Care Act, they have health insurance, but thanks to community health centers, they have health care.

H.R. 2 also extends the CHIP program and keeps over 8 million low-income children and pregnant women in families from losing their health insurance.

Lastly, H.R. 2 finally fixes the SGR, the Medicare Sustainable Growth Rate. The SGR was an ill-conceived plan to control the growth in health care costs by slashing doctor pay. We were in danger of doctors dropping Medicare patients, putting seniors’ access to critical care at risk. The yearly shallow fixes have cost us more over the years than it would have to get rid of it, so I am pleased we are finally doing the right thing today in a way that moves us toward quality health care for Americans.

Mr. Speaker, I’d like to take this opportunity to clarify a provision in H.R. 2 and how it differs from S. 178—the Senate Justice for Victims of Trafficking Act of 2015 (JVTA).

As you know, the Senate is having a debate about a provision to make the Hyde Amendment permanent law and to apply it to non-taxpayer funds. As co-chair of the Pro Choice Caucus, I want to make clear that the Senate bill creates a new Domestic Trafficking Victims’ Fund that would be funded—not by taxpayer dollars—but through fines imposed on defendants convicted of human trafficking, sexual exploitation and human smuggling crimes. The Hyde Amendment only applies to taxpayer dollars and therefore not eligible for Hyde. The pro-choice senators who are fighting against this expansion have my full support.

Mr. BURGESS. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered. The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BURGESS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 402, nays 12, answered “present” 5, not voting 13, as follows:

(Roll No. 143)

YEARS—402

Mr. AMASH changed his vote from “yea” to “nay.” Messrs. BISHOP of Georgia, WALZ, LOEBBACK, MCMENROPY, CAPUANO, O’HOURKE, HANNA, and SEAN PAT RICK MALONEY of New York changed their vote from “nay” to “yea.” So the resolution was agreed to. The result of the vote was announced and ordered recorded. A motion to reconsider was laid on the table.

Stated for:

Mr. CONYERS. Mr. Speaker, I was not present; the resolution 101.

Mr. PITTS. Mr. Speaker, pursuant to House Resolution 173, the amendment printed in House Report 114-50 is considered adopted. The bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

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.

SEC. 1. SHORT TITLE; TABLE OF CONTENTS.

SEC. 1. SHORT TITLE; TABLE OF CONTENTS.

SEC. 1. SHORT TITLE; TABLE OF CONTENTS.

SEC. 1. SHORT TITLE; TABLE OF CONTENTS.
b) Table of Contents.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

Sec. 101. Repealing the sustainable growth rate (SGR) and improving Medicare care for physicians’ services.

Sec. 102. Priorities and funding for measure development.

Sec. 103. Encouraging care management for individuals with chronic care needs.

Sec. 104. Empowering beneficiary choices through continued access to information on physicians’ services.

Sec. 105. Expanding availability of Medicare data.

Sec. 106. Reducing administrative burden and other provisions.

TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS

Subtitle A—Medicare Extenders

Sec. 201. Extension of work GPCI floor.

Sec. 202. Extension of therapy cap exceptions process.

Sec. 203. Extension of ambulance add-ons.

Sec. 204. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.

Sec. 205. Extension of the Medicare-dependent hospital (MDH) program.

Sec. 206. Extension for specialized Medicare Advantage plans for special needs individuals.

Sec. 207. Extension of funding for quality measures endorsement, input, and selection.

Sec. 208. Extension of funding outreach and assistance for low-income programs.

Sec. 209. Extension and transition of reasonable cost reimbursement contracts.


Subtitle B—Other Health Extenders

Sec. 211. Permanent extension of the qualifying individual (QI) program.

Sec. 212. Permanent extension of transitional medical assistance (TMA).

Sec. 213. Extension of special diabetes program for type I diabetes and for Indians.

Sec. 214. Extension of abstinence education.

Sec. 215. Extension of personal responsibility education program (PREP).

Sec. 216. Extension of funding for family-to-family health information centers.

Sec. 217. Extension of health workforce demonstration project for low-income individuals.

Sec. 218. Extension of maternal, infant, and early childhood home visiting programs.

Sec. 219. Tennessee DSH allotment for fiscal years 2015 through 2025.

Sec. 220. Delay in effective date for Medicaid amendments relating to beneficiary liability settlements.

Sec. 221. Extension of funding for community health centers, the National Health Service Corps, and teaching health centers.

TITLE III—CHIP

Sec. 301. 2-year extension of the Children’s Health Insurance Program.

Sec. 302. Extension of express lane eligibility.

Sec. 303. Extension of outreach and enrollment program.

Sec. 304. Extension of certain programs and demonstration projects.

Sec. 305. Report of inspection general of HHS on use of express lane option under Medicaid and CHIP.

TITLE IV—OFFSETS

Subtitle A—Medicare Reimbursement Reforms

Sec. 401. Limitation on certain medigap policies for newly eligible Medicare beneficiaries.

Sec. 402. Income-related premium adjustment for parts B and D.

Subtitle B—Other Offsets

Sec. 411. Medicare payment updates for post-acute providers.

Sec. 412. Delaying adjustment to Medicaid DSH allotments.

Sec. 413. Levy on delinquent providers.

Sec. 414. Adjustments to inpatient hospital payment rates.

Subtitle V—MISCELLANEOUS

Subtitle A—Protecting the Integrity of Medicare

Sec. 501. Prohibition of inclusion of Social Security account numbers on Medicare cards.

Sec. 502. Preventing wrongful Medicare payments for items and services furnished to incarcerated individuals, individuals not lawfully present, and deceased individuals.

Sec. 503. Consideration of measures regarding Medicare beneficiary smart cards.

Sec. 504. Modifying Medicare durable medical equipment face-to-face encounter documentation requirement.

Sec. 505. Reducing improper Medicare payments.

Sec. 506. Improving senior Medicare patrol programs.

Sec. 507. Requiring valid prescriber National Provider Identifiers on pharmacy claims.

Sec. 508. Option to receive Medicare Summary Notice electronically.

Sec. 509. Renewal of MAC contracts.

Sec. 510. Study on pathway for incentives to States for State participation in medicaid data match program.

Sec. 511. Guidance on application of Common Rule to clinical data registries.

Sec. 512. Eliminating certain civil money penalties; gainsharing study.

Sec. 513. Modification of Medicare home health surety bond condition of participation requirement.

Sec. 514. Oversight of Medicare coverage of manual manipulation of the spine to correct subluxation.

Sec. 515. National expansion of prior authorization model for repetitive scheduled non-emergent ambulance transport.

Sec. 516. Repealing duplicative Medicare secondary payer provision.

Sec. 517. Plan for expanding data in annual CERT report.

Sec. 518. Removing funds for Medicare Improvement Fund added by IM- PACT Act of 2014.

Sec. 519. Rule of construction.

Subtitle B—Other Provisions

Sec. 520. Extension of two-midnight PAMA rules on certain medical review activities.

Sec. 521. Requiring bid surety bonds and State licensure for entities submitting claims under the Medicare DMEPOS competitive acquisition program.

Sec. 522. Requiring bid surety bonds and State licensure for entities submitting claims under the Medicare DMEPOS competitive acquisition program.

Sec. 523. Payment for global surgical packages.


Sec. 525. Exclusion from PAYGO scorecards.

TITLE V—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

Sec. 101. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians’ services.

(a) Stabilizing Payment Updates.—(1) REPEAL OF SGR PAYMENT METHODOLOGY.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (d), by inserting “and ending with 2025” after “beginning with 2011”; and

(B) by inserting “or a subsequent paragraph” after “paragraph (4)”; and

(ii) in paragraph (4)—

(I) in the heading, by inserting “AND ENDING WITH 2014” after “YEARS BEGINNING WITH 2011”;

(ii) in subparagraph (A), by inserting “AND ENDING WITH 2014” after “YEARS BEGINNING WITH 2011”;

(ii) in subparagraph (B), by inserting “and ending with 2014” after “a year beginning with 2011”;

(B) in subsection (f), by inserting “through 2026” after “of each succeeding year”;

(i) in paragraph (1)(A), by inserting “and ending with 2014” after “YEARS BEGINNING WITH 2011”;

(ii) in paragraph (1)(B), by inserting “and ending with 2014” after “a year beginning with 2011”;

(iii) in paragraph (1)(C), by inserting “and ending with 2014” after “a year beginning with 2011”;

(iv) in subparagraph (A), by inserting “and ending with 2014” after “beginning with 2005”;

(B) in paragraph (1)(D), by inserting “or a subsequent paragraph” after “paragraph (4)”; and

(C) by striking paragraph (16) and inserting the following new paragraphs:

(16) Update for January through June of 2015.—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 (19) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on June 30, 2015, the update to the single conversion factor shall be 0.0 percent.

(17) Recovery for January through December of 2015.—The update to the single conversion factor established in paragraph (19) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.

(19) Update for January through June of 2016.—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 (19) that would otherwise apply for 2016 for the period beginning on January 1, 2016, and ending on June 30, 2016, the update to the single conversion factor shall be 0.0 percent.

(20) Update for July through December of 2016.—The update to the single conversion factor established in paragraph (19) for the period beginning on July 1, 2016, and ending on December 31, 2016, shall be 0.5 percent.

(21) Update for January through June of 2017.—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 (19) that would otherwise apply for 2017 for the period beginning on January 1, 2017, and ending on June 30, 2017, the update to the single conversion factor shall be 0.5 percent.

(22) Update for July through December of 2017.—The update to the single conversion factor established in paragraph (19) for the period beginning on July 1, 2017, and ending on December 31, 2017, shall be 0.5 percent.
(20) UPDATE FOR 2019 AND SUBSEQUENT YEARS.—For 2026 and each subsequent year, the update to the qualifying APM conversion factor established under paragraph (1)(A) is 0.75 percent, applied to the nonqualifying APM conversion factor established under such paragraph is 0.25 percent.’’.

(3) MEDPAC REPORTS.—(A) INITIAL REPORT.—Not later than July 1, 2017, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship between—

(i) physician and other health professional utilization and expenditures (and the rate of increase of such utilization and expenditures) of items and services for which payment may be made under title XVIII of such Act, and

(ii) total utilization and expenditures (and the rate of increase of such utilization and expenditures) under parts A, B, and D of such title.

Such report shall include a methodology to describe such relationship and the impact of changes in such physician and other health professional practice and service ordering patterns on total utilization and expenditures under parts A, B, and D of such title.

(B) FINAL REPORT.—Not later than July 1, 2021, the Medicare Payment Advisory Commission shall submit to Congress a report on—

(i) the payment update for professional services applied under the Medicare program under title XVIII of the Social Security Act for the period of years 2015 through 2019;

(ii) such update on efficiency, economy, and quality of care provided under such program;

(iii) the effect of such update on ensuring a sufficient number of providers to maintain adequate access to care by Medicare beneficiaries; and

(iv) recommendations for any future payment updates for professional services under such program;

(b) CONSOLIDATION OF CERTAIN CURRENT LAW PROVISIONS WITH NEW MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

(II) SUNSETTING SEPARATE MEANINGFUL USE PAYMENT ADJUSTMENTS.—Section 1848(a)(7)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(7)(A)) is amended—

(i) in clause (i), by striking ‘‘2015 or any subsequent year’’ and inserting ‘‘each of 2015 through 2018’’; and

(ii) in clause (ii), by striking ‘‘and each subsequent year’’ and inserting ‘‘2017, and 2018’’;

(c) TERMINATIONS FOR MIPS.—Section 1848(o)(2) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)) is amended—

(i) in paragraph (1), by striking ‘‘2015 or any subsequent year’’ and inserting ‘‘each of 2015 through 2018’’; and

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

‘‘(D) CONTINUATION OF VALUE-BASED PAYMENT MODIFYING FACTORS FOR MIPS.—Section 1848(p)(1)(B) of the Social Security Act (42 U.S.C. 1395w–4(p)(1)(B)) is amended to read as follows:

(i) IN GENERAL.—The Secretary shall apply the payment modifier established under subsection (a) for the performance period for a year to determine the total payment of each MIPS eligible professional for a year based on—

(A) the performance score of the MIPS eligible professional for a year; and

(B) the MIPS adjustment factor for such year.

(ii) INCREASE.—If the payment modifier established under subsection (a) for any year is an increase for such year, the payment modifier is treated as an automatic update for the succeeding year for such year.

(iii) AMOUNT.—The amount of the increase (or decrease) for any year for which an increase is applied is—

(A) the amount of the increase for the year, plus the amount of the increase for the preceding year; and

(B) the amount of any decrease for the year, plus the amount of any decrease for the preceding year.

(iv) SCHEDULE.—The schedule of increases and decreases is—

(A) for years 2015 through 2019, as follows:

(i) for year 2015, the increase is 0.25 percent; and

(ii) for year 2016, the increase is 0.50 percent; and

(iii) for year 2017, the increase is 0.75 percent; and

(iv) for year 2018, the increase is 1.00 percent.

(B) for years 2020 through 2026, as follows:

(i) for year 2020, the increase is 1.50 percent; and

(ii) for year 2021 through 2026, the amount of the increase (or decrease) for any year for which an increase is applied is the amount of the increase for the year, plus the amount of the increase for the preceding year.

(v) EFFECT.—For purposes of this subsection, any increase (or decrease) that is applied under paragraph (4)(A) is treated as if it were an automatic update for the succeeding year for such year.

(e) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

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

(q) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

(2) ESTABLISHMENT.—(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional Merit-Based Incentive Payment System (hereinafter in this subsection referred to as the ‘‘MIPS’’) under which the Secretary shall—

(i) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for the performance period for such year.

(iii) use such composite performance score of the MIPS eligible professional for a performance period for a year to determine the adjustment factor (as applicable, an additional MIPS adjustment factor) under paragraph (6) to the professional for the year.

Notwithstanding subparagraph (C)(i), under the MIPS, the Secretary shall permit any eligible professional (as defined in subsection (k)(3)(B)) to report on applicable measures and activities described in subsection (D).

(B) PROGRAM IMPLEMENTATION.—The MIPS shall apply to payments for items and services furnished on or after January 1, 2019.

