RULE.—Subject to subparagraph (F)(ii), this subsection shall constitute the exclusive provision of this title for payment for covered items under this part or under part A to a home health agency.

(D) REDUCTION IN FEE SCHEDULES FOR CERTAIN ITEMS.—With respect to a seat-lift chair or transcutaneous electrical nerve stimulator furnished on or after April 1, 1990, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent, and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 45 percent.

(E) CLINICAL CONDITIONS FOR COVERAGE.—

(i) IN GENERAL.—The Secretary shall establish standards for clinical conditions for payment for covered items under this subsection.

(ii) REQUIREMENTS.—The standards established under clause (i) shall include the specification of types or classes of covered items that require, as a condition of payment under this subsection, a face-to-face examination of the individual by a physician (as defined in section 1861(r)), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) and a prescription for the item.

(iii) PRIORITY OF ESTABLISHMENT OF STANDARDS.—In establishing the standards under this subparagraph, the Secretary shall first establish standards for those covered items for which the Secretary determines there has been a proliferation of use, consistent findings of charges for covered items that are not delivered, or consistent findings of falsification of docu-

mentation to provide for payment of such covered items under this part.

(iv) STANDARDS FOR POWER WHEELCHAIRS.—Effective on the date of the enactment of this subparagraph, in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in section 1861(r)(1)), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has conducted a face-to-face examination of the individual and written a prescription for the item.

(v) LIMITATION ON PAYMENT FOR COVERED ITEMS.—Payment may not be made for a covered item under this subsection unless the item meets any standards established under this subparagraph for clinical condition of coverage.

(F) APPLICATION OF COMPETITIVE ACQUISITION; LIMITATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of covered items furnished on or after January 1, 2011, subject to subparagraphs (G) and (H), that are included in a competitive acquisition program in a competitive acquisition area under section 1847(a)—

(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program;

(ii) the Secretary may (and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall) use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847 and in the case of such adjustment, paragraph (10)(B) shall not be applied; and

(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary shall continue to make such adjustments described in clause (ii) as, under such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1847 are re-competed in accordance with section 1847(b)(3)(B).

(G) USE OF INFORMATION ON COMPETITIVE BID RATES.—The Secretary shall specify by regulation the methodology to be used in applying the provisions of subparagraph (F)(ii) and subsection (h)(1)(H)(ii). In promulgating such regulation, the Secretary shall consider the costs of items and services in areas in which such provisions would be applied compared to the payment rates for such items and services in competitive acquisition areas. In the case of items and services furnished on or after January 1, 2019, in making any adjustments under clause (ii) or (iii) of subparagraph (F), under subsection (h)(1)(H)(ii), or under section 1842(s)(3)(B), the Secretary shall—

(i) solicit and take into account stakeholder input; and

(ii) take into account the highest amount bid by a winning supplier in a competitive acquisition area and a comparison of each of the following with respect to non-competitive acquisition areas and competitive acquisition areas:

(I) The average travel distance and cost associated with furnishing items and services in the area.

(II) The average volume of items and services furnished by suppliers in the area.

(III) The number of suppliers in the area.

(H) DIABETIC SUPPLIES.—

(i) IN GENERAL.—On or after the date described in clause (ii), the payment amount under this part for diabetic supplies, including testing strips, that are non-mail order items (as defined by the Secretary) shall be equal to the single payment amounts established under the national mail order competition for diabetic supplies under section 1847.

(ii) DATE DESCRIBED.—The date described in this clause is the date of the implementation of the single payment amounts under the national mail order competition for diabetic supplies under section 1847.

(I) TREATMENT OF VACUUM ERECTION SYSTEMS.—Effective for items and services furnished on and after July 1, 2015, vacuum erection systems described as prosthetic devices described in section 1861(s)(8) shall be treated in the same manner as erectile dysfunction drugs are treated for purposes of section 1860D-2(e)(2)(A).

(2) PAYMENT FOR INEXPENSIVE AND OTHER ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT.—

(A) IN GENERAL.—Payment for an item of durable medical equipment (as defined in paragraph (13))—

(i) the purchase price of which does not exceed \$150,

(ii) which the Secretary determines is acquired at least 75 percent of the time by purchase,

(iii) which is an accessory used in conjunction with a nebulizer, aspirator, or a ventilator excluded under paragraph (3)(A), or

(iv) in the case of devices furnished on or after October 1, 2015, which serves as a speech generating device or which is an accessory that is needed for the individual to effectively utilize such a device,

shall be made on a rental basis or in a lump-sum amount for the purchase of the item. The payment amount recognized for purchase or rental of such equipment is the amount specified in subparagraph (B) for purchase or rental, except that the total amount of payments with respect to an item may not exceed the payment amount specified in subparagraph (B) with respect to the purchase of the item.

(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with re-

spect to the purchase or rental of an item furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the purchase or rental, respectively, of the item for the 12-month period ending on June 30, 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes).

(C) COMPUTATION OF LOCAL PAYMENT AMOUNT AND NATIONAL LIMITED PAYMENT AMOUNT.—For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994 the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(3) PAYMENT FOR ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.—

(A) IN GENERAL.—Payment for a covered item (such as IPPB machines and ventilators, excluding ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices) for which there must be frequent and substantial servicing in order to avoid risk to the patient's health shall be made on a monthly basis for the rental of the item and the amount recognized is the amount specified in subparagraph (B).

(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to an item or device furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the rental of the item or device for the 12-month period ending with June 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year.

(C) COMPUTATION OF LOCAL PAYMENT AMOUNT AND NATIONAL LIMITED PAYMENT AMOUNT.—For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994 the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(4) PAYMENT FOR CERTAIN CUSTOMIZED ITEMS.—Payment with respect to a covered item that is uniquely constructed or substantially modified to meet the specific needs of an individual patient, and for that reason cannot be grouped with similar items for purposes of payment under this title, shall be made in a lump-sum amount (A) for the purchase of the item in a payment amount based upon the carrier's individual consideration for that item, and (B) for the reasonable and necessary maintenance and servicing for parts and labor not covered by the supplier's or manufacturer's warranty, when necessary during the period of medical need, and the amount recognized for such maintenance and servicing shall be paid on a lump-sum, as needed basis based upon the carrier's individual consideration for that item. In the case of a wheelchair furnished on or after January 1, 1992, the wheelchair shall be treated as a customized item for purposes of this paragraph if the wheelchair has been measured, fitted, or adapted in consideration of the patient's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features,

modifications, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician.

(5) PAYMENT FOR OXYGEN AND OXYGEN EQUIPMENT.—

(A) IN GENERAL.—Payment for oxygen and oxygen equipment shall be made on a monthly basis in the monthly payment amount recognized under paragraph (9) for oxygen and oxygen equipment (other than portable oxygen equipment), subject to subparagraphs (B), (C), (E), and (F).

(B) ADD-ON FOR PORTABLE OXYGEN EQUIPMENT.—When portable oxygen equipment is used, but subject to subparagraph (D), the payment amount recognized under subparagraph (A) shall be increased by the monthly payment amount recognized under paragraph (9) for portable oxygen equipment.

(C) VOLUME ADJUSTMENT.—When the attending physician prescribes an oxygen flow rate—

(i) exceeding 4 liters per minute, the payment amount recognized under subparagraph (A), subject to subparagraph (D), shall be increased by 50 percent, or

(ii) of less than 1 liter per minute, the payment amount recognized under subparagraph (A) shall be decreased by 50 percent.

(D) LIMIT ON ADJUSTMENT.—When portable oxygen equipment is used and the attending physician prescribes an oxygen flow rate exceeding 4 liters per minute, there shall only be an increase under either subparagraph (B) or (C), whichever increase is larger, and not under both such subparagraphs.

(E) RECERTIFICATION FOR PATIENTS RECEIVING HOME OXYGEN THERAPY.—In the case of a patient receiving home oxygen therapy services who, at the time such services are initiated, has an initial arterial blood gas value at or above a partial pressure of 56 or an arterial oxygen saturation at or above 89 percent (or such other values, pressures, or criteria as the Secretary may specify) no payment may be made under this part for such services after the expiration of the 90-day period that begins on the date the patient first receives such services unless the patient's attending physician certifies that, on the basis of a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 30 days of such 90-day period, there is a medical need for the patient to continue to receive such services.

(F) RENTAL CAP.—

(i) IN GENERAL.—Payment for oxygen equipment (including portable oxygen equipment) under this paragraph may not extend over a period of continuous use (as determined by the Secretary) of longer than 36 months.

(ii) PAYMENTS AND RULES AFTER RENTAL CAP.—After the 36th continuous month during which payment is made for the equipment under this paragraph—

(I) the supplier furnishing such equipment under this subsection shall continue to furnish the

equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary;

(II) payments for oxygen shall continue to be made in the amount recognized for oxygen under paragraph (9) for the period of medical need; and

(III) maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.

(6) PAYMENT FOR OTHER COVERED ITEMS (OTHER THAN DURABLE MEDICAL EQUIPMENT).—Payment for other covered items (other than durable medical equipment and other covered items described in paragraph (3), (4), or (5)) shall be made in a lump-sum amount for the purchase of the item in the amount of the purchase price recognized under paragraph (8).

(7) PAYMENT FOR OTHER ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(A) PAYMENT.—In the case of an item of durable medical equipment not described in paragraphs (2) through (6), the following rules shall apply:

(i) RENTAL.—

(I) IN GENERAL.—Except as provided in clause (iii), payment for the item shall be made on a monthly basis for the rental of the item during the period of medical need (but payments under this clause may not extend over a period of continuous use (as determined by the Secretary) of longer than 13 months).

(II) PAYMENT AMOUNT.—Subject to subclause (III) and subparagraph (B), the amount recognized for the item, for each of the first 3 months of such period, is 10 percent of the purchase price recognized under paragraph (8) with respect to the item, and, for each of the remaining months of such period, is 7.5 percent of such purchase price.

(III) SPECIAL RULE FOR POWER-DRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting “15 percent” and “6 percent” for “10 percent” and “7.5 percent”, respectively.

(ii) OWNERSHIP AFTER RENTAL.—On the first day that begins after the 13th continuous month during which payment is made for the rental of an item under clause (i), the supplier of the item shall transfer title to the item to the individual.

(iii) PURCHASE AGREEMENT OPTION FOR COMPLEX, REHABILITATIVE POWER-DRIVEN WHEELCHAIRS.—In the case of a complex, rehabilitative power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual the option to pur-

chase the item, and payment for such item shall be made on a lump-sum basis if the individual exercises such option.

(iv) MAINTENANCE AND SERVICING.—After the supplier transfers title to the item under clause (ii) or in the case of a power-driven wheelchair for which a purchase agreement has been entered into under clause (iii), maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.

(B) RANGE FOR RENTAL AMOUNTS.—

(i) FOR 1989.—For items furnished during 1989, the payment amount recognized under subparagraph (A)(i) shall not be more than 115 percent, and shall not be less than 85 percent, of the prevailing charge established for rental of the item in January 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987.

(ii) FOR 1990.—For items furnished during 1990, clause (i) shall apply in the same manner as it applies to items furnished during 1989.

(C) REPLACEMENT OF ITEMS.—

(i) ESTABLISHMENT OF REASONABLE USEFUL LIFETIME.—In accordance with clause (iii), the Secretary shall determine and establish a reasonable useful lifetime for items of durable medical equipment for which payment may be made under this paragraph.

(ii) PAYMENT FOR REPLACEMENT ITEMS.—If the reasonable lifetime of such an item, as so established, has been reached during a continuous period of medical need, or the carrier determines that the item is lost or irreparably damaged, the patient may elect to have payment for an item serving as a replacement for such item made—

(I) on a monthly basis for the rental of the replacement item in accordance with subparagraph (A); or

(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(iii), in a lump-sum amount for the purchase of the item.

(iii) LENGTH OF REASONABLE USEFUL LIFETIME.—The reasonable useful lifetime of an item of durable medical equipment under this subparagraph shall be equal to 5 years, except that, if the Secretary determines that, on the basis of prior experience in making payments for such an item under this title, a reasonable useful lifetime of 5 years is not appropriate with re-

spect to a particular item, the Secretary shall establish an alternative reasonable lifetime for such item.

