Myeloma Awareness Month. Myeloma is a cancer of the bone marrow that can have a variety of effects on the body, ranging from bone pain to organ failure. The National Cancer Institute estimates that over 22,000 new cases will be diagnosed and 11,000 deaths will occur due to myeloma this year.

While myeloma is not curable, it is treatable. I thank my colleagues, Congressman BACHUS and Congressman RANGEL, for drafting a resolution to establish March as National Multiple Myeloma Awareness Month and the International Myeloma Foundation for raising awareness of the disease yearround.

Additionally, as Congress begins to develop a budget, I encourage strong support for medical research, increasing funding to the National Institutes of Health to $32 billion.

Finally, I urge the House leadership to bring the Cancer Drug Coverage Parity Act to the floor, a bill I introduced to make sure that patients with myeloma and other cancers who are prescribed oral chemotherapy by their doctors will have the insurance coverage they need to treat their illness and to get healthy.

MEDICARE ADVANTAGE

(Mr. BARROW of Georgia asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BARROW of Georgia. Mr. Speaker, I rise today to shed some light on a very serious issue facing more than 15 million Medicare Advantage recipients across the country, including more than 300,000 seniors in my home State of Georgia.

Medicare Advantage provides care and support to the constituents of every Member of this body. It reduces the need for hospitalization and reduces health care costs by focusing on prevention and disease management. The Centers for Medicare and Medicaid Services recently proposed a 5.9 percent cut to this program which will reduce benefits and increase premiums by $35 to $75 per month for beneficiaries all across the country.

This month, my colleague from the other side of the aisle, Dr. BILL CASSIDY, and I led an effort with over 200 Members of this body to urge the Centers for Medicare and Medicaid Services to prevent these devastating cuts to this program.

I urge this body and our friends in the Senate to do all we can to preserve this critical program. We simply cannot place the country's financial burdens on the back of seniors by undermining Medicare Advantage.

HONORING DR. FRANK KITAMOTO

(Mr. KILMER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KILMER. Mr. Speaker, I rise today to recognize Dr. Frank Kitamoto and offer my condolences to his family and friends in light of his recent passing.

At the age of 2, Dr. Kitamoto and his family were among the 277 Bainbridge Island, Washington, residents forced from their homes during World War II and taken to a war relocation center in California. In total, 12,000 Japanese American Washingtonians were forced out of their homes for the duration of the war.

Dr. Kitamoto returned to Bainbridge Island after the end of the war and he began an oral history project. He traveled the country to educate others about Japanese American history and forced relocation during World War II. He served as president of the Bainbridge Island Japanese American Community for more than 25 years. Dr. Kitamoto also played an integral role in the installation of the Bainbridge Island Exclusion Memorial.

Mr. Speaker, our Nation owes a debt of gratitude to Dr. Kitamoto for his dedication to ensuring that the stories of this difficult period in American history are told. I am pleased to honor his legacy in the United States Congress today.

MEDICARE ADVANTAGE CUTS PROPOSED FOR 2015 WOULD BE SHORTSIGHTED AND COUNTERPRODUCTIVE

(Mr. MURPHY of Florida asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MURPHY of Florida. Mr. Speaker, with all the questions surrounding health insurance today, it is vital that seniors can keep the health care coverage on which they depend. I remain committed to working in a bipartisan manner to address the long-term drivers of our debt. I also understand we must consider the impact the decisions we make have on real Americans.

Recent efforts to bring Medicare Advantage payments in line with traditional Medicare makes sense if you think of the budget solely as numbers on a spreadsheet; but we are seeing these cuts resulting in smaller networks of doctors, cuts to add-on benefits, and higher out-of-pocket limits, shifting the cost and burden onto our Nation's seniors on fixed incomes.

The Medicare Advantage cuts proposed for 2015 would be shortsighted and counterproductive if it meant elimination of health care innovations and led to hospital readmissions and worse health outcomes.

I add my voice to the growing bipartisan chorus calling for no more cuts to seniors on Medicare Advantage. I urge the administration to keep the rates flat for this year, protecting seniors' continued access to health care choices that they have earned after a lifetime of hard work.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 9 o'clock and 20 minutes a.m.), the House stood in recess.

□ 0942

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. WOODALL) at 9 o'clock and 42 minutes a.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

PROTECTING ACCESS TO MEDICARE ACT OF 2014

Mr. PITTS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4302) to amend the Social Security Act to extend Medicare payments to physicians and other provisions of the Medicare and Medicaid programs, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4302

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Protecting Access to Medicare Act of 2014''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—MEDICARE EXTENDERS

SEC. 101. PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended—

(1) in paragraph (15)—

(A) in the heading, by striking ''JANUARY THROUGH MARCH OF'';

(B) in subparagraph (A), by striking ''for the period beginning on January 1, 2014, and ending on March 31, 2014''; and

(C) in subparagraph (B)—

(i) in the heading, by striking ''REMAINING PORTION OF 2014 AND''; and

(ii) by striking ''the period beginning on April 1, 2014, and ending on December 31, 2014, and for''; and

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

''(16) UPDATE FOR JANUARY THROUGH MARCH OF 2015.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on March 31, 2015, the update to the single conversion factor shall be 0.0 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR REMAINING PORTION OF 2015 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on April 1, 2015, and ending on December 31, 2015, and for 2016 and subsequent years as if subparagraph (A) had never applied.''.

SEC. 102. EXTENSION OF WORK GPCI FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''April 1, 2014'' and inserting ''April 1, 2015''.

SEC. 103. EXTENSION OF THERAPY CAP EXCEPTIONS PROCESS.

Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(1) in paragraph (5)(A), in the first sentence, by striking ''March 31, 2014'' and inserting ''March 31, 2015''; and

(2) in paragraph (6)(A)—

(A) by striking ''March 31, 2014'' and inserting ''March 31, 2015''; and

(B) by striking ''2012, 2013, or the first three months of 2014'' and inserting ''2012, 2013, 2014, or the first three months of 2015''.

SEC. 104. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended by striking ''April 1, 2014'' and inserting ''April 1, 2015'' each place it appears.

(b) SUPER RURAL GROUND AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended, in the first sentence, by striking ''April 1, 2014'' and inserting ''April 1, 2015''.

SEC. 105. EXTENSION OF INCREASED INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR CERTAIN LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B), in the matter preceding clause (i), by striking ''in the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years'' and inserting ''in fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years'';

(2) in subparagraph (C)(i), by striking ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before'' and inserting ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),'' each place it appears; and

(3) in subparagraph (D), by striking ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before April 1, 2014,'' and inserting ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),''.

SEC. 106. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''April 1, 2014'' and inserting ''April 1, 2015''; and

(2) in clause (ii)(II), by striking ''April 1, 2014'' and inserting ''April 1, 2015''.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''April 1, 2014'' and inserting ''April 1, 2015''; and

(B) in clause (iv), by striking ''through fiscal year 2013 and the portion of fiscal year 2014 before April 1, 2014'' and inserting ''through fiscal year 2014 and the portion of fiscal year 2015 before April 1, 2015''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''through the first 2 quarters of fiscal year 2014'' and inserting ''through the first 2 quarters of fiscal year 2015''.

SEC. 107. EXTENSION FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.

Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking ''2016'' and inserting ''2017''.

SEC. 108. EXTENSION OF MEDICARE REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking ''January 1, 2015'' and inserting ''January 1, 2016''.

SEC. 109. EXTENSION OF FUNDING FOR QUALITY MEASURE ENDORSEMENT, INPUT, AND SELECTION.

Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended—

(1) by inserting ''(1)'' before ''For purposes''; and

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

''(2) For purposes of carrying out this section and section 1890A (other than subsections (e) and (f)), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, to the Centers for Medicare & Medicaid Services Program Management Account of $5,000,000 for fiscal year 2014 and $15,000,000 for the first 6 months of fiscal year 2015. Amounts transferred under the preceding sentence shall remain available until expended.''.

SEC. 110. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note), as amended by section 3306 of the Patient Protection and Affordable Care Act Public Law 111–148), section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112–240), and section 1110 of the Pathway for SGR Reform Act of 2013 (Public Law 113–67), is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) by striking clause (iv); and

(3) by adding at the end the following new clauses:

''(iv) for fiscal year 2014, of $7,500,000; and

''(v) for the portion of fiscal year 2015 before April 1, 2015, of $3,750,000.''.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) by striking clause (iv); and

(3) by inserting after clause (iii) the following new clauses:

''(iv) for fiscal year 2014, of $7,500,000; and

''(v) for the portion of fiscal year 2015 before April 1, 2015, of $3,750,000.''.

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) by striking clause (iv); and

(3) by inserting after clause (iii) the following new clauses:

''(iv) for fiscal year 2014, of $5,000,000; and

''(v) for the portion of fiscal year 2015 before April 1, 2015, of $2,500,000.''.

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119, as so amended, is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) by striking clause (iv); and

(3) by inserting after clause (iii) the following new clauses:

''(iv) for fiscal year 2014, of $5,000,000; and

''(v) for the portion of fiscal year 2015 before April 1, 2015, of $2,500,000.''.

SEC. 111. EXTENSION OF TWO-MIDNIGHT RULE.

(a) CONTINUATION OF CERTAIN MEDICAL REVIEW ACTIVITIES.—The Secretary of Health and Human Services may continue medical review activities described in the notice entitled ''Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013'', posted on the Internet website of the Centers for Medicare & Medicaid Services, through the first 6 months of fiscal year 2015 for such additional hospital claims as the Secretary determines appropriate.

(b) LIMITATION.—The Secretary of Health and Human Services shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) for inpatient claims with dates of admission October 1, 2013, through March 31, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services (as defined in section 1861(u) of such Act (42 U.S.C. 1395x(u))).

SEC. 112. TECHNICAL CHANGES TO MEDICARE LTCH AMENDMENTS.

(a) IN GENERAL.—Subclauses (I) and (II) of section 1886(m)(6)(C)(iv) of the Social Security Act (42 U.S.C. 1395ww(m)(6)(C)(iv)) are each amended by striking ''discharges'' and inserting ''Medicare fee-for-service discharges''.

(b) MMSEA CORRECTION.—Section 114(d) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(b) and 10312(b) of Public Law 111–148 and by section 1206(b)(2) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67), is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''January 1, 2015,'' and inserting ''on the date of the enactment of paragraph (7) of this subsection'';

(2) in paragraph (6), by striking ''January 1, 2015,'' and inserting ''on the date of the enactment of paragraph (7) of this subsection''; and

(3) by adding at the end the following new paragraph:

''(7) ADDITIONAL EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that—

''(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of enactment of this paragraph;

''(B) has a binding written agreement as of the date of the enactment of this paragraph with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before such date of enactment, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

''(C) has obtained an approved certificate of need in a State where one is required on or before such date of enactment.''.

(c) ADDITIONAL AMENDMENTS.—Section 1206(a) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67) is amended—

(1) in paragraph (2)(A), by striking ''Assessment'' and inserting ''Advisory''; and

(2) in paragraph (3)(B), by striking ''shall not apply to a hospital that is classified as of December 10, 2013, as a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B))'' and inserting ''shall only apply to a hospital that is classified as of December 10, 2013, as a long-term care hospital (as defined in section 1861(ccc) of the Social Security Act, 42 U.S.C. 1395x(ccc))''.

(d) EFFECTIVE DATE.—The amendments made by this section are effective as of the date of the enactment of this Act.

TITLE II—OTHER HEALTH PROVISIONS

SEC. 201. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking ''March 2014'' and inserting ''March 2015''.

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) of the Social Security Act (42 U.S.C. 1396u–3(g)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (T), by striking ''and'' at the end;

(B) in subparagraph (U)—

(i) by striking ''March 31, 2014'' and inserting ''September 30, 2014''; and

(ii) by striking ''$200,000,000.'' and inserting ''$485,000,000;''; and

(C) by adding at the end the following new subparagraphs:

''(V) for the period that begins on October 1, 2014, and ends on December 31, 2014, the total allocation amount is $300,000,000; and

''(W) for the period that begins on January 1, 2015, and ends on March 31, 2015, the total allocation amount is $250,000,000.''; and

(2) in paragraph (3), in the matter preceding subparagraph (A), by striking ''or (T)'' and inserting ''(T), or (V)''.

SEC. 202. TEMPORARY EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA).

Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are each amended by striking ''March 31, 2014'' and inserting ''March 31, 2015''.

SEC. 203. EXTENSION OF MEDICAID AND CHIP EXPRESS LANE OPTION.

Section 1902(e)(13)(I) of the Social Security Act (42 U.S.C. 1396a(e)(13)(I)) is amended by striking ''September 30, 2014'' and inserting ''September 30, 2015''.

SEC. 204. EXTENSION OF SPECIAL DIABETES PROGRAM FOR TYPE I DIABETES AND FOR INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by striking ''2014'' and inserting ''2015''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking ''2014'' and inserting ''2015''.

SEC. 205. EXTENSION OF ABSTINENCE EDUCATION.

Subsections (a) and (d) of section 510 of the Social Security Act (42 U.S.C. 710) are each amended by striking ''2014'' and inserting ''2015''.

SEC. 206. EXTENSION OF PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP).

Section 513 of the Social Security Act (42 U.S.C. 713) is amended—

(1) in paragraphs (1)(A) and (4)(A) of subsection (a), by striking ''2014'' and inserting ''2015'' each place it appears;

(2) in subsection (a)(4)(B)(i), by striking ''and 2014'' and inserting ''2014, and 2015''; and

(3) in subsection (f), by striking ''2014'' and inserting ''2015''.