(C) MIPS ELIGIBLE PROFESSIONAL DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iv), the term ‘‘MIPS eligible professional’’ means—

(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(b)(2)), a nurse (as defined in section 1861(b)(2)), or a certified registered nurse anesthetist (as defined in section 1861(b)(2)), and a group that includes such professionals; and

(II) for the third year and each subsequent year for which the MIPS applies to payments (and for the performance period for such third year and for each succeeding year) and for the performance period for each such year, the professionals described in subclause (I), such other eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary and a group that includes such professionals;

(ii) EXCLUSIONS.—For purposes of clause (i), the term ‘‘MIPS eligible professional’’ does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who—

(I) is a qualifying APM participant (as defined in section 1833(z)(2));

(II) subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a participant under the MIPS for such year; and

(III) for the performance period with respect to such year, does not exceed the low-
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use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.

(11) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PROFESSIONAL TYPES OR SUBCATEGORIES.—In carrying out the previous sentence, the Secretary shall consult with professionals of professional types or subcategories, alternative measures that fulfill the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures that fulfill the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—

(1) REQUEST FOR INFORMATION.—In initially applying subparagraph (B)(ii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such subparagraph and specifying criteria for such activities.

(2) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE AND DEVELOPMENT.—In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

(III) identifying activities described in subparagraph (B)(ii); and

(2A) specifying criteria for such activities; and

(III) determining whether a MIPS eligible professional meets such criteria.

(2B) In general.—Subject to the succeeding provisions of this paragraph, the Secretary shall have a focus that is evidenced-based, is peer-reviewed and, where feasible, is requested to identify and submit activities to such professional with respect to a performance period.

(2C) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE AND DEVELOPMENT.—In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

(2A) identifying activities described in subparagraph (B)(ii); and

(2B) specifying criteria for such activities; and

(2C) determining whether a MIPS eligible professional meets such criteria.

(2D) ANNUAL LIST OF QUALITY MEASURES AVAILABLE FOR MIPS ASSESSMENT.—

(1) IN GENERAL.—Under the MIPS, the Secretary, through notice and comment rulemaking and subject to the succeeding clauses of this subparagraph, shall, with respect to the performance period for a year, establish an annual final list of quality measures from which MIPS eligible professionals may choose for purposes of assessment under this subsection for such performance period. Pursuant to the previous sentence, the Secretary shall—

(1A) not later than November 1 of the year prior to the first day of the first performance period under the MIPS, establish and publish in the Federal Register a final list of quality measures for the performance period (and publish such updated final list in the Federal Register), by—

(1B) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are mapped to the current list) or that have undergone substantive changes should be included in the updated list.

(1C) CALL FOR QUALITY MEASURES.—

(1) IN GENERAL.—Eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures (for selection under this subparagraph in the annual final list of quality measures published under clause (i) and to identify and submit updated quality measures under paragraph (2). For purposes of the previous sentence, measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

(2) ELIGIBLE PROFESSIONAL ORGANIZATION DEFINED.—In this subparagraph, the term ‘eligible professional organization’ means a professional organization as defined by nationally recognized specialty boards of certification or equivalent certification boards.

(3) REQUIREMENTS.—In selecting quality measures for inclusion in the annual final list under clause (1), the Secretary shall—

(3A) provide, to the extent practicable, all quality measures developed under subsection (s)(1)(B) are addressed by such measures; and

(3B) ensure that such selection is consistent with the process for selection of measures under subsections (k), (m), and (p)(2).

(4) MEER REVIEW.—Before including a new measure in the final list of measures published under clause (i) for a year, the Secretary shall submit for publication in applicable specialty-appropriate, peer-reviewed journals such measure and the method for developing and selecting such measure, including clinical and other data supporting such measure.

(5) MEASURES FOR INCLUSION.—The final list of quality measures published under clause (i) shall include, as applicable, measures under subsections (k), (m), and (p)(2).

(6) MEASURES DEVELOPED.—

(6A) measures developed under subsection (s); and

(6B) measures submitted under clause (1D).

Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity shall have a focus that is evidence-based.

(7) EXCEPTION FOR QUALIFIED CLINICAL DATA REGISTRY MEASURES.—Measures used by a qualified clinical data registry under subsection (m)(3)(E) shall not be subject to the requirements of paragraphs (4), (5), and (6) of this subparagraph. The Secretary shall publish the list of measures used by such qualified clinical data registries on the Internet website of the Centers for Medicare & Medicaid Services.

(8) EXCEPTION FOR EXISTING QUALITY MEASURES.—Any quality measure specified by the Secretary under subsection (k) or (m), including under subsection (m)(3)(E), and any measure of quality of care established under subsection (p)(2) for the reporting period, that is subject to the respective subsection beginning before the first performance period under the MIPS—

(8A) shall not be subject to the requirement under item (aa) and (cc) of subclause (II) of such clause or to the requirement under clause (iv); and

(8B) shall be included in the final list of quality measures published under clause (i) unless removed under clause (i)(II)(aa).

(9) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph (1) of this paragraph, for a year.

(10) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the selection of measures under this subparagraph.

(11) PERFORMANCE STANDARDS.—

(A) ESTABLISHMENT.—Under the MIPS, the Secretary shall establish performance standards with respect to MIPS eligible professionals of such professional types or subcategories applicable to such professional.

(B) INCENTIVE TO REPORT, ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY AND QUALIFIED CLINICAL DATA REGISTRIES FOR REPORTING QUALITY MEASURES.—Under the methodology established under subparagraph (A), the Secretary shall—

(1) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A), through the use of certified EHR technology and qualified clinical data registries;
"(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treated as a positive modifier as described in subsection (b), the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

"(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE.—

"(i) RULE FOR CERTIFICATION.—A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

"(ii) APM PARTICIPATION.—Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn each such eligible professional a minimum score of one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

"(iii) SUBCATEGORIES.—A MIPS eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) or participate in an alternative payment model in order to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

"(D) ACHIEVEMENT AND IMPROVEMENT.—

"(i) TAKING INTO ACCOUNT IMPROVEMENT.—Beginning with the second year to which the MIPS applies, in addition to the achievement of a MIPS eligible professional, if data sufficient to measure improvement is available, the methodology developed under subparagraph (A)—

"(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), shall take into account the improvement of the professional; and

"(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional involved;

"(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT.—Subject to clause (i), under the methodology developed under subparagraph (A), a MIPS eligible professional may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible professional than with respect to any improvement of such professional applicable under clause (i) with respect to a measure, activity, or category described in paragraph (2).

"(E) WEIGHTS FOR THE PERFORMANCE CATEGORY DESCRIBED IN CLAUSE (I) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to subparagraph (F)(i) and clause (ii), the composite performance score shall be determined as follows:

"(I) QUALITY.—

"(aa) IN GENERAL.—Subject to item (bb), thirty-five percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A).

"(bb) FIRST 2 YEARS.—For the first and second years for which the MIPS applies under item (aa) shall be increased in a manner such that the total percentage points of the increase under this clause, with respect to such performance category described in clause (i) of paragraph (2)(A), equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

"(II) RESOURCE USE.—

"(aa) IN GENERAL.—Subject to item (bb), the composite performance score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

"(bb) FIRST 2 YEARS.—For the first year for which the MIPS applies under this clause, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For the second year, MIPS eligible professionals may apply to支付 such reduction for a year, subject to subclause (I)(IV), but if such reduction for a year results in a MIPS adjustment factor for such year that is less than 30 percent of such score shall be based on performance with respect to the combined performance of such MIPS eligible professional in such virtual group for such performance period, such virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

"(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

"(G) RESOURCE USE.—

"(i) RULE FOR CERTIFICATION.—A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

"(ii) APM PARTICIPATION.—Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn each such eligible professional a minimum score of one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

"(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

"(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

"(I) IN GENERAL.—In the case of MIPS eligible professionals who are in a virtual group under clause (ii) with respect to a performance period, for the second year the Secretary shall establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph, with respect to one or more MIPS eligible professionals in such virtual group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

"(II) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Secretary shall, in accordance with the requirements under clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph, with respect to one or more MIPS eligible professionals in such virtual group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

"(III) PROVIDING FOR FORMAL WRITTEN AGREEMENTS.—The Secretary shall provide for formal written agreements among MIPS eligible professionals electing to be a virtual group under this subparagraph; and

"(IV) INCLUDE SUCH OTHER REQUIREMENTS AS THE SECRETARY DETERMINES APPROPRIATE.

"(6) MIPS PAYMENTS.—

"(A) MIPS ADJUSTMENT FACTOR.—Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined—

"(i) by comparing the composite performance score for the eligible professional for such year to the performance threshold established under subparagraph (D)(i) for such year;

"(ii) in a manner such that the adjustment factors specified under this subparagraph for each MIPS eligible professional for such year result in differential payments under paragraph (E)(1)(B) for each MIPS eligible professional for a year.

"(I) IN GENERAL.—In the case of MIPS eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A) with respect to the performance scores described in clauses (I) and (II) of paragraph (2)(A)—

"(I) the assessment of performance provided under such methodology with respect to such performance category described in clauses (I) and (II) of paragraph (2)(A) that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of such professionals in such group for such period; and

"(II) with respect to the composite performance score under subparagraph (A) with respect to a performance period for each such MIPS eligible professional in such virtual group, the components of the composite performance score that are calculated with respect to such performance categories shall be based on the assessment of the combined performance under subclause (I) for such performance categories and performance period.

"(I) IN GENERAL.—In the case of MIPS eligible professionals who are in a virtual group under clause (ii) with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period.

"(II) PROVIDE THAT AN INDIVIDUAL MIPS ELIGIBLE PROFESSIONAL AND A GROUP PRACTICE DESCRIBED IN CLAUSE (II) MAY ELECT TO BE IN MORE THAN ONE VIRTUAL GROUP FOR A PERFORMANCE PERIOD AND THAT, IN THE CASE OF SUCH ELECTED PROFESSIONALS OR GROUPS, THE SECRETARY MAY AGGREGATE PERFORMANCE FOR EACH MIPS ELIGIBLE PROFESSIONAL OR GROUP PRACTICE FOR SUCH PERIOD, SUCH ELECTED PROFESSIONALS OR GROUPS MAY ELECT TO BE A VIRTUAL GROUP UNDER THIS SUBPARAGRAPH;

"(III) PROVIDE THAT A VIRTUAL GROUP BE A COMBINATION OF TAX IDENTIFICATION NUMBERS;

"(IV) PROVIDE FOR FORMAL WRITTEN AGREEMENTS AMONG MIPS ELIGIBLE PROFESSIONALS ELECTING TO BE A VIRTUAL GROUP UNDER THIS SUBPARAGRAPH; AND

"(V) INCLUDE SUCH OTHER REQUIREMENTS AS THE SECRETARY DETERMINES APPROPRIATE.
with clause (iii), with such professionals hav-
ing higher composite performance scores re-
ceiving higher adjustment factors; and

(‘‘II’’) MIPS eligible professionals with com-
posite performance scores in a year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

(‘‘iii’’) in a manner such that MIPS eligible professionals with composite performance scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive an adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

(‘‘iv’’) in a manner such that:

(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in clause (ii)(II) for such year receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

(‘‘B’’) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term ‘‘applicable percent’’ means—

(i) for 2019, 4 percent;

(ii) for 2020, 5 percent;

(iii) for 2021, 7 percent; and

(iv) for 2022 and subsequent years, 9 percent.

(‘‘C’’) ADDITIONAL MIPS ADJUSTMENT FACTORS FOR EXCEPTIONAL PERFORMANCE.—For 2019 and each subsequent year through 2024, in the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(i) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to subparagraph (F)(v), the Secretary shall specify an additional MIPS adjustment factor determined under subparagraph (A) for the eligible professional for such year.

Such additional MIPS adjustment factors shall be in the form of a percent and determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

(‘‘D’’) ESTABLISHMENT OF PERFORMANCE THRESHOLDS.—

(I) PERFORMANCE THRESHOLD.—For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared. For purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. In establishing such a threshold, the Secretary shall apply either of the following methods for computing such additional performance threshold for such a year:

(1) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold determined under clause (i).

(2) The threshold shall be the score that is equal to the 25th percentile of the actual composite performance scores for MIPS eligible professionals at or above the performance thresholds at or above the performance thresholds described in clause (i).

(III) SPECIAL RULE FOR INITIAL 2 YEARS.—With respect to each of the first two years to which the MIPS applies, the Secretary shall, prior to the performance period for such year, assign an adjustment factor under subparagraph (A) that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

(IV) TAKE INTO ACCOUNT.—(a) data available with respect to performance on measures and activities that may be used under the performance categories specified in subparagraph (B); and

(‘‘bb’’) other factors determined appropriate by the Secretary.

(E) APPLICATION OF MIPS ADJUSTMENT FACTORS.—In the case of items and services furnished by a MIPS eligible professional during a year (beginning with 2019), the amount otherwise paid under this part with respect to such items and services and MIPS eligible professionals for such year shall be multiplied by:

(1) 1, plus

(2) the sum of—

(I) the MIPS adjustment factor determined under subparagraph (A) divided by 100, and

(II) as applicable, the additional MIPS adjustment factor determined under subparagraph (C) divided by 100.

(F) AGGREGATE APPLICATION OF MIPS ADJUSTMENT FACTORS.—

(I) ALTERNATIVE SCALING FACTOR.—

(1) IN GENERAL.—With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to clause (II), the Secretary shall increase or decrease the estimated aggregate adjustment factor under such subparagraph (D)(ii) for such year, the application of clause (i) results in a scaling factor specified in clause (i), such scaling factor shall include factors determined appropriate by the Secretary.

(II) LIMITATION ON ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—For each year, the Secretary shall write MIPS adjustment factors under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subclause (II) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments to MIPS eligible professionals under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.

(II) LIMITATION ON ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—The MIPS additional adjustment factor under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subparagraph (D)(i) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments to MIPS eligible professionals under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024. The aggregate amount of such additional incentive payments to MIPS eligible professionals under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.

(II) LIMITATION ON ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—For each year under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subparagraph (D)(i) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments to MIPS eligible professionals under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024. The aggregate amount of such additional incentive payments to MIPS eligible professionals under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.
"(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category.

"(II) may include the performance of each such MIPS eligible professional with respect to each measure or activity specified in paragraph (2)(A).