(8) PURCHASE PRICE RECOGNIZED FOR MISCELLANEOUS DEVICES AND ITEMS.—For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for a covered item is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) COMPUTATION OF LOCAL PURCHASE PRICE.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price, for each item described—

(I) in paragraph (6) equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987, or

(II) in paragraph (7) equal to the average of the purchase prices on the claims submitted on an assignment-related basis for the unused item supplied during the 6-month period ending with December 1986.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987,

(II) in 1991, equal to the local purchase price computed under this clause for the previous year, increased by the covered item update for 1991, and decreased by the percentage by which the average of the reasonable charges for claims paid for all items described in paragraph (7) is lower than the average of the purchase prices submitted for such items during the final 9 months of 1988; or

(III) in 1992, 1993, and 1994 equal to the local purchase price computed under this clause for the previous year increased by the covered item update for the year.

(B) COMPUTATION OF NATIONAL LIMITED PURCHASE PRICE.—With respect to the furnishing of a particular item in a year, the Secretary shall compute a national limited purchase price—

(i) for 1991, equal to the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the median of all local purchase prices computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local purchase prices computed under such subparagraph for the item for the year; and

(iv) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.

(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989 or 1990, is 100 percent of the local purchase price computed under subparagraph (A)(ii)(I);

(ii) in 1991, is the sum of (I) 67 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1991, and (II) 33 percent of the national limited purchase price computed under subparagraph (B) for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local purchase price computed under subparagraph (A)(ii)(III) for 1992, and (II) 67 percent of the national limited purchase price computed under subparagraph (B) for 1992; and

(iv) in 1993 or a subsequent year, is the national limited purchase price computed under subparagraph (B) for that year.

(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an “item”).

(A) COMPUTATION OF LOCAL MONTHLY PAYMENT RATE.—Each carrier under this section shall compute a base local payment rate for each item as follows:

(i) The carrier shall compute a base local average monthly payment rate per beneficiary as an amount equal to (I) the total reasonable charges for the item during the 12-month period ending with December 1986, divided by (II) the total number of months for all beneficiaries receiving the item in the area during the 12-month period for which the carrier made payment for the item under this title.

(ii) The carrier shall compute a local average monthly payment rate for the item applicable—

(I) to 1989 and 1990, equal to 95 percent of the base local average monthly payment rate computed under clause (i) for the item increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987, or

(II) to 1991, 1992, 1993, and 1994 equal to the local average monthly payment rate computed under this clause for the item for the previous year increased by the covered item increase for the year.

(B) COMPUTATION OF NATIONAL LIMITED MONTHLY PAYMENT RATE.—With respect to the furnishing of an item in a year, the Secretary shall compute a national limited monthly payment rate equal to—

(i) for 1991, the local monthly payment rate computed under subparagraph (A)(ii)(II) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local monthly payment rate computed under subparagraph (A)(ii) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year;

(iv) for 1995, 1996, and 1997, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(v) for 1998, 75 percent of the amount determined under this subparagraph for 1997; and

(vi) for 1999 and each subsequent year, 70 percent of the amount determined under this subparagraph for 1997.

(C) MONTHLY PAYMENT AMOUNT RECOGNIZED.—For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

(i) in 1989 and in 1990, is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii) for the item;

(ii) in 1991, is the sum of (I) 67 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1991, and (II) 33 percent of the national limited monthly payment rate computed under subparagraph (B)(i) for the item for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 67 percent of the national limited monthly payment rate computed under subparagraph (B)(ii) for the item for 1992; and

(iv) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for that year.

(10) EXCEPTIONS AND ADJUSTMENTS.—

(A) AREAS OUTSIDE CONTINENTAL UNITED STATES.—Exceptions to the amounts recognized under the previous provisions of this subsection shall be made to take into account the unique circumstances of covered items furnished in Alaska, Hawaii, or Puerto Rico.

(B) ADJUSTMENT FOR INHERENT REASONABLENESS.—The Secretary is authorized to apply the provisions of paragraphs (8) and (9) of section 1842(b) to covered items and suppliers of such items and payments under this subsection in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(F).

(C) TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS).—In order to permit an attending physician time to determine whether the purchase of a transcutaneous electrical nerve stimulator is medically appropriate for a particular patient, the Secretary may determine an appropriate payment amount for the initial rental of such item for a period of not more than 2 months. If such item is subsequently purchased, the payment amount with respect to such purchase is the payment amount determined under paragraph (2).

(11) IMPROPER BILLING AND REQUIREMENT OF PHYSICIAN ORDER.—

(A) IMPROPER BILLING FOR CERTAIN RENTAL ITEMS.—Notwithstanding any other provision of this title, a supplier of a covered item for which payment is made under this subsection and which is furnished on a rental basis shall continue to supply the item without charge (other than a charge provided under this subsection for the maintenance and servicing of the item) after rental payments may no longer be made under this subsection. If a supplier knowingly and willfully violates the previous sentence, the Secretary may apply sanctions against the supplier under section 1842(j)(2) in the same manner such sanctions may apply with respect to a physician.

(B) REQUIREMENT OF PHYSICIAN ORDER.—

(i) IN GENERAL.—The Secretary is authorized to require, for specified covered items, that payment may be made under this subsection with respect to the item only if a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B) that is enrolled under section 1866(j) has communicated to the supplier, before delivery of the item, a written order for the item.

(ii) REQUIREMENT FOR FACE TO FACE ENCOUNTER.—The Secretary shall require that such an order be written pursuant to a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) documenting such physician, physician assistant, practitioner, or specialist has had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.

(12) REGIONAL CARRIERS.—The Secretary may designate, by regulation under section 1842, one carrier for one or more entire regions to process all claims within the region for covered items under this section.

(13) COVERED ITEM.—In this subsection, the term “covered item” means durable medical equipment (as defined in section 1861(n)), including such equipment described in section 1861(m)(5), but not including implantable items for which payment may be made under section 1833(t).

(14) COVERED ITEM UPDATE.—In this subsection, the term “covered item update” means, with respect to a year—

(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point;

(B) for 1993, 1994, 1995, 1996, and 1997, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year;

(C) for each of the years 1998 through 2000, 0 percentage points;

(D) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;

(E) for 2002, 0 percentage points;

(F) for 2003, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of 2002;

(G) for 2004 through 2006—

(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C.

360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(H) for 2007—

(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage change determined by the Secretary to be appropriate taking into account recommendations contained in the report of the Comptroller General of the United States under section 302(c)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(I) for 2008—

(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) (as applied to the payment amount for 2007 determined after the application of the percentage change under subparagraph (H)(i)); and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(J) for 2009—

(i) in the case of items and services furnished in any geographic area, if such items or services were selected for competitive acquisition in any area under the competitive acquisition program under section 1847(a)(1)(B)(i)(I) before July 1, 2008, including related accessories but only if furnished with such items and services selected for such competition and diabetic supplies but only if furnished through mail order, - 9.5 percent; or

(ii) in the case of other items and services, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2008;

(K) for 2010, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year; and

(L) for 2011 and each subsequent year—

(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(ii) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection

for a year being less than such payment rates for the preceding year.

(15) ADVANCE DETERMINATIONS OF COVERAGE FOR CERTAIN ITEMS.—

(A) DEVELOPMENT OF LISTS OF ITEMS BY SECRETARY.—

The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area.

(B) DEVELOPMENT OF LISTS OF SUPPLIERS BY SECRETARY.—The Secretary may develop and periodically update a list of suppliers of items for which payment may be made under this subsection with respect to whom—

(i) the Secretary has found that a substantial number of claims for payment under this part for items furnished by the supplier have been denied on the basis of the application of section 1862(a)(1); or

(ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

(C) DETERMINATIONS OF COVERAGE IN ADVANCE.—A carrier shall determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered or because of the application of section 1862(a)(1) if—

(i) the item is included on the list developed by the Secretary under subparagraph (A);

(ii) the item is furnished by a supplier included on the list developed by the Secretary under subparagraph (B); or

(iii) the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests that such advance determination be made.

(16) DISCLOSURE OF INFORMATION AND SURETY BOND.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

(A) with—

(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such

an ownership or control interest in the disclosing entity; and

(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000 that the Secretary determines is commensurate with the volume of the billing of the supplier.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law. The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1842(b)(18)(C)) who furnish items or services under this part.

(17) PROHIBITION AGAINST UNSOLICITED TELEPHONE CONTACTS BY SUPPLIERS.—

(A) IN GENERAL.—A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual unless 1 of the following applies:

(i) The individual has given written permission to the supplier to make contact by telephone regarding the furnishing of a covered item.

(ii) The supplier has furnished a covered item to the individual and the supplier is contacting the individual only regarding the furnishing of such covered item.

(iii) If the contact is regarding the furnishing of a covered item other than a covered item already furnished to the individual, the supplier has furnished at least 1 covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

(B) PROHIBITING PAYMENT FOR ITEMS FURNISHED SUBSEQUENT TO UNSOLICITED CONTACTS.—If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

(C) EXCLUSION FROM PROGRAM FOR SUPPLIERS ENGAGING IN PATTERN OF UNSOLICITED CONTACTS.—If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier's conduct establishes a pattern of contacts in violation of such subparagraph, the Secretary shall exclude the supplier from participation in the programs under this Act, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1128.

(18) REFUND OF AMOUNTS COLLECTED FOR CERTAIN DISALLOWED ITEMS.—

(A) IN GENERAL.—If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B), the supplier shall refund

on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B), or

(ii) before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item.

(B) SANCTIONS.—If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1842(j)(2).

(C) NOTICE.—Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

(D) TIMELY BASIS DEFINED.—A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.

(19) CERTAIN UPGRADED ITEMS.—

(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of this title, the Secretary may issue regulations under which an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

(C) CONSUMER PROTECTION SAFEGUARDS.—Any regulations under subparagraph (A) shall provide for consumer protection standards with respect to the furnishing of up-

graded equipment under subparagraph (A). Such regulations shall provide for—

- (i) determination of fair market prices with respect to an upgraded item;
- (ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;
- (iii) conditions of participation for suppliers in the billing arrangement;
- (iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and
- (v) such other safeguards as the Secretary determines are necessary.

(20) IDENTIFICATION OF QUALITY STANDARDS.—

(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for suppliers of items and services described in subparagraph (D) to be applied by recognized independent accreditation organizations (as designated under subparagraph (B)) and with which such suppliers shall be required to comply in order to—

- (i) furnish any such item or service for which payment is made under this part; and
- (ii) receive or retain a provider or supplier number used to submit claims for reimbursement for any such item or service for which payment may be made under this title.

(B) DESIGNATION OF INDEPENDENT ACCREDITATION ORGANIZATIONS.—Not later than the date that is 1 year after the date on which the Secretary implements the quality standards under subparagraph (A), notwithstanding section 1865(a), the Secretary shall designate and approve one or more independent accreditation organizations for purposes of such subparagraph.

(C) QUALITY STANDARDS.—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

(D) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services, as the Secretary determines appropriate:

- (i) Covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection.
- (ii) Prosthetic devices and orthotics and prosthetics described in section 1834(h)(4).
- (iii) Items and services described in section 1842(s)(2).

(E) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the quality standards under this paragraph, including subparagraph (F), after

consultation with representatives of relevant parties. Such standards shall be applied prospectively and shall be published on the Internet website of the Centers for Medicare & Medicaid Services.

(F) APPLICATION OF ACCREDITATION REQUIREMENT.—In implementing quality standards under this paragraph—

(i) subject to clause (ii) and subparagraph (G), the Secretary shall require suppliers furnishing items and services described in subparagraph (D) on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted to the Secretary evidence of accreditation by an accreditation organization designated under subparagraph (B) as meeting applicable quality standards, except that the Secretary shall not require under this clause pharmacies to obtain such accreditation before January 1, 2010, except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011; and

(ii) in applying such standards and the accreditation requirement of clause (i) with respect to eligible professionals (as defined in section 1848(k)(3)(B)), and including such other persons, such as orthotists and prosthetists, as specified by the Secretary, furnishing such items and services—

(I) such standards and accreditation requirement shall not apply to such professionals and persons unless the Secretary determines that the standards being applied are designed specifically to be applied to such professionals and persons; and

(II) the Secretary may exempt such professionals and persons from such standards and requirement if the Secretary determines that licensing, accreditation, or other mandatory quality requirements apply to such professionals and persons with respect to the furnishing of such items and services.

(G) APPLICATION OF ACCREDITATION REQUIREMENT TO CERTAIN PHARMACIES.—

(i) IN GENERAL.—With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

(ii) PHARMACIES DESCRIBED.—A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

(I) The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.

(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary.