SEC. 207. EXTENSION OF FUNDING FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501(c)(1)(A) of the Social Security Act (42 U.S.C. 701(c)(1)(A)) is amended—

(1) in clause (iii), by striking at the end ''and'';

(2) in clause (iv), by striking the period at the end and inserting a semicolon and by moving the margin to align with the margin for clause (iii); and

(3) by adding at the end the following new clauses:

''(v) $2,500,000 for the portion of fiscal year 2014 on or after April 1, 2014; and

''(vi) $2,500,000 for the portion of fiscal year 2015 before April 1, 2015.''.

SEC. 208. EXTENSION OF HEALTH WORKFORCE DEMONSTRATION PROJECT FOR LOW-INCOME INDIVIDUALS.

Section 2008(c)(1) of the Social Security Act (42 U.S.C. 1397g(c)(1)) is amended by striking ''2014'' and inserting ''2015''.

SEC. 209. EXTENSION OF MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Section 511(j) of the Social Security Act (42 U.S.C. 711(j)) is amended—

(1) in paragraph (1)—

(A) by striking ''and'' at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(F) for the period beginning on October 1, 2014, and ending on March 31, 2015, an amount equal to the amount provided in subparagraph (E).''; and

(2) in paragraphs (2) and (3), by inserting ''(or portion of a fiscal year)'' after ''for a fiscal year'' each place it appears.

SEC. 210. PEDIATRIC QUALITY MEASURES.

(a) CONTINUATION OF FUNDING FOR PEDIATRIC QUALITY MEASURES FOR IMPROVING THE QUALITY OF CHILDREN'S HEALTH CARE.—Section 1139B(e) of the Social Security Act (42 U.S.C. 1320b–9b(e)) is amended by adding at the end the following: ''Of the funds appropriated under this subsection, not less than $15,000,000 shall be used to carry out section 1139A(b).''.

(b) ELIMINATION OF RESTRICTION ON MEDICAID QUALITY MEASUREMENT PROGRAM.—Section 1139B(b)(5)(A) of the Social Security Act (42 U.S.C. 1320b–9b(b)(5)(A)) is amended by striking ''The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A)''.

SEC. 211. DELAY OF EFFECTIVE DATE FOR MEDICAID AMENDMENTS RELATING TO BENEFICIARY LIABILITY SETTLEMENTS.

Effective as if included in the enactment of the Bipartisan Budget Act of 2013 (Public Law 113–67), section 202(c) of such Act is amended by striking ''October 1, 2014'' and inserting ''October 1, 2016''.

SEC. 212. DELAY IN TRANSITION FROM ICD–9 TO ICD–10 CODE SETS.

The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations.

SEC. 213. ELIMINATION OF LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED HEALTH PLANS.

(a) IN GENERAL.—Section 1302(c) of the Patient Protection and Affordable Care Act (Public Law 111–148; 42 U.S.C. 18022(c)) is amended—

(1) by striking paragraph (2); and

(2) in paragraph (4)(A), by striking ''paragraphs (1)(B)(i) and (2)(B)(i)'' and inserting ''paragraph (1)(B)(i)''.

(b) CONFORMING AMENDMENT.—Section 2707(b) of the Public Health Service Act (42 U.S.C. 300gg–6(b)) is amended by striking ''paragraphs (1) and (2)'' and inserting ''paragraph (1)''.

(c) EFFECTIVE DATE.—The amendments made by this Act shall be effective as if included in the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148).

SEC. 214. GAO REPORT ON THE CHILDREN'S HOSPITAL GRADUATE MEDICAL EDUCATION PROGRAM.

(a) IN GENERAL.—In the case that the Children's Hospital GME Support Reauthorization Act of 2013 is enacted into law, the Comptroller General of the United States shall, not later than November 30, 2017, conduct an independent evaluation, and submit to the appropriate committees of Congress a report, concerning the implementation of section 340E(h) of the Public Health Service Act, as added by section 3 of the Children's Hospital GME Support Reauthorization Act of 2013.

(b) CONTENT.—The report described in subsection (a) shall review and assess each of the following, with respect to hospitals receiving payments under such section 340E(h) during the period of fiscal years 2015 through 2017:

(1) The number and type of such hospitals that applied for such payments.

(2) The number and type of such hospitals receiving such payments.

(3) The amount of such payments awarded to such hospitals.

(4) How such hospitals used such payments.

(5) The impact of such payments on—

(A) the number of pediatric providers; and

(B) health care needs of children.

SEC. 215. SKILLED NURSING FACILITY VALUE-BASED PURCHASING.

(a) IN GENERAL.—Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(g) SKILLED NURSING FACILITY READMISSION MEASURE.—

''(1) READMISSION MEASURE.—Not later than October 1, 2015, the Secretary shall specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such a measure).

''(2) RESOURCE USE MEASURE.—Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities.

''(3) MEASURE ADJUSTMENTS.—When specifying the measures under paragraphs (1) and (2), the Secretary shall devise a methodology to achieve a high level of reliability and validity, especially for skilled nursing facilities with a low volume of readmissions.

''(4) PRE-RULEMAKING PROCESS (MEASURE APPLICATION PARTNERSHIP PROCESS).—The application of the provisions of section 1890A shall be optional in the case of a measure specified under paragraph (1) and a measure specified under paragraph (2).

''(5) FEEDBACK REPORTS TO SKILLED NURSING FACILITIES.—Beginning October 1, 2016, and every quarter thereafter, the Secretary shall provide confidential feedback reports to skilled nursing facilities on the performance of such facilities with respect to a measure specified under paragraph (1) or (2).

''(6) PUBLIC REPORTING OF SKILLED NURSING FACILITIES.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary shall establish procedures for making available to the public by posting on the Nursing Home Compare Medicare website (or a successor website) described in section 1819(i) information on the performance of skilled nursing facilities with respect to a measure specified under paragraph (1) and a measure specified under paragraph (2).

''(B) OPPORTUNITY TO REVIEW.—The procedures under subparagraph (A) shall ensure that a skilled nursing facility has the opportunity to review and submit corrections to the information that is to be made public with respect to the facility prior to such information being made public.

''(C) TIMING.—Such procedures shall provide that the information described in subparagraph (A) is made publicly available beginning not later than October 1, 2017.

''(7) NON-APPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly referred to as the 'Paperwork Reduction Act of 1995') shall not apply to this subsection.''.

(b) VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES.—Section 1888 of the Social Security Act (42 U.S.C. 1395yy), as amended by subsection (a), is further amended by adding at the end the following new subsection:

''(h) SKILLED NURSING FACILITY VALUE-BASED PURCHASING PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a skilled nursing facility value-based purchasing program (in this subsection referred to as the 'SNF VBP Program') under which value-based incentive payments are made in a fiscal year to skilled nursing facilities.

''(B) PROGRAM TO BEGIN IN FISCAL YEAR 2019.—The SNF VBP Program shall apply to payments for services furnished on or after October 1, 2018.

''(2) APPLICATION OF MEASURES.—

''(A) IN GENERAL.—The Secretary shall apply the measure specified under subsection (g)(1) for purposes of the SNF VBP Program.

''(B) REPLACEMENT.—For purposes of the SNF VBP Program, the Secretary shall apply the measure specified under (g)(2) instead of the measure specified under (g)(1) as soon as practicable.

''(3) PERFORMANCE STANDARDS.—

''(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to the measure applied under paragraph (2) for a performance period for a fiscal year.

''(B) HIGHER OF ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement. In calculating the SNF performance score under paragraph (4), the Secretary shall use the higher of either improvement or achievement.

''(C) TIMING.—The Secretary shall establish and announce the performance standards established under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

''(4) SNF PERFORMANCE SCORE.—

''(A) IN GENERAL.—The Secretary shall develop a methodology for assessing the total performance of each skilled nursing facility based on performance standards established under paragraph (3) with respect to the measure applied under paragraph (2). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the 'SNF performance score') for each skilled nursing facility for each such performance period.

''(B) RANKING OF SNF PERFORMANCE SCORES.—The Secretary shall, for the performance period for each fiscal year, rank the SNF performance scores determined under subparagraph (A) from low to high.

''(5) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—With respect to a skilled nursing facility, based on the ranking under paragraph (4)(B) for a performance period for a fiscal year, the Secretary shall increase the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to such skilled nursing facility (and after application of paragraph (6)) for services furnished by such facility during such fiscal year by the value-based incentive payment amount under subparagraph (B).

''(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for services furnished by a skilled nursing facility in a fiscal year shall be equal to the product of—

''(i) the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to such skilled nursing facility for such services furnished by the skilled nursing facility during such fiscal year; and

''(ii) the value-based incentive payment percentage specified under subparagraph (C) for the skilled nursing facility for such fiscal year.

''(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

''(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a skilled nursing facility for a fiscal year which may include a zero percentage.

''(ii) REQUIREMENTS.—In specifying the value-based incentive payment percentage for each skilled nursing facility for a fiscal year under clause (i), the Secretary shall ensure that—

''(I) such percentage is based on the SNF performance score of the skilled nursing facility provided under paragraph (4) for the performance period for such fiscal year;

''(II) the application of all such percentages in such fiscal year results in an appropriate distribution of value-based incentive payments under subparagraph (B) such that—

''(aa) skilled nursing facilities with the highest rankings under paragraph (4)(B) receive the highest value-based incentive payment amounts under subparagraph (B);

''(bb) skilled nursing facilities with the lowest rankings under paragraph (4)(B) receive the lowest value-based incentive payment amounts under subparagraph (B); and

''(cc) in the case of skilled nursing facilities in the lowest 40 percent of the ranking under paragraph (4)(B), the payment rate under subparagraph (A) for services furnished by such facility during such fiscal year shall be less than the payment rate for such services for such fiscal year that would otherwise apply under subsection (e)(4)(G) without application of this subsection; and

''(III) the total amount of value-based incentive payments under this paragraph for all skilled nursing facilities in such fiscal year shall be greater than or equal to 50 percent, but not greater than 70 percent, of the total amount of the reductions to payments for such fiscal year under paragraph (6), as estimated by the Secretary.

''(6) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—The Secretary shall reduce the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to a skilled nursing facility for services furnished by such facility during

a fiscal year (beginning with fiscal year 2019) by the applicable percent (as defined in subparagraph (B)). The Secretary shall make such reductions for all skilled nursing facilities in the fiscal year involved, regardless of whether or not the skilled nursing facility has been determined by the Secretary to have earned a value-based incentive payment under paragraph (5) for such fiscal year.

''(B) APPLICABLE PERCENT.—For purposes of subparagraph (A), the term 'applicable percent' means, with respect to fiscal year 2019 and succeeding fiscal years, 2 percent.

''(7) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the SNF VBP Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each skilled nursing facility of the adjustments to payments to the skilled nursing facility for services furnished by such facility during the fiscal year under paragraphs (5) and (6).

''(8) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (5) and the payment reduction under paragraph (6) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a skilled nursing facility under this section in a subsequent fiscal year.

''(9) PUBLIC REPORTING.—

''(A) SNF SPECIFIC INFORMATION.—The Secretary shall make available to the public, by posting on the Nursing Home Compare Medicare website (or a successor website) described in section 1819(i) in an easily understandable format, information regarding the performance of individual skilled nursing facilities under the SNF VBP Program, with respect to a fiscal year, including—

''(i) the SNF performance score of the skilled nursing facility for such fiscal year; and

''(ii) the ranking of the skilled nursing facility under paragraph (4)(B) for the performance period for such fiscal year.

''(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Nursing Home Compare Medicare website (or a successor website) described in section 1819(i) aggregate information on the SNF VBP Program, including—

''(i) the range of SNF performance scores provided under paragraph (4)(A); and

''(ii) the number of skilled nursing facilities receiving value-based incentive payments under paragraph (5) and the range and total amount of such value-based incentive payments.

''(10) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(A) The methodology used to determine the value-based incentive payment percentage and the amount of the value-based incentive payment under paragraph (5).

''(B) The determination of the amount of funding available for such value-based incentive payments under paragraph (5)(C)(ii)(III) and the payment reduction under paragraph (6).

''(C) The establishment of the performance standards under paragraph (3) and the performance period.

''(D) The methodology developed under paragraph (4) that is used to calculate SNF performance scores and the calculation of such scores.

''(E) The ranking determinations under paragraph (4)(B).

''(11) FUNDING FOR PROGRAM MANAGEMENT.—The Secretary shall provide for the one time transfer from the Federal Hospital Insurance Trust Fund established under section 1817 to the Centers for Medicare & Medicaid Services Program Management Account of—

''(A) for purposes of subsection (g)(2), $2,000,000; and

''(B) for purposes of implementing this subsection, $10,000,000.

Such funds shall remain available until expended.''.

(c) MEDPAC STUDY.—Not later than June 30, 2021, the Medicare Payment Advisory Commission shall submit to Congress a report that reviews the progress of the skilled nursing facility value-based purchasing program established under section 1888(h) of the Social Security Act, as added by subsection (b), and makes recommendations, as appropriate, on any improvements that should be made to such program. For purposes of the previous sentence, the Medicare Payment Advisory Commission shall consider any unintended consequences with respect to such skilled nursing facility value-based purchasing program and any potential adjustments to the readmission measure specified under section 1888(g)(1) of such Act, as added by subsection (a), for purposes of determining the effect of the socio-economic status of a beneficiary under the Medicare program under title XVIII of the Social Security Act for the SNF performance score of a skilled nursing facility provided under section 1888(h)(4) of such Act, as added by subsection (b).