"(III) The names of eligible professionals in eligible alternative payment models (as defined in section 1332(z)(3) (D)) and, to the extent practicable, the names of such eligible alternative payment models and performance of such models.

"(B) INFORMATION.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professionals, the entire set of patients, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

"(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

"(D) INFORMATION.—The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores, the performance of all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

"(10) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures and performance standards under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (6) and regarding the use of qualified clinical data registries. Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

"(11) TECHNICAL ASSISTANCE TO SMALL PRACTICES AND PRACTICES IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

"(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate entities, such as quality improvement organizations, regional extension centers (as described in section 3302(c) of the Public Health Service Act), or regional health collaboratives to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to practices located in rural areas, health professional shortage areas (as designated under section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to:

"(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

"(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1832(x)(3)(C).

"(B) FUNDING FOR TECHNICAL ASSISTANCE.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of $30,000,000 for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

"(12) MANAGE INFORMATION TO IMPROVE PERFORMANCE.—

"(A) PERFORMANCE FEEDBACK.—

"(I) IN GENERAL.—Beginning July 1, 2017, the Secretary:

"(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professional references to performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

"(II) may make available confidential feedback to such professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A).

"(II) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available to professionals, which may include the use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (q)(3)(B).

"(III) USE OF DATA.—For purposes of clause (i), the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

"(IV) DISCLOSURE EXEMPTION.—Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5, United States Code.

"(V) RECEIPT OF INFORMATION.—The Secretary may use the mechanisms established under clause (i) to receive information from professionals, such as information with respect to this subsection.

"(B) ADDITIONAL INFORMATION.—

"(I) IN GENERAL.—Beginning July 1, 2018, the Secretary shall submit to Congress a report evaluating the impact of the alternative payment model described in subsection (q)(1)(B) and the methodologies developed under paragraph (6) on the ability of professionals to participate in a data registry for purposes of this section (including registries under paragraphs (5)(A) and (6)) and the methodologies developed under paragraph (6) and the amount of information made public with respect to the professionals under this subparagraph prior to such information being made public.

"(13) REVIEW.—

"(A) REPORTED REVIEW.—The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor (or factors) for such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not affect the calculation of the MIPS adjustment factor (or factors) for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of paragraph have been determined for such year.

"(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1876, or otherwise of the following:

"(i) The methodology used to determine the amount of the MIPS adjustment factor for a year under paragraph (6)(C) and the determination of such amount.

"(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

"(iii) The identification of measures and associated specifications under subsection (q)(3)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (9).


"(13) REVIEW.—

"(A) REPORTED REVIEW.—The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor (or factors) for such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not affect the calculation of the MIPS adjustment factor (or factors) for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of paragraph have been determined for such year.

"(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1876, or otherwise of the following:

"(i) The methodology used to determine the amount of the MIPS adjustment factor for a year under paragraph (6)(C) and the determination of such amount.

"(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

"(iii) The identification of measures and associated specifications under subsection (q)(3)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (9).

the Comptroller General of the United States shall submit to Congress a report that—

(I) compares the similarities and differences in the use of quality measures under the core quality measures incentive program under part A and B of title XVII of the Social Security Act, the Medicare Advantage program under part C of such title, selected physician payment programs under the Social Security Act, and the program under the Social Security Act for York, and medically underserved areas to partici-

areas, health professional shortage areas, consisting of 15 or fewer professionals, in rural

tions for removing administrative barriers to

States shall submit to Congress a report that—

whether entities that pool financial risk for

the Comptroller General of the United States shall submit to Congress a report examining

the Social Security Act (42 U.S.C. 1395w–

porting entities under part C of such title, the Social Security Act, the Medicare Ad-

the original Medicare fee-for-service pro-

whether physician practices in participating in two-sided management entities that could assist physi-

risk for treating patients, the types of risk

the treatment of patients. Such report shall

financial and other potential conflicts of in-

no more than 5 members of the Committee shall be providers of services or suppliers, or representatives of

bers of the Committee shall be providers of

health professional shortage areas, to partici-

fiscal years 2015 through 2019. Amounts

Mel to a system for public disclosure of

medical and other potential conflicts of in-

interest relating to such members. Members of

be provided for the transfer, from the Federal Sup-

the Supreme Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395f) to the

the Social Security Act, as added by subsection (e).

the types of risk management entities that could assist physician practices in participating in two-sided risk payment models, and how such entities could improve risk management and quality improvement activities. Such report shall also include an analysis of any existing legal barriers to such arrangements.

(C) STUDY ON ROLE OF INDEPENDENT RISK MANAGERS.—Not later than January 1, 2017, the Comptroller General of the United States shall submit to Congress a report examining whether current financial risk for physician practices, as independent risk managers, can play a role in supporting physi-

purposes of implementing the provisions of

the Supplementary Medical Insurance program under title I of the Social Security Act

March 26, 2015

of Congress for purposes of applying title I of

the Ethics in Government Act of 1978 (Public

the Secretary for Planning and Evaluation shall provide technical and operational support for the

Report, following a

(iv) RULEMAKING.—Not later than Novem-

B. MEMBERSHIP.—

(ii) MEDPAC SUBMISSION OF COMMENTS .—

(iii) DUTIES.—The Committee shall meet, as needed, to provide comments and rec-

improved "(C) Term; Vacancies.—

(i) GENERAL.—Except as provided in

(ii) TRAVEL EXPENSES.—A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agen-

(ii) VACANCIES.—Any member appointed

(iii) DATE OF INITIAL APPOINTMENTS .—The

(ii) MEDPAC SUBMISSION OF COMMENTS .—

B. MEMBERSHIP.—

ABBREVIATION OF PHYSICIAN-FOCUSED PAYMENT MODELS.—

the Comptroller General shall designate staggered terms for the members first ap-

(ii) Changes for Group Reporting Op-

(A) In General.—Section 1848(o)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(C)(i)) is amended by inserting "and, for

B. FINANCING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the amendments made by this section, the Secretary of Health and Human Services shall provide for the transfer of $50,000,000 from the Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395f) to the

participating in two-sided risk payment models, and how such entities could improve risk management and quality improvement activities. Such report shall also include an analysis of any existing legal barriers to such arrangements.

(B) Study to Examine Rural and Health Professional Shortage Area Alternative Payment Models.—Not later than October 1, 2021, the Comptroller General of the United States shall submit to Congress a report that examines the transition of professionals in rural areas, health professional shortage areas, or medically underserved areas to alternative payment models that are designed to improve access to care in rural areas and health professional shortage areas, or medically underserved areas.

(iii) PROHIBITION ON FEDERAL EMPLOY-

A. ESTABLISHMENT.—There is established an ad hoc committee to be known as the Physician-Focused Payment Model Technical Advisory Committee (referred to in this subsection as the Committee).

(iii) Date of Initial Appointments.—The Committee shall be composed of 11 members ap-

the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is amended by inserting "and, for 2016 and subsequent years, may provide" after "shall provide".

The Clarification of Qualified Clinical Data Registry Reporting to Group Practices—Section 1848(o)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)(i)) is amended by inserting "and, for 2016 and subsequent years, subparagraph (A) or (C)" after "subparagraph (A)".

Changes for Multiple Reporting Periods and Alternative Criteria for Satisfactory Reporting.—Section 1848(o)(2)(F) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(F)) is amended—

(i) by striking "and subsequent years" and inserting "through reporting periods occurring in 2015"; and

(ii) by inserting "and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish" after "shall establish".

Physician Feedback Program Reports Suceeded by Reports Under MIPs.—Section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(m)(4)) is amended by adding at the end the following new paragraph:

(iii) R EQUIREMENTS.—The report under

(ii) QUALIFICATIONS.—The membership of the Committee shall include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than 5 mem-

of the Committee shall be allowed travel expenses, while away from the

the Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

(ii) FUNDING.—The Secretary shall pro-

concerning models for specialist physicians, that could be used by the Committee for

(iii) MODIFICATIONS TO MEDPAC CRITERIA AND PROCESS FOR SUBMISSION AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT MODELS.—

(A) CRITERIA FOR ASSESSING PHYSICIAN-FOCUSED PAYMENT MODELS.—(i) RULEMAKING.—Not later than November 1, 2016, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, models to provide for the transfer, from the Federal Sup-

the Comptroller General shall designate staggered terms for the members first ap-

the Committee shall be treated as employees

the Comptroller General shall designate staggered terms for the members first ap-

the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

(iv) DUTIES.—The Secretary may update the criteria established under the

the Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

the Secretary shall, through no-

(iii) For Fiscal Years 2015 Through 2019.—Amounts made available under

the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

the Comptroller General shall designate staggered terms for the members first ap-

B. COMMITTEE REVIEW OF MODELS SUBMITTED.—The Committee shall submit, on a periodic

(iii) For Fiscal Years 2015 Through 2019.—Amounts made available under

the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.
basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.

(D) SECRETARY REVIEW AND RESPONSE.—The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and recommendations on the Internet website of the Centers for Medicare & Medicaid Services.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to impact the development or testing of models under this title or titles XI, XIX, or XXI.".

(2) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—The Secretary shall establish policies (including the establishment of an alternative payment threshold under section 1833 of the Social Security Act (42 U.S.C. 1365)) by which the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under an eligible alternative payment entity.

(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

(1) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under an eligible alternative payment entity.

(iii) REQUIREMENT.—For purposes of clause (ii) of subparagraph (C), the requirements described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity.

(iii) TREATMENT OF PAYMENT INCENTIVE.—An eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under an eligible alternative payment entity.

IV. ADDITIONAL DEFINITIONS

(A) COVERED PROFESSIONAL SERVICES.—The term 'covered professional services' has the meaning given in section 1115A(c) of the Social Security Act (42 U.S.C. 1315a(c)).
that term in section 1848(k)(3)(B) and includes a group that includes such professionals.

(3) ALTERNATIVE PAYMENT MODEL (APM).—

The term ‘eligible alternative payment entity’ means, other than for purposes of subparagraphs (B)(i)(1)(bb) and (C)(ii)(1)(bb) of paragraph (2), any of the following:

(i) A model under section 1115A (other than a health care innovation award).

(ii) The shared savings program under section 1899.

(iii) Demonstration under section 1896cc.

(iv) A demonstration required by Federal law.

(D) ELIGIBLE ALTERNATIVE PAYMENT ENTITIES.—In general, the term ‘eligible alternative payment entity’ means, with respect to a year, an entity that—

(i) participates in an alternative payment model that—

(1) requires participants in such model to use certified EHRR technology (as defined in section 1115A(c));

(2) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1869(q)(2)(B)(1); and

(3) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

(ii) is a Medicaid home expanded under section 1115A(c).

(4) LIMITATION.—There shall be no administrative or judicial review under section 1899, 1975, or otherwise, of the following:

(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an eligible alternative payment entity under paragraph (3)(D).

(B) The determination of the amount of the 5 percent payment incentive under paragraph (2) and the determination of any estimation as part of such determination.

(3) COORDINATION CONFORMING AMENDMENTS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is further amended—

(A) in subsection (x)(3), by adding at the end the following new sentence: “The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.”;

(B) in subsection (y)(3), by adding at the end the following new sentence: “The amount of the additional payment for a service under subsection (x) and this subsection shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.”;

(C) in subsection (c), by adding at the end the following new clause: “other public sector or private sector payment models, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under section 1833(c), the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.”;

(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

(1) establish care episode groups and patient condition groups for a target for an estimated 1/2 of expenditures under parts A and B with such target increasing over time as appropriate; and

(2) assign codes to the care episode and patient condition groups established under paragraph (1).

(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

(1) the patient’s clinical problems at the time items and services are furnished during an episode of care, such as clinical condition, diagnoses, or current patient hospitalization occurs, and the principal procedures or services furnished; and

(3) OTHER FACTORS DETERMINED APPROPRIATE BY THE SECRETARY.

(3) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

(1) the patient’s clinical history at the time of a medical visit, such as the patient’s combination of chronic conditions, current health status, and serious health condition (such as hospitalization and major surgery during a previous period, such as 3 months); and

(2) OTHER FACTORS DETERMINED APPROPRIATE BY THE SECRETARY, SUCH AS ELIGIBILITY STATUS UNDER THIS TITLE (INCLUDING ELIGIBILITY UNDER SECTIONS 419A, 422, OR 428A, AND DUAL ELIGIBILITY UNDER THIS TITLE AND TITLE XIX).

(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

(i) LATER THAN 270 DAYS AFTER THE END OF THE COMMENT PERIOD DESCRIBED IN SUBPARAGRAPH (C), THE SECRETARY SHALL POST ON THE INTERNET WEBSITE OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES A LIST OF CARE EPISODE AND PATIENT CONDITION CODES ESTABLISHED UNDER SUBPARAGRAPH (D) (AND THE CRITERIA AND CHARACTERISTICS ASSIGNED TO SUCH CODE).

(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 120 days after the date the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or prescription drug coverage under part D, and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(1) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

(a) IN GENERAL.—In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.
(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.— Not later than one year after the date of enactment of this subsection, the Secretary shall—

(i) develop, and post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition categories and codes determined appropriate by the Secretary.

(ii) address how measures used by private physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use with respect to, care episode and patient condition groups and codes established under paragraph (5).

(iii) shall use per patient total allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services, including utilization of specific items and services and the ratio of specific items and services among attributed patients or episodes.

(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with the project year 2016), the Secretary shall—

(i) provide for the Secretary to develop, make revisions to the operational list of care episode and patient condition codes as the Secretary determines may be appropriate, such as by incorporating new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(ii) conduct if there are any patients to physician or practitioners.—

(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes in whole or in part to one or more physicians or practitioners furnishing items and services, the Secretary shall—

(i) consider how measures used by private physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use with respect to, care episode and patient condition groups and codes established under paragraph (5).

(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall—

(i) develop, and post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition categories and codes determined appropriate by the Secretary.

(ii) address how measures used by private physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use with respect to, care episode and patient condition groups and codes established under paragraph (5).

(C) MEASUREMENT OF RESOURCE USE.—In order to facilitate the attribution of patients and episodes in whole or in part to one or more physicians and applicable practitioners, the Secretary shall—

(i) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

(ii) measure resource use with respect to care episode and patient condition groups and codes established under paragraph (5).