(21) SPECIAL PAYMENT RULE FOR SPECIFIED ITEMS AND SUPPLIES.—

(A) IN GENERAL.—Notwithstanding the preceding provisions of this subsection, for specified items and supplies (described in subparagraph (B)) furnished during 2005, the payment amount otherwise determined under this subsection for such specified items and supplies shall be reduced by the percentage difference between—

(i) the amount of payment otherwise determined for the specified item or supply under this subsection for 2002, and

(ii) the amount of payment for the specified item or supply under chapter 89 of title 5, United States Code, as identified in the column entitled “Median FEHP Price” in the table entitled “SUMMARY OF MEDICARE PRICES COMPARED TO VA, MEDICAID, RETAIL, AND FEHP PRICES FOR 16 ITEMS” included in the Testimony of the Inspector General before the Senate Committee on Appropriations, June 12, 2002, or any subsequent report by the Inspector General.

(B) SPECIFIED ITEM OR SUPPLY DESCRIBED.—For purposes of subparagraph (A), a specified item or supply means oxygen and oxygen equipment, standard wheelchairs (including standard power wheelchairs), nebulizers, diabetic supplies consisting of lancets and testing strips, hospital beds, and air mattresses, but only if the HCPCS code for the item or supply is identified in a table referred to in subparagraph (A)(ii).

(C) APPLICATION OF UPDATE TO SPECIAL PAYMENT AMOUNT.—The covered item update under paragraph (14) for specified items and supplies for 2006 and each subsequent year shall be applied to the payment amount under subparagraph (A) unless payment is made for such items and supplies under section 1847.

(22) SPECIAL PAYMENT RULE FOR DIABETIC SUPPLIES.—Notwithstanding the preceding provisions of this subsection, for purposes of determining the payment amount under this subsection for diabetic supplies furnished on or after the first day of the calendar quarter during 2013 that is at least 30 days after the date of the enactment of this paragraph and before the date described in paragraph (1)(H)(ii), the Secretary shall recalculate and apply the covered item update under paragraph (14) as if subparagraph (J)(i) of such paragraph was amended by striking “but only if furnished through mail order”.

(b) FEE SCHEDULES FOR RADIOLOGIST SERVICES.—

(1) DEVELOPMENT.—The Secretary shall develop—

(A) a relative value scale to serve as the basis for the payment for radiologist services under this part, and

(B) using such scale and appropriate conversion factors and subject to subsection (c)(1)(A), fee schedules (on a regional, statewide, locality, or carrier service area basis) for payment for radiologist services under this part, to be implemented for such services furnished during 1989.

(2) CONSULTATION.—In carrying out paragraph (1), the Secretary shall regularly consult closely with the Physician Payment Review Commission, the American College of Radiology, and other organizations representing physicians or suppliers who furnish radiologist services and shall share with them the data and data analysis being used to make the determinations under paragraph (1), including data on variations in current medicare payments by geographic area, and by service and physician specialty.

(3) CONSIDERATIONS.—In developing the relative value scale and fee schedules under paragraph (1), the Secretary—

(A) shall take into consideration variations in the cost of furnishing such services among geographic areas and among different sites where services are furnished, and

(B) may also take into consideration such other factors respecting the manner in which physicians in different specialties furnish such services as may be appropriate to assure that payment amounts are equitable and designed to promote effective and efficient provision of radiologist services by physicians in the different specialties.

(4) SAVINGS.—

(A) BUDGET NEUTRAL FEE SCHEDULES.—The Secretary shall develop preliminary fee schedules for 1989, which are designed to result in the same amount of aggregate payments (net of any coinsurance and deductibles under sections 1833(a)(1)(J) and 1833(b)) for radiologist services furnished in 1989 as would have been made if this subsection had not been enacted.

(B) INITIAL SAVINGS.—The fee schedules established for payment purposes under this subsection for services furnished in 1989 shall be 97 percent of the amounts permitted under these preliminary fee schedules developed under subparagraph (A).

(C) 1990 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1990, after March 31 of such year, the conversion factors used under this subsection shall be 96 percent of the conversion factors that applied under this subsection as of December 31, 1989.

(D) 1991 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1991, the conversion factors used in a locality under this subsection shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:

(i) NATIONAL WEIGHTED AVERAGE CONVERSION FACTOR.—The Secretary shall estimate the national weighted average of the conversion factors used under this subsection for services furnished during 1990 beginning on April 1, using the best available data.

(ii) REDUCED NATIONAL WEIGHTED AVERAGE.—The national weighted average estimated under clause (i) shall be reduced by 13 percent.

(iii) COMPUTATION OF 1990 LOCALITY INDEX RELATIVE TO NATIONAL AVERAGE.—The Secretary shall establish an index which reflects, for each locality, the ratio of the conversion factor used in the locality under this subsection to the national weighted average estimated under clause (i).

(iv) ADJUSTED CONVERSION FACTOR.—The adjusted conversion factor for the professional or technical component of a service in a locality is the sum of $\frac{1}{2}$ of the locally-adjusted amount determined under clause (v) and $\frac{1}{2}$ of the GPCI-adjusted amount determined under clause (vi).

(v) LOCALLY-ADJUSTED AMOUNT.—For purposes of clause (iv), the locally adjusted amount determined under this clause is the product of (I) the national weighted average conversion factor computed under clause (ii), and (II) the index value established under clause (iii) for the locality.

(vi) GPCI-ADJUSTED AMOUNT.—For purposes of clause (iv), the GPCI-adjusted amount determined under this clause is the sum of—

(I) the product of (a) the portion of the reduced national weighted average conversion factor com-

puted under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238–36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average conversion factor computed under clause (ii), and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause with respect to the professional component of a service, 80 percent of the conversion factor shall be considered to be attributable to physician work and with respect to the technical component of the service, 0 percent shall be considered to be attributable to physician work.

(vii) LIMITS ON CONVERSION FACTOR.—The conversion factor to be applied to a locality to the professional or technical component of a service shall not be reduced under this subparagraph by more than 9.5 percent below the conversion factor applied in the locality under subparagraph (C) to such component, but in no case shall the conversion factor be less than 60 percent of the national weighted average of the conversion factors (computed under clause (i)).

(E) RULE FOR CERTAIN SCANNING SERVICES.—In the case of the technical components of magnetic resonance imaging (MRI) services and computer assisted tomography (CAT) services furnished after December 31, 1990, the amount otherwise payable shall be reduced by 10 percent.

(F) SUBSEQUENT UPDATING.—For radiologist services furnished in subsequent years, the fee schedules shall be the schedules for the previous year updated by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year.

(G) NONPARTICIPATING PHYSICIANS AND SUPPLIERS.—Each fee schedule so established shall provide that the payment rate recognized for nonparticipating physicians and suppliers is equal to the appropriate percent (as defined in section 1842(b)(4)(A)(iv)) of the payment rate recognized for participating physicians and suppliers.

(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS AND SUPPLIERS.—

(A) IN GENERAL.—In the case of radiologist services furnished after January 1, 1989, for which payment is made under a fee schedule under this subsection, if a nonparticipating physician or supplier furnishes the service to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B)).

(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term “limiting charge” means, with respect to a service furnished—

(i) in 1989, 125 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1),

(ii) in 1990, 120 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1), and

(iii) after 1990, 115 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1).

(C) ENFORCEMENT.—If a physician or supplier knowingly and willfully bills in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2) in the same manner as such sanctions may apply to a physician.

(6) RADIOLOGIST SERVICES DEFINED.—For the purposes of this subsection and section 1833(a)(1)(J), the term “radiologist services” only includes radiology services performed by, or under the direction or supervision of, a physician—

(A) who is certified, or eligible to be certified, by the American Board of Radiology, or

(B) for whom radiology services account for at least 50 percent of the total amount of charges made under this part.

(c) PAYMENT AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

(1) IN GENERAL.—With respect to expenses incurred for screening mammography (as defined in section 1861(jj)), payment may be made only—

(A) for screening mammography conducted consistent with the frequency permitted under paragraph (2); and

(B) if the screening mammography is conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act.

(2) FREQUENCY COVERED.—

(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

(i) no payment may be made under this part for screening mammography performed on a woman under 35 years of age;

(ii) payment may be made under this part for only one screening mammography performed on a woman over 34 years of age, but under 40 years of age; and

(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

(B) REVISION OF FREQUENCY.—

(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with

which screening mammography may be paid for under this subsection.

(d) FREQUENCY LIMITS AND PAYMENT FOR COLORECTAL CANCER SCREENING TESTS.—

(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

(A) PAYMENT AMOUNT.—The payment amount for colorectal cancer screening tests consisting of screening fecal-occult blood tests is equal to the payment amount established for diagnostic fecal-occult blood tests under section 1833(h).

(B) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening fecal-occult blood test—

(i) if the individual is under 50 years of age; or

(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

(A) FEE SCHEDULE.—With respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies, payment under section 1848 shall be consistent with payment under such section for similar or related services.

(B) PAYMENT LIMIT.—In the case of screening flexible sigmoidoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services.

(C) FACILITY PAYMENT LIMIT.—

(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening flexible sigmoidoscopy services furnished on or after January 1, 1999, that—

(I) in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part, and

(II) are performed in an ambulatory surgical center or hospital outpatient department,

payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) LIMITATION ON COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable copayment, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

- (i) if the individual is under 50 years of age; or
- (ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy or, in the case of an individual who is not at high risk for colorectal cancer, if the procedure is performed within the 119 months after a previous screening colonoscopy.

(3) SCREENING COLONOSCOPY.—

(A) FEE SCHEDULE.—With respect to colorectal cancer screening test consisting of a screening colonoscopy, payment under section 1848 shall be consistent with payment amounts under such section for similar or related services.

(B) PAYMENT LIMIT.—In the case of screening colonoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services.

(C) FACILITY PAYMENT LIMIT.—

(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening colonoscopy services furnished on or after January 1, 1999, that are performed in an ambulatory surgical center or a hospital outpatient department, payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) LIMITATION ON COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable coinsurance, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening colonoscopy, a lesion or growth is

detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy or for other individuals if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a previous screening flexible sigmoidoscopy.

(e) ACCREDITATION REQUIREMENT FOR ADVANCED DIAGNOSTIC IMAGING SERVICES.—

(1) IN GENERAL.—

(A) IN GENERAL.—Beginning with January 1, 2012, with respect to the technical component of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) and that are furnished by a supplier, payment may only be made if such supplier is accredited by an accreditation organization designated by the Secretary under paragraph (2)(B)(i).

(B) ADVANCED DIAGNOSTIC IMAGING SERVICES DEFINED.—In this subsection, the term “advanced diagnostic imaging services” includes—

(i) diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography); and

(ii) such other diagnostic imaging services, including services described in section 1848(b)(4)(B) (excluding X-ray, ultrasound, and fluoroscopy), as specified by the Secretary in consultation with physician specialty organizations and other stakeholders.

(C) SUPPLIER DEFINED.—In this subsection, the term “supplier” has the meaning given such term in section 1861(d).

(2) ACCREDITATION ORGANIZATIONS.—

(A) FACTORS FOR DESIGNATION OF ACCREDITATION ORGANIZATIONS.—The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B)(i) and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

(i) The ability of the organization to conduct timely reviews of accreditation applications.

(ii) Whether the organization has established a process for the timely integration of new advanced diagnostic imaging services into the organization’s accreditation program.

(iii) Whether the organization uses random site visits, site audits, or other strategies for ensuring accredited suppliers maintain adherence to the criteria described in paragraph (3).

(iv) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1886(d)(2)(D)).

(v) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

(vi) Such other factors as the Secretary determines appropriate.

(B) DESIGNATION.—Not later than January 1, 2010, the Secretary shall designate organizations to accredit suppliers furnishing the technical component of advanced diagnostic imaging services. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

(C) REVIEW AND MODIFICATION OF LIST OF ACCREDITATION ORGANIZATIONS.—

(i) IN GENERAL.—The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the results of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

(ii) SPECIAL RULE FOR ACCREDITATIONS DONE PRIOR TO REMOVAL FROM LIST OF DESIGNATED ACCREDITATION ORGANIZATIONS.—In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

(3) CRITERIA FOR ACCREDITATION.—The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality. Such criteria shall include—

(A) standards for qualifications of medical personnel who are not physicians and who furnish the technical component of advanced diagnostic imaging services;

(B) standards for qualifications and responsibilities of medical directors and supervising physicians, including standards that recognize the considerations described in paragraph (4);

(C) procedures to ensure that equipment used in furnishing the technical component of advanced diagnostic imaging services meets performance specifications;

(D) standards that require the supplier have procedures in place to ensure the safety of persons who furnish the technical component of advanced diagnostic imaging services and individuals to whom such services are furnished;

(E) standards that require the establishment and maintenance of a quality assurance and quality control program by the supplier that is adequate and appropriate to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by such supplier; and

(F) any other standards or procedures the Secretary determines appropriate.