SEC. 216. IMPROVING MEDICARE POLICIES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by inserting after section 1834 (42 U.S.C. 1395m) the following new section:

''SEC. 1834A. IMPROVING POLICIES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

''(a) REPORTING OF PRIVATE SECTOR PAYMENT RATES FOR ESTABLISHMENT OF MEDICARE PAYMENT RATES.—

''(1) IN GENERAL.—Beginning January 1, 2016, and every 3 years thereafter (or, annually, in the case of reporting with respect to an advanced diagnostic laboratory test, as defined in subsection (d)(5)), an applicable laboratory (as defined in paragraph (2)) shall report to the Secretary, at a time specified by the Secretary, applicable information (as defined in paragraph (3)) for a data collection period (as defined in paragraph (4)) for each clinical diagnostic laboratory test that the laboratory furnishes during such period for which payment is made under this part.

''(2) DEFINITION OF APPLICABLE LABORATORY.—In this section, the term 'applicable laboratory' means a laboratory that, with respect to its revenues under this title, a majority of such revenues are from this section, section 1833(h), or section 1848. The Secretary may establish a low volume or low expenditure threshold for excluding a laboratory from the definition of applicable laboratory under this paragraph, as the Secretary determines appropriate.

''(3) APPLICABLE INFORMATION DEFINED.—

''(A) IN GENERAL.—In this section, subject to subparagraph (B), the term 'applicable information' means, with respect to a laboratory test for a data collection period, the following:

''(i) The payment rate (as determined in accordance with paragraph (5)) that was paid by each private payor for the test during the period.

''(ii) The volume of such tests for each such payor for the period.

''(B) EXCEPTION FOR CERTAIN CONTRACTUAL ARRANGEMENTS.—Such term shall not include information with respect to a laboratory test for which payment is made on a capitated basis or other similar payment basis during the data collection period.

''(4) DATA COLLECTION PERIOD DEFINED.—In this section, the term 'data collection period' means a period of time, such as a previous 12 month period, specified by the Secretary.

''(5) TREATMENT OF DISCOUNTS.—The payment rate reported by a laboratory under this subsection shall reflect all discounts, rebates, coupons, and other price concessions, including those described in section 1847A(c)(3).

''(6) ENSURING COMPLETE REPORTING.—In the case where an applicable laboratory has more than one payment rate for the same payor for the same test or more than one payment rate for different payors for the same test, the applicable laboratory shall report each such payment rate and the volume for the test at each such rate under this subsection. Beginning with January 1, 2019, the Secretary may establish rules to aggregate reporting with respect to the situations described in the preceding sentence.

''(7) CERTIFICATION.—An officer of the laboratory shall certify the accuracy and completeness of the information reported under this subsection.

''(8) PRIVATE PAYOR DEFINED.—In this section, the term 'private payor' means the following:

''(A) A health insurance issuer and a group health plan (as such terms are defined in section 2791 of the Public Health Service Act).

''(B) A Medicare Advantage plan under part C.

''(C) A medicaid managed care organization (as defined in section 1903(m)).

''(9) CIVIL MONEY PENALTY.—

''(A) IN GENERAL.—If the Secretary determines that an applicable laboratory has failed to report or made a misrepresentation or omission in reporting information under this subsection with respect to a clinical diagnostic laboratory test, the Secretary may apply a civil money penalty in an amount of up to $10,000 per day for each failure to report or each such misrepresentation or omission.

''(B) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(10) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by a laboratory under this subsection is confidential and shall not be disclosed by the Secretary or a Medicare contractor in a form that discloses the identity of a specific payor or laboratory, or prices charged or payments made to any such laboratory, except—

''(A) as the Secretary determines to be necessary to carry out this section;

''(B) to permit the Comptroller General to review the information provided;

''(C) to permit the Director of the Congressional Budget Office to review the information provided; and

''(D) to permit the Medicare Payment Advisory Commission to review the information provided.

''(11) PROTECTION FROM PUBLIC DISCLOSURE.—A payor shall not be identified on information reported under this subsection. The name of an applicable laboratory under this subsection shall be exempt from disclosure under section 552(b)(3) of title 5, United States Code.

''(12) REGULATIONS.—Not later than June 30, 2015, the Secretary shall establish through notice and comment rulemaking parameters for data collection under this subsection.

''(b) PAYMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—

''(1) USE OF PRIVATE PAYOR RATE INFORMATION TO DETERMINE MEDICARE PAYMENT RATES.—

''(A) IN GENERAL.—Subject to paragraph (3) and subsections (c) and (d), in the case of a clinical diagnostic laboratory test furnished on or after January 1, 2017, the payment amount under this section shall be equal to the weighted median determined for the test under paragraph (2) for the most recent data collection period.

''(B) APPLICATION OF PAYMENT AMOUNTS TO HOSPITAL LABORATORIES.—The payment amounts established under this section shall apply to a clinical diagnostic laboratory test furnished by a hospital laboratory if such test is paid for separately, and not as part of a bundled payment under section 1833(t).

''(2) CALCULATION OF WEIGHTED MEDIAN.—For each laboratory test with respect to which information is reported under subsection (a) for a data collection period, the Secretary shall calculate a weighted median for the test for the period, by arraying the distribution of all payment rates reported for the period for each test weighted by volume for each payor and each laboratory.

''(3) PHASE-IN OF REDUCTIONS FROM PRIVATE PAYOR RATE IMPLEMENTATION.—

''(A) IN GENERAL.—Payment amounts determined under this subsection for a clinical diagnostic laboratory test for each of 2017 through 2022 shall not result in a reduction in payments for a clinical diagnostic laboratory test for the year of greater than the applicable percent (as defined in subparagraph (B)) of the amount of payment for the test for the preceding year.

''(B) APPLICABLE PERCENT DEFINED.—In this paragraph, the term 'applicable percent' means—

''(i) for each of 2017 through 2019, 10 percent; and

''(ii) for each of 2020 through 2022, 15 percent.

''(C) NO APPLICATION TO NEW TESTS.—This paragraph shall not apply to payment amounts determined under this section for either of the following.

''(i) A new test under subsection (c).

''(ii) A new advanced diagnostic test (as defined in subsection (d)(5)) under subsection (d).

''(4) APPLICATION OF MARKET RATES.—

''(A) IN GENERAL.—Subject to paragraph (3), once established for a year following a data collection period, the payment amounts under this subsection shall continue to apply until the year following the next data collection period.

''(B) OTHER ADJUSTMENTS NOT APPLICABLE.—The payment amounts under this section shall not be subject to any adjustment (including any geographic adjustment, budget neutrality adjustment, annual update, or other adjustment).

''(5) SAMPLE COLLECTION FEE.—In the case of a sample collected from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, the nominal fee that would otherwise apply under section 1833(h)(3)(A) shall be increased by $2.

''(c) PAYMENT FOR NEW TESTS THAT ARE NOT ADVANCED DIAGNOSTIC LABORATORY TESTS.—

''(1) PAYMENT DURING INITIAL PERIOD.—In the case of a clinical diagnostic laboratory test that is assigned a new or substantially revised HCPCS code on or after the date of enactment of this section, and which is not an advanced diagnostic laboratory test (as defined in subsection (d)(5)), during an initial period until payment rates under subsection (b) are established for the test, payment for the test shall be determined—

''(A) using cross-walking (as described in section 414.508(a) of title 42, Code of Federal Regulations, or any successor regulation) to the most appropriate existing test under the fee schedule under this section during that period; or

''(B) if no existing test is comparable to the new test, according to the gapfilling process described in paragraph (2).

''(2) GAPFILLING PROCESS DESCRIBED.—The gapfilling process described in this paragraph shall take into account the following sources of information to determine gapfill amounts, if available:

''(A) Charges for the test and routine discounts to charges.

''(B) Resources required to perform the test.

''(C) Payment amounts determined by other payors.

''(D) Charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant.

''(E) Other criteria the Secretary determines appropriate.

''(3) ADDITIONAL CONSIDERATION.—In determining the payment amount under crosswalking or gapfilling processes under this subsection, the Secretary shall consider recommendations from the panel established under subsection (f)(1).

''(4) EXPLANATION OF PAYMENT RATES.—In the case of a clinical diagnostic laboratory test for which payment is made under this subsection, the Secretary shall make available to the public an explanation of the payment rate for the test, including an explanation of how the criteria described in paragraph (2) and paragraph (3) are applied.

''(d) PAYMENT FOR NEW ADVANCED DIAGNOSTIC LABORATORY TESTS.—

''(1) PAYMENT DURING INITIAL PERIOD.—

''(A) IN GENERAL.—In the case of an advanced diagnostic laboratory test for which payment has not been made under the fee schedule under section 1833(h) prior to the date of enactment of this section, during an initial period of three quarters, the payment amount for the test for such period shall be based on the actual list charge for the laboratory test.

''(B) ACTUAL LIST CHARGE.—For purposes of subparagraph (A), the term 'actual list charge', with respect to a laboratory test furnished during such period, means the publicly available rate on the first day at which the test is available for purchase by a private payor.

''(2) SPECIAL RULE FOR TIMING OF INITIAL REPORTING.—With respect to an advanced diagnostic laboratory test described in paragraph (1)(A), an applicable laboratory shall initially be required to report under subsection (a) not later than the last day of the second quarter of the initial period under such paragraph.

''(3) APPLICATION OF MARKET RATES AFTER INITIAL PERIOD.—Subject to paragraph (4), data reported under paragraph (2) shall be used to establish the payment amount for an advanced diagnostic laboratory test after the initial period under paragraph (1)(A) using the methodology described in subsection (b). Such payment amount shall continue to apply until the year following the next data collection period.

''(4) RECOUPMENT IF ACTUAL LIST CHARGE EXCEEDS MARKET RATE.—With respect to the initial period described in paragraph (1)(A), if, after such period, the Secretary determines that the payment amount for an advanced diagnostic laboratory test under paragraph (1)(A) that was applicable during the period was greater than 130 percent of the payment amount for the test established using the methodology described in subsection (b) that is applicable after such period, the Secretary shall recoup the difference between such payment amounts for tests furnished during such period.

''(5) ADVANCED DIAGNOSTIC LABORATORY TEST DEFINED.—In this subsection, the term 'advanced diagnostic laboratory test' means a clinical diagnostic laboratory test covered under this part that is offered and furnished only by a single laboratory and not sold for use by a laboratory other than the original developing laboratory (or a successor owner) and meets one of the following criteria:

''(A) The test is an analysis of multiple biomarkers of DNA, RNA, or proteins combined with a unique algorithm to yield a single patient-specific result.

''(B) The test is cleared or approved by the Food and Drug Administration.

''(C) The test meets other similar criteria established by the Secretary.

''(e) CODING.—

''(1) TEMPORARY CODES FOR CERTAIN NEW TESTS.—

''(A) IN GENERAL.—The Secretary shall adopt temporary HCPCS codes to identify new advanced diagnostic laboratory tests (as defined in subsection (d)(5)) and new laboratory tests that are cleared or approved by the Food and Drug Administration.

''(B) DURATION.—

''(i) IN GENERAL.—Subject to clause (ii), the temporary code shall be effective until a permanent HCPCS code is established (but not to exceed 2 years).

''(ii) EXCEPTION.—The Secretary may extend the temporary code or establish a permanent HCPCS code, as the Secretary determines appropriate.

''(2) EXISTING TESTS.—Not later than January 1, 2016, for each existing advanced diagnostic laboratory test (as so defined) and each existing clinical diagnostic laboratory test that is cleared or approved by the Food and Drug Administration for which payment is made under this part as of the date of enactment of this section, if such test has not already been assigned a unique HCPCS code, the Secretary shall—

''(A) assign a unique HCPCS code for the test; and

''(B) publicly report the payment rate for the test.

''(3) ESTABLISHMENT OF UNIQUE IDENTIFIER FOR CERTAIN TESTS.—For purposes of tracking and monitoring, if a laboratory or a manufacturer requests a unique identifier for an advanced diagnostic laboratory test (as so defined) or a laboratory test that is cleared or approved by the Food and Drug Administration, the Secretary shall utilize a means to uniquely track such test through a mechanism such as a HCPCS code or modifier.

''(f) INPUT FROM CLINICIANS AND TECHNICAL EXPERTS.—

''(1) IN GENERAL.—The Secretary shall consult with an expert outside advisory panel, established by the Secretary not later than July 1, 2015, composed of an appropriate selection of individuals with expertise, which may include molecular pathologists, researchers, and individuals with expertise in laboratory science or health economics, in issues related to clinical diagnostic laboratory tests, which may include the development, validation, performance, and application of such tests, to provide—

''(A) input on—

''(i) the establishment of payment rates under this section for new clinical diagnostic laboratory tests, including whether to use crosswalking or gapfilling processes to determine payment for a specific new test; and

''(ii) the factors used in determining coverage and payment processes for new clinical diagnostic laboratory tests; and

''(B) recommendations to the Secretary under this section.

''(2) COMPLIANCE WITH FACA.—The panel shall be subject to the Federal Advisory Committee Act (5 U.S.C. App.).

''(3) CONTINUATION OF ANNUAL MEETING.—The Secretary shall continue to convene the annual meeting described in section 1833(h)(8)(B)(iii) after the implementation of

this section for purposes of receiving comments and recommendations (and data on which the recommendations are based) as described in such section on the establishment of payment amounts under this section.