SEC. 102. PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.

Section 1348 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (f) of section 101, is further amended by inserting at the end the following new subsection:

"(g) PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.—

(1) PLAN IDENTIFYING MEASURES DEVELOPMENT PRIORITIES AND TIMELINES.—

(A) DRAFT MEASURE DEVELOPMENT PLAN.—Not later than January 1, 2016, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for attribution under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

(i) ensure how measures used by private payers and integrated delivery systems could be incorporated under title XVIII;
“(ii) describe how coordination, to the extent possible, will occur across organizations developing such measures; and
“(iii) take into account how clinical best practices and the practice guidelines and quality measures should be used in the development of quality measures.

“(B) QUALITY DOMAINS.—For purposes of this subsection, the term ‘quality domains’ means at least the following domains:

“(i) Clinical care.
“(ii) Safety.
“(iii) Care coordination.
“(iv) Patient and caregiver experience.
“(v) Population health and prevention.

“(C) CONSIDERATION.—In developing the draft plan under this paragraph, the Secretary shall consider—

“(i) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities;
“(ii) whether measures are applicable across health care settings;
“(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(v) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures; and
“(iv) the quality domains applied under this subsection.

“(D) PRIORITIES.—In developing the draft plan under this paragraph, the Secretary shall give priority to the following:

“(i) Outcome measures, including patient reported outcome and functional status measures.
“(ii) Patient experience measures.
“(iii) Care coordination measures.
“(iv) Measures of appropriate use of services, including measures of over use.

“(E) STAKEHOLDER INPUT.—The Secretary shall accept through March 1, 2016, comments on the draft plan posted under paragraph (A) from the public, including health care providers, payers, consumers, and other stakeholders.

“(F) FINAL MEASURE DEVELOPMENT PLAN.—Not later than May 1, 2016, taking into account the comments received under this subparagraph, the Secretary shall finalize the plan and post it on the Internet website of the Centers for Medicare & Medicaid Services.

“(G) R EQUIREMENTS.—Each report submitted pursuant to subparagraph (A) shall include the following:

“(i) A description of the Secretary’s efforts to implement this paragraph.
“(ii) With respect to the measures developed during the previous year:

“(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;
“(II) the name of each measure developed;
“(III) the name of the developer and steward of each of such measures;
“(IV) with respect to each type of measure, an estimate of the total amount expended under this title to develop all measures of such type; and
“(V) whether the measure would be electronically specified.

“(iii) With respect to measures in development at the time of the report:

“(I) the information described in clause (i), if available; and
“(II) a timeline for completion of the development of each measure.

“(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and any other quality measure domains applicable under the applicable provisions.

“(v) Other information the Secretary determines to be appropriate.

“(d) STAKEHOLDER INPUT.—With respect to paragraph (1), the Secretary shall seek stakeholder input with respect to—

“(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(D); and
“(B) prioritizing quality measure development to address such gaps; and
“(C) other areas related to quality measure development determined appropriate by the Secretary.

“(e) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term ‘applicable provisions’ means the following provisions:

“(A) Subsection (q)(2)(B)(i).
“(B) Section 1833(z)(2)(C).
“(C) Other areas related to quality measure development determined appropriate by the Secretary.

“(f) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide, from the Federal Supplemental Medical Insurance Trust Fund under section 1861(r)(1), not to exceed $10,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2015 through 2019. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2022.

“(g) ADMINISTRATION.—Chapter 35 of title 42, United States Code, shall not apply to the information required under this section for chronic care management services described in section 1848(b)(4) of the Social Security Act, as added by subsection (a), and encourage such individuals with chronic care needs to receive such services.

“(h) REQUIREMENTS.—Such campaign shall—

“(I) be directed by the Health Policy of the Department of Health and Human Services and the Office of Minority Health of the Centers for Medicare & Medicaid Services; and
“(II) focus on encouraging participation by underserved rural populations and racial and ethnic minority populations.

“(i) REPORT.—Not later than December 31, 2017, the Secretary shall submit to Congress a report on the use of chronic care management services described in such section 1848(b)(4) by individuals living in rural areas and by racial and ethnic minority populations.

SECTION 103. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS

“(a) IN GENERAL.—The information made available under this section shall be similar to the type of information in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File by the Secretary with respect to 2012 and shall be made available in a manner similar to the manner in which the information in such file is made available.

“(b) T YPE AND MANNER OF INFORMATION.—The information made available under this section shall be in a format and manner that—

“(I) is available in an easily understandable format, information with respect to physicians and, as appropriate, other eligible professionals on items and services furnished to Medicare beneficiaries under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

“(II) is available publicly available, in an easily understandable format, information with respect to physicians and, as appropriate, other eligible professionals on items and services furnished to Medicare beneficiaries under title XVIII of the Social Security Act and individuals enrolled under such part of the benefits of chronic care management services described in section 1848(b)(4) of the Social Security Act, as added by subsection (a), and encourage such individuals with chronic care needs to receive such services.

“(c) REQUIREMENTS.—The information made available under this section shall, at a minimum, the following:

“(I) The information described in the number of services furnished by the physician or other eligible professional under part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that may include information on the most frequent services furnished or groupings of services.
(2) Information on submitted charges and payments for services under such part.

(3) A unique identifier for the physician or other eligible professional that is available to the public, such as a national provider identifier.

(d) Searchability.—The information made available under subsection (a) shall be searchable by at least the following:

(1) The specialty or type of the physician or other eligible professional.

(2) A characteristic of the services furnished, such as volume or groupings of services.

(3) The location of the physician or other eligible professional.

(e) Integration on Physician Compare.—Beginning with 2016, the Secretary shall integrate the information made available under this section on the Physician Compare.

(f) Definitions.—In this section:

(1) Eligible professional; physician; secretary.—The terms "eligible professional", "physician", and "Secretary" have the meaning given such terms in section 10331(i) of Public Law 111–146.

(2) Physician compare.—The term "Physician Compare" means the Physician Compare Internet website of the Centers for Medicare & Medicaid Services (or a successor website).

SEC. 105. EXPANDING AVAILABILITY OF MEDICARE DATA.

(a) Expanding uses of Medicare data by qualified entities.—

(1) Additional analyses.—

(A) In general.—Subject to subparagraph (B), to the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3), notwithstanding paragraph 4(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph 4(D) of such section, beginning July 1, 2016, a qualified entity may use the combined data described in paragraph (4)(B)(iii) of such section received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of providing services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(B) Limitations with respect to analyses.—

(i) Employers.—Any analyses provided or sold under paragraph (A) to an employer that is described in paragraph (9)(A)(ii) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

(ii) Health insurance issuers.—A qualified entity may not provide or sell an analysis or data under paragraph (1) or (2) to an employer for purposes of performance improvement and care coordination activities but shall not make public such analysis or data or any analysis using such data.

(2) Access.—To the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3), notwithstanding paragraph 4(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph 4(D) of such section, beginning July 1, 2016, a qualified entity may provide or sell the combined data described in paragraph (4)(B)(iii) of such section received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of providing services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(C) Information on patients of the provider of services or supplier.—To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraphs (1) or (2) shall not contain information that individually identifies a patient.

(D) Information on patients of the provider of services or supplier.—To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold under paragraph (1)(i) or (2) may, as determined by the Secretary, be used by such employer for purposes of performance improvement and care coordination activities but shall not make public such analysis or data or any analysis using such data.

(E) Access.—To the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3), notwithstanding paragraph 4(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph 4(D) of such section, beginning July 1, 2016, a qualified entity may provide or sell the combined data described in paragraphs (4)(B)(iii) of such section received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of providing services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(F) Prohibition on using analyses or data for marketing purposes.—An authorized user shall not use an analysis or data provided or sold under paragraph (1) or (2) for marketing purposes.

(G) Data use agreement.—A qualified entity and an authorized user described in clauses (1), (ii), and (v) of paragraph (9)(A) shall enter into an agreement regarding the use of any data that the qualified entity is providing or selling to such authorized user under paragraph (2). Such agreement shall describe the requirements for privacy and security of the data and, as determined appropriate by the Secretary, any prohibitions on using such data to link to other individually identifiable sources of information. If the authorized user is not a covered entity under the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, the agreement shall identify the relevant regulations, as determined by the Secretary, that the user shall comply with as if it were acting in the capacity of such a covered entity.

(H) No redisclosure of analyses or data.—

(A) In general.—Except as provided in subparagraph (B), an authorized user that is provided or sold an analysis or data under paragraph (1) or (2) shall not redisclose or make public such analysis or data or any analysis using such data.

(B) Permissible uses.—A provider of services or supplier that is provided or sold an analysis or data under paragraph (1) or (2) may, as determined by the Secretary, use such data for the purposes of performance improvement and care coordination activities but shall not make public such analysis or data or any analysis using such data.

(I) Opportunity for providers of services and suppliers to review.—Prior to a qualified entity providing or selling an analysis or data under paragraph (1), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such data, such qualified entity shall provide such supplier or supplier with the opportunity to appeal and correct errors in the manner described in section 1874(e)(4)(C) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(J) Assessment for a breach.—

(A) In general.—In the case of a breach of a data use agreement under this section or section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), the Secretary shall impose an assessment on the qualified entity both in the case of—

(i) an agreement between the Secretary and a qualified entity; and

(ii) an agreement between a qualified entity and an authorized user.

(B) Assessment.—The assessment under subsection (A) shall be an amount up to $100 per individual entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B of such title, in the case of an agreement described in subparagraph (A)(i), for whom the Secretary provided data on to the qualified entity under paragraph (2); and

(ii) in the case of an agreement described in subparagraph (A)(ii), for whom the qualified entity provided data on to the authorized user under paragraph (2).

(C) Deposit of amounts collected.—Any amounts collected pursuant to this paragraph shall be deposited in Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1396d).

(D) Annual reports.—Any qualified entity that provides or sells an analysis or data under paragraph (1) or (2) shall annually submit to the Secretary a report that includes—

(A) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses;

(B) a description of the topics and purposes of such analyses;

(C) information on the entities who received the data under paragraph (2), the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and

(D) other information determined appropriate by the Secretary.

(2) Authorization.—The term "authorized user" means the following:

(i) A provider of services.

(ii) A supplier.

(iii) An employer (as defined in section 3(5) of the Employee Retirement Income Security Act of 1974).

(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act).

(v) A medical society or hospital association.

(vi) Any entity not described in clauses (i) through (v) that is approved by the Secretary (other than an employer or health insurance issuer not described in clauses (ii) and (iv), respectively, as determined by the Secretary).

(B) Provider of services.—The term "provider of services" has the meaning given such term in section 1861(u) of the Social Security Act (42 U.S.C. 1395(u)).

(C) Qualified entity.—The term "qualified entity" has the meaning given such term in section 1874(e)(2) of the Social Security Act (42 U.S.C. 1395kk(e)).

(D) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.

(E) Supplier.—The term "supplier" has the meaning given such term in section 1861(d) of the Social Security Act (42 U.S.C. 1395x(d)).

(F) Access to Medicare data by qualified clinical data registries to facilitate quality improvement.—

(A) Access.—

(i) Information on submitted charges and payments for services under such part.

(ii) A unique identifier for the physician or other eligible professional that is available to the public, such as a national provider identifier.

(iii) The specialty or type of the physician or other eligible professional.

(iv) A characteristic of the services furnished, such as volume or groupings of services.

(v) The location of the physician or other eligible professional.

(vi) Information on the entities who received the data under paragraph (2), the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and

(vii) Any entity not described in clauses (i) through (v) that is approved by the Secretary (other than an employer or health insurance issuer not described in clauses (ii) and (iv), respectively, as determined by the Secretary).

(G) Definitions.—In this subsection and section 1874(e) of the Social Security Act (42 U.S.C. 1395x(u)):

(A) Authorized user.—The term "authorized user" means the following:

(i) A provider of services.

(ii) A supplier.

(iii) An employer (as defined in section 3(5) of the Employee Retirement Income Security Act of 1974).

(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act).

(v) A medical society or hospital association.

(H) Access to Medicare data by qualified clinical data registries to facilitate quality improvement.—

(A) Access.—
(A) MEDICARE PHYSICIAN AND PRACTITIONER OPT-OUT TO PRIVATE CONTRACT.—

(F) DEF. —Data described in paragraph (1(b)) shall be provided to a qualified data analysis and research organization in electronic format (such as to disable functionality) to conduct the analysis or research that identifies a hospital in accordance with the end the following new subparagraph:

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

(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, requirements to achieve widespread exchange means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary) that the affidavit is not to extend beyond the affidavit for such subsequent 2-year period.

(B) EFFECTIVE DATE.—The amendments made by paragraph (A) shall apply to affidavits entered on or after the date that is 60 days after the date of the enactment of this Act.

(2) PUBLIC AVAILABILITY OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—

Section 1828(b) of the Social Security Act (42 U.S.C. 1395w–3(b)) is amended—

(A) IN GENERAL.—Beginning not later than February 1, 2016, the Secretary shall make publically available through an appropriate publicly accessible website of the Department of Health and Human Services information on such websites not less often than annually.

(i) TO INFORMATION TO BE INCLUDED.—The information to be made available under subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

(i) Their number.

(ii) Their physician or professional specialty or other information.

(iii) Their geographic distribution.

(iv) The timing of their becoming opt-out physicians and practitioners, relative to the extent feasible in which they first enrolled in the program under this title and with respect to applicable 2-year periods.

(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.

(b) PROMOTING INTEROPERABILITY OF ELECTRONIC HEALTH RECORDS.—

(1) RECOMMENDATIONS FOR ACHIEVING WIDESPREAD EHR INTEROPERABILITY.—

(A) OBJECTIVE.—As a consequence of a significant increase in the implicit function of health information technology through the Medicare and Medicaid EHR incentive programs, Congress declares it a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide by December 31, 2018.

(B) DEFINITIONS.—In this paragraph:

(i) WIDESPREAD INTEROPERABILITY.—The term "widespread interoperability" means interoperability between certified EHR technology products and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall be effective on the date that is one year after the date of the enactment of this Act.