(4) RECOGNITION IN STANDARDS FOR THE EVALUATION OF MEDICAL DIRECTORS AND SUPERVISING PHYSICIANS.—The standards described in paragraph (3)(B) shall recognize whether a medical director or supervising physician—

(A) in a particular specialty receives training in advanced diagnostic imaging services in a residency program;

(B) has attained, through experience, the necessary expertise to be a medical director or a supervising physician;

(C) has completed any continuing medical education courses relating to such services; or

(D) has met such other standards as the Secretary determines appropriate.

(5) RULE FOR ACCREDITATIONS MADE PRIOR TO DESIGNATION.—In the case of a supplier that is accredited before January 1, 2010, by an accreditation organization designated by the Secretary under paragraph (2)(B) as of January 1, 2010, such supplier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2012, for the remaining period such accreditation is in effect.

(f) REDUCTION IN PAYMENTS FOR PHYSICIAN PATHOLOGY SERVICES DURING 1991.—

(1) IN GENERAL.—For physician pathology services furnished under this part during 1991, the prevailing charges used in a locality under this part shall be 7 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

(2) LIMITATION.—The prevailing charge for the technical and professional components of an physician pathology service furnished by a physician through an independent laboratory shall not be reduced pursuant to paragraph (1) to the extent that such reduction would reduce such prevailing charge below 115 percent of the prevailing charge for the professional component of such service when furnished by a hospital-based physician in the same locality. For purposes of the preceding sentence, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians' office.

(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) IN GENERAL.—The amount of payment for outpatient critical access hospital services of a critical access hospital is equal to 101 percent of the reasonable costs of the hospital in pro-

viding such services, unless the hospital makes the election under paragraph (2).

(2) ELECTION OF COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—A critical access hospital may elect to be paid for outpatient critical access hospital services amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1866(a)(2)(A):

(A) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under subparagraph (B), 101 percent of the reasonable costs of the critical access hospital in providing such services.

(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, 115 percent of such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services. Subsections (x) and (y) of section 1833 shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.

The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician or other practitioner providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians and practitioners who have not assigned such billing rights.

(3) DISREGARDING CHARGES.—The payment amounts under this subsection shall be determined without regard to the amount of the customary or other charge.

(4) TREATMENT OF CLINICAL DIAGNOSTIC LABORATORY SERVICES.—No coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under this part shall apply with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital service. Nothing in this title shall be construed as providing for payment for clinical diagnostic laboratory services furnished as part of outpatient critical access hospital services, other than on the basis described in this subsection. For purposes of the preceding sentence and section 1861(mm)(3), clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital, or in a skilled nursing facility or a clinic (including a rural health clinic) that is operated by a critical access hospital, at the time the specimen is collected.

(5) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—In determining the reasonable costs of outpatient critical access hospital services under paragraphs (1) and (2)(A), the Secretary shall recognize as allowable costs, amounts (as defined by the Secretary) for reasonable compensation and related costs for physicians, physician assist-

ants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services but who are not present on the premises of the critical access hospital involved, and are not otherwise furnishing services covered under this title and are not on-call at any other provider or facility.

(h) PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.—

(1) GENERAL RULE FOR PAYMENT.—

(A) IN GENERAL.—Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) PAYMENT BASIS.—Except as provided in subparagraphs (C), (E), and (H)(i), the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item; or

(ii) the amount recognized under paragraph (2) as the purchase price for the item.

(C) EXCEPTION FOR CERTAIN PUBLIC HOME HEALTH AGENCIES.—Subparagraph (B)(i) shall not apply to an item furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(D) EXCLUSIVE PAYMENT RULE.—Subject to subparagraph (H)(ii), this subsection shall constitute the exclusive provision of this title for payment for prosthetic devices, orthotics, and prosthetics under this part or under part A to a home health agency.

(E) EXCEPTION FOR CERTAIN ITEMS.—Payment for ostomy supplies, tracheostomy supplies, and urologicals shall be made in accordance with subparagraphs (B) and (C) of section 1834(a)(2).

(F) SPECIAL PAYMENT RULES FOR CERTAIN PROSTHETICS AND CUSTOM-FABRICATED ORTHOTICS.—

(i) IN GENERAL.—No payment shall be made under this subsection for an item of custom-fabricated orthotics described in clause (ii) or for an item of prosthetics unless such item is—

(I) furnished by a qualified practitioner; and

(II) fabricated by a qualified practitioner or a qualified supplier at a facility that meets such criteria as the Secretary determines appropriate.

(ii) DESCRIPTION OF CUSTOM-FABRICATED ITEM.—

(I) IN GENERAL.—An item described in this clause is an item of custom-fabricated orthotics that requires education, training, and experience to custom-fabricate and that is included in a list established by the Secretary in subclause (II). Such an item does not include shoes and shoe inserts.

(II) LIST OF ITEMS.—The Secretary, in consultation with appropriate experts in orthotics (including national organizations representing manufacturers of orthotics), shall establish and update as appropriate a list of items to which this subparagraph applies. No item may be included in such list unless the item is individually fabricated for the patient over a positive model of the patient.

(iii) QUALIFIED PRACTITIONER DEFINED.—In this subparagraph, the term “qualified practitioner” means a physician or other individual who—

(I) is a qualified physical therapist or a qualified occupational therapist;

(II) in the case of a State that provides for the licensing of orthotics and prosthetics, is licensed in orthotics or prosthetics by the State in which the item is supplied; or

(III) in the case of a State that does not provide for the licensing of orthotics and prosthetics, is specifically trained and educated to provide or manage the provision of prosthetics and custom-designed or -fabricated orthotics, and is certified by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or is credentialed and approved by a program that the Secretary determines, in consultation with appropriate experts in orthotics and prosthetics, has training and education standards that are necessary to provide such prosthetics and orthotics.

(iv) QUALIFIED SUPPLIER DEFINED.—In this subparagraph, the term “qualified supplier” means any entity that is accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or accredited and approved by a program that the Secretary determines has accreditation and approval standards that are essentially equivalent to those of such Board.

(G) REPLACEMENT OF PROSTHETIC DEVICES AND PARTS.—

(i) IN GENERAL.—Payment shall be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(I) A change in the physiological condition of the patient.

(II) An irreparable change in the condition of the device, or in a part of the device.

(III) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost

of a replacement device, or, as the case may be, of the part being replaced.

(ii) CONFIRMATION MAY BE REQUIRED IF DEVICE OR PART BEING REPLACED IS LESS THAN 3 YEARS OLD.—If a physician determines that a replacement device, or a replacement part, is necessary pursuant to clause (i)—

(I) such determination shall be controlling; and

(II) such replacement device or part shall be deemed to be reasonable and necessary for purposes of section 1862(a)(1)(A);

except that if the device, or part, being replaced is less than 3 years old (calculated from the date on which the beneficiary began to use the device or part), the Secretary may also require confirmation of necessity of the replacement device or replacement part, as the case may be.

(H) APPLICATION OF COMPETITIVE ACQUISITION TO ORTHOTICS; LIMITATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of orthotics described in paragraph (2)(C) of section 1847(a) furnished on or after January 1, 2009, subject to subsection (a)(1)(G), that are included in a competitive acquisition program in a competitive acquisition area under such section—

(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

(ii) subject to subsection (a)(1)(G), the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.

(2) PURCHASE PRICE RECOGNIZED.—For purposes of paragraph (1), the amount that is recognized under this paragraph as the purchase price for prosthetic devices, orthotics, and prosthetics is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) COMPUTATION OF LOCAL PURCHASE PRICE.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price for each item equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (United

States city average) for the 6-month period ending with December 1987, or

(II) in 1991, 1992 or 1993, equal to the local purchase price computed under this clause for the previous year increased by the applicable percentage increase for the year.

(B) COMPUTATION OF REGIONAL PURCHASE PRICE.—With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

(i) for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the applicable percentage increase for the year.

(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraph (1) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989, 1990, or 1991, is 100 percent of the local purchase price computed under subparagraph (A)(ii);

(ii) in 1992, is the sum of (I) 75 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1992, and (II) 25 percent of the regional purchase price computed under subparagraph (B) for 1992;

(iii) in 1993, is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1993, and (II) 50 percent of the regional purchase price computed under subparagraph (B) for 1993; and

(iv) in 1994 or a subsequent year, is the regional purchase price computed under subparagraph (B) for that year.

(D) RANGE ON AMOUNT RECOGNIZED.—The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

(i) in 1992, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

(3) APPLICABILITY OF CERTAIN PROVISIONS RELATING TO DURABLE MEDICAL EQUIPMENT.—Paragraphs (12) and (17) and subparagraphs (A) and (B) of paragraph (10) and paragraph (11) of subsection (a) shall apply to prosthetic devices, orthotics,

and prosthetics in the same manner as such provisions apply to covered items under such subsection.

(4) DEFINITIONS.—In this subsection—

(A) the term “applicable percentage increase” means—

- (i) for 1991, 0 percent;
- (ii) for 1992 and 1993, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;
- (iii) for 1994 and 1995, 0 percent;
- (iv) for 1996 and 1997, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;
- (v) for each of the years 1998 through 2000, 1 percent;
- (vi) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;
- (vii) for 2002, 1 percent;
- (viii) for 2003, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;
- (ix) for 2004, 2005, and 2006, 0 percent;
- (x) for for each of 2007 through 2010, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year; and
- (xi) for 2011 and each subsequent year—
 - (I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—
 - (II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

(B) the term “prosthetic devices” has the meaning given such term in section 1861(s)(8), except that such term does not include parenteral and enteral nutrition nutrients, supplies, and equipment and does not include an implantable item for which payment may be made under section 1833(t); and

(C) the term “orthotics and prosthetics” has the meaning given such term in section 1861(s)(9) (and includes shoes described in section 1861(s)(12)), but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5).

The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(5) DOCUMENTATION CREATED BY ORTHOTISTS AND PROSTHETISTS.—For purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by an orthotist or prosthetist shall be considered part of the individual's medical record to support documentation created by eligible professionals described in section 1848(k)(3)(B).

(i) PAYMENT FOR SURGICAL DRESSINGS.—

(1) IN GENERAL.—Payment under this subsection for surgical dressings (described in section 1861(s)(5)) shall be made in a lump sum amount for the purchase of the item in an amount equal to 80 percent of the lesser of—

(A) the actual charge for the item; or

(B) a payment amount determined in accordance with the methodology described in subparagraphs (B) and (C) of subsection (a)(2) (except that in applying such methodology, the national limited payment amount referred to in such subparagraphs shall be initially computed based on local payment amounts using average reasonable charges for the 12-month period ending December 31, 1992, increased by the covered item updates described in such subsection for 1993 and 1994).

(2) EXCEPTIONS.—Paragraph (1) shall not apply to surgical dressings that are—

(A) furnished as an incident to a physician's professional service; or

(B) furnished by a home health agency.

(j) REQUIREMENTS FOR SUPPLIERS OF MEDICAL EQUIPMENT AND SUPPLIES.—

(1) ISSUANCE AND RENEWAL OF SUPPLIER NUMBER.—

(A) PAYMENT.—Except as provided in subparagraph (C), no payment may be made under this part after the date of the enactment of the Social Security Act Amendments of 1994 for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number.

(B) STANDARDS FOR POSSESSING A SUPPLIER NUMBER.—A supplier may not obtain a supplier number unless—

(i) for medical equipment and supplies furnished on or after the date of the enactment of the Social Security Act Amendments of 1994 and before January 1, 1996, the supplier meets standards prescribed by the Secretary in regulations issued on June 18, 1992; and

(ii) for medical equipment and supplies furnished on or after January 1, 1996, the supplier meets revised standards prescribed by the Secretary (in consultation with representatives of suppliers of medical equipment and supplies, carriers, and consumers) that shall include requirements that the supplier—

(I) comply with all applicable State and Federal licensure and regulatory requirements;

(II) maintain a physical facility on an appropriate site;

(III) have proof of appropriate liability insurance; and

(IV) meet such other requirements as the Secretary may specify.

(C) EXCEPTION FOR ITEMS FURNISHED AS INCIDENT TO A PHYSICIAN'S SERVICE.—Subparagraph (A) shall not apply with respect to medical equipment and supplies furnished incident to a physician's service.

(D) PROHIBITION AGAINST MULTIPLE SUPPLIER NUMBERS.—The Secretary may not issue more than one supplier number to any supplier of medical equipment and supplies unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

(E) PROHIBITION AGAINST DELEGATION OF SUPPLIER DETERMINATIONS.—The Secretary may not delegate (other than by contract under section 1842) the responsibility to determine whether suppliers meet the standards necessary to obtain a supplier number.