''(g) COVERAGE.—

''(1) ISSUANCE OF COVERAGE POLICIES.—

''(A) IN GENERAL.—A medicare administrative contractor shall only issue a coverage policy with respect to a clinical diagnostic laboratory test in accordance with the process for making a local coverage determination (as defined in section 1869(f)(2)(B)), including the appeals and review process for local coverage determinations under part 426 of title 42, Code of Federal Regulations (or successor regulations).

''(B) NO EFFECT ON NATIONAL COVERAGE DETERMINATION PROCESS.—This paragraph shall not apply to the national coverage determination process (as defined in section 1869(f)(1)(B)).

''(C) EFFECTIVE DATE.—This paragraph shall apply to coverage policies issued on or after January 1, 2015.

''(2) DESIGNATION OF ONE OR MORE MEDICARE ADMINISTRATIVE CONTRACTORS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—The Secretary may designate one or more (not to exceed 4) medicare administrative contractors to either establish coverage policies or establish coverage policies and process claims for payment for clinical diagnostic laboratory tests, as determined appropriate by the Secretary.

''(h) IMPLEMENTATION.—

''(1) IMPLEMENTATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the establishment of payment amounts under this section.

''(2) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information collected under this section.

''(3) FUNDING.—For purposes of implementing this section, 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, for each of fiscal years 2014 through 2018, $4,000,000, and for each of fiscal years 2019 through 2023, $3,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

''(i) TRANSITIONAL RULE.—During the period beginning on the date of enactment of this section and ending on December 31, 2016, with respect to advanced diagnostic laboratory tests under this part, the Secretary shall use the methodologies for pricing, coding, and coverage in effect on the day before such date of enactment, which may include cross-walking or gapfilling methods.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (1)(D)—

(i) by striking ''(i) on the basis'' and inserting ''(i)(I) on the basis'';

(ii) in subclause (I), as added by clause (i), by striking ''subsection (h)(1)'' and inserting ''subsection (h)(1) (for tests furnished before January 1, 2017)'';

(iii) by striking ''or (ii)'' and inserting ''or (II) under section 1834A (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii)''; and

(iv) in clause (ii), by striking ''on the basis'' and inserting ''for tests furnished before January 1, 2017, on the basis'';

(B) in paragraph (2)(D)—

(i) by striking ''(i) on the basis'' and inserting ''(i)(I) on the basis'';

(ii) in subclause (I), as added by clause (i), by striking ''subsection (h)(1)'' and inserting ''subsection (h)(1) (for tests furnished before January 1, 2017)'';

(iii) by striking ''or (ii)'' and inserting ''or (II) under section 1834A (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii)''; and

(iv) in clause (ii), by striking ''on the basis'' and inserting ''for tests furnished before January 1, 2017, on the basis'';

(C) in subsection (b)(3)(B), by striking ''on the basis'' and inserting ''for tests furnished before January 1, 2017, on the basis'';

(D) in subsection (h)(2)(A)(i), by striking ''and subject to'' and inserting ''and, for tests furnished before the date of enactment of section 1834A, subject to'';

(E) in subsection (h)(3), in the matter preceding subparagraph (A), by striking ''fee schedules'' and inserting ''fee schedules (for tests furnished before January 1, 2017) or under section 1834A (for tests furnished on or after January 1, 2017), subject to subsection (b)(5) of such section'';

(F) in subsection (h)(6), by striking ''In the case'' and inserting ''For tests furnished before January 1, 2017, in the case''; and

(G) in subsection (h)(7), in the first sentence—

(i) by striking ''and (4)'' and inserting ''and (4) and section 1834A''; and

(ii) by striking ''under this subsection'' and inserting ''under this part''.

(2) Section 1869(f)(2) of the Social Security Act (42 U.S.C. 1395ff(f)(2)) is amended by adding at the end the following new subparagraph:

''(C) LOCAL COVERAGE DETERMINATIONS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—For provisions relating to local coverage determinations for clinical diagnostic laboratory tests, see section 1834A(g).''.

(c) GAO STUDY AND REPORT; MONITORING OF MEDICARE EXPENDITURES AND IMPLEMENTATION OF NEW PAYMENT SYSTEM FOR LABORATORY TESTS.—

(1) GAO STUDY AND REPORT ON IMPLEMENTATION OF NEW PAYMENT RATES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—

(A) STUDY.—The Comptroller General of the United States (in this subsection referred to as the ''Comptroller General'') shall conduct a study on the implementation of section 1834A of the Social Security Act, as added by subsection (a). The study shall include an analysis of—

(i) payment rates paid by private payors for laboratory tests furnished in various settings, including—

(I) how such payment rates compare across settings;

(II) the trend in payment rates over time; and

(III) trends by private payors to move to alternative payment methodologies for laboratory tests;

(ii) the conversion to the new payment rate for laboratory tests under such section;

(iii) the impact of such implementation on beneficiary access under title XVIII of the Social Security Act;

(iv) the impact of the new payment system on laboratories that furnish a low volume of services and laboratories that specialize in a small number of tests;

(v) the number of new Healthcare Common Procedure Coding System (HCPCS) codes issued for laboratory tests;

(vi) the spending trend for laboratory tests under such title;

(vii) whether the information reported by laboratories and the new payment rates for laboratory tests under such section accurately reflect market prices;

(viii) the initial list price for new laboratory tests and the subsequent reported rates for such tests under such section;

(ix) changes in the number of advanced diagnostic laboratory tests and laboratory tests cleared or approved by the Food and Drug Administration for which payment is made under such section; and

(x) healthcare economic information on downstream cost impacts for such tests and decision making based on accepted methodologies.

(B) REPORT.—Not later than October 1, 2018, the Comptroller General shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the study under subparagraph (A), including recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) MONITORING OF MEDICARE EXPENDITURES AND IMPLEMENTATION OF NEW PAYMENT SYSTEM FOR LABORATORY TESTS.—The Inspector General of the Department of Health and Human Services shall—

(A) publicly release an annual analysis of the top 25 laboratory tests by expenditures under title XVIII of the Social Security Act; and

(B) conduct analyses the Inspector General determines appropriate with respect to the implementation and effect of the new payment system for laboratory tests under section 1834A of the Social Security Act, as added by subsection (a).

SEC. 217. REVISIONS UNDER THE MEDICARE ESRD PROSPECTIVE PAYMENT SYSTEM.

(a) DELAY OF IMPLEMENTATION OF ORAL-ONLY POLICY.—Section 632(b)(1) of the American Taxpayer Relief Act of 2012 (42 U.S.C. 1395rr note) is amended—

(1) by striking ''2016'' and inserting ''2024''; and

(2) by adding at the end the following new sentence: ''Notwithstanding section 1881(b)(14)(A)(ii) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(A)(ii)), implementation of the policy described in the previous sentence shall be based on data from the most recent year available.''.

(b) MITIGATION OF THE APPLICATION OF ADJUSTMENT TO ESRD BUNDLED PAYMENT RATE TO ACCOUNT FOR CHANGES IN THE UTILIZATION OF CERTAIN DRUGS AND BIOLOGICALS.—

(1) IN GENERAL.—Section 1881(b)(14)(I) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(I)) is amended by inserting ''and before January 1, 2015,'' after ''January 1, 2014,''.

(2) MARKET BASKET.—Section 1881(b)(14)(F)(i) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(F)(i)) is amended—

(A) in subclause (I)—

(i) by striking ''subclause (II)'' and inserting ''subclauses (II) and (III)''; and

(ii) by adding at the end the following new sentence: ''In order to accomplish the purposes of subparagraph (I) with respect to 2016, 2017, and 2018, after determining the increase factor described in the preceding sentence for each of 2016, 2017, and 2018, the Secretary shall reduce such increase factor by 1.25 percentage points for each of 2016 and 2017 and by 1 percentage point for 2018.'';

(B) in subclause (II), by striking ''For 2012'' and inserting ''Subject to subclause (III), for 2012''; and

(C) by adding at the end the following new subclause:

''(III) Notwithstanding subclauses (I) and (II), in order to accomplish the purposes of subparagraph (I) with respect to 2015, the increase factor described in subclause (I) for 2015 shall be 0.0 percent pursuant to the regulation issued by the Secretary on December 2, 2013, entitled 'Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Final Rule' (78 Fed. Reg. 72156).''.

(c) DRUG DESIGNATIONS.—As part of the promulgation of annual rule for the Medicare end stage renal disease prospective payment system under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) for calendar year 2016, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a process for—

(1) determining when a product is no longer an oral-only drug; and

(2) including new injectable and intravenous products into the bundled payment under such system.

(d) QUALITY MEASURES RELATED TO CONDITIONS TREATED BY ORAL-ONLY DRUGS UNDER THE ESRD QUALITY INCENTIVE PROGRAM.—Section 1881(h)(2) of the Social Security Act (42 U.S.C. 1395rr(h)(2)) is amended—

(1) in subparagraph (A)—

(A) in clause (ii), by striking ''and'' at the end;

(B) by redesignating clause (iii) as clause (iv); and

(C) by inserting after clause (ii) the following new clause:

''(iii) for 2016 and subsequent years, measures described in subparagraph (E)(i); and'';

(2) in subparagraph (B)(i), by striking ''(A)(iii)'' and inserting ''(A)(iv)''; and

(3) by adding at the end the following new subparagraph:

''(E) MEASURES SPECIFIC TO THE CONDITIONS TREATED WITH ORAL-ONLY DRUGS.—

''(i) IN GENERAL.—The measures described in this subparagraph are measures specified by the Secretary that are specific to the conditions treated with oral-only drugs. To the extent feasible, such measures shall be outcomes-based measures.

''(ii) CONSULTATION.—In specifying the measures under clause (i), the Secretary shall consult with interested stakeholders.

''(iii) USE OF ENDORSED MEASURES.—

''(I) IN GENERAL.—Subject to subclause (I), any measures specified under clause (i) must have been endorsed by the entity with a contract under section 1890(a).

''(II) EXCEPTION.—If the entity with a contract under section 1890(a) has not endorsed a measure for a specified area or topic related to measures described in clause (i) that the Secretary determines appropriate, the Secretary may specify a measure that is endorsed or adopted by a consensus organization recognized by the Secretary that has expertise in clinical guidelines for kidney disease.''.

(e) AUDITS OF COST REPORTS OF ESRD PROVIDERS AS RECOMMENDED BY MEDPAC.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct audits of Medicare cost reports beginning during 2012 for a representative sample of providers of services and renal dialysis facilities furnishing renal dialysis services.

(2) FUNDING.—For purposes of carrying out paragraph (1), the Secretary of Health and Human Services shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Services Program Management Account of $18,000,000 for fiscal year 2014. Amounts transferred under this paragraph for a fiscal year shall be available until expended.

SEC. 218. QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY DIAGNOSTIC IMAGING AND PROMOTING EVIDENCE-BASED CARE.

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

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(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 rulemaking, 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).''.

(2) CONFORMING AMENDMENTS.—

(A) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—Section 1833(t) of the Social Security Act (42 1395l(t)) is amended by adding at the end the following new paragraph:

''(20) NOT BUDGET NEUTRAL APPLICATION OF REDUCED EXPENDITURES RESULTING FROM QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—The Secretary shall not take into account the reduced expenditures that result from the application of section 1834(p) in making any budget neutrality adjustments this subsection.''.

(B) PHYSICIAN FEE SCHEDULE.—Section 1848(c)(2)(B)(v) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(v)) is amended by adding at the end the following new subclause:

''(VIII) REDUCED EXPENDITURES ATTRIBUTABLE TO APPLICATION OF QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—Effective for fee schedules established beginning with 2016, reduced expenditures attributable to the application of the quality incentives for computed tomography under section 1834(p)''.

(b) PROMOTING EVIDENCE-BASED CARE.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by subsection (a), is amended by adding at the end the following new subsection:

''(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 rulemaking.

''(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.''.

(2) CONFORMING AMENDMENT.—Section 1833(t)(16) of the Social Security Act (42 U.S.C. 1395l(t)(16)) is amended by adding at the end the following new subparagraph:

''(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(q).''.

(3) REPORT ON EXPERIENCE OF IMAGING APPROPRIATE USE CRITERIA PROGRAM.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that includes a description of the extent to which appropriate use criteria could be used for other services under part B of

title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), such as radiation therapy and clinical diagnostic laboratory services.

SEC. 219. USING FUNDING FROM TRANSITIONAL FUND FOR SUSTAINABLE GROWTH RATE (SGR) REFORM.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''$2,300,000,000'' and inserting ''$0''.

SEC. 220. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

''(M) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

''(i) COLLECTION OF INFORMATION.—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

''(ii) USE OF INFORMATION.—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

''(iii) TYPES OF INFORMATION.—The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

''(I) Time involved in furnishing services.

''(II) Amounts and types of practice expense inputs involved with furnishing services.

''(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

''(IV) Overhead and accounting information for practices of physicians and other suppliers.

''(V) Any other element that would improve the valuation of services under this section.

''(iv) INFORMATION COLLECTION MECHANISMS.—Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

''(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

''(II) Surgical logs, billing systems, or other practice or facility records.

''(III) Electronic health records.

''(IV) Any other mechanism determined appropriate by the Secretary.

''(v) TRANSPARENCY OF USE OF INFORMATION.—

''(I) IN GENERAL.—Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

''(II) THRESHOLDS FOR USE.—The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

''(III) DISCLOSURE OF INFORMATION.—The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

''(vi) INCENTIVE TO PARTICIPATE.—The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

''(vii) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information collected or obtained under this subparagraph.

''(viii) DEFINITION OF ELIGIBLE PROFESSIONAL.—In this subparagraph, the term 'eligible professional' has the meaning given such term in subsection (k)(3)(B).