(3) STUDY AND REPORT ON THE FEASIBILITY OF ESTABLISHING A MECHANISM TO COMPARE CERTIFIED EHR TECHNOLOGY PRODUCTS.—

(A) STUDY.—The Secretary shall conduct a study to examine the feasibility of establishing one or more mechanisms to assist providers in comparing and selecting certified EHR technology products. Such mechanisms may include—

(i) a website with aggregated results of surveys of meaningful EHR users on the functionality of certified EHR technology products to enable such users to directly compare the functionality and other features of such products; and

(ii) information from vendors of certified products that is made publicly available in a standardized format.

The aggregated results of the surveys described in clause (i) may be made available through contracts with physicians, hospitals, or other organizations that maintain such comparative information described in such clause.
the resources involved in furnishing such services under the Medicare program under title XVIII of the Social Security Act; (m) of section 1853, and section 1886(n) of the Social Security Act, incentives for such legislation and administrative (A) by striking ''March 31, 2015'' and inserting ''January 1, 2018''.

(c) GAO STUDIES AND REPORTS ON THE USE OF TELEHEALTH UNDER FEDERAL PROGRAMS AND ON REMOTE PATIENT MONITORING SERVICES.—

(1) STUDY ON TELEHEALTH SERVICES.—The Comptroller General of the United States shall conduct a study on the following:

(A) How the definition of telehealth across various Federal programs and Federal efforts to inform the use of telehealth in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the incentive programs under section 1841(a)(3), section 1848(o), subsections (l) and (m) of section 1833, and section 1868(n) of the Social Security Act (42 U.S.C. 1395f(1)(c), 1395w–4(o), 1395w–23, 1395w(v)); and

(B) Issues that can facilitate or inhibit the use of telehealth under the Medicare program under such title, including oversight and professional licensure, changing technology, privacy and security, infrastructure requirements, and varying needs across urban and rural areas.

(2) POTENTIAL IMPLICATIONS OF INCREASED USE OF TELEHEALTH WITH RESPECT TO PAYMENT AND DELIVERY OF CARE.—The study conducted under paragraph (1) may include the following:

(i) The development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

(d) RULE OF CONSTRUCTION REGARDING HEALTH CARE PROVIDERS.—

(1) In general.—Subject to paragraph (3), the term ''medical malpractice or medical product liability action or claim'' means a medical malpractice action or claim (as defined in section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as added by section 202 of the Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or the Medicare Act (42 U.S.C. 1395 et seq., 42 U.S.C. 1395 et seq.) shall be construed to preempt any State or common law governing medical professional or product liability actions.

(2) TARGETED REVIEWS UNDER MANUAL MEDICAL REVIEW PROCESS FOR OUTPATIENT THERAPY SERVICES.—

(1) IN GENERAL.—Section 1333(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) shall be amended—

(A) in subparagraph (C)(i), by inserting ''subject to subparagraph (E)'', after ''manual medical review process that''; and

(B) by adding at the end the following new subparagraph: "(E) In place of the manual medical review process under subparagraph (C)(i), the Secretary shall implement a process for medical review under this subparagraph under which the Secretary shall identify and conduct medical review for services described in subparagraph (C)(i) furnished by a provider of services under the Medicare program, as described in subparagraph referred to as a 'therapy provider' using such factors as the Secretary determines to be appropriate.''

(2) OTHER FACTORS.—Such factors may include the following:

(i) The therapy provider has a high clinical denial percentage for the services under this part or is less compliant with applicable requirements under this title.

(ii) The therapy provider has a pattern of billing for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services.

(iii) The therapy provider is newly enrolled under this title or has not previously furnished therapy services under this part.

(iv) The services are furnished to treat a type of medical condition.

(v) The therapy provider is part of a group that includes another therapy provider identified as a ''fast follower''

(iv) For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer from the Federal Supplemental Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal years 2015 and 2016, to remain available until expended.

Note: Amendments made by this section are in effect beginning the date of the enactment of this Act.
under section 1893(h) for medical reviews under this subparagraph.

"(iv) The targeted review process under this subparagraph shall not apply to services for which a reasonable cost reimbursement contract is extended beyond the period for which the exceptions process under subparagraph (A) is implemented.".

(2) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to requests described in section 1833(g)(5)(C)(i) of the Social Security Act (42 U.S.C. 1395(s)(5)(C)(i)) with respect to which the Secretary of Health and Human Services has not conducted medical review under such section by a date (not later than 90 days after the date of the enactment of this Act) specified by the Secretary.

SEC. 203. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395aaa(d)(2)) is amended by striking "April 1, 2015" and inserting "January 1, 2018.";

(b) SUPER RURAL GROUND AMBULANCE.—Section 1834(k)(12)(A) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(1) in the first sentence, by striking "April 1, 2015," and inserting "January 1, 2018,";

(2) in subparagraph (C)(ii), by striking "fiscal years 2015 through 2014 and fiscal year 2015 (beginning on April 1, 2015)," and inserting "fiscal years 2016 and subsequent fiscal years; and\n
(c) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Section 1834(l)(13)(A) of such section 119, as so amended, is amended—

(1) in clause (iv), by striking "at the end;\n
(2) by striking clause (v); and\n
(3) by adding at the end the following new clauses:

"(v) for fiscal year 2015, of $7,500,000;\n
(vi) for fiscal year 2016, of $13,000,000; and\n
(vii) for fiscal year 2017, of $13,000,000.".

SEC. 204. EXTENSION OF INPAtENT 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 "in fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years and inserting "in fiscal year 2016 and subsequent fiscal years; and\n
(2) in subparagraph (C)(i), by striking "fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015)," and inserting "fiscal years 2011 through 2017," each place it appears; and\n
(3) in subparagraph (D), by striking "fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015)," and inserting "fiscal years 2011 through 2017,".

SEC. 205. 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, 2015," and inserting "October 1, 2017;" and\n
(2) in clause (ii)(I), by striking "April 1, 2015," and inserting "October 1, 2017.\n
(b) CONFORMING AMPENDMENTS.—

(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, 2015," and inserting "October 1, 2017;" and\n
(B) clause (iv), by striking "through fiscal year 2014 and the portion of fiscal year 2015 before April 1, 2015," and inserting "through fiscal year 2017;\n
(c) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Section 119(a)(3) of such section 119, as so amended, is amended—

(1) in clause (iv), by striking "and at the end;\n
(2) by striking clause (v); and\n
(3) by inserting after clause (iv) the following new clause:

"(v) for fiscal year 2015, of $5,000,000;\n
(vi) for fiscal year 2016, of $5,000,000; and\n
(vii) for fiscal year 2017, of $5,000,000.".

(d) ADDITIONAL FUNDING FOR FUNDING THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Section 119(a)(3) of such section 119, as so amended, is amended—

(1) in clause (iv), by striking "whereby notices described in subclause (III) that the contract year for the contract, the organization shall provide notice to the Secretary as to whether the organization will apply to have the contract converted over, in whole or in part, and offered as a Medicare Advantage plan under part C for the year following the last reasonable cost reimbursement contract year for the contract.

(IV) IF the organization provides the notice described in subclause (III) that the contract will be converted, in whole or in part, the organization shall, not later than a date determined appropriate by the Secretary, provide notice to the Secretary with such information as the Secretary determines appropriate in order to carry out section 1851(c)(4) and to section 1851(c)(6) through 1851(c)(9).

(V) In the case that the organization enrolls a new enrollee under such contract during the last reasonable cost reimbursement contract year for the contract, the organization shall provide the individual with a notification that such year is the last year for such contract.

(VI) If an eligible organization that is offering a reasonable cost reimbursement contract that is extended pursuant to this subsection, inserts a notice described in clause (iv) of such section 1851(c)(4) that the contract will be converted, in whole or in part, the following shall apply:

"(1) The deemed enrollment under section 1851(c)(4).\n
(II) The special rule for quality increase under section 1859(c) (4).\n
(III) During the last reasonable cost reimbursement contract year for the contract and the year immediately preceding such year, the eligible organization, or the corporate parent organization of the eligible organization, shall be permitted to offer an MA plan in the area that such contract is being converted, enrolled Medicare eligible individuals in such MA plan and such cost plan.".
(b) DEEMED ENROLLMENT FROM REASONABLE COST REIMBURSEMENT CONTRACTS CONVERTED TO MEDICARE ADVANTAGE PLANS.—

(1) IN GENERAL.—Section 1851(c) of the Social Security Act (42 U.S.C. 1395w–21(c)) is amended—

(A) in paragraph (1), by striking “Such elections” and inserting “Subject to paragraph (2)”;

(B) by adding at the end the following:

“(2) DEEMED ENROLLMENT RELATING TO CONVERTED REASONABLE COST REIMBURSEMENT CONTRACTS.—

“(A) IN GENERAL.—On the first day of the annual, coordinated election period under parts A and B for plan years beginning on or after January 1, 2017, an MA eligible individual described in clause (i) or (ii) of subparagraph (B) is deemed, unless the individual otherwise has elected to receive benefits under this title through an applicable MA plan and shall be enrolled in such plan beginning with such plan year, if—

“(i) the individual is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year;

“(ii) the reasonable cost reimbursement contract was extended or renewed for the last reasonable cost reimbursement contract year of the contract (as described in subclause (B) of section 1876(h)(5)(C)(v)) pursuant to such section; and

“(iii) the eligible organization that is offering a Medicare Advantage plan that is offering a Medicare Advantage plan described in clause (i) or (ii) of subparagraph (B) is offered by the same entity (or an organization affiliated with such entity) that has a common ownership interest of control) that entered into such contract; and

“(II) in clause (iii), the term ‘applicable MA plan’ means, in the case of an individual described in—

“(I) subparagraph (B)(i), an MA plan that is not an MA–PD plan;

“(II) subparagraph (B)(ii), an MA–PD plan.

“(D) IDENTIFICATION AND NOTIFICATION OF DEEMED INDIVIDUALS.—Not later than 45 days before the beginning of the coordinated election period under section 1876(h)(5)(C)(v) for plan years beginning on or after January 1, 2017, the Secretary shall identify and notify the individuals who will be subject to deemed elections under subparagraph (A) on the first day of such period.’’.

(2) BENEFICIARY OPTION TO DISCONTINUE OR CHANGE MA OR MA–PD PLAN AFTER DEEMED ENROLLMENT.—

“(A) IN GENERAL.—Section 1851(e)(2) of the Social Security Act (42 U.S.C. 1395w–21(e)(2)) is amended by adding at the end the following:

“(F) SPECIAL PERIOD FOR CERTAIN DEEMED ELECTIONS.—

“(1) IN GENERAL.—At any time during the period beginning after the last day of the annual, coordinated election period under paragraph (3) in which an individual is deemed to have elected to enroll in an MA plan or MA–PD plan under subsection (c)(4) and ending on the last day of February of the first plan year in which such individual is enrolled in such plan, such individual may change the election under subsection (a)(1) (including changing the MA plan or MA–PD plan in which the individual is enrolled).

“(ii) LIMITATION OF ONE CHANGE.—An individual may exercise the right under clause (i) only once during the applicable period described in such clause. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).”.

(2) CONFORMING AMENDMENTS.—

(I) PLAN REQUIREMENT FOR OPEN ENROLLMENT.—Section 1851(e)(6)(A) of the Social Security Act (42 U.S.C. 1395w–21(e)(6)(A)) is amended by striking “paragraph (1),” and inserting “paragraph (1), during the period described in paragraph (2)(F).”.

(II) PART D.—Section 1860D–1(b)(1)(B) of such Act (42 U.S.C. 1320d–1(b)(1)(B)) is amended in paragraph (1)(A) in clause (ii), by adding “and (paragraph (4))” after “(paragraph (3));” and

(III) IN clause (ii), by striking “(E)” and inserting “and (E)”.

(3) TREATMENT OF ESHD FOR DEEMED ENROLLMENT.—Section 1851(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(3)(B)) is amended by striking “An individual who develops end-stage renal disease while enrolled in a reasonable cost reimbursement contract under section 1876(h) shall be treated as an MA or MA–PD plan under this subsection beginning at the time the individual is enrolled in such plan,” and adding the following

finishing sentence: “An individual who develops end-stage renal disease while enrolled in a reasonable cost reimbursement contract under section 1876(h) shall be treated as an MA or MA–PD plan under this subsection beginning at the time the individual is enrolled in such plan, or during a special enrollment period under subsection (c)(4).”.

(4) INFORMATION REQUIREMENTS.—Section 1851(d)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(d)(2)(B)) is amended—

(I) in the heading, by striking “NOTIFICATION TO NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGIBLE INDIVIDUALS;” and inserting the following:

“(i) NOTIFICATION TO NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGIBLE INDIVIDUALS;—”;

(II) by adding at the end the following new clause:

“(ii) NOTIFICATION RELATED TO CERTAIN DEEMED ELECTIONS.—The Secretary shall require a Medicare Advantage organization to notify an MA or MA–PD plan that has been converted from a reasonable cost reimbursement contract pursuant to section 1876(h)(5)(C)(v) to mail, not later than 60 days prior to the first day of the annual, coordinated election period under subsection (e)(3) of any year, to any individual enrolled under such contract and identified by the Secretary under subsection (c)(4)(D) for such year—

“(I) a notification that such individual will, on such day, be deemed to have made an election with respect to such plan to receive benefits under this title through an MA plan or MA–PD plan (and shall be enrolled in such plan) for the next plan year under subsection (c)(4)(A), but that the individual may make a separate election during the annual, coordinated election period for such year;

“(II) the information described in subparagraph (A);

“(III) a description of the differences between such MA plan or MA–PD plan and the reasonable cost reimbursement contract in which the individual is enrolled with respect to benefits covered under such plans, including cost-sharing, premiums, drug coverage, and provider networks;

“(IV) information about the special period for elections under subsection (e)(2)(F); and

“(V) other information the Secretary may specify.”.

(d) TRANSITION PLAN FOR QUALITY RATING FOR PAYMENT PURPOSES.—

Section 1853(o)(6)(A) of the Social Security Act (42 U.S.C. 1395w–25(o)(6)(A)) is amended by adding at the end the following new subparagraph:

“(C) SPECIAL RULE FOR FIRST 3 PLAN YEARS FOR PLANS THAT WERE CONVERTED FROM A REASONABLE COST REIMBURSEMENT CONTRACT.—For purposes of applying paragraph (1) and section 1854(b)(1)(C) for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1851(c)(4) of title 42, such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)) and—

“(ii) in determining the star rating of the plan under subparagraph (B), the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.”.