(2) CERTIFICATES OF MEDICAL NECESSITY.—

(A) LIMITATION ON INFORMATION PROVIDED BY SUPPLIERS ON CERTIFICATES OF MEDICAL NECESSITY.—

(i) IN GENERAL.—Effective 60 days after the date of the enactment of the Social Security Act Amendments of 1994, a supplier of medical equipment and supplies may distribute to physicians, or to individuals entitled to benefits under this part, a certificate of medical necessity for commercial purposes which contains no more than the following information completed by the supplier:

(I) An identification of the supplier and the beneficiary to whom such medical equipment and supplies are furnished.

(II) A description of such medical equipment and supplies.

(III) Any product code identifying such medical equipment and supplies.

(IV) Any other administrative information (other than information relating to the beneficiary's medical condition) identified by the Secretary.

(ii) INFORMATION ON PAYMENT AMOUNT AND CHARGES.—If a supplier distributes a certificate of medical necessity containing any of the information permitted to be supplied under clause (i), the supplier shall also list on the certificate of medical necessity the fee schedule amount and the supplier's charge for the medical equipment or supplies being furnished prior to distribution of such certificate to the physician.

(iii) PENALTY.—Any supplier of medical equipment and supplies who knowingly and willfully distributes a certificate of medical necessity in violation of clause (i) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an

amount not to exceed \$1,000 for each such certificate of medical necessity so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

(B) DEFINITION.—For purposes of this paragraph, the term “certificate of medical necessity” means a form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(3) COVERAGE AND REVIEW CRITERIA.—The Secretary shall annually review the coverage and utilization of items of medical equipment and supplies to determine whether such items should be made subject to coverage and utilization review criteria, and if appropriate, shall develop and apply such criteria to such items.

(4) LIMITATION ON PATIENT LIABILITY.—If a supplier of medical equipment and supplies (as defined in paragraph (5))—

(A) furnishes an item or service to a beneficiary for which no payment may be made by reason of paragraph (1);

(B) furnishes an item or service to a beneficiary for which payment is denied in advance under subsection (a)(15); or

(C) furnishes an item or service to a beneficiary for which payment is denied under section 1862(a)(1); any expenses incurred for items and services furnished to an individual by such a supplier not on an assigned basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of subsection (a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such subsection.

(5) DEFINITION.—The term “medical equipment and supplies” means—

(A) durable medical equipment (as defined in section 1861(n));

(B) prosthetic devices (as described in section 1861(s)(8));

(C) orthotics and prosthetics (as described in section 1861(s)(9));

(D) surgical dressings (as described in section 1861(s)(5));

(E) such other items as the Secretary may determine; and

(F) for purposes of paragraphs (1) and (3)—

(i) home dialysis supplies and equipment (as described in section 1861(s)(2)(F)),

(ii) immunosuppressive drugs (as described in section 1861(s)(2)(J)),

(iii) therapeutic shoes for diabetics (as described in section 1861(s)(12)),

(iv) oral drugs prescribed for use as an anticancer therapeutic agent (as described in section 1861(s)(2)(Q)), and

(v) self-administered erythropoetin (as described in section 1861(s)(2)(P)).

(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES AND COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—

(1) IN GENERAL.—With respect to services described in section 1833(a)(8) or 1833(a)(9) for which payment is determined under this subsection, the payment basis shall be—

(A) for services furnished during 1998, the amount determined under paragraph (2); or

(B) for services furnished during a subsequent year, 80 percent of the lesser of—

(i) the actual charge for the services, or

(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

(2) PAYMENT IN 1998 BASED UPON ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of—

(A) the charges imposed for the services, or

(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services,

less 20 percent of the amount of the charges imposed for such services.

(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this subsection, the term “applicable fee schedule amount” means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1848 for such services furnished during the year or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.

(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term “adjusted reasonable costs” means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to services described in section 1833(a)(8)(B) (relating to services provided by hospitals).

(5) UNIFORM CODING.—For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

(7) ADJUSTMENT IN DISCOUNT FOR CERTAIN MULTIPLE THERAPY SERVICES.—In the case of therapy services furnished on or after April 1, 2013, and for which payment is made under this subsection pursuant to the applicable fee schedule amount (as

defined in paragraph (3)), instead of the 25 percent multiple procedure payment reduction specified in the final rule published by the Secretary in the Federal Register on November 29, 2010, the reduction percentage shall be 50 percent.

(1) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services whether provided directly by a supplier or provider or under arrangement with a provider under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

(B) establish definitions for ambulance services which link payments to the type of services provided;

(C) consider appropriate regional and operational differences;

(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner consistent with paragraph (11), except that such phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported.

(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4531(a) of the Balanced Budget Act of 1997 continued in effect, except that in making such determination the Secretary shall assume an update in such payments for 2002 equal to percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points;

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services furnished during the previous year, increased, subject to subparagraph (C) and the succeeding sentence of this paragraph, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending

with June of the previous year reduced in the case of 2002 by 1.0 percentage points; and

(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year.

(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

(7) CODING SYSTEM.—The Secretary may require the claim for any services for which the amount of payment is determined under this subsection to include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(8) SERVICES FURNISHED BY CRITICAL ACCESS HOSPITALS.—Notwithstanding any other provision of this subsection, the Secretary shall pay 101 percent of the reasonable costs incurred in furnishing ambulance services if such services are furnished—

(A) by a critical access hospital (as defined in section 1861(mm)(1)), or

(B) by an entity that is owned and operated by a critical access hospital,

but only if the critical access hospital or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such critical access hospital.

(9) TRANSITIONAL ASSISTANCE FOR RURAL PROVIDERS.—In the case of ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which the transportation originates in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip

above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than $\frac{1}{2}$ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.

(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of ground service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under such fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

(A) For 2004 (for services furnished on or after July 1, 2004), the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the nine census divisions (referred to in section 1886(d)(2)) using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.

(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by $\frac{1}{4}$ of the payment per mile otherwise applicable to miles in excess of 50 miles in such trip.

(12) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW POPULATION DENSITY AREAS.—

(A) IN GENERAL.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2023, for which the transportation originates in a qualified rural area (identified under subparagraph (B)(iii)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Sec-

retary shall estimate the average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

(B) IDENTIFICATION OF QUALIFIED RURAL AREAS.—

(i) DETERMINATION OF POPULATION DENSITY IN AREA.—Based upon data from the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, the population density for that area.

(ii) RANKING OF AREAS.—The Secretary shall rank each such area based on such population density.

(iii) IDENTIFICATION OF QUALIFIED RURAL AREAS.—The Secretary shall identify those areas (in subparagraph (A) referred to as “qualified rural areas”) with the lowest population densities that represent, if each such area were weighted by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.

(iv) RURAL AREA.—For purposes of this paragraph, the term “rural area” has the meaning given such term in section 1886(d)(2)(D). If feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.

(v) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of an area under this subparagraph.

(13) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

(A) IN GENERAL.—After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services furnished on or after July 1, 2004, and before January 1, 2007, and for such services furnished on or after July 1, 2008, and before January 1, 2023, for which the transportation originates in—

(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent (or 3 percent if such service is furnished on or after July 1, 2008, and before January 1, 2023); and

(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph

(11), shall be increased by 1 percent (or 2 percent if such service is furnished on or after July 1, 2008, and before January 1, 2023).

(B) APPLICATION OF INCREASED PAYMENTS AFTER APPLICABLE PERIOD.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished after the applicable period specified in such subparagraph.

(14) PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.—

(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall provide, to the extent that any ambulance services (whether ground or air) may be covered under such section, that a rural air ambulance service (as defined in subparagraph (C)) is reimbursed under this subsection at the air ambulance rate if the air ambulance service—

(i) is reasonable and necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

(ii) complies with equipment and crew requirements established by the Secretary.

(B) SATISFACTION OF REQUIREMENT OF MEDICALLY NECESSARY.—The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if—

(i) subject to subparagraph (D), such service is requested by a physician or other qualified medical personnel (as specified by the Secretary) who certifies or reasonably determines that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or

(ii) such service is furnished pursuant to a protocol that is established by a State or regional emergency medical service (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service.

(C) RURAL AIR AMBULANCE SERVICE DEFINED.—For purposes of this paragraph, the term “rural air ambulance service” means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(D) LIMITATION.—

(i) IN GENERAL.—Subparagraph (B)(i) shall not apply if there is a financial or employment relationship between the person requesting the rural air ambulance service and the entity furnishing the ambulance service, or an entity under common ownership with the entity furnishing the air ambulance service, or a finan-

cial relationship between an immediate family member of such requester and such an entity.

(ii) EXCEPTION.—Where a hospital and the entity furnishing rural air ambulance services are under common ownership, clause (i) shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member if the remuneration is for provider-based physician services furnished in a hospital (as described in section 1887) which are reimbursed under part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.

(15) PAYMENT ADJUSTMENT FOR NON-EMERGENCY AMBULANCE TRANSPORTS FOR ESRD BENEFICIARIES.—The fee schedule amount otherwise applicable under the preceding provisions of this subsection shall be reduced by 10 percent for ambulance services furnished during the period beginning on October 1, 2013, and ending on September 30, 2018, and by 23 percent for such services furnished on or after October 1, 2018, consisting of non-emergency basic life support services involving transport of an individual with end-stage renal disease for renal dialysis services (as described in section 1881(b)(14)(B)) furnished other than on an emergency basis by a provider of services or a renal dialysis facility.

(16) PRIOR AUTHORIZATION FOR REPETITIVE SCHEDULED NON-EMERGENCY AMBULANCE TRANSPORTS.—

(A) IN GENERAL.—Beginning January 1, 2017, if the expansion to all States of the model of prior authorization described in paragraph (2) of section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015 meets the requirements described in paragraphs (1) through (3) of section 1115A(c), then the Secretary shall expand such model to all States.

(B) FUNDING.—The Secretary shall use funds made available under section 1893(h)(10) to carry out this paragraph.

(C) CLARIFICATION REGARDING BUDGET NEUTRALITY.—Nothing in this paragraph may be construed to limit or modify the application of section 1115A(b)(3)(B) to models described in such section, including with respect to the model described in subparagraph (A) and expanded beginning on January 1, 2017, under such subparagraph.

(17) SUBMISSION OF COST AND OTHER INFORMATION.—

(A) DEVELOPMENT OF DATA COLLECTION SYSTEM.—The Secretary shall develop a data collection system (which may include use of a cost survey) to collect cost, revenue, utilization, and other information determined appropriate by the Secretary with respect to providers of services (in this paragraph referred to as “providers”) and suppliers of ground ambulance services. Such system shall be designed to collect information—

(i) needed to evaluate the extent to which reported costs relate to payment rates under this subsection;

(ii) on the utilization of capital equipment and ambulance capacity, including information consistent with the type of information described in section 1121(a); and

(iii) on different types of ground ambulance services furnished in different geographic locations, including rural areas and low population density areas described in paragraph (12).

(B) SPECIFICATION OF DATA COLLECTION SYSTEM.—

(i) IN GENERAL.—The Secretary shall—

(I) not later than December 31, 2019, specify the data collection system under subparagraph (A); and

(II) identify the providers and suppliers of ground ambulance services that would be required to submit information under such data collection system, including the representative sample described in clause (ii).

(ii) DETERMINATION OF REPRESENTATIVE SAMPLE.—

(I) IN GENERAL.—Not later than December 31, 2019, with respect to the data collection for the first year under such system, and for each subsequent year through 2024, the Secretary shall determine a representative sample to submit information under the data collection system.

(II) REQUIREMENTS.—The sample under subclause (I) shall be representative of the different types of providers and suppliers of ground ambulance services (such as those providers and suppliers that are part of an emergency service or part of a government organization) and the geographic locations in which ground ambulance services are furnished (such as urban, rural, and low population density areas).

(III) LIMITATION.—The Secretary shall not include an individual provider or supplier of ground ambulance services in the sample under subclause (I) in 2 consecutive years, to the extent practicable.

(C) REPORTING OF COST INFORMATION.—For each year, a provider or supplier of ground ambulance services identified by the Secretary under subparagraph (B)(i)(II) as being required to submit information under the data collection system with respect to a period for the year shall submit to the Secretary information specified under the system. Such information shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) PAYMENT REDUCTION FOR FAILURE TO REPORT.—

(i) IN GENERAL.—Beginning January 1, 2022, subject to clause (ii), a 10 percent reduction to payments under this subsection shall be made for the applicable period (as defined in clause (ii)) to a provider or supplier of ground ambulance services that—

(I) is required to submit information under the data collection system with respect to a period under subparagraph (C); and

(II) does not sufficiently submit such information, as determined by the Secretary.