''(ix) FUNDING.—For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.''.

(2) LIMITATION ON REVIEW.—Section 1848(i)(1) of the Social Security Act (42 U.S.C. 1395w–4(i)(1)) is amended—

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).''.

(b) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

''(N) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).''.

(c) REVISED AND EXPANDED IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—Section 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(K)(ii)) is amended to read as follows:

''(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

''(I) Codes that have experienced the fastest growth.

''(II) Codes that have experienced substantial changes in practice expenses.

''(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

''(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

''(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

''(VI) Codes that have not been subject to review since implementation of the fee schedule.

''(VII) Codes that account for the majority of spending under the physician fee schedule.

''(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

''(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

''(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

''(XI) Codes for which there may be anomalies in relative values within a family of codes.

''(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

''(XIII) Codes with high intra-service work per unit of time.

''(XIV) Codes with high practice expense relative value units.

''(XV) Codes with high cost supplies.

''(XVI) Codes as determined appropriate by the Secretary.''.

(d) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

''(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2017 through 2020, the following shall apply:

''(i) DETERMINATION OF NET REDUCTION IN EXPENDITURES.—For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

''(ii) BUDGET NEUTRAL REDISTRIBUTION OF FUNDS IF TARGET MET AND COUNTING OVERAGES TOWARDS THE TARGET FOR THE SUCCEEDING YEAR.—If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

''(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

''(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of determining whether the target has or has not been met under this subparagraph with respect to that year.

''(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2017.

''(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

''(I) the target for the year; and

''(II) the estimated net reduction in expenditures determined under clause (i) for the year.

''(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent of the estimated

amount of expenditures under the fee schedule under this section for the year.''.

(2) CONFORMING AMENDMENT.—Section 1848(c)(2)(B)(v) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(v)) is amended by adding at the end the following new subclause:

''(VIII) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2017, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).''.

(e) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—

(1) IN GENERAL.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w–4(c)) is amended by adding at the end the following new paragraph:

''(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2017, for services that are not new or revised codes, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.''.

(2) CONFORMING AMENDMENTS.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)(ii)(I), by striking ''subclause (II)'' and inserting ''subclause (II) and paragraph (7)''; and

(B) in subparagraph (K)(iii)(VI)—

(i) by striking ''provisions of subparagraph (B)(ii)(II)'' and inserting ''provisions of subparagraph (B)(ii)(II) and paragraph (7)''; and

(ii) by striking ''under subparagraph (B)(ii)(II)'' and inserting ''under subparagraph (B)(ii)(I)''.

(f) AUTHORITY TO SMOOTH RELATIVE VALUES WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)) is amended—

(1) in each of clauses (i) and (iii), by striking ''the service'' and inserting ''the service or group of services'' each place it appears; and

(2) in the first sentence of clause (ii), by inserting ''or group of services'' before the period.

(g) GAO STUDY AND REPORT ON RELATIVE VALUE SCALE UPDATE COMMITTEE.—

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the ''Comptroller General'') shall conduct a study of the processes used by the Relative Value Scale Update Committee (RUC) to provide recommendations to the Secretary of Health and Human Services regarding relative values for specific services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1).

(h) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

(1) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w–4(e)) is amended by adding at the end the following new paragraph:

''(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

''(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

''(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

''(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

''(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

''(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

''(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

''(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

''(I) for 2017, is 5/6; and

''(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

''(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

''(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

''(D) TRANSITION AREA DEFINED.—In this paragraph, the term 'transition area' means each of the following fee schedule areas for 2013:

''(i) The rest-of-State payment locality.

''(ii) Payment locality 3.

''(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.''.

(2) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)) is amended by striking ''The term'' and inserting ''Except as provided in subsection (e)(6)(D), the term''.

(i) DISCLOSURE OF DATA USED TO ESTABLISH MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—The Secretary of Health and Human Services shall make publicly available the information used to establish the multiple procedure payment reduction policy to the professional component of imaging services in the final rule published in the Federal Register, v. 77, n. 222, November 16, 2012, pages 68891–69380 under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

SEC. 221. MEDICAID DSH.

(a) MODIFICATIONS OF REDUCTIONS TO ALLOTMENTS.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (7)(A)—

(A) in clause (i), by striking ''2016 through 2020'' and inserting ''2017 through 2024''; and

(B) in clause (ii), by striking subclauses (I) through (IV), and inserting the following:

''(I) $1,800,000,000 for fiscal year 2017;

''(II) $4,700,000,000 for fiscal year 2018;

''(III) $4,700,000,000 for fiscal year 2019;

''(IV) $4,700,000,000 for fiscal year 2020;

''(V) $4,800,000,000 for fiscal year 2021;

''(VI) $5,000,000,000 for fiscal year 2022;

''(VII) $5,000,000,000 for fiscal year 2023; and

''(VIII) $4,400,000,000 for fiscal year 2024.''; and

(2) by striking paragraph (8) and inserting the following:

''(8) CALCULATION OF DSH ALLOTMENTS AFTER REDUCTIONS PERIOD.—The DSH allotment for a State for fiscal years after fiscal year 2024 shall be calculated under paragraph (3) without regard to paragraph (7).''.

(b) MACPAC REVIEW AND REPORT.—Section 1900(b)(6) of the Social Security Act (42 U.S.C. 1396(b)(6)) is amended—

(1) by striking ''MACPAC shall consult'' and inserting the following:

''(A) IN GENERAL.—MACPAC shall consult''; and

(2) by adding at the end the following:

''(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

''(i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

''(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

''(I) Data relating to changes in the number of uninsured individuals.

''(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

''(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

''(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

''(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

''(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.''.

SEC. 222. REALIGNMENT OF THE MEDICARE SEQUESTER FOR FISCAL YEAR 2024.

Paragraph (6) (relating to implementing direct spending reductions) of section 251A of

the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901a) is amended by adding at the end the following new subparagraph:

''(D) Notwithstanding the 2 percent limit specified in subparagraph (A) for payments for the Medicare programs specified in section 256(d), the sequestration order of the President under such subparagraph for fiscal year 2024 shall be applied to such payments so that—

''(i) with respect to the first 6 months in which such order is effective for such fiscal year, the payment reduction shall be 4.0 percent; and

''(ii) with respect to the second 6 months in which such order is so effective for such fiscal year, the payment reduction shall be 0.0 percent.''.

SEC. 223. DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES.

(a) CRITERIA FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS TO PARTICIPATE IN DEMONSTRATION PROGRAMS.—

(1) PUBLICATION.—Not later than September 1, 2015, the Secretary shall publish criteria for a clinic to be certified by a State as a certified community behavioral health clinic for purposes of participating in a demonstration program conducted under subsection (d).

(2) REQUIREMENTS.—The criteria published under this subsection shall include criteria with respect to the following:

(A) STAFFING.—Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.

(B) AVAILABILITY AND ACCESSIBILITY OF SERVICES.—Availability and accessibility of services, including crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence.

(C) CARE COORDINATION.—Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

(i) Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

(iv) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code.

(v) Inpatient acute care hospitals and hospital outpatient clinics.

(D) SCOPE OF SERVICES.—Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(ii) Screening, assessment, and diagnosis, including risk assessment.

(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

(iv) Outpatient mental health and substance use services.

(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(vi) Targeted case management.

(vii) Psychiatric rehabilitation services.

(viii) Peer support and counselor services and family supports.

(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

(E) QUALITY AND OTHER REPORTING.—Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.

(F) ORGANIZATIONAL AUTHORITY.—Criteria that a clinic be a non-profit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the establishment of a prospective payment system that shall only apply to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d).

(2) REQUIREMENTS.—The guidance issued by the Secretary under paragraph (1) shall provide that—

(A) no payment shall be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; and

(B) no payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

(c) PLANNING GRANTS.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall award planning grants to States for the purpose of developing proposals to participate in time-limited demonstration programs described in subsection (d).

(2) USE OF FUNDS.—A State awarded a planning grant under this subsection shall—

(A) solicit input with respect to the development of such a demonstration program from patients, providers, and other stakeholders;

(B) certify clinics as certified community behavioral health clinics for purposes of participating in a demonstration program conducted under subsection (d); and

(C) establish a prospective payment system for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d) in accordance with the guidance issued under subsection (b).

(d) DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Not later than September 1, 2017, the Secretary shall select States to participate in demonstration programs that are developed through planning grants awarded under subsection (c), meet the requirements of this subsection, and represent a diverse selection of geographic areas, including rural and underserved areas.

(2) APPLICATION REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall solicit applications to participate in demonstration programs under this subsection solely from States awarded planning grants under subsection (c).

(B) REQUIRED INFORMATION.—An application for a demonstration program under this subsection shall include the following:

(i) The target Medicaid population to be served under the demonstration program.

(ii) A list of participating certified community behavioral health clinics.

(iii) Verification that the State has certified a participating clinic as a certified community behavioral health clinic in accordance with the requirements of subsection (b).

(iv) A description of the scope of the mental health services available under the State Medicaid program that will be paid for under the prospective payment system tested in the demonstration program.

(v) Verification that the State has agreed to pay for such services at the rate established under the prospective payment system.

(vi) Such other information as the Secretary may require relating to the demonstration program including with respect to determining the soundness of the proposed prospective payment system.

(3) NUMBER AND LENGTH OF DEMONSTRATION PROGRAMS.—Not more than 8 States shall be selected for 2-year demonstration programs under this subsection.

(4) REQUIREMENTS FOR SELECTING DEMONSTRATION PROGRAMS.—

(A) IN GENERAL.—The Secretary shall give preference to selecting demonstration programs where participating certified community behavioral health clinics—

(i) provide the most complete scope of services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

(ii) will improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

(iii) will improve availability of, access to, and participation in assisted outpatient mental health treatment in the State; or

(iv) demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending.

(5) PAYMENT FOR MEDICAL ASSISTANCE FOR MENTAL HEALTH SERVICES PROVIDED BY CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.—

(A) IN GENERAL.—The Secretary shall pay a State participating in a demonstration program under this subsection the Federal

matching percentage specified in subparagraph (B) for amounts expended by the State to provide medical assistance for mental health services described in the demonstration program application in accordance with paragraph (2)(B)(iv) that are provided by certified community behavioral health clinics to individuals who are enrolled in the State Medicaid program. Payments to States made under this paragraph shall be considered to have been under, and are subject to the requirements of, section 1903 of the Social Security Act (42 U.S.C. 1396b).

(B) FEDERAL MATCHING PERCENTAGE.—The Federal matching percentage specified in this subparagraph is with respect to medical assistance described in subparagraph (A) that is furnished—

(i) to a newly eligible individual described in paragraph (2) of section 1905(y) of the Social Security Act (42 U.S.C. 1396d(y)), the matching rate applicable under paragraph (1) of that section; and

(ii) to an individual who is not a newly eligible individual (as so described) but who is eligible for medical assistance under the State Medicaid program, the enhanced FMAP applicable to the State.

(C) LIMITATIONS.—

(i) IN GENERAL.—Payments shall be made under this paragraph to a State only for mental health services—

(I) that are described in the demonstration program application in accordance with paragraph (2)(iv);

(II) for which payment is available under the State Medicaid program; and

(III) that are provided to an individual who is eligible for medical assistance under the State Medicaid program.

(ii) PROHIBITED PAYMENTS.—No payment shall be made under this paragraph—

(I) for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; or

(II) with respect to payments made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

(6) WAIVER OF STATEWIDENESS REQUIREMENT.—The Secretary shall waive section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) (relating to statewideness) as may be necessary to conduct demonstration programs in accordance with the requirements of this subsection.

(7) ANNUAL REPORTS.—

(A) IN GENERAL.—Not later than 1 year after the date on which the first State is selected for a demonstration program under this subsection, and annually thereafter, the Secretary shall submit to Congress an annual report on the use of funds provided under all demonstration programs conducted under this subsection. Each such report shall include—

(i) an assessment of access to community-based mental health services under the Medicaid program in the area or areas of a State targeted by a demonstration program compared to other areas of the State;

(ii) an assessment of the quality and scope of services provided by certified community behavioral health clinics compared to community-based mental health services provided in States not participating in a demonstration program under this subsection and in areas of a demonstration State that are not participating in the demonstration program; and

(iii) an assessment of the impact of the demonstration programs on the Federal and State costs of a full range of mental health services (including inpatient, emergency and ambulatory services).

(B) RECOMMENDATIONS.—Not later than December 31, 2021, the Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated.

(e) DEFINITIONS.—In this section:

(1) FEDERALLY-QUALIFIED HEALTH CENTER SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC SERVICES; RURAL HEALTH CLINIC.—The terms ''Federally-qualified health center services'', ''Federally-qualified health center'', ''rural health clinic services'', and ''rural health clinic'' have the meanings given those terms in section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l)).

(2) ENHANCED FMAP.—The term ''enhanced FMAP'' has the meaning given that term in section 2105(b) of the Social Security Act (42 U.S.C. 1397dd(b)) but without regard to the second and third sentences of that section.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(f) FUNDING.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary—

(A) for purposes of carrying out subsections (a), (b), and (d)(7), $2,000,000 for fiscal year 2014; and

(B) for purposes of awarding planning grants under subsection (c), $25,000,000 for fiscal year 2016.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

SEC. 224. ASSISTED OUTPATIENT TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

(a) IN GENERAL.—The Secretary shall establish a 4-year pilot program to award not more than 50 grants each year to eligible entities for assisted outpatient treatment programs for individuals with serious mental illness.