SEC. 210. EXTENSION OF HOME HEALTH RURAL ADD-ON.

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283; 42 U.S.C. 1320d note) and section 5501(b) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 46) and by section 3313(c) of the Patient Protection and Affordable Care Act (Public Law 111–148; 124 Stat. 428), is amended by striking “January 1, 2016” and inserting “January 1, 2018” each place it appears.

Subtitle B—Other Health Extenders

SEC. 211. PERMANENT EXTENSION OF THE QUALIFYING INDIVIDUAL (Q) PROGRAM.

(a) PERMANENT 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 “(but only for premiums payable
with respect to months during the period begin
ning with January 1998, and ending with March 2015’’.

(b) ALLOCATIONS.—Section 1923(g) of the Social
Security Act (42 U.S.C. 1396a–s(g)) is amended—

(1) in paragraph (2)—
(A) by striking subparagraphs (A) through (H);
(B) in subparagraph (V), by striking ‘‘and’’ at
the end;
(C) in subparagraph (W), by striking the period at
the end and inserting a semicolon;
(D) by redesignating subparagraphs (I) through (W)
as subparagraphs (A) through (O), respectively; and
(E) by adding at the end the following new
subparagraphs:
‘‘(P) for the period that begins on April 1, 2015, and
ends on December 31, 2015, the total allocation
amount is $535,000,000; and
‘‘(Q) for 2016 and, subject to paragraph (4), for
each subsequent year, the total alloca-
tion amount is $690,000,000. ‘’

(2) in paragraph (3), by striking ‘‘(P), (R),
(T), (V)’’ and inserting ‘‘(P);’’ and
(3) by adding at the end the following new
paragraph:
‘‘(4) ADJUSTMENT TO ALLOCATIONS.—The
Secretary may increase the allocation amount
described in paragraph (2)(Q) for a year
(beginning with 2017) up to an amount that
does not exceed the product of the following:
(A) MAXIMUM ALLOCATION AMOUNT FOR
PREVIOUS YEAR.—For each calendar year beginning with 2017,
the allocation amount for 2016, or in the case of a
subsequent year, the maximum allocation amount allowed under this paragraph for the
previous year.
(B) INCREASE IN PART B PREMIUM.—The
monthly premium rate determined under
section 1839 for the previous year.
(C) INCREASE IN PART B ENROLLMENT.—The
average number of individuals (as estimated
by the Chief Actuary of the Centers for Medi-
care & Medicaid Services in September of
the previous year) to be enrolled under part
B of title XVIII for months in the year di-
vided by the average number of such individu-
als (as so estimated) under this subparagraph
with respect to enrollments in months in the
previous year.

SEC. 212. PHANTOM EXTENSION OF TRANSI-
TIONAL MEDICAL ASSISTANCE (TMA).

(a) IN GENERAL.—Section 1925 of the Social
Security Act (42 U.S.C. 1396d–6) is amended—

(1) by striking subsection (f); and
(2) by redesignating subsection (g) as sub-
section (f).

(b) CONFORMING AMENDMENT.—Section
1902(e)(1) of the Social Security Act (42
U.S.C. 1396a(e)(1)) is amended to read as fol-
ows:
‘‘(1) Beginning April 1, 1990, for provisions
relating to the extension of eligibility for
medical assistance for certain families who
have received aid pursuant to a State plan
approved under part A of title IV and have
earned income, see section 1925.’’

SEC. 213. 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 ‘‘2015’’ and
inserting ‘‘2017’’.

(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 ‘‘2015’’ and
inserting ‘‘2017’’.

SEC. 214. EXTENSION OF ABSTINENCE EDU-
CATION PROGRAM.

(a) IN GENERAL.—Section 510 of the Social
Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), striking ‘‘2015’’ and
inserting ‘‘2017’’; and
(2) in subsection (d), by inserting ‘‘and an
additional $75,000,000 for each of fiscal years
2016 and 2017’’ after ‘‘2015’’.

(b) BUDGET SCORING.—Notwithstanding sec-
tion 257(b)(2) of the Balanced Budget and
Emergency Deficit Control Act of 1985, the
total amount that may not be spent shall be
calculated as that amount that shall not be
made available under section 510 of the Social
Security Act (42 U.S.C. 710) after fiscal year
2015, and for each fiscal year thereafter through fiscal year 2025, shall be
$33,100,000 for each such fiscal year.’’.

SEC. 220. DELAY IN EFFECTIVE DATE FOR MED-
ICARE AMENDMENTS RELATING TO BENEFICIARY LIABILITY SETTLE-
MENTS.

Section 302(c) of the Bipartisan Budget Act of
2015 (division A of Public Law 114–51, 42
U.S.C. 1396 note), as amended by section 211
of the Protecting Access to Medicare Act of
2014 (Public Law 113–93; 128 Stat. 1047) is
amended by striking ‘‘October 1, 2016’’ and
inserting ‘‘October 1, 2017’’.

SEC. 221. EXTENSION OF FUNDING FOR COMMU-
NITY HEALTH CENTERS, THE NA-
TIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS.

(a) FUNDING FOR COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS.—

(1) COMMUNITY HEALTH CENTERS.—Section
1005(b)(1)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(1)(E)) is amended by striking ‘‘2015’’ and inserting ‘‘for each of fiscal years 2015 through 2017’’.

(2) NATIONAL HEALTH SERVICE CORPS.—Sec-
tion 1005(b)(2)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–
2(b)(2)(E)) is amended by striking ‘‘for fiscal year 2015’’ and inserting ‘‘for each of fiscal years 2015 through 2017’’.

(b) EXTENSION OF TEACHING HEALTH CENTERS PROGRAM.—Section 330(b)(2)(E) of the Public Health Service Act (42 U.S.C. 254b–
2(b)(2)(E)) is amended by striking ‘‘2015’’ and inserting ‘‘for each of fiscal years 2015 through 2017’’.

SEC. 230. 2-YEAR EXTENSION OF THE CHILDREN’S
HEALTH INSURANCE PROGRAM.

(a) FUNDING.—Section 211 of the Social
Security Act (42 U.S.C. 1397d(aa)) is amended—

(1) in paragraph (17), by striking ‘‘and’’ at
the end;
(2) in paragraph (18)(B), by striking the pe-
riod at the end and inserting a semicolon; and
(3) by adding at the end the following new
paragraphs:
‘‘(19) for fiscal year 2016, $19,300,000,000; and
‘‘(20) for fiscal year 2017, for purposes of making 2 semi-annual allotments—
(A) $2,850,000,000 for the period beginning
on October 1, 2016, and ending on March 31,
2017; and
(B) $2,850,000,000 for the period beginning
on April 1, 2017, and ending on September 30, 2017.’’

(b) ALLOCMENTS.—Section 2104(m) of the So-
cial Security Act (42 U.S.C. 1397d(mm)) is amended—

(A) in the subsection heading, by striking
‘‘and inserting ‘‘AND THERE-
AFTER’’;’’
(B) in paragraph (2)—
(1) in the paragraph heading, by striking ‘‘SPEC
IFIC’’ and inserting ‘‘AND’’;
(2) by striking subparagraph (B) and in-
serting the following new subparagraph:
‘‘(B) FISCAL YEARS 2015 THROUGH 2025.—Sec-
tion 1922(x)(6)(A) of the Social Security Act
(42 U.S.C. 1396d–4(f)(6)(A)) is amended by adding at the end the following:
‘‘(vi) ALLOTMENT FOR FISCAL YEARS 2015 THROUGH 2025.—Notwithstanding any other provision of this subsection, any other provi-
sion of law, or the terms of the TennCare Demonstration Projects for the State, the DSH allotment for Tennessee for
fiscal year 2015, and for each fiscal year thereafter through fiscal year 2025, shall be
$33,100,000 for each such fiscal year.’’.’’
commonwealth and territory) for each such fiscal year as follows:

“(i) REBASE IN FISCAL YEAR 2013 AND EACH SUCCEEDING ODD-NUMBERED FISCAL YEAR.—For fiscal year 2013 and each succeeding odd-numbered fiscal year (other than fiscal years 2015 and 2017), the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable toward) the total amount of allotments available under this section to the State in the preceding fiscal year (including payments made to the State under subsection (a) for such preceding fiscal year as well as amounts redistributed to the State in such preceding fiscal year), multiplied by the allotment increase factor determined under paragraph (6) for such odd-numbered fiscal year.

“(ii) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2014 AND EACH SUCCEEDING EVEN-NUMBERED FISCAL YEAR.—Except as provided in clauses (ii) and (iv), for fiscal year 2014 and each succeeding even-numbered fiscal year, the allotment of the State is equal to the sum of—

“(I) the amount of the State allotment under clause (i) for the preceding fiscal year; and

“(II) the amount of any payments made to the State under subsection (n) for such preceding fiscal year, multiplied by the allotment increase factor under paragraph (6) for such even-numbered fiscal year.

“(iii) SPECIAL RULE FOR 2016.—For fiscal year 2016, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable toward) the total amount of allotments available under this section to the State in the preceding fiscal year (including payments made to the State under subsection (a) for such preceding fiscal year as well as amounts redistributed to the State in such preceding fiscal year), determined as if the last two sentences of section 2105(b) were in effect in such preceding fiscal year and then multiplying the result by the allotment increase factor determined under paragraph (6) for fiscal year 2016.

“(iv) REDUCTION IN 2016.—For fiscal year 2016, with respect to the allotment of the State for fiscal year 2017, any amounts of such allotment that remain available for expenditure by the State in fiscal year 2018 shall be reduced by one-third.

(E) in paragraph (8)—

“(i) in the paragraph heading, by striking “FISCAL YEAR 2013” and inserting “FISCAL YEARS 2013 AND 2015”; and

“(ii) by inserting “or fiscal year 2017” after “2015”;

(F) by redesigning paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

(G) by inserting after paragraph (3) the following new paragraph:

“(4) FOR FISCAL YEAR 2017.—

“(A) FIRST HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (20) of subsection (a) for the semi-annual period described in such subparagraph, increased by the amount of the appropriation for such period under section 301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015, the Secretary shall compute a State allotment (including the District of Columbia and each commonwealth and territory) for each semi-annual period in an amount equal to the first half ratio (described in subparagraph (D) of the amount described in subparagraph (C)).

“(B) SECOND HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (20) of subsection (a) for the semi-annual period described in such paragraph, the Secretary shall compute a State allotment for each such State (including the District of Columbia and each commonwealth and territory) for each such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

“(i) the amount of the allotment to such State under subparagraph (A) of paragraph (20) of such preceding fiscal year as well as amounts redistributed to the State under paragraph (4) of such preceding fiscal year; and

“(ii) the total amount of all the allotments made available under such subparagraph.

“(C) FULL YEAR AMOUNT BASED ON REBASED AMOUNT.—The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2016 (including payments made to the State under subsection (n) for fiscal year 2016 as well as amounts redistributed to the State in fiscal year 2016), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2017.

“(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—

“(I) the sum of—

“(i) the amount made available under subsection (a)(20)(A); and

“(II) the amount of the appropriation for such period under section 301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015; to

“(I) the amount described in clause (i); and

“(II) the amount made available under subsection (a)(20)(B).”.

(2) CONFORMING AMENDMENTS.—

(A) Section 2104(c)(1) of the Social Security Act (42 U.S.C. 1397dd(c)(1)) is amended by striking “(m)4)” and inserting “(m)5)”.

(B) Section 2104(m) of such Act (42 U.S.C. 1397dd(m)) is amended by inserting “subject to paragraph (1)” after “subject to paragraph (1),”.

(3) ONE-TIME APPROPRIATION FOR FISCAL YEAR 2017.—There is appropriated to the Secretary of Health and Human Services out of any money in the Treasury not otherwise appropriated, $14,700,000,000 to accommodate the allotment made for the period beginning on October 1, 2016, and ending on March 31, 2017, under paragraph (20)(A) of section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) (as added by subsection (a)(I)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (4) of section 2104(m) of such Act (42 U.S.C. 1397dd(m)) (as amended by paragraph (1)(G)) for the first 6 months of fiscal year 2017 in the same manner as allotments are provided under subsection (a)(20)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(20)(A).

(3) EXTENSION OF QUALIFYING STATES OPTION.—Section 2105(g)(4) of the Social Security Act (42 U.S.C. 1397dd(g)(4)) is amended—

(1) in the paragraph heading, by striking “2015” and inserting “2015” and “2017”; and

(2) in subparagraph (B), by striking “2015” and inserting “2015” and “2017”.

(4) EXTENSION OF THE CHILD ENROLLMENT CONTINGENCY FUND.—

(1) in general.—Section 2104(n) of the Social Security Act (42 U.S.C. 1397dd(n)) is amended—

(A) by adding “or fiscal year 2015” after “2015”;

(B) by redesigning paragraphs (3) and (4) as paragraphs (4) and (5); and

(C) by inserting “and fiscal year 2017” after “2015”.

(2) in paragraph (4), by striking “2015” and inserting “2015” and “2017”.

(3) in paragraph (5), by inserting “fiscal year 2014” and fiscal year 2017” after “2015”.

(4) EXTENSION OF OUTREACH AND ENROLLMENT PROGRAM.—

SEC. 303. EXTENSION OF OUTREACH AND ENROLLMENT PROGRAM.


(b) in paragraph (b) (1) (I) by striking “2010 through 2014” and inserting “2010, 2011, 2012, 2013, and 2014”.

(c) in paragraph (b) (2), by striking “2015” and inserting “2015”.

SEC. 304. EXTENSION OF CERTAIN PROGRAMS AND DEMONSTRATION PROJECTS.

(a) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—Section 1189A(e)(8) of the Social Security Act (42 U.S.C. 1397dd(n)) is amended by striking “2010” and inserting “2015”.

(b) PEDIATRIC QUALITY MEASURES PROGRAM.—Section 1138A(1) of the Social Security Act (42 U.S.C. 1397dd(n)(1)) is amended in the first sentence by inserting before the period at the end following: “; and there is
appropriated for the period of fiscal years 2016 and 2017, $20,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)).