(ii) APPLICABLE PERIOD DEFINED.—For purposes of clause (i), the term “applicable period” means, with respect to a provider or supplier of ground ambulance services, a year specified by the Secretary not more than 2 years after the end of the period with respect to which the Secretary has made a determination under clause (i)(II) that the provider or supplier of ground ambulance services failed to sufficiently submit information under the data collection system.

(iii) HARDSHIP EXEMPTION.—The Secretary may exempt a provider or supplier from the payment reduction under clause (i) with respect to an applicable period in the event of significant hardship, such as a natural disaster, bankruptcy, or other similar situation that the Secretary determines interfered with the ability of the provider or supplier of ground ambulance services to submit such information in a timely manner for the specified period.

(iv) INFORMAL REVIEW.—The Secretary shall establish a process under which a provider or supplier of ground ambulance services may seek an informal review of a determination that the provider or supplier is subject to the payment reduction under clause (i).

(E) ONGOING DATA COLLECTION.—

(i) REVISION OF DATA COLLECTION SYSTEM.—The Secretary may, as the Secretary determines appropriate and, if available, taking into consideration the report (or reports) under subparagraph (F), revise the data collection system under subparagraph (A).

(ii) SUBSEQUENT DATA COLLECTION.—In order to continue to evaluate the extent to which reported costs relate to payment rates under this subsection and for other purposes the Secretary deems appropriate, the Secretary shall require providers and suppliers of ground ambulance services to submit information for years after 2024 as the Secretary determines appropriate, but in no case less often than once every 3 years.

(F) GROUND AMBULANCE DATA COLLECTION SYSTEM STUDY.—

(i) IN GENERAL.—Not later than March 15, 2023, and as determined necessary by the Medicare Payment Advisory Commission thereafter, such Commission shall assess, and submit to Congress a report on, information submitted by providers and suppliers of ground ambulance services through the data collection system under subparagraph (A), the adequacy of payments for ground ambulance services under this subsection, and geographic variations in the cost of furnishing such services.

(ii) CONTENTS.—A report under clause (i) shall contain the following:

(I) An analysis of information submitted through the data collection system.

(II) An analysis of any burden on providers and suppliers of ground ambulance services associated with the data collection system.

(III) A recommendation as to whether information should continue to be submitted through such data collection system or if such system should be revised under subparagraph (E)(i).

(IV) Other information determined appropriate by the Commission.

(G) PUBLIC AVAILABILITY.—The Secretary shall post information on the results of the data collection under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services, as determined appropriate by the Secretary.

(H) IMPLEMENTATION.—The Secretary shall implement this paragraph through notice and comment rulemaking.

(I) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information required under this subsection.

(J) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the data collection system or identification of respondents under this paragraph.

(K) FUNDING FOR IMPLEMENTATION.—For purposes of carrying out subparagraph (A), the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of \$15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2018. Amounts transferred under this subparagraph shall remain available until expended.

(m) PAYMENT FOR TELEHEALTH SERVICES.—

(1) IN GENERAL.—The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r)) or a practitioner (described in section 1842(b)(18)(C)) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary. For purposes of the preceding sentence, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term “telecommunications system” includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.

(2) PAYMENT AMOUNT.—

(A) DISTANT SITE.—The Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such serv-

ice been furnished without the use of a telecommunications system.

(B) FACILITY FEE FOR ORIGINATING SITE.—

(i) IN GENERAL.—Subject to clause (ii) and paragraph (7)(E), with respect to a telehealth service, subject to section 1833(a)(1)(U), there shall be paid to the originating site a facility fee equal to—

(I) for the period beginning on October 1, 2001, and ending on December 31, 2001, and for 2002, \$20; and

(II) for a subsequent year, the facility fee specified in subclause (I) or this subclause for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

(ii) NO FACILITY FEE IF ORIGINATING SITE FOR HOME DIALYSIS THERAPY IS THE HOME.—No facility fee shall be paid under this subparagraph to an originating site described in paragraph (4)(C)(ii)(X).

(C) TELEPRESENTER NOT REQUIRED.—Nothing in this subsection shall be construed as requiring an eligible telehealth individual to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary (as determined by the physician or practitioner at the distant site).

(3) LIMITATION ON BENEFICIARY CHARGES.—

(A) PHYSICIAN AND PRACTITIONER.—The provisions of section 1848(g) and subparagraphs (A) and (B) of section 1842(b)(18) shall apply to a physician or practitioner receiving payment under this subsection in the same manner as they apply to physicians or practitioners under such sections.

(B) ORIGINATING SITE.—The provisions of section 1842(b)(18) shall apply to originating sites receiving a facility fee in the same manner as they apply to practitioners under such section.

(4) DEFINITIONS.—For purposes of this subsection:

(A) DISTANT SITE.—The term “distant site” means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.

(B) ELIGIBLE TELEHEALTH INDIVIDUAL.—The term “eligible telehealth individual” means an individual enrolled under this part who receives a telehealth service furnished at an originating site.

(C) ORIGINATING SITE.—

(i) IN GENERAL.—Except as provided in paragraph (6), the term “originating site” means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—

(I) in an area that is designated as a rural health professional shortage area under section

332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));

(II) in a county that is not included in a Metropolitan Statistical Area; or

(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

(ii) SITES DESCRIBED.—The sites referred to in clause (i) are the following sites:

(I) The office of a physician or practitioner.

(II) A critical access hospital (as defined in section 1861(mm)(1)).

(III) A rural health clinic (as defined in section 1861(aa)(2)).

(IV) A Federally qualified health center (as defined in section 1861(aa)(4)).

(V) A hospital (as defined in section 1861(e)).

(VI) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

(VII) A skilled nursing facility (as defined in section 1819(a)).

(VIII) A community mental health center (as defined in section 1861(ff)(3)(B)).

(IX) A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).

(X) The home of an individual, but only for purposes of section 1881(b)(3)(B).

(D) PHYSICIAN.—The term “physician” has the meaning given that term in section 1861(r).

(E) PRACTITIONER.—The term “practitioner” has the meaning given that term in section 1842(b)(18)(C).

(F) TELEHEALTH SERVICE.—

(i) IN GENERAL.—The term “telehealth service” means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.

(ii) YEARLY UPDATE.—The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).

(5) TREATMENT OF HOME DIALYSIS MONTHLY ESRD-RELATED VISIT.—The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of section 1881(b)(3)(B), at an originating site described in subclause (VI), (IX), or (X) of paragraph (4)(C)(ii).

(6) TREATMENT OF STROKE TELEHEALTH SERVICES.—

(A) NON-APPLICATION OF ORIGINATING SITE REQUIREMENTS.—The requirements described in paragraph (4)(C)

shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke, as determined by the Secretary.

(B) **INCLUSION OF CERTAIN SITES.**—With respect to telehealth services described in subparagraph (A), the term “originating site” shall include any hospital (as defined in section 1861(e)) or critical access hospital (as defined in section 1861(mm)(1)), any mobile stroke unit (as defined by the Secretary), or any other site determined appropriate by the Secretary, at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system.

(C) **NO ORIGINATING SITE FACILITY FEE FOR NEW SITES.**—No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (A) if the originating site does not otherwise meet the requirements for an originating site under paragraph (4)(C).

(7) **AUTHORITY NOT TO APPLY CERTAIN REQUIREMENTS IN THE CASE OF CERTAIN TREATMENT OF SUBSTANCE USE DISORDER OR CO-OCCURRING MENTAL HEALTH DISORDER.**—

(A) **IN GENERAL.**—For purposes of payment under this subsection, in the case of telehealth services described in subparagraph (C) furnished on or after January 1, 2020, to an eligible beneficiary (as defined in subparagraph (F)) for the treatment of a substance use disorder or a mental health disorder that is co-occurring with a substance use disorder, the Secretary is authorized to, through rulemaking, not apply any of the requirements described in subparagraph (B).

(B) **REQUIREMENTS DESCRIBED.**—For purposes of this paragraph, the requirements described in this subparagraph are any of the following:

(i) Qualifications for an originating site under paragraph (4)(C)(ii).

(ii) Geographic limitations under paragraph (4)(C)(i).

(C) **TELEHEALTH SERVICES DESCRIBED.**—For purposes of this paragraph, the telehealth services described in this subparagraph are services that are both telehealth services and identified by the Secretary, through rulemaking, as services that are the most commonly furnished (as defined by the Secretary) under this part to individuals diagnosed with a substance use disorder or a mental health disorder that is co-occurring with a substance use disorder.

(D) **CLARIFICATION.**—Nothing in this paragraph shall be construed as limiting or otherwise affecting the authority of the Secretary to limit or eliminate the non-application pursuant to this paragraph of any of the requirements under subparagraph (B).

(E) **TREATMENT OF ORIGINATING SITE FACILITY FEE.**—No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (B) for which payment is made under this subsection by reason of the non-application of a require-

ment described in subparagraph (B) pursuant to this paragraph if payment for such service would not otherwise be permitted under this subsection if such requirement were applied.

(F) *ELIGIBLE BENEFICIARY DEFINED.*—For purposes of this paragraph, the term “eligible beneficiary” means an individual who—

(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under this part;

(ii) has a diagnosis for a substance use disorder; and

(iii) meets such other criteria as the Secretary determines appropriate.

(G) *REPORT.*—Not later than 5 years after the date of the enactment of this paragraph, the Secretary shall submit to Congress a report on the impact of any non-application under this paragraph of any of the requirements described in subparagraph (B) on

(i) the utilization of health care services related to substance use disorder, such as behavioral health services and emergency department visits; and

(ii) health outcomes related to substance use disorder, such as substance use overdose deaths.

(H) *FUNDING.*—For purposes of carrying out this paragraph, in addition to funds otherwise available, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of \$3,000,000 to the Centers for Medicare & Medicaid Services Program Management Account to remain available until expended.

(8) *RULE OF CONSTRUCTION.*—Nothing in this subsection may be construed as waiving requirements under this title to comply with applicable State law, including State licensure requirements.

(n) *AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.*—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

(1) modify—

(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.

(o) *DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.*—

(1) *DEVELOPMENT.*—

(A) *IN GENERAL.*—The Secretary shall develop a prospective payment system for payment for Federally qualified health center services furnished by Federally qualified

health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

(B) COLLECTION OF DATA AND EVALUATION.—By not later than January 1, 2011, the Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this subsection, including the reporting of services using HCPCS codes.

(2) IMPLEMENTATION.—

(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(A), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

(B) PAYMENTS.—

(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates (determined prior to the application of section 1833(a)(1)(Z)) under this title for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1866(a)(2)(A)(ii)) that would have occurred for such services under this title in such year if the system had not been implemented.

(ii) PAYMENTS IN SUBSEQUENT YEARS.—Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

(I) in the first year after implementation of such system, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved; and

(II) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

(C) PREPARATION FOR PPS IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may establish and implement by program instruction or otherwise the payment codes to be used under the prospective payment system under this section.

(p) QUALITY INCENTIVES TO PROMOTE PATIENT SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOGRAPHY.—

(1) QUALITY INCENTIVES.—In the case of an applicable computed tomography service (as defined in paragraph (2)) for which payment is made under an applicable payment system (as defined in paragraph (3)) and that is furnished on or after January 1, 2016, using equipment that is not consistent with the CT equipment standard (described in paragraph (4)), the payment amount for such service shall be reduced by the applicable percentage (as defined in paragraph (5)).

(2) APPLICABLE COMPUTED TOMOGRAPHY SERVICES DEFINED.—In this subsection, the term “applicable computed tomography service” means a service billed using diagnostic radiological imaging codes for computed tomography (identified as of January 1, 2014, by HCPCS codes 70450–70498, 71250–71275, 72125–72133, 72191–72194, 73200–73206, 73700–73706, 74150–74178, 74261–74263, and 75571–75574 (and any succeeding codes)).

(3) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term “applicable payment system” means the following:

(A) The technical component and the technical component of the global fee under the fee schedule established under section 1848(b).

(B) The prospective payment system for hospital outpatient department services under section 1833(t).

(4) CONSISTENCY WITH CT EQUIPMENT STANDARD.—In this subsection, the term “not consistent with the CT equipment standard” means, with respect to an applicable computed tomography service, that the service was furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) Standard XR–29–2013, entitled “Standard Attributes on CT Equipment Related to Dose Optimization and Management”. Through rule-making, the Secretary may apply successor standards.