(b) CONSULTATION.—The Secretary shall carry out this section in consultation with the Director of the National Institute of Mental Health, the Attorney General of the United States, the Administrator of the Administration for Community Living, and the Administrator of the Substance Abuse and Mental Health Services Administration.

(c) SELECTING AMONG APPLICANTS.—The Secretary—

(1) may only award grants under this section to applicants that have not previously implemented an assisted outpatient treatment program; and

(2) shall evaluate applicants based on their potential to reduce hospitalization, homelessness, incarceration, and interaction with the criminal justice system while improving the health and social outcomes of the patient.

(d) USE OF GRANT.—An assisted outpatient treatment program funded with a grant awarded under this section shall include—

(1) evaluating the medical and social needs of the patients who are participating in the program;

(2) preparing and executing treatment plans for such patients that—

(A) include criteria for completion of court-ordered treatment; and

(B) provide for monitoring of the patient's compliance with the treatment plan, including compliance with medication and other treatment regimens;

(3) providing for such patients case management services that support the treatment plan;

(4) ensuring appropriate referrals to medical and social service providers;

(5) evaluating the process for implementing the program to ensure consistency with the patient's needs and State law; and

(6) measuring treatment outcomes, including health and social outcomes such as rates of incarceration, health care utilization, and homelessness.

(e) REPORT.—Not later than the end of each of fiscal years 2016, 2017, and 2018, the Secretary shall submit a report to the appropriate congressional committees on the grant program under this section. Each such report shall include an evaluation of the following:

(1) Cost savings and public health outcomes such as mortality, suicide, substance abuse, hospitalization, and use of services.

(2) Rates of incarceration by patients.

(3) Rates of homelessness among patients.

(4) Patient and family satisfaction with program participation.

(f) DEFINITIONS.—In this section:

(1) The term ''assisted outpatient treatment'' means medically prescribed mental health treatment that a patient receives while living in a community under the terms of a law authorizing a State or local court to order such treatment.

(2) The term ''eligible entity'' means a county, city, mental health system, mental health court, or any other entity with authority under the law of the State in which the grantee is located to implement, monitor, and oversee assisted outpatient treatment programs.

(3) The term ''Secretary'' means the Secretary of Health and Human Services.

(g) FUNDING.—

(1) AMOUNT OF GRANTS.—A grant under this section shall be in an amount that is not more than $1,000,000 for each of fiscal years 2015 through 2018. Subject to the preceding sentence, the Secretary shall determine the amount of each grant based on the population of the area, including estimated patients, to be served under the grant.

(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2015 through 2018.

SEC. 225. EXCLUSION FROM PAYGO SCORECARDS.

(a) STATUTORY PAY-AS-YOU-GO SCORECARDS.—The budgetary effects of this Act shall not be entered on either PAYGO scorecard maintained pursuant to section 4(d) of the Statutory Pay-As-You-Go Act of 2010.

(b) SENATE PAYGO SCORECARDS.—The budgetary effects of this Act shall not be entered on any PAYGO scorecard maintained for purposes of section 201 of S. Con. Res. 21 (110th Congress).

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

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

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

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

There was no objection.

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

I sorely wish I were here getting ready to vote on a bill that would permanently repeal and replace the sustainable growth rate. In this Chamber, we passed a bill that would do that and that would have fully offset the cost of the repeal by delaying a provision of the Affordable Care Act that the administration just keeps delaying itself. In fact, it was partially delayed again just yesterday. Unfortunately, we have reached another doc fix deadline. I believe that we must act to protect America's seniors and ensure that they can continue to see the doctors whom they know and trust.

That is why I have introduced legislation that represents a bipartisan-bicameral agreement that will give us additional time to work out our differences and pass permanent repeal. We are closer than ever to reaching that goal. We have an agreement on policy. We need to overcome our differences about the responsible way to pay for those new policies. I hope that we can act before we reach the new deadline of March 31, 2015. In fact, we should try to reach a bicameral agreement before the end of this Congress.

I am glad that Speaker BOEHNER has offered his continuing support to this effort. With the House's having acted, we hope that the Senate can also pass an SGR repeal that has real pay-fors. Then we can begin the process of working through our differences in a conference committee. I am sponsoring this bill today because it is my earnest hope that this is the last patch we will have to pass, and I urge all of my colleagues to support this bill.

I reserve the balance of my time.

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

I am sorry, but I simply cannot support yet another temporary SGR patch. This bill is bad for seniors, and it is bad for doctors. We want to achieve a permanent solution to this ongoing problem. This bill does nothing to achieve that goal. In fact, it sets back months and months of hard work. What we should be considering today is the bipartisan-bicameral agreement that my colleagues and I developed. That bill is what doctors' groups and patients' groups support. That bill can also be offset without robbing one provider to pay another provider.

What is before us today doesn't fix the problem. It exacerbates it. We had a true opportunity to finally accomplish what our constituents have asked us to do for a decade, and that is to pass a permanent repeal of the SGR, but the Republican leadership is letting that opportunity slip away. I respect my colleague from Pennsylvania, but I don't believe that if we pass another patch that we are going to go back and do a permanent fix. My fear is, by doing this, we will lose the opportunity to do the permanent fix and that it will simply slip away.

Two weeks ago, the Republicans brought to the floor our agreement, and they added a poison pill offset that they knew the President and the Senate would never accept, a delay of critical Affordable Care Act provisions. All that accomplished was wasting time, which has led us to this scenario of spending another nearly $20 billion on a patch. Meanwhile, this bill includes health policies that have never seen the light of day. Some have been used as offsets, others as sweeteners, to get Members to vote for it, but I am not falling for it. That is no way to govern. The Senate is actually poised to vote on our bipartisan agreement that is fully offset. It does so without cutting from the health care system, and that is the bill we should be considering here today.

Seniors do not want us to kick the can again for another year. The doctor community spoke loudly and clearly yesterday—no more patches. So I say to my colleagues: let's not go down this road again. Instead, let's come together and pass a permanent solution. Let's get the job done. Vote ''no'' on this bill.

I reserve the balance of my time.

Mr. PITTS. Mr. Speaker, at this time, I am pleased to yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), an important member of the Health Subcommittee.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Speaker, the SGR cuts would reduce doctors' compensation for treating Medicare patients by 24 percent. Seniors and physicians cannot afford that, and Congress cannot let it happen in 5 days.

The legislation before us would patch the SGR for a year. I support this legislation—of course, reluctantly. Two weeks ago, the House passed a permanent repeal and replacement of the SGR that was fully paid for. The fix provided certainty for doctors who treat Medicare patients—that is what they need—and it incentivized and rewarded doctors to keep seniors healthy.

The Senate needs to negotiate, Mr. Speaker. If they don't like the House pay-for, come up with one. Let's come together and get this done. A patch isn't the best solution. We can replace the SGR, but the Senate has to work with us. Again, let's get this done. Let's work together, and let's get it done for our seniors.

Mr. PALLONE. Mr. Speaker, I now yield 3 minutes to the gentleman from Washington (Mr. MCDERMOTT).

Mr. MCDERMOTT. Mr. Speaker, apparently, Winston Churchill once said:

> Americans will always do the right thing but only after they have tried everything else.

Then again, Churchill never tried to get the doc fix passed in the United States Congress.

For 10 years, we have been trying to fix the sustainable growth rate in Medicare, and for 10 years, we have kicked the can down the road with 17 different short-term patch votes. The Protecting Access to Medicare Act of 2014 is a mixed bag of some important compromises, like ensuring that there is an accurate valuation of services of the Physician Fee Schedule; some problematic provisions, such as the end-stage renal disease policy; and some provisions that have never been vetted in front of the Congress, in front of committees—at all. More importantly, this bill represents our 18th failure to rebuild the bedrock of the Medicare program, our 18th failure to provide America's seniors with the safety and security of a permanent fix to the SGR.

That is why the AMA is voting ''no'' on this bill. That is why most physicians' groups are strongly opposed to this bill. Last night, my office was flooded with messages from various physician groups.

I, for one, still believe in finding the will to do what is right. I, for one, am dedicated to the principle of seizing the moment and accomplishing big things on behalf of the American people. We thought we were going to do it this time.

When it comes to this mixed-bag piece of legislation, cooked up in the dead of night, put on the Web at 2 minutes before midnight a couple of days ago, revised several times since—not much more than 48 hours ago this stuff started—I vote ''no.'' Enough with trying everything else. It is time to do what is right—a permanent doc fix that is argued, debated, agreed upon. It is what our seniors need. It is what our doctors need to help them manage their practices. It is what our Nation needs and deserves.

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

We have groups who have expressed support for this bill: the American Clinical Laboratory Association; the American College of Radiology; Easter Seals; the Family Research Council; the Juvenile Diabetes Research Foundation; the Medical Imaging and Technology Alliance, MITA; the National Abstinence Education Association; the Pennsylvania Partnerships for Children; the Pew Charitable Trusts; the ZERO to THREE: National Center on Infants, Toddlers, and Families; AdvaMed, among others.

I would urge Members to seriously consider this.

Mr. Speaker, at this time, I am pleased to yield such time as he may consume to the gentleman from Michigan (Mr. UPTON), the chairman of the Energy and Commerce Committee.

Mr. UPTON. I thank the distinguished chair of the Health Subcommittee.

Mr. Speaker, here we are at the very end of when the doc fix expires, March 31. That is next week. We have tried in a very responsible way for many months to try and resolve this issue, and I commend my friend Mr. WAXMAN and others for passing our bill out of committee last summer at 51–0. I think it was Speaker BOEHNER who said he

didn't think we could honor Mother Teresa for sainthood with a vote like that.

I commend my good friend Mr. CAMP from Michigan and SANDY LEVIN, the gentleman from Michigan, who is on the floor now, as we worked together and worked with the Senate as well to actually lock in place a bill on literally the last day that Chairman BAUCUS was in the United States Senate in order to try and resolve this, and we knew all along that we were going to have to have a pay-for. Here in the House a couple weeks ago, we passed a bill, somewhat on partisan lines, I know—it was not 100 percent on either side—but we passed a 10-year fix with a pay-for.

Now, I had a great ninth grade civics teacher, Mr. Denekas, who is no longer with us. He is with the Lord. I will tell you, as I sit down with my students as I did this week—a lot of them are here in town, my Close Up groups and others—and as I speak to my high schools and colleges, they know there is never such a thing, maybe, as a perfect bill. One of the first lessons in civics is that you pass a bill in the House, and you pass a bill in the Senate, and they are always different. You go to conference, and you work out the differences, and it comes back.

Nobody wants this expiration of the doc fix—nobody. It hurts our physician community. They care about the folks that they treat. Literally, they are going to have almost a 30 percent reduction cut as early as next week in the services that they provide. Let's think about our most vulnerable, too—our seniors. They have got those doctor appointments, and they want to be there. Maybe, with a 30 percent cut, those physicians will say: Gosh, we just can't do this. That appointment is canceled. We are going to just stop serving Medicare patients—period—those over 65.

We don't want that. We don't want that hurting our most vulnerable. So we passed here in the House a couple of weeks ago a 10-year bill. The response from the Senate is—nothing. Yes, we have had some discussions. We have talked with Senator WYDEN, a former member of our committee. He is diligently trying to get something done, but they have got no bill ready for passage on the Senate floor that matches what we did to go to conference. They have got nothing. There is a lot of talk about maybe just doing a bill without a pay-for or some phony savings. That is not what this House is about. It is a lot of money, and we have some rules in the House that you have got to have a pay-for for it, and that is the real difficulty in trying to get things done.

So here we are at the end of the week. The cuts come in next Tuesday, April 1, so we are trying to send another offer to the Senate. If you are not going to take the 10-year fix, let's try a 1-year fix. It is paid for. It is about $20 billion, and there are a number of little provisions that are in there that, I think, are important, again, in working with all sides. Last night, we were somewhat surprised that a number of groups came out against it, but the alternative is that the door gets shut. We don't have a backup plan, all right?

This is the bill. If we can get 290 votes—everybody is here—a two-thirds vote, that is great. We will send yet another offer to the Senate, and they can choose either one. They can take our 10-year bill. They can take a 1-year bill. They can pass something different, and we can go to conference. I must say that this bill is now a 1-year bill, but it doesn't stop us from still trying to negotiate something for a permanent fix, because that is what every one of us wants. It doesn't stop us from getting that done, but at least it stops what otherwise will be the denial of services to the most vulnerable, our seniors, who may not understand what is happening. It continues the process moving forward.

We have got a couple of options that we are teeing up, but, obviously, we have to pass it today, here, with a two-thirds vote. Then let the Senate decide which alternative or it can pass something else, but pass something so that we can go to conference; but if that happens, then the doc fix is not fixed, and for however long that period is the cuts go into place. It would be nice if we could actually pass this by voice. What do you think? It will get us off the dime, and, again, we will toss it to the Senate to try and get it done. No one wants it to expire, but without one of these two bills, it expires, and we don't want that to happen.

I would urge my colleagues on both sides of the aisle—my friend Mr. PALLONE, my friend Mr. WAXMAN, and others—because, yes, we need to get this done. It is the best that we can do right now, and there is not a plan B for next week.

Mr. Speaker, the specter of physician cuts under Medicare, or SGR, has been an unwelcome threat to seniors' access to quality health care well for over a decade. I rise in support of Chairman PITTS' H.R. 4302, the Protecting Access to Medicare Act, so we can ensure that seniors' access to quality health care is not jeopardized as we continue the effort to permanently resolving this broken system.

While we're not yet over the finish line, we are closer than ever before. Republicans and Democrats of the House and Senate have agreed to the policy of a permanent solution, and this chamber has already passed a bipartisan, fully paid-for bill that would make it a reality.