SEC. 305. REPORT OF INSPECTOR GENERAL OF THIS ON USE OF EXPRESS LANE OPTION UNDER MEDICAID AND CHIP.

Not later than 18 months after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that—

(1) provides data on the number of individuals enrolled in the Medicaid program under title XIX of the Social Security Act (as referred to in this section as "Medicaid") and the Children's Health Insurance Program under title XXI of such Act (referred to in this section as "CHIP") through the use of the Express Lane option under section 1902(e)(13) of the Social Security Act (42 U.S.C. 1396a(e)(13));

(2) assesses the extent to which individuals so enrolled meet the eligibility requirements under Medicaid or CHIP (as applicable); and

(3) provides data on Federal and State expenditures under Medicaid and CHIP for individuals so enrolled and disaggregates such data between expenditures made for individuals who meet the eligibility requirements under Medicaid or CHIP (as applicable) and expenditures made for individuals who do not meet such requirements.

"If the modified adjusted gross income is:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than $85,000 but not more than $107,000</td>
<td>35 percent</td>
</tr>
<tr>
<td>More than $107,000 but not more than $133,500</td>
<td>50 percent</td>
</tr>
<tr>
<td>More than $133,500 but not more than $160,000</td>
<td>65 percent</td>
</tr>
<tr>
<td>More than $160,000</td>
<td>80 percent</td>
</tr>
</tbody>
</table>

(b) CONFORMING AMENDMENTS.—Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (2)(A), by inserting "(or, beginning with 2018, $85,000)" after "$80,000";

(2) in paragraph (3)(A)(i), by inserting "applicable" before "table";

(3) by adding a new paragraph (4) at the end of subsection (a)—

(A) in the matter before clause (i), by inserting "(other than 2018 and 2019)" after "2007";

(B) by clause (ii), by inserting "(or, in the case of a calendar year beginning with 2020, August 2018)" after "August 2006"; and

(4) in paragraph (6), in the matter before subparagraph (A), by striking "2019" and inserting "2017".

Subtitle B—Other Offsets

SEC. 411. MEDICARE PAYMENT UPDATES FOR POST-ACTUARY PROVIDERS.

(a) SNFs.—Section 1886(e) of the Social Security Act (42 U.S.C. 1395y(e)(5)) is amended—

(1) in paragraph (5)(B)—

(A) in clause (i), by striking "clause (ii)" and inserting "clauses (ii) and (iii)";

(B) in clause (ii), by inserting "subject to clause (ii)" after "each subsequent fiscal year";

and

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

"(iii) SPECIAL RULE FOR FISCAL YEAR 2022.—The increase factor to be applied under this subparagraph for fiscal year 2018, after the application of clause (ii), shall be 1 percent.;

(2) in paragraph (6)(A), by striking "paragraph (5)(B)(i)" and inserting "clauses (ii) and (iii) of paragraph (5)(B)" each place it appears;

(b) IRFs.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395yy(j)) is amended—

(1) in paragraph (3)(C)—

(A) in clause (i), by striking "clause (ii)" and inserting "clauses (ii) and (iii)";

(B) in clause (ii), by striking "after" and inserting "Subject to clause (iii), after"; and

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

"(iii) SPECIAL RULE FOR FISCAL YEAR 2022.—The increase factor to be applied under this subparagraph for fiscal year 2018, after the application of clause (ii), shall be 1 percent.;

The applicable percentage is:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than $85,000 but not more than $107,000</td>
<td>35 percent</td>
</tr>
<tr>
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SEC. 401. LIMITATION ON CERTAIN MEDIGAP POLICIES FOR NEWLY ELIGIBLE MEDICARE BENEFICIARIES.

Section 1822 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

"(2) LIMITATION ON CERTAIN MEDIGAP POLICIES FOR NEWLY ELIGIBLE MEDICARE BENEFICIARIES.—

"(I) IN GENERAL.—Notwithstanding any other provision of this section, on or after January 1, 2020, a medicare supplemental policy that provides coverage of the part B deductible, including any such policy (or such a policy issued under a waiver granted under subsection (p)(6), may not be sold or issued to a newly eligible medicare beneficiary.

"(II) NEWLY ELIGIBLE MEDICARE BENEFICIARY DEFINED.—In this subsection, the term ‘newly eligible medicare beneficiary’ means an individual who is neither of the following:

(A) An individual who has attained age 65 before January 1, 2020.

(B) An individual who was entitled to benefits under part A pursuant to section 226(b) or 226A, or deemed to be eligible for benefits under section 226(a), before January 1, 2020.

(3) TREATMENT OF WAIVED STATES.—In the case of a State described in subsection (p)(6), nothing in this section shall be construed as preventing the State from modifying its alternative simplification program under such subsection so as to eliminate the coverage of the part B deductible for any medical supplemental policy sold or issued under such program to a newly eligible medicare beneficiary on or after January 1, 2020.

(4) TREATMENT OF REFERENCES TO CERTAIN POLICIES.—In the case of a newly eligible medicare beneficiary, except as the Secretary may otherwise provide, any reference in this section to a medicare supplemental policy which has a benefit package classified as ‘C’ or ‘F’ shall be deemed, as of January 1, 2020, to be a reference to a medicare supplemental policy which has a benefit package classified as ‘D’ or ‘G’, respectively.

(5) ENFORCEMENT.—The penalties described in clause (ii) of subsection (d)(3)(A) shall apply with respect to a violation of paragraph (1) in the same manner as it applies to a violation of clause (i) of such subsection.

SEC. 402. INCOME-RELATED PREMIUM ADJUSTMENT FOR PARTS B AND D.

(a) IN GENERAL.—Section 1839(i)(3)(C)(i) of the Social Security Act (42 U.S.C. 1395r(i)(3)(C)(i)) is amended—

(1) by inserting after "‘August 2006’; and” the following:

"(2) for years before 2018:"; and

(2) by adding at the end the following:

"(II) Subject to paragraph (5), for years beginning with 2018:

The applicable percentage is:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than $85,000 but not more than $107,000</td>
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</tr>
<tr>
<td>More than $160,000</td>
<td>80 percent</td>
</tr>
</tbody>
</table>

"If the modified adjusted gross income is:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percentage</th>
</tr>
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<tbody>
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<tr>
<td>More than $160,000</td>
<td>80 percent</td>
</tr>
</tbody>
</table>

(b) CONFORMING AMENDMENTS.—Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (3)(C)—

(A) in clause (i), by striking "clause (ii)" and inserting "clauses (ii) and (iii)";

(B) in clause (ii), by striking "after" and inserting "Subject to clause (iii), after"; and

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

"(iii) SPECIAL RULE FOR FISCAL YEAR 2022.—The increase factor to be applied under this subparagraph for fiscal year 2018, after the application of clause (ii), shall be 1 percent.;

(2) in paragraph (7)(A)—

(A) by striking "paragraph (7)(B)" and inserting "paragraph (7)(D)";

(B) by clause (ii), by inserting "Subject to subparagraph (C), in implementing" and adding at the end the following new subparagraph:

"(C) ADDITIONAL SPECIAL RULE.—For fiscal year 2018, the annual update under subparagraph (A) for the fiscal year, after application of clauses (i) and (ii) of subparagraph (A), shall be 1 percent.;

SEC. 412. DELAY OF REDUCTION TO MEDICAID DSH ALLOTMENTS.

Section 1923(f) of the Social Security Act (42 U.S.C. 1396d–4(f)) is amended—

(1) in paragraph (7)(A)—

(A) by striking "2017 through 2021" and inserting "2018 through 2025";

(B) by striking clause (ii) and inserting the following new clause:

"(ii) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under clause (i) shall be equal to—

1. $2,000,000,000 for fiscal year 2018;

2. $3,000,000,000 for fiscal year 2019;

3. $4,000,000,000 for fiscal year 2020;

4. $5,000,000,000 for fiscal year 2021;

5. $6,000,000,000 for fiscal year 2022;

6. $7,000,000,000 for fiscal year 2023;

7. $8,000,000,000 for fiscal year 2024; and

8. $9,000,000,000 for fiscal year 2025;"
(C) by adding at the end the following new clause:

"(v) DISTRIBUTION OF AGGREGATE REDUCTIONS.—The Secretary shall distribute the aggregate reduction provided under clause (ii) among States in accordance with subparagraph (B);"; and

(2) in paragraph (8), by striking "2024" and inserting "2025".

SEC. 413. LEVY ON DELINQUENT PROVIDERS.

(a) IN GENERAL.—Paragraph (3) of section 6331(h) of the Internal Revenue Code of 1986 is amended by striking "30 percent" and inserting "100 percent".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made on or after 180 days after the date of the enactment of this Act.

SEC. 414. ADJUSTMENTS TO INPATIENT HOSPITAL PAYMENT RATES.

Section 7(b) of the TMA, Abstinence Education, and QI Programs Extension Act of 2007 (Public Law 110–90), as amended by section 631(b) of the American Taxpayer Relief Act of 2012 (Public Law 112–240), is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by striking "2009, or 2010" and inserting "2009";

(B) in subparagraph (B)—

(i) in clause (i), by striking "and" at the end;

(ii) in clause (ii), by striking the period at the end and inserting "; and"; and

(iii) by adding at the end the following new clause:

"(iii) make an additional adjustment to the standardized amounts under such section 1886(d) of an increase of 0.5 percentage points for discharges occurring during each of fiscal years 2018 through 2023 and not make the adjustment (estimated to be an increase of 3.2 percent) that would otherwise apply for discharges occurring during fiscal year 2018 by reason of the completion of the adjustments required under clause (ii)."

(2) in paragraph (3)—

(A) by striking "shall be construed" and all that follows through "providing authority" and inserting "shall be construed as providing authority"; and

(B) by striking each succeeding fiscal year through fiscal year 2023" after "2017";

(3) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively; and

(4) by inserting after paragraph (2) the following new paragraph:

"(5) PROHIBITION.—The Secretary shall not make an additional prospective adjustment (estimated to be a decrease of 0.55 percent) to the standardized amounts under such section 1886(d) to offset the amount of the increase in aggregate payments related to documentation and coding changes for discharges occurring during fiscal year 2018.".

TITLE V—MISCELLANEOUS

Subtitle A—Protecting the Integrity of Medicare

SEC. 501. PROHIBITION OF INCLUSION OF SOCIAL SECURITY ACCOUNT NUMBERS ON MEDICARE CARDS.

(a) IN GENERAL.—Section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)) is amended—

(1) by moving clause (x), as added by section 1114(a)(2) of the Patient Protection and Affordable Care Act, 6 eams to the left;

(2) by redesignating clause (x), as added by section 205(c)(2)(C) of the Social Security Number Protection Act of 2010, and clause (xii) as clauses (xi) and (xii), respectively; and

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

"(xiii) The Secretary of Health and Human Services, in consultation with the Commissioner of Social Security, shall establish cost-effective procedures to ensure that a Social Security account number (or derivative thereof) is not displayed, coded, or embedded in Medicare cards issued to an individual who is entitled to benefits under part A of title XVIII or enrolled under part B of title XVIII, and either (A) that such Social Security account number (or derivative thereof) displayed on such card is not identifiable as a Social Security account number (or derivative thereof)."

(b) IMPLEMENTATION.—In implementing clause (xiii) of section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)), as added by subsection (a)(3), the Secretary of Health and Human Services shall do the following:

(1) IN GENERAL.—Establish a cost-effective process that involves the least amount of disruption to, as well as necessary assistance for, Medicare beneficiaries and health care providers, such as a process that provides such beneficiaries with access to assistance through toll-free telephone number and provides outreach to providers.

(2) CONSIDERATION OF MEDICARE BENEFICIARY IDENTIFIED.—Consider implementing a process involving the process involving the Medicare Retirement Board beneficiaries, under which a Medicare beneficiary identified with the Social Security account number (or derivative thereof) is used external to the Department of Health and Human Services and is convertible over to a Social Security beneficiary number (or derivative thereof) for use internal to such Department and the Social Security Administration.

(c) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of this section, the Secretary of Health and Human Services shall provide for the following transfers from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395j) and from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines appropriate:

(1) To the Medicare and Medicaid Program Management Account, transfers of the following amounts:

(A) For fiscal year 2015, $65,000,000, to be made available through fiscal year 2018.

(B) For fiscal years 2016 and 2017, $55,000,000, to be made available through fiscal year 2018.

(C) For fiscal year 2018, $48,000,000, to be made available until expended.

(2) To the Social Security Administration Limitation on Administration Account, transfers of the following amounts:

(A) For fiscal year 2015, $27,000,000, to be made available through fiscal year 2018.

(B) For each of fiscal years 2016 and 2017, $22,000,000, to be made available through fiscal year 2018.

(C) For fiscal year 2018, $27,000,000, to be made available until expended.

(3) To the Railroad Retirement Board Limitation on Administration Account, the following amount:

(A) For fiscal year 2015, $3,000,000, to be made available until expended.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Clause (xiii) of section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)), as added by subsection (a)(3), shall apply with respect to Medicare cards issued on and after an effective date specified by the Secretary of Health and Human Services, such effective date not later than four years after the date of enactment of this Act.

(2) REISSUANCE.—The Secretary shall provide for the reissuance of Medicare cards that comply with the requirements of such clause not later than four years after the effective date specified by the Secretary under paragraph (1).

SEC. 502. PREVENTING WRONGFUL MEDICARE PAYMENTS TO INCARCERATED INDIVIDUALS AND INDIVIDUALS NOT LAWFULLY PRESENT, AND DECEASED INDIVIDUALS.

(a) REQUIREMENT FOR THE SECRETARY TO ESTABLISH POLICIES AND CLAIMS EDITS RETAINING THE DEBT COLLECTOR MECHANISM FOR INCARCERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY PRESENT, AND DECEASED INDIVIDUALS.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended—

(1) by striking "(h)" and inserting "(g)"; and

(2) by striking "(i)" and inserting "(j)".

(b) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on January 1, 2015.

(c) CONGRESSIONAL RECORD — HOUSE

March 26, 2015

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CONGRESSIONAL RECORD — HOUSE

March 26, 2015
the Secretary determines appropriate which may be on a quarterly basis.