(5) APPLICABLE PERCENTAGE DEFINED.—In this subsection, the term “applicable percentage” means—

(A) for 2016, 5 percent; and

(B) for 2017 and subsequent years, 15 percent.

(6) IMPLEMENTATION.—

(A) INFORMATION.—The Secretary shall require that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable computed tomography service was furnished that was not consistent with the CT equipment standard (described in paragraph (4)). Such information may be included on a claim and may be a modifier. Such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under section 1834(e) and hospitals under section 1865(a).

(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information described in subparagraph (A).

(q) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

(1) PROGRAM ESTABLISHED.—

(A) IN GENERAL.—The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term “appropriate use criteria” means criteria, only developed or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition for an individual. To the extent feasible, such criteria shall be evidence-based.

(C) APPLICABLE IMAGING SERVICE DEFINED.—In this subsection, the term “applicable imaging service” means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

- (i) one or more applicable appropriate use criteria specified under paragraph (2) apply;
- (ii) there are one or more qualified clinical decision support mechanisms listed under paragraph (3)(C); and
- (iii) one or more of such mechanisms is available free of charge.

(D) APPLICABLE SETTING DEFINED.—In this subsection, the term “applicable setting” means a physician’s office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.

(E) ORDERING PROFESSIONAL DEFINED.—In this subsection, the term “ordering professional” means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who orders an applicable imaging service.

(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term “furnishing professional” means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service.

(2) ESTABLISHMENT OF APPLICABLE APPROPRIATE USE CRITERIA.—

(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services only from among appropriate use criteria

developed or endorsed by national professional medical specialty societies or other provider-led entities.

(B) CONSIDERATIONS.—In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

- (i) have stakeholder consensus;
- (ii) are scientifically valid and evidence based; and
- (iii) are based on studies that are published and reviewable by stakeholders.

(C) REVISIONS.—The Secretary shall review, on an annual basis, the specified applicable appropriate use criteria to determine if there is a need to update or revise (as appropriate) such specification of applicable appropriate use criteria and make such updates or revisions through rule-making.

(D) TREATMENT OF MULTIPLE APPLICABLE APPROPRIATE USE CRITERIA.—In the case where the Secretary determines that more than one appropriate use criterion applies with respect to an applicable imaging service, the Secretary shall apply one or more applicable appropriate use criteria under this paragraph for the service.

(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(i) IN GENERAL.—The Secretary shall specify qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, health care technology experts, and other stakeholders in specifying mechanisms under this paragraph.

(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1848(o)(4)).

(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

(III) Use of a clinical decision support mechanism established by the Secretary.

(B) QUALIFIED CLINICAL DECISION SUPPORT MECHANISMS.—

(i) IN GENERAL.—For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

(ii) REQUIREMENTS.—The requirements described in this clause are the following:

(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

(II) In the case where there is more than one applicable appropriate use criterion specified under such paragraph for an applicable imaging service, the mechanism indicates the criteria that it uses for the service.

(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

(VI) The mechanism meets privacy and security standards under applicable provisions of law.

(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(i) INITIAL LIST.—Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

(ii) PERIODIC UPDATING OF LIST.—The Secretary shall identify on an annual basis the list of qualified clinical decision support mechanisms specified under this paragraph.

(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(A) CONSULTATION BY ORDERING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

(i) consult with a qualified decision support mechanism listed under paragraph (3)(C); and

(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

(B) REPORTING BY FURNISHING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C),

with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), payment for such service may only be made if the claim for the service includes the following:

(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

(ii) Information regarding—

(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

(II) whether the service ordered would not adhere to such criteria; or

(III) whether such criteria was not applicable to the service ordered.

(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

(i) EMERGENCY SERVICES.—An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1867(e)(1)).

(ii) INPATIENT SERVICES.—An applicable imaging service ordered for an inpatient and for which payment is made under part A.

(iii) SIGNIFICANT HARDSHIP.—An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

(D) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term “applicable payment system” means the following:

(i) The physician fee schedule established under section 1848(b).

(ii) The prospective payment system for hospital outpatient department services under section 1833(t).

(iii) The ambulatory surgical center payment systems under section 1833(i).

(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on an annual basis, no more than five percent of the total number of ordering professionals who are outlier ordering professionals.

(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

(D) PROCESS.—The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

(E) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

(B) APPROPRIATE USE CRITERIA IN PRIOR AUTHORIZATION.—In applying prior authorization under subparagraph (A), the Secretary shall utilize only the applicable appropriate use criteria specified under this subsection.

(C) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of \$5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.

(7) CONSTRUCTION.—Nothing in this subsection shall be construed as granting the Secretary the authority to develop or initiate the development of clinical practice guidelines or appropriate use criteria.

(r) PAYMENT FOR RENAL DIALYSIS SERVICES FOR INDIVIDUALS WITH ACUTE KIDNEY INJURY.—

(1) PAYMENT RATE.—In the case of renal dialysis services (as defined in subparagraph (B) of section 1881(b)(14)) furnished under this part by a renal dialysis facility or provider of services paid under such section during a year (beginning with 2017) to an individual with acute kidney injury (as defined in paragraph (2)), the amount of payment under this part for such services shall be the base rate for renal dialysis services determined for such year under such section, as adjusted by any applicable geographic adjustment factor applied under subparagraph (D)(iv)(II) of such section and may be adjusted by the Secretary (on a budget neutral basis for payments under this paragraph) by any other adjustment factor under subparagraph (D) of such section.

(2) INDIVIDUAL WITH ACUTE KIDNEY INJURY DEFINED.—In this subsection, the term “individual with acute kidney injury” means an individual who has acute loss of renal function and does not receive renal dialysis services for which payment is made under section 1881(b)(14).

(s) PAYMENT FOR APPLICABLE DISPOSABLE DEVICES.—

(1) SEPARATE PAYMENT.—The Secretary shall make a payment (separate from the payments otherwise made under section 1895) in the amount established under paragraph (3) to a home health agency for an applicable disposable device (as defined in paragraph (2)) when furnished on or after January 1, 2017, to an individual who receives home health services for which payment is made under section 1895(b).

(2) APPLICABLE DISPOSABLE DEVICE.—In this subsection, the term applicable disposable device means a disposable device that, as determined by the Secretary, is—

(A) a disposable negative pressure wound therapy device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy; and

(B) a substitute for, and used in lieu of, a negative pressure wound therapy durable medical equipment item that is an integrated system of a negative pressure vacuum pump, a separate exudate collection canister, and dressings that would otherwise be covered for individuals for such wound therapy.

(3) PAYMENT AMOUNT.—The separate payment amount established under this paragraph for an applicable disposable device for a year shall be equal to the amount of the payment that would be made under section 1833(t) (relating to payment for covered OPD services) for the year for the Level I Healthcare Common Procedure Coding System (HCPCS) code for which the description for a professional service includes the furnishing of such device.

(t) SITE-OF-SERVICE PRICE TRANSPARENCY.—

(1) IN GENERAL.—In order to facilitate price transparency with respect to items and services for which payment may be made either to a hospital outpatient department or to an ambulatory surgical center under this title, the Secretary shall, for 2018 and each year thereafter, make available to the public via a searchable Internet website, with respect to an appropriate number of such items and services—

(A) the estimated payment amount for the item or service under the outpatient department fee schedule under subsection (t) of section 1833 and the ambulatory surgical center payment system under subsection (i) of such section; and

(B) the estimated amount of beneficiary liability applicable to the item or service.

(2) CALCULATION OF ESTIMATED BENEFICIARY LIABILITY.—For purposes of paragraph (1)(B), the estimated amount of beneficiary liability, with respect to an item or service, is the amount for such item or service for which an individual who does not have coverage under a Medicare supplemental policy

certified under section 1882 or any other supplemental insurance coverage is responsible.

(3) IMPLEMENTATION.—In carrying out this subsection, the Secretary—

(A) shall include in the notice described in section 1804(a) a notification of the availability of the estimated amounts made available under paragraph (1); and

(B) may utilize mechanisms in existence on the date of enactment of this subsection, such as the portion of the Internet website of the Centers for Medicare & Medicaid Services on which information comparing physician performance is posted (commonly referred to as the Physician Compare Internet website), to make available such estimated amounts under such paragraph.

(4) FUNDING.—For purposes of implementing this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account, of \$6,000,000 for fiscal year 2017, to remain available until expended.

(u) PAYMENT AND RELATED REQUIREMENTS FOR HOME INFUSION THERAPY.—

(1) PAYMENT.—

(A) SINGLE PAYMENT.—

(i) IN GENERAL.—Subject to clause (iii) and subparagraphs (B) and (C), the Secretary shall implement a payment system under which a single payment is made under this title to a qualified home infusion therapy supplier for items and services described in subparagraphs (A) and (B) of section 1861(iii)(2) furnished by a qualified home infusion therapy supplier (as defined in section 1861(iii)(3)(D)) in coordination with the furnishing of home infusion drugs (as defined in section 1861(iii)(3)(C)) under this part.

(ii) UNIT OF SINGLE PAYMENT.—A unit of single payment under the payment system implemented under this subparagraph is for each infusion drug administration calendar day in the individual's home. The Secretary shall, as appropriate, establish single payment amounts for types of infusion therapy, including to take into account variation in utilization of nursing services by therapy type.

(iii) LIMITATION.—The single payment amount determined under this subparagraph after application of subparagraph (B) and paragraph (3) shall not exceed the amount determined under the fee schedule under section 1848 for infusion therapy services furnished in a calendar day if furnished in a physician office setting, except such single payment shall not reflect more than 5 hours of infusion for a particular therapy in a calendar day.

(B) REQUIRED ADJUSTMENTS.—The Secretary shall adjust the single payment amount determined under subparagraph (A) for home infusion therapy services under section 1861(iii)(1) to reflect other factors such as—

- (i) a geographic wage index and other costs that may vary by region; and
- (ii) patient acuity and complexity of drug administration.

(C) DISCRETIONARY ADJUSTMENTS.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary may adjust the single payment amount determined under subparagraph (A) (after application of subparagraph (B)) to reflect outlier situations and other factors as the Secretary determines appropriate.

(ii) REQUIREMENT OF BUDGET NEUTRALITY.—Any adjustment under this subparagraph shall be made in a budget neutral manner.

(2) CONSIDERATIONS.—In developing the payment system under this subsection, the Secretary may consider the costs of furnishing infusion therapy in the home, consult with home infusion therapy suppliers, consider payment amounts for similar items and services under this part and part A, and consider payment amounts established by Medicare Advantage plans under part C and in the private insurance market for home infusion therapy (including average per treatment day payment amounts by type of home infusion therapy).

(3) ANNUAL UPDATES.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall update the single payment amount under this subsection from year to year beginning in 2022 by increasing the single payment amount from the prior year by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year.

(B) ADJUSTMENT.—For each year, the Secretary shall reduce the percentage increase described in subparagraph (A) by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in a percentage being less than 0.0 for a year, and may result in payment being less than such payment rates for the preceding year.

(4) AUTHORITY TO APPLY PRIOR AUTHORIZATION.—The Secretary may, as determined appropriate by the Secretary, apply prior authorization for home infusion therapy services under section 1861(iii)(1).

(5) ACCREDITATION OF QUALIFIED HOME INFUSION THERAPY SUPPLIERS.—

(A) FACTORS FOR DESIGNATION OF ACCREDITATION ORGANIZATIONS.—The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B) and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

- (i) The ability of the organization to conduct timely reviews of accreditation applications.
- (ii) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1886(d)(2)(D)).

(iii) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

(iv) Such other factors as the Secretary determines appropriate.

(B) DESIGNATION.—Not later than January 1, 2021, the Secretary shall designate organizations to accredit suppliers furnishing home infusion therapy. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

(C) REVIEW AND MODIFICATION OF LIST OF ACCREDITATION ORGANIZATIONS.—

(i) IN GENERAL.—The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the results of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

(ii) SPECIAL RULE FOR ACCREDITATIONS DONE PRIOR TO REMOVAL FROM LIST OF DESIGNATED ACCREDITATION ORGANIZATIONS.—In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

(D) RULE FOR ACCREDITATIONS MADE PRIOR TO DESIGNATION.—In the case of a supplier that is accredited before January 1, 2021, by an accreditation organization designated by the Secretary under subparagraph (B) as of January 1, 2019, such supplier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2023, for the remaining period such accreditation is in effect.