We understand that our colleagues in the Senate may have a different vision for next steps, and we'd be happy to meet with them to find a package of true offsets that we can all get behind. But, while we wait for the Senate to join us, it is important for us to keep the promises we have made to seniors who depend on the Medicare program.

By coming together with this patch, we will ensure that care will be there when Medicare beneficiaries need it. This package prevents the scheduled 24 percent cut in payment rates, updates the rate through the end of the year, and maintains many of the so-called extenders programs for another year, including the Special Diabetes Program and abstinence program. Finally, it includes important mental health provisions like the Assistant Outpatient Treatment program from Chairman MURPHY'S H.R. 3717, the Helping Families in Mental Health Crisis Act of 2013. All of this is achieved in a fiscally responsible manner, saving $1.2 billion while we continue to strive for our permanent solution.

Our work is far from done, but today we restore some certainty to our seniors that their trusted doctor will be available when they are in need of care.

I ask my colleagues to support this bill.

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Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. Thank you, Mr. PALLONE.

Mr. Speaker, I cannot express my disappointment with the proposed additional temporary patch to the sustainable growth rate, or the SGR—the ''doc fix.''

This was a contrived solution from the very beginning, and it has morphed into a shameful annual ritual, disrupting the provision of medical services in this country, as the parade of medical professionals come to Washington, D.C., to plead with us to not do something crazy.

It is simply, today, an accounting sleight of hand. It is a power play and a fundraising tool, to be sure, that disrupts the practice of medicine.

We have absolutely no intention of ever having the SGR cut occur, but we are not going to allow a reduction on that order of magnitude. We will find some sort of adjustment, as we always have, that will not be satisfactory and will continue the uncertainty and the indignity that is inflicted on people in the health care space and, more important, on the people that they serve.

If you want to actually cut health care spending, we could do so. And if we would stop this charade of meaningless gestures of repealing the Affordable Care Act and actually get down to cases, fine-tuning, and moving forward, we could be there.

There are a range of potential savings within the health care space that is acknowledged by virtually everybody in the industry and every expert that has looked at it. But it can't be done in a cavalier fashion according to some ritualistic formula, and it can't be done overnight, and it is going to require a steady hand, including politicians acting like grownups.

In the meantime, I think it is important to stop this travesty.

Remember, when we had a similar pointless exercise with the alternative minimum tax, realizing that the supposed savings were not real, that the full bite would never take effect, what did we do? We didn't ''pay for it,'' we finally reset the budget baseline and moved on.

That is exactly what we should do with the SGR, and then deal meaningfully with the adjustments in accelerating health care reform, not a 54th time to repeal the Affordable Care Act.

We should be rewarding people who are providing high-value care and finding ways to be more efficient, and adjusting the system to slowly squeeze out our areas of inefficiency. It won't be easy, but it is definitely within our capacity—and it is already starting around the country.

Maybe Congress should consider debating this issue with an open rule, allowing everybody to come to the floor to speak, to offer amendments, to debate it fully, and see what we can come up with. It won't be any worse.

Let's end this charade, give the health care space some certainty, and get down to work being a full partner in the reform and enhancement of our health care system.

Mr. PITTS. Mr. Speaker, may I inquire of the time remaining?

The SPEAKER pro tempore (Mr. DUNCAN of Tennessee). The gentleman from Pennsylvania has 10½ minutes remaining. The gentleman from New Jersey has 12½ minutes remaining.

Mr. PITTS. Mr. Speaker, can I inquire of the minority how many speakers they have left?

Mr. PALLONE. I have at least two left.

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

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. WAXMAN), the ranking member of the Energy and Commerce Committee.

Mr. WAXMAN. I thank the gentleman for yielding to me.

Mr. Speaker, today, Congress will vote on yet another patch to the Medicare physician payment system. But it should not be that way. We need a permanent fix.

Earlier this year, we seemed on track for a permanent fix. We reached a bipartisan agreement on what a permanent fix should look like. That bill was introduced by both Republican and Democratic leaders: Mr. CAMP, Mr. UPTON, Dr. BURGESS, Mr. LEVIN, myself, Mr. PALLONE, Senator BAUCUS, and Senator HATCH. That bipartisan bill is broadly supported by physician and patient groups.

That bill would not cut providers or beneficiaries to fix payments to physicians, and that bill would fix this problem permanently. The bill before us today is not a permanent fix. It is a short-term fix.

Two weeks ago, Republicans brought up a bipartisan bill with a poison pill offset for the permanent fix that undermines reform for low-income families. That was 2 weeks wasted, where we could have worked towards a permanent solution.

I have heard my Republican colleagues say it is too hard to find offsets or we don't have enough time to come up with the offsets to get a permanent bill done. Let's not forget, Republicans do not insist on offsets for things they really care about. Trillions in tax cuts for the wealthy? No need to offset that. A Medicare prescription drug bill that costs far more than this permanent fix to the SGR? No need to offset that. But when we talk about protecting seniors' access to their doctors, their answer is different.

Mr. Speaker, I would urge that, in the end, this is a vote Members will need to make up their own minds on. We may end up being forced to support a short-term patch, but I am not ready to concede that yet.

I am not ready to support this bill that is before us. Let's keep working on getting a permanent solution.

Mr. PITTS. Mr. Speaker, I continue to reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. LEVIN), the ranking member of the Ways and Means Committee.

(Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Speaker, let me describe briefly the challenge before us.

This bill is very disappointing. The three committees have worked on a bipartisan basis to put together a bill that would address once and for all SGR and would reform the payment system. Indeed, it would transform this bill that we worked on on a bipartisan basis—the physician payment system—into one that is more acceptable for high quality care, rewards value, and provides needed stability for providers and beneficiaries.

The bill has a much larger cost than this patch, though patches themselves are expensive.

In response to the chairman of the Energy and Commerce Committee, I want to make a few comments.

There has been no serious discussion all of these weeks about how we would pay for the permanent fix. There has been a dereliction of responsibility.

Also, what has happened here is this patch is a product that hasn't gone through the legislative process. Instead, it is a complex $20 billion bill with no public hearing, no committee hearings, and no regular order.

The draft of the bill became publicly available at midnight Tuesday, and there were flaws, so it was refiled, and we got this bill just 24 hours ago.

This present legislation contains a completely new, unvetted lab payment system. It undermines delivery system reforms for dialysis patients. It includes promising policy to hold nursing homes accountable for patient care but fails to include key protections to minimize discrimination against certain patients.

In a few words, we deserve better, and we need to do better.

As a result, a large number of physician groups have expressed their opposition to this.

What this bill does today is miss the opportunity to do full-scale repeal and replace the physician payment system.

The Senate still needs to vote on a permanent fix. The chairman of the Energy and Commerce Committee said, We passed that kind of bill. Yes, the 10-year fix was a partisan bill that had no chance of passage in the Senate. It has zero chance of passage. The Senate still plans, as I understand, to vote on a permanent fix. We should let the Senate process unfold. We have more time to get this right.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. PALLONE. I yield the gentleman an additional 1 minute.

Mr. LEVIN. It is not correct that, if we don't act today, there will be any impact on seniors. We could let the Senate act to try to do something permanently and come back next week, if we have to, and take up this bill.

So this is the challenge before us. We are here once again doing something that is very temporary, that is very, very expensive, and we are failing to step up to the plate on permanent reform and a permanent fix, and doing it with a legislative process with a product that has not gone through committee, has had no public hearings, has had no real airing. We should not be acting blindly.

Mr. PITTS. Mr. Speaker, I continue to reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. PELOSI), the Democratic leader.

Ms. PELOSI. Mr. Speaker, I thank the gentleman for yielding. I also thank him for his leadership on issues that relate to the health and well-being of the American people. I also commend the leadership of the previous speaker, Mr WAXMAN, and our ranking member on the Ways and Means committee, Mr. LEVIN. They have been two champions on the subject of health care in America—and doing so in a fiscally sound way.

While I appreciate and share the concerns here—and I will speak to that—I do think that we have to think carefully about the decision that we make. I know that they have.

The leadership is bringing this bill to the floor on a short fuse, with an expiration date of March 31, without most people in this room having ever seen what is in the bill, which is a missed opportunity.

We should be considering right now a bill that would permanently speak to the SGR. For those in the public, I know it is inside baseball talk, SGR. That is the rate that docs are compensated for treating Medicare patients.

So don't think of SGR—think of the patients. That is what we are doing here. Think of the certainty that they need in terms of their health care, and that is our seniors. Think of the certainty that a permanent fix, paid for or not—but let's say paid for—would mean to remove the uncertainty from this debate.

The American Medical Association is opposed to this bill that is on the floor today because it is a patch.

How many times have you heard people talk about a Band-Aid? We are just putting a Band-Aid on it. We are not getting to the underlying challenge that we face. This is a Band-Aid, and that is why the docs oppose this patch.

I did hear the distinguished gentleman from Florida (Mr. BILIRAKIS) say, If you don't like these pay-fors, suggest your own. Well, we have suggested our own. It is called OCO. It is the Overseas Contingency Operations. The Republicans said that is a gimmick, but it wasn't a gimmick when you put it in the Ryan budget. It is in the Ryan budget. So it works for you where it works for you, but you don't want to put it to work for America's seniors.

□ 1015

So here is the thing. The Senate majority and the House majority came together to produce this patch—this Band-Aid. It is the wrong way to go. It does not address the underlying problem.

We could have done that. We have been trying to do it for 10 years, and it is always, always, always something that the Republican majority has backed away from and limited and done on a short fuse.

There are so many things that are wrong with this bill, but the simple fact is that the clock is ticking, and on March 31, it is bad news for seniors and for the doctors who treat them and the Medicare program.

Our seniors depend on Medicare. They depend on Medicare, and this is a weakening of it. It is just the same old-same old let's see what we can do to find some pay-fors that really undermine the health and well-being of the American people.

Those same pay-fors, done properly, could be part of a permanent fix, but instead, they are part of the Band-Aid. So this is all to say to my colleagues: you are going to have to make your decision as you weigh the equities.

Is it better to just succumb to what we have, no matter how mediocre and how missed an opportunity it is? Or is it better to say: Let's hold out until our Republican colleagues agree to the full SGR, essentially, a fix forever, paid for by OCO?

It is really important to note the following: the shorter the fix, the more expensive it is. We have been seeing that year in and year out. If we had dealt with this, say, 6, 7 years ago, it would have cost much less than it is to patch 1 year to the next, sometimes less than a year to the next.

This is not about reducing the deficit. It is not about the good health of the American people. It is just an ideological reality that we have to deal with from the Republican side of the aisle.

So when the docs—the AMA—says, We are opposed to this, vote it down, that is important to us. I say to them, Talk to your Republican friends, they have the power to do a permanent fix paid for by OCO; they refuse to do it.

So we have something less good that we can do for the American people, and if this sounds a little confusing, it is because it is; and Members have to make the decision as to whether they will vote for this, just because we are forced into it, or whether they want to hold out for something much better.

This would be a more appropriate debate a month ago, where the clock does not run out over the weekend, but this is a tactic. It is a technique used by the majority to force the hand without the proper weighing of equities in all of it.

So, my colleagues, I just urge you to try to weigh those equities. I, myself, come down on the side of supporting the legislation because, frankly, I believe that any uncertainty in the minds of our seniors about their ability to see their doctors will certainly be—the Republicans will say this is because of the Affordable Care Act, and I just don't want to give them another opportunity to misrepresent what this is about.

If the Affordable Care Act never existed, we would still be here debating SGR. They are two separate subjects; but as we know, any excuse will do to undermine the great legislation that the Affordable Care Act was about, life, a healthier life, the liberty of people to pursue their happiness because they had the freedom to do so—better quality, lower cost, more accessibility.

So that is how I come to the conclusion of let's not give them another false claim. Let's just get this done, but let us not give up on the prospect, even before this expires, of having a long-term, permanent fix to SGR.

It makes all the sense in the world. It has no partisanship about it. It is sensible, and it will cost less to do more for our seniors. The challenge is there. The solution is clear. The Republicans have rejected it, so we are at their mercy.

My conclusion is to vote ''yes.'' Members will have to come to their own conclusions on it. I, frankly, wish that the Republicans, in their power, would have brought the bill to the floor under a rule, so we could have a proper debate on it, instead of requiring a 290-vote requirement to pass it.

With the shortness of receiving this information, only this morning, Members are finding out what it is. It is really hard to predict who will vote pro, who will vote con, who will vote ''aye,'' who will vote ''no.'' This is really a silly decision to bring this to the floor in this form when we know the path that is much better.

I am not going to give you another reason to go out there and make your claims about the Affordable Care Act, which have no basis in fact.

With that, I urge my colleagues to pray over it, as I will.

The SPEAKER pro tempore. The gentleman from Pennsylvania has 10½ minutes remaining. The gentleman from New Jersey has 5 minutes remaining.

Mr. PITTS. Mr. Speaker, may I inquire of the minority how many speakers they have left?

We are prepared to close.

Mr. PALLONE. At this time, I have one more speaker.

Mr. PITTS. Mr. Speaker, I continue to reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Connecticut (Mr. COURTNEY), a member of the Armed Services Committee.

Mr. COURTNEY. Mr. Speaker, I just wanted to follow up on a point that Leader PELOSI just made regarding the OCO account, the Overseas Contingency Operations account, which, at Armed Services, we are dealing with actually right now.

The President came over with his OCO request for this year of $80 billion. This funds the troops over in Afghanistan, the 34,000 that are still fighting courageously to defend our country.