(6) NOTIFICATION OF INFUSION THERAPY OPTIONS AVAILABLE PRIOR TO FURNISHING HOME INFUSION THERAPY.—Prior to the furnishing of home infusion therapy to an individual, the physician who establishes the plan described in section 1861(iii)(1) for the individual shall provide notification (in a form, manner, and frequency determined appropriate by the Secretary) of the options available (such as home, physician's office, hospital outpatient department) for the furnishing of infusion therapy under this part.

(7) HOME INFUSION THERAPY SERVICES TEMPORARY TRANSITIONAL PAYMENT.—

(A) TEMPORARY TRANSITIONAL PAYMENT.—

(i) IN GENERAL.—The Secretary shall, in accordance with the payment methodology described in subpara-

graph (B) and subject to the provisions of this paragraph, provide a home infusion therapy services temporary transitional payment under this part to an eligible home infusion supplier (as defined in subparagraph (F)) for items and services described in subparagraphs (A) and (B) of section 1861(iii)(2) furnished during the period specified in clause (ii) by such supplier in coordination with the furnishing of transitional home infusion drugs (as defined in clause (iii)).

(ii) PERIOD SPECIFIED.—For purposes of clause (i), the period specified in this clause is the period beginning on January 1, 2019, and ending on the day before the date of the implementation of the payment system under paragraph (1)(A).

(iii) TRANSITIONAL HOME INFUSION DRUG DEFINED.—For purposes of this paragraph, the term “transitional home infusion drug” has the meaning given to the term “home infusion drug” under section 1861(iii)(3)(C), except that clause (ii) of such section shall not apply if a drug described in such clause is identified in clauses (i), (ii), (iii) or (iv) of subparagraph (C) as of the date of the enactment of this paragraph.

(B) PAYMENT METHODOLOGY.—For purposes of this paragraph, the Secretary shall establish a payment methodology, with respect to items and services described in subparagraph (A)(i). Under such payment methodology the Secretary shall—

(i) create the three payment categories described in clauses (i), (ii), and (iii) of subparagraph (C);

(ii) assign drugs to such categories, in accordance with such clauses;

(iii) assign appropriate Healthcare Common Procedure Coding System (HCPCS) codes to each payment category; and

(iv) establish a single payment amount for each such payment category, in accordance with subparagraph (D), for each infusion drug administration calendar day in the individual’s home for drugs assigned to such category.

(C) PAYMENT CATEGORIES.—

(i) PAYMENT CATEGORY 1.—The Secretary shall create a payment category 1 and assign to such category drugs which are covered under the Local Coverage Determination on External Infusion Pumps (LCD number L33794) and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J0133, J0285, J0287, J0288, J0289, J0895, J1170, J1250, J1265, J1325, J1455, J1457, J1570, J2175, J2260, J2270, J2274, J2278, J3010, or J3285.

(ii) PAYMENT CATEGORY 2.—The Secretary shall create a payment category 2 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS

codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J1555 JB, J1559 JB, J1561 JB, J1562 JB, J1569 JB, or J1575 JB.

(iii) PAYMENT CATEGORY 3.—The Secretary shall create a payment category 3 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J9000, J9039, J9040, J9065, J9100, J9190, J9200, J9360, or J9370.

(iv) INFUSION DRUGS NOT OTHERWISE INCLUDED.—With respect to drugs that are not included in payment category 1, 2, or 3 under clause (i), (ii), or (iii), respectively, the Secretary shall assign to the most appropriate of such categories, as determined by the Secretary, drugs which are—

(I) covered under such local coverage determination and billed under HCPCS codes J7799 or J7999 (as identified as of July 1, 2017, and as subsequently modified by the Secretary); or

(II) billed under any code that is implemented after the date of the enactment of this paragraph and included in such local coverage determination or included in subregulatory guidance as a home infusion drug described in subparagraph (A)(i).

(D) PAYMENT AMOUNTS.—

(i) IN GENERAL.—Under the payment methodology, the Secretary shall pay eligible home infusion suppliers, with respect to items and services described in subparagraph (A)(i) furnished during the period described in subparagraph (A)(ii) by such supplier to an individual, at amounts equal to the amounts determined under the physician fee schedule established under section 1848 for services furnished during the year for codes and units of such codes described in clauses (ii), (iii), and (iv) with respect to drugs included in the payment category under subparagraph (C) specified in the respective clause, determined without application of the geographic adjustment under subsection (e) of such section.

(ii) PAYMENT AMOUNT FOR CATEGORY 1.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 1 described in subparagraph (C)(i), are one unit of HCPCS code 96365 plus three units of HCPCS code 96366 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(iii) PAYMENT AMOUNT FOR CATEGORY 2.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 2 described in subparagraph (C)(i), are one unit of HCPCS code 96369 plus three units of HCPCS code 96370 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(iv) PAYMENT AMOUNT FOR CATEGORY 3.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 3 described in subparagraph (C)(i), are one unit of HCPCS code 96413 plus three units of HCPCS code 96415 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(E) CLARIFICATIONS.—

(i) INFUSION DRUG ADMINISTRATION DAY.—For purposes of this subsection, with respect to the furnishing of transitional home infusion drugs or home infusion drugs to an individual by an eligible home infusion supplier or a qualified home infusion therapy supplier, a reference to payment to such supplier for an infusion drug administration calendar day in the individual's home shall refer to payment only for the date on which professional services (as described in section 1861(iii)(2)(A)) were furnished to administer such drugs to such individual. For purposes of the previous sentence, an infusion drug administration calendar day shall include all such drugs administered to such individual on such day.

(ii) TREATMENT OF MULTIPLE DRUGS ADMINISTERED ON SAME INFUSION DRUG ADMINISTRATION DAY.—In the case that an eligible home infusion supplier, with respect to an infusion drug administration calendar day in an individual's home, furnishes to such individual transitional home infusion drugs which are not all assigned to the same payment category under subparagraph (C), payment to such supplier for such infusion drug administration calendar day in the individual's home shall be a single payment equal to the amount of payment under this paragraph for the drug, among all such drugs so furnished to such individual during such calendar day, for which the highest payment would be made under this paragraph.

(F) ELIGIBLE HOME INFUSION SUPPLIERS.—In this paragraph, the term “eligible home infusion supplier” means a supplier that is enrolled under this part as a pharmacy that provides external infusion pumps and external infusion pump supplies and that maintains all pharmacy licensure requirements in the State in which the applicable infusion drugs are administered.

(G) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(v) PAYMENT FOR OUTPATIENT PHYSICAL THERAPY SERVICES AND OUTPATIENT OCCUPATIONAL THERAPY SERVICES FURNISHED BY A THERAPY ASSISTANT.—

(1) IN GENERAL.—In the case of an outpatient physical therapy service or outpatient occupational therapy service furnished on or after January 1, 2022, for which payment is made under section 1848 or subsection (k), that is furnished in whole or in part by a therapy assistant (as defined by the Secretary), the amount of payment for such service shall be an amount

equal to 85 percent of the amount of payment otherwise applicable for the service under this part. Nothing in the preceding sentence shall be construed to change applicable requirements with respect to such services.

(2) USE OF MODIFIER.—

(A) ESTABLISHMENT.—Not later than January 1, 2019, the Secretary shall establish a modifier to indicate (in a form and manner specified by the Secretary), in the case of an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined), that the service was furnished by a therapy assistant.

(B) REQUIRED USE.—Each request for payment, or bill submitted, for an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined) on or after January 1, 2020, shall include the modifier established under subparagraph (A) for each such service.

(3) IMPLEMENTATION.—The Secretary shall implement this subsection through notice and comment rulemaking.

* * * * *

EXCHANGE OF LETTERS WITH ADDITIONAL COMMITTEES OF
REFERRALGREG WALDEN, OREGON
CHAIRMANFRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States**House of Representatives**

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115Majority (2021) 225-2927
Minority (2021) 225-3641

June 7, 2018

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady:

On May 9 and 17, 2018, the Committee on Energy and Commerce ordered favorably reported over 50 bills to address the opioid epidemic facing communities across our nation. Several of the bills were also referred to the Committee on Ways and Means.

I ask that the Committee on Ways and Means not insist on its referral of the following bills so that they may be scheduled for consideration by the Majority Leader:

- **H.R. 1925**, At-Risk Youth Medicaid Protection Act of 2017;
- **H.R. 3331**, To amend title XI of the Social Security Act to promote testing of incentive payments for behavioral health providers for adoption and use of certified electronic health record technology;
- **H.R. 3528**, Every Prescription Conveyed Securely Act;
- **H.R. 4841**, Standardizing Electronic Prior Authorization for Safe Prescribing Act of 2018;
- **H.R. 5582**, Abuse Deterrent Access Act of 2018;
- **H.R. 5590**, Opioid Addiction Action Plan Act;
- **H.R. 5603**, Access to Telehealth Services for Opioid Use Disorder;

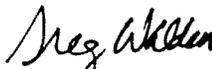
The Honorable Kevin Brady
Page 2

- **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.

This concession in no way affects your jurisdiction over the subject matter of these bills, and it will not serve as precedent for future referrals. In addition, should a conference on the bills be necessary, I would support your request to have the Committee on Ways and Means on the conference committee. Finally, I would be pleased to include this letter and your response in the bill reports and the Congressional Record.

Thank you for your consideration of my request and for the extraordinary cooperation shown by you and your staff over matters of shared jurisdiction. I look forward to further opportunities to work with you this Congress.

Sincerely,


Greg Walden
Chairman

Congress of the United States
U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625

Washington, DC 20515-6118
<http://waysandmeans.house.gov>

RICHARD E. NEAL, MASSACHUSETTS, RANKING MEMBER
SANDER M. LEVIN, MICHIGAN
JOHN LEWIS, GEORGIA
LLOYD DOUGGETT, TEXAS
MIKE THOMPSON, CALIFORNIA
JOHN B. LARSON, CONNECTICUT
EARL BLUMENAUER, OREGON
RON KIND, WISCONSIN
BILL PASCRELL, JR., NEW JERSEY
JOSEPH CROWLEY, NEW YORK
DANNY K. DAVIS, ILLINOIS
LINDA SANCHEZ, CALIFORNIA
BRIAN HIGGINS, NEW YORK
TERRI SEWELL, ALABAMA
SUZANne DUBÉ, WASHINGTON
JUDY GRUB, CALIFORNIA

BRANDON CASEY,
MINORITY CHIEF OF STAFF

KEVIN BRADY, TEXAS
CHAIRMAN

SAM JOHNSON, TEXAS
DEVIN NUNES, CALIFORNIA
DAVID G. REICHERT, WASHINGTON
PETER J. ROSKAM, ILLINOIS
VERN BUCHANAN, FLORIDA
ADRIAN SMITH, NEBRASKA
LYNN JENNINGS, KANSAS
ERIK PAULSEN, MINNESOTA
KENNY MARCHANT, TEXAS
DIANE BLACK, TENNESSEE
TOM REED, NEW YORK
MIKE KELLY, PENNSYLVANIA
JIM RENKACZ, OHIO
KRISTI NOEM, SOUTH DAKOTA
GEORGE NOLDING, NORTH CAROLINA
JASON SMITH, MISSOURI
TOM RICE, SOUTH CAROLINA
DAVID SCHWEIKERT, ARIZONA
JACKIE WALCZAK, INDIANA
CARLOS CUMBELLO, FLORIDA
MIKE BISHOP, MICHIGAN
DARIN LAHOD, ILLINOIS
BRAD R. WENSTRUP, OHIO

GARY J. ANDRES,
STAFF DIRECTOR

June 8, 2018

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Walden,

Thank you for your letter concerning several bills favorably reported out of the Committee on Energy and Commerce to address the opioid epidemic and which the Committee on Ways and Means was granted an additional referral.

As a result of your having consulted with us on provisions within these bills that fall within the Rule X jurisdiction of the Committee on Ways and Means, I agree to waive formal consideration of the following bills so that they may move expeditiously to the floor:

- **H.R. 1925**, At-Risk Youth Medicaid Protection Act of 2017;
- **H.R. 3331**, To amend title XI of the Social Security Act to promote testing of incentive payments for behavioral health providers for adoption and use of certified electronic health record technology;
- **H.R. 3528**, Every Prescription Conveyed Securely Act;
- **H.R. 4841**, Standardizing Electronic Prior Authorization for Safe Prescribing Act of 2018;
- **H.R. 5582**, Abuse Deterrent Access Act of 2018;
- **H.R. 5590**, Opioid Addiction Action Plan Act;
- **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

cc: The Honorable Paul Ryan, Speaker
The Honorable Richard E. Neal
The Honorable Frank Pallone
Thomas J. Wickham, Jr., Parliamentarian