At the end of this year, the projection is that that troop level will be brought down to, at the highest level of 10,000, possibly even lower, and combat missions, for all intents and purposes, are going to come to an end.

As the Congressional Budget Office has demonstrated over and over again, they will score savings with the OCO drawdown that is going to happen at the end of this year. Indeed, the Ryan budget has used those OCO savings to help balance its own priorities, so this is not funny money. This is not hypothetical.

Anyone who has been on a CODEL over to Afghanistan knows we are spending money over there, and starting next year, we are going to spend a lot less money because of the change in our deployments over in Afghanistan.

The cost of the permanent fix to SGR is $135 billion over the next 10 years. You only need a portion of the OCO account to permanently fix SGR, and everybody who has even come close to discussing this issue knows that in this building.

Hopefully, the Senate, when they take this up next week, are going to move forward with a permanent fix using totally valid, verified savings by the Congressional Budget Office in the OCO account.

It is a peace dividend, in terms of drawing down from Afghanistan, that we can finally stabilize the Medicare system by making sure that fees are not going to be subjected to this annual cliff that, again, denies access in far too many cases in doctors' offices all across the country.

So, again, I just want to emphasize the point that it is not like we are powerless here to come up with an SGR fix for which there is bipartisan support, using verifiable, valid savings by the Congressional Budget Office in the OCO account.

Our brave soldiers are going to be drawing down closer to the end of this year to zero. We can use those savings to fix America's health care system.

Mr. PITTS. Mr. Speaker, I am prepared to close. I will continue to reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, do I still have 3 minutes?

The SPEAKER pro tempore. Yes. The gentleman from New Jersey has 3 minutes remaining.

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

First of all, Mr. Speaker, I would like to point out and I would like to enter into the RECORD a letter from the American Medical Association and many, many other physicians' groups, as well as State medical societies, in opposition to the legislation.

Let me just read the first paragraph. It is addressed to the Speaker and to the Democratic leader. It says:

On behalf of the undersigned physician organizations, we are writing to express our strong opposition to H.R. 4302, and we urge you to vote against the bill when it is considered on the floor.

Again, that is from the AMA, many specialty doctor groups, and a number of State medical societies.

I would also point out that it is my strong belief—and I know that my chairman of the subcommittee disagrees on this, but it is my strong belief that if this bill passes, that we will not have an opportunity to bring up the larger permanent fix. We will not negotiate that. I doubt very much that that would be the case.

MARCH 26, 2014.

Hon. JOHN A. BOEHNER,
Speaker, House of Representatives, Washington, DC.

Hon. NANCY PELOSI,
Minority Leader, House of Representatives, Washington, DC.

DEAR SPEAKER BOEHNER AND REPRESENTATIVE PELOSI: On behalf of the undersigned physician organizations, we are writing to express our strong opposition to H.R. 4302, the ''Protecting Access to Medicare Act of 2014,'' and we urge you to vote against the bill when it is considered on the floor.

Instead of reforming the Medicare physician payment system, Congress seems intent on imposing yet another round of arbitrary provider payment reductions to maintain a corrosive policy that essentially every Member of Congress says should be scrapped. Importantly, by selectively choosing cost savings proposals that were included in the bipartisan, bicameral policy framework set forth in H.R. 4015 and S. 2000, the bill being considered would undermine future passage of that framework and add to the instability that now impedes the development and adoption of health care delivery and payment innovations that can strengthen the Medicare program.

It appears that an unprecedented, bipartisan agreement on Medicare reform is on the verge of being cast aside because elected leaders are unwilling to make tough choices to strengthen programs serving 50 million Americans. We strongly urge Members to vote against this legislation and renew our call for all parties to engage in good faith, bipartisan efforts to enact the physician payment and delivery system reform policy contained in H.R. 4015/S. 2000, the SGR Repeal and Medicare Provider Payment Modernization Act. The endless cycle of short-term remedies that serve to support a failed policy are no longer acceptable.

Sincerely,

American Medical Association; American Academy of Allergy, Asthma & Immunology; American Academy of Dermatology Association; American Academy of Neurology; American Academy of Ophthalmology; American Academy of Otolaryngology—Head and Neck Surgery; American Academy of Physical Medicine & Rehabilitation; American Academy of Sleep Medicine; American Association for Geriatric Psychiatry; American Association of Hip and Knee Surgeons; American Association of Orthopaedic Surgeons; American College of Emergency Physicians; American College of Gastroenterology; American College of Mohs Surgery; American College of Occupational and Environmental Medicine; American College of Osteopathic Family Physicians; American College of Osteopathic Internists; American College of Osteopathic Surgeons; American College of Phlebology; American College of Physicians.

American College of Surgeons; American Congress of Obstetricians and Gynecologists; American Gastroenterological Association; American Geriatrics Society; American Orthopaedic Foot and Ankle Society; American Osteopathic Association; American Pediatric Surgical Association; American Society for Dermatologic Surgery Association; American Society for Gastrointestinal Endoscopy; American Society for Reproductive Medicine; American Society of Cataract and Refractive Surgery; American Society of Disability Evaluating Physicians; American Society of General Surgeons; American Society of Hematology; American Society of Nephrology; American Urogynecologic Society; American Urological Association; College of American Pathologists; Infectious Diseases Society of America; Medical Group Management Association.

National Association of Medical Examiners; North American Spine Society; National Association of Spine Specialists; Renal Physicians Association; Society of Cardiovascular Angiography and Interventions; Society of Critical Care Medicine; Society of Gynecologic Oncology; Society of Hospital Medicine; Society of Thoracic Surgeons; Alaska State Medical Association; Arkansas Medical Society; Connecticut State Medical Society; Medical Society of the District of Columbia; Medical Association of Georgia; Hawaii Medical Association; Idaho Medical Association; Illinois State Medical Society; Indiana State Medical Association; Iowa Medical Society; Kentucky Medical Association; Maine Medical Association.

Massachusetts Medical Society; Michigan State Medical Society; Minnesota Medical Association; Mississippi State Medical Association; Missouri State Medical Association; Montana Medical Association; Nebraska Medical Association; Nevada State Medical Association; Medical Society of the State of New York; North Dakota Medical Association; Ohio State Medical Association; Oregon Medical Association; Pennsylvania Medical Society; Rhode Island Medical Society; South Dakota State Medical Association; Utah Medical Association; Vermont Medical Society; Medical Society of Virginia; Washington State Medical Association; Wisconsin Medical Society; Wyoming Medical Society.

Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. HOYER), our Democratic whip.

Mr. HOYER. I thank the gentleman for yielding.

Mr. Speaker, perhaps we ought to have a criteria of everybody who has read this bill can vote on it. My bet is there would be very few Members who would be able to vote on this bill.

This is an 8-page summary of this bill with probably 50 paragraphs in it about changes that have been effected in the Medicare system. None of us know what the substance of this bill is.

We had a lot of rhetoric in 2010 about reading the bills. I challenge any Member to come up here and say: I have read this bill.

I am for a permanent fix in the sustainable growth rate for doctors. I have pledged that for the last 4 or 5 years. We have a bipartisan agreement to effect that exact end; but, as so often is the case, we do not have the courage to rationally fund that agreement. That is why America is in trouble fiscally. This is a game unworthy of this institution and of the American people.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. PALLONE. Mr. Speaker, I yield the balance of my time to the Democratic whip.

Mr. HOYER. It is unfortunate that we have been put in this position with less than 48 hours' notice of what is in this bill to do something that all of us know needs to be done.

The doctors of America, at least the organized doctors of America, have said vote ''no'' on this bill because they know, we know, The Wall Street Journal knows, we have to fix this permanently, not patch it every year. It is a fraud. Both sides have committed that fraud, and we ought to stop it.

We ought to fix this. Americans ought to expect us to fix it. The doctors expect us to fix it. Seniors expect us to fix it. What a lamentable fact that we cannot summon the courage and the judgment and the wisdom to do just that.

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

I want to read out the title of a blast that I just received from The Heritage Foundation. Some of our Members might be interested in this. ''A temporary SGR patch is better than permanent deficits in support of the bill.''

My colleagues, this morning, seniors are watching. This is not a game. We are thinking of seniors and certainty for them. A vote ''no'' today is a vote against seniors. We are not voting for the AMA today. We are voting for or against seniors today.

We will continue to work with all of our might for a permanent repeal of SGR. We have worked on this for 3 years. We must get there as soon as possible, but we are at a deadline, and this is the last vote we will have.

If you vote ''no'' on this bill, you are voting for more uncertainty. You are voting for a cut to doctor reimbursement. You are voting against seniors.

Let us vote for seniors this morning. Vote for H.R. 4302.

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

Mr. DINGELL. Mr. Speaker, I rise in opposition to H.R. 4302, the Protecting Access to Medicare Act of 2014. It is embarrassing that a year of hard work on a permanent replacement for the Sustainable Growth Rate is being thrown in the trash can for yet another politically motivated short-term fix. The American people sent us here to solve our nation's problems, not kick the can down the road yet again. Now is the time for a permanent solution to this annual problem, and the legislation before us today does nothing to give our seniors and our doctors any certainty moving forward.

Everyone in this body agrees that we need to start rewarding our doctors for the quality of their work rather than the quantity of their work. After months of hearings in the House Committee on Energy and Commerce, and in conjunction with our colleagues on the House Committee on Ways and Means and the Senate Committee on Finance, we put our heads together and came up with a common-sense proposal to pay our doctors under Medicare for the next decade. Everyone agrees that this policy makes sense and should be adopted. We have work to do to find pay-fors for the legislation, but that is not an insurmountable task. Congress should be moving full steam ahead to find offsets for the policy we all agree on, rather than doing yet another short-term patch that will make a permanent fix more expensive and ultimately harder to attain.

Our constituents are tired of gimmickry and want real results. We should not have to deal with this issue on an annual basis. I urge my colleagues to join me in voting against H.R. 4302 and instead come together to find the necessary offsets to make a permanent fix to the Sustainable Growth Rate a reality.

Mr. HARRIS. Mr. Speaker, I oppose this bill because we need to provide a permanent solution rather than just a band-aid approach to maintaining seniors' access to quality health care.

Ms. JACKSON LEE. Mr. Speaker, I rise to speak in opposition to H.R. 4302, the so-called ''Protecting Access to Medicare Act,'' which extends current Medicare physician reimbursement rates for one year.

I strongly support providing adequate compensation to our physicians who serve Medicare patients. Medicare patients in every state make up 10% or more of those who have health insurance.

I oppose H.R. 4302 because it does not provide a long-term fix for Medicare payments to physicians, and the misvalued services under the physician payment system has not been addressed.

The core purpose of the bill is found in its name, the ''Sustainable Growth Rate,'' but that purpose is not being met because the reimbursement rate to physicians is not sustainable for a robust medical care safety net for our nation's seniors.

CMS has made changes to the Medicare Physician Fee Schedule and other Medicare payment policies to improve efficiency and accuracy in Medicare payment and the quality of care for our beneficiaries.

CMS has improved payment for primary care services, while enhancing efforts to address payment for misvalued services under the physician payment system.

CMS has begun to implement important delivery system reforms included in the Affordable Care Act, which includes the value-based payment modifier that provides incentives for physicians and physician groups to furnish high-quality, efficient care.

Congress needs to do its part in implementing a reimbursement rate that reflects the reality of providing the care our nation's seniors need and expect.

Medicare patients and the medical payments made to their physicians and medical service providers' is critical to our nation's health care economy.

It is important for our seniors to know that Medicare will be there when they need it. But it is equally important that there are physicians who are willing to attend to them without going broke.

That is why we have a Sustainable Growth Rate or ''SGR.'' Medicare reimbursement enables rural physicians and hospitals to remain open for business.

This bill should not impose another round of arbitrary provider payment reductions to maintain a dysfunctional policy that many member of this House knows should be ended.

This bill undermines the future passage of the framework that was part of the original bipartisan SGR bill that the House had the chance to vote on earlier this month.

We should return to that bill and pass it without any gimmicks so that the modernization of the Medicare health care delivery and payment innovations that can strengthen the program can be implemented.

Mr. Speaker, I have always strongly supported providing adequate compensation to our physicians who serve Medicare patients because it is important for our seniors to know that Medicare will be there when they need it.

Thus, it is critical that we not disrupt timely and adequate payment to Medicare providers.

The bill before us will provide payment certainty for one year, but only for one year. This is not acceptable—if we do not press the issue of reform now—when will it be addressed?

This is better than nothing but what must really be done to provide our seniors and physicians the certainty and security they deserve is to reach an agreement on a permanent replacement for the SGR that is fair, responsible, and fiscally sustainable.

Instead of wasting time trying to repeal, impede, or undermine the Affordable Care Act, or making it more difficult for physicians who care for the elderly we should be working together to reach an agreement on a permanent replacement for the SGR and the $138 billion in offsets needed to pay for that legislation.

That is what the American people sent us here to do.

□ 1030

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Pennsylvania (Mr. PITTS) that the House suspend the rules and pass the bill, H.R. 4302, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. PITTS. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

The point of no quorum is considered withdrawn.

UKRAINE SUPPORT ACT

Mr. ROYCE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4278) to support the independence, sovereignty, and territorial integrity of Ukraine, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4278

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Ukraine Support Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. UNITED STATES POLICY.

It is the policy of the United States—

(1) to support the right of the people of Ukraine to freely determine their future, including their country's relationship with other nations and international organizations, without interference, intimidation, or coercion by other countries;

(2) to support the people of Ukraine in their desire to address endemic corruption,