(B) INFORMATION.—The information described in subparagraph (A) shall include information described in the following:

(i) Providers of services and suppliers that have the highest rate of improper payments.

(ii) Providers of services and suppliers that have the greatest total dollar amounts of improper payments.

(iii) Items and services furnished in the region that have the highest rates of improper payments.

(iv) Items and services furnished in the region that are responsible for the greatest total dollar amounts of improper payments.

(v) Other information the Secretary determines to assist the contractor in carrying out the program.

(C) COMMUNICATIONS.—Communications with providers of services and suppliers under an improper payment outreach and education program are subject to the standards and requirements of subsection (g).

(2) The amounts described in the preceding sentence shall be conducted on a regular basis.

(2) INFORMATION TO BE PROVIDED THROUGH ACTIVITIES.—The information to be provided under such payment outreach and education program shall include information the Secretary determines to be appropriate, which may include the following information:

(A) Providers’ or suppliers’ most frequent and expensive payment errors over the last quarter.

(B) Specific instructions regarding how to correct or avoid such errors in the future.

(C) A notice of new topics that have been approved by the Secretary for audits conducted by recovery audit contractors under section 1893(h).

(D) Specific instructions to prevent future issues related to such new audits.

(E) Other information determined appropriate by the Secretary.

(3) PRIORITY.—A Medicare administrative contractor shall give priority to activities under such program that will reduce improper payments that are one or more of the following:

(A) Are for items and services that have the highest rate of improper payment.

(B) Are for items and service that have the greatest total dollar amount of improper payments.

(C) Are due to clear misapplication or misunderstanding of Medicare policy.

(D) Are clearly due to common and inadvertent clerical or administrative errors.

(E) Are due to other types of errors that the Secretary determines could be prevented through activities under the program.

(4) INFORMATION ON IMPROPER PAYMENTS FROM RECOVERY AUDIT CONTRACTORS.—(A) In general.—In order to assist Medicare administrative contractors in carrying out improper payment outreach and education programs, the Secretary shall provide each Medicare administrative contractor with a complete list of the types of improper payments identified by recovery audit contractors under section 1833(b) with respect to providers of services and suppliers in the region the list is adopted by the contractor under this section. Such information shall be provided on a time frame the Secretary determines appropriate which may be on a quarterly basis.

(B) INFORMATION.—The information described in subparagraph (A) shall include information described in the following:

(i) Providers of services and suppliers that have the highest rate of improper payments.

(ii) Providers of services and suppliers that have the greatest total dollar amounts of improper payments.

(iii) Items and services furnished in the region that have the highest rates of improper payments.

(iv) Items and services furnished in the region that are responsible for the greatest total dollar amounts of improper payments.

(v) Other information the Secretary determines to assist the contractor in carrying out the program.

(C) COMMUNICATIONS.—Communications with providers of services and suppliers under an improper payment outreach and education program are subject to the standards and requirements of subsection (g).

(2) INDIVIDUALS IDENTIFIED BY THE SECRETARY.—The Secretary, in consultation with appropriate stakeholders, shall establish procedures for determining which individuals identified by Medicare administrative contractors under an improper payment outreach and education program are subject to the program under this section.

(3) SIGNIFICANT IMPROPER PAYMENTS.—The Secretary shall establish procedures for determining which Medicare administrative contractors under an improper payment outreach and education program are subject to the program under this section.

(4) IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—In order to reduce improper payments that have the greatest total dollar amounts of improper payments, the Secretary shall develop a plan to encourage greater participation by individuals to report fraud and abuse in the Medicare program. Such plan shall include recommendations for:

(1) ways to enhance rewards for individuals reporting under the incentive program, including rewarding information that leads to an administrative action; and

(2) extending the incentive program to the Medicaid program.

(5) PUBLIC AWARENESS AND EDUCATION CAMPAIGN.—The plan developed under subsection (a) shall also include recommendations for a public awareness and education campaign to encourage participation in the revised incentive program under subsection (a).

(c) SUBMISSION OF PLAN.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress the plan developed under subsection (a).

SEC. 507. REQUIRING VALID PRESCRIBER IDENTIFIERS ON PHARMACY CLAIMS.

Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

(4) REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.—

(A) IN GENERAL.—For plan year 2016 and subsequent plan years, the Secretary shall require a claim for a covered part D drug for a covered beneficiary enrolled in a Medicare part D prescription drug plan under this part or an MA–PD plan under part C to include a prescriber National Provider Identifier that is determined to be valid under the procedures established under subparagraph (B)(i).

(B) PROCEDURES.—

(i) VALIDITY OF PRESCRIBER NATIONAL PROVIDER IDENTIFIERS.—The Secretary, in consultation with appropriate stakeholders, shall establish procedures for determining which prescriber National Provider Identifier is determined to be valid under the procedures established under subparagraph (B)(i).

(C) REPORT.—Not later than January 1, 2018, the Secretary shall submit to Congress a report on the implementation of the procedures established under subparagraph (B)(i).

SEC. 508. OPTION TO RECEIVE MEDICARE SUMMARY NOTICE ELECTRONICALLY.

(a) IN GENERAL.—Section 1806 of the Social Security Act (42 U.S.C. 1395b–7) is amended by adding at the end the following new subsection:

(b) PROCEDURES.—

(1) IN GENERAL.—The Secretary shall establish procedures for determining which individuals are entitled to receive summary notices under this section.

(2) LIMITATION ON REVOCATION OPTION.—(A) IN GENERAL.—Subject to paragraph (2), for individuals described in subsection (a) that are furnished services in 2016 or 2017, in the case that an individual described in subsection (a) elects, in accordance with such form, manner, and time specified by the Secretary, to receive such statement in an electronic format, such statement shall be furnished to such individual for each period subsequent to such election in such election in such format and shall not be mailed to the individual.

(3) LIMITATION ON REVOCATION OPTION.—(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may determine the maximum number of elections described in paragraph (1) by an individual that may be revoked by the individual.

(B) MINIMUM OF ONE REVOCATION OPTION.—In no case may the Secretary determine a maximum number under subparagraph (A) that is less than one.

(4) NOTICE TO INDIVIDUALS.—(A) ELECTRONIC OR HARD COPY.—The Secretary shall ensure that, in the most cost effective manner and beginning January 1, 2017, a clear notification of the option to elect to receive summary notices under this section described in subparagraph (a) in an electronic format is made available, such as through the notices distributed under section 1904, to individuals described in subparagraph (a).

(B) ENCOURAGED EXPANSION OF ELECTRONIC STATEMENTS.—To the extent to which the
Secretary of Health and Human Services determines appropriate, the Secretary shall—

(1) apply an option similar to the option described in subsection (c)(1) of section 1866 of the Social Security Act (42 U.S.C. 1395g–7) (relating to the provision of the Medicare Summary Notice in an electronic format), as added by subsection (a), to other statements and notifications on a more frequent basis than is otherwise required under such title.

SEC. 509. RENEWAL OF MAC CONTRACTS.

(a) In General.—Section 1874A(b)(1)(B) of the Social Security Act (42 U.S.C. 1395kk–1(b)(1)(B)) is amended by striking "5 years" and inserting "10 years".

(b) Application.—The amendments made by this section shall apply to any such statement and notification under title XVIII of such Act (42 U.S.C. 1395 et seq.)

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into on or after, and to contracts in effect as of, the date of the enactment of this Act.

(c) CONTRACTOR PERFORMANCE TRANSPARENCY.—Section 1874A(b)(3)(A) of the Social Security Act (42 U.S.C. 1395kk–1(b)(3)(A)) is amended by adding at the end the following new clause:

"(iv) CONTRACTOR PERFORMANCE TRANSPARENCY.—To the extent possible without compromising confidentiality of existing and renewal contracts with Medicare administrative contractors under this section, the Secretary shall make available to the public a performance report of each Medicare administrative contractor with respect to such performance requirements and measurement standards.

SEC. 510. STUDY ON PATHWAY FOR INCENTIVES TO STATES FOR STATE PARTICIPATION IN MEDICAID DATA MATCH PROGRAM.

Section 1899(g) of the Social Security Act (42 U.S.C. 1395ddd(g)) is amended by adding at the end the following new paragraph:

"(5) In general.—The Secretary shall study and, as appropriate, may specify incentives for States to work with the Secretary for the purposes described in paragraph (1) of section 1862(a). The application of the waiver authority described in paragraph (2) of subsection (a) of text of such section 1862(a) may include use of the waiver authority described in paragraph (2).

SEC. 511. GUIDANCE ON APPLICATION OF COMMON RULE TO CLINICAL DATA REGISTRIES.

Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue a clarification or modification with respect to the application of subpart A of part 46 of title 45, Code of Federal Regulations, governing the protection of human subjects in research (and commonly known as the "Common Rule"), to activities, including quality improvement activities, involving clinical data registries, including entities that are qualified clinical data registries pursuant to section 1861(r)(5) of such Act (42 U.S.C. 1395ww–6(r)(5)).

SEC. 512. ELIMINATING CERTAIN CIVIL MONEY PENALTIES; GAINSHARING STUDY AND REPORT.

(a) ELIMINATING CIVIL MONEY PENALTIES FOR INDUCMENTS TO PHYSICIANs TO LIMIT SERVICES THAT ARE NOT MEDICALLY NECESSARY.

(1) IN GENERAL.—Section 1128A(b)(1) of the Social Security Act (42 U.S.C. 1320a–7(b)(1)) is amended by inserting "medically necessary" after "the term".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payments made on or after the date of the enactment of this Act.

(b) GAINSHARING STUDY AND REPORT.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall submit to Congress an application of the existing fraud and abuse laws in, and regulations related to, titles XI and XVIII of the Social Security Act (42 U.S.C. 301 et seq.), through a process for entering into gainsharing agreements, or other relationships, to permit gainsharing arrangements that otherwise would be subject to the civil money penalties described in section 1873(b)(1)(B) of such Act (42 U.S.C. 1395kk–1(b)(1)(B)), or similar arrangements between physicians and hospitals that improve care while reducing waste and increasing efficiency. The report shall—

(1) consider whether such provisions should apply to other arrangements, compensation arrangements, or other relationships;

(2) describe how the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care; and

(3) consider whether a portion of any savings generated by such arrangements (as compared to an historical benchmark or other metric specified by the Secretary to determine whether delivery and payment system changes under such title XVIII on expenditures made under such title) should accrue to the Medicare program under title XVIII of the Social Security Act.

SEC. 513. MODIFICATION OF MEDICARE HOME HEALTH SECURITY BOND CONDITION OR PARTICIPATION REQUIREMENT.

Section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) is amended to read as follows:

"(7) provides the Secretary with a surety bond—

"(A) in a form specified by the Secretary and in an amount that is not less than the minimum of $50,000; and

"(B) that the Secretary determines is commensurate with the volume of payments to the home health agency; and"

SEC. 514. OVERSIGHT OF MEDICARE COVERAGE OF MANUAl MANIPULATION OF THE SPINE TO CORRECT SUBLUXATION.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1320b–7) is amended by adding at the end the following new subsection:

"(r) MEDICAL REVIEW OF SPINAL SUBLUXATION SERVICES.—

"(1) IN GENERAL.—The Secretary shall implement a process for the medical review (as described in paragraph (4)) of treatment by a chiropractor described in section 1861(r)(5) by means of manual manipulation of the spine to correct a subluxation (as described in such section) of treatment by a chiropractor if the Secretary determines it to be appropriate and the chiropractor has, in the most recent time period, to the determination by the Secretary of a low denial rate under section 1862(a) and section 1885(a) of such Act (42 U.S.C. 1395x–1(a) and 1320b–7(a));

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payments made on or after the date of the enactment of this Act;

"(3) NO PAYMENT WITHOUT PRIOR AUTHORIZATION.—With respect to a service described in paragraph (1) for which prior authorization medical review under this subsection applies, the following shall apply:

"(A) PRIOR AUTHORIZATION DETERMINATION.—The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1862(a). The Secretary shall make such determination no later than 12 months after the date of the receipt of medical documentation needed to make such determination, paragraph (3)(B) shall not apply.

"(B) DENIAL OF PAYMENT.—Subject to paragraph (5), no payment may be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would or would not meet the applicable requirements of such section 1862(a).

"(C) SUBMISSION OF INFORMATION.—A chiropractor described in paragraph (1) may submit the information necessary for medical review by fax, mail, or by electronic means. The Secretary shall make available to any chiropractor so described in paragraph (1) the information that is necessary for medical review under this subsection in a manner so practical as to allow an individual described in paragraph (1) to obtain, at a single time rather...
than on a service-by-service basis, an authorization in accordance with paragraph (3)(A) for multiple services.

(9) CONSTRUCTION.—With respect to a service described in paragraph (1) that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of that service or the denial of other applicable requirements under this Act.

(10) IMPLEMENTATION.—

(A) AUTHORITY.—The Secretary may implement the provisions of this subsection by interim final rule with comment period.

(B) SUBCONTRACT.—Chapter 35 of title 44, United States Code, shall not apply to medical review under this subsection.

(b) IMPROVING DOCUMENTATION OF SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with stakeholders (including the American Chiropractic Association and representatives of Medicare administrative contractors (as defined in section 1874(a)(3)(A) of the Social Security Act (42 U.S.C. 1395kk–

(a)(3)(A))), develop educational and training programs to improve the ability of chiropractors to provide documentation to the Secretary of services described in section 1861(t)(2)(B)(i)(IV) of this title that demonstrate that such services are, in accordance with section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(2) TIMING.—The Secretary shall make the educational and training programs described in paragraph (1) publicly available not later than January 1, 2016.

(c) FUNDING.—The Secretary shall use funds made available under paragraph (10) of section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), as added by section 513 of the Medicare Access and CHIP Reauthorization Act of 2015, to carry out this subsection.

(d) NATIONAL EXPANSION.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new paragraph:

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

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

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

SEC. 516. REPEALING DUPLICATIVE MEDICARE SECONDARY PAYOR PROVISION.

(a) IN GENERAL.—Section 1862(b)(6) of the Social Security Act (42 U.S.C. 1395y(b)(5)) is amended by inserting at the end the following new subparagraph:

(5) IN GENERAL.—Beginning January 1, 2017, section 1862(b)(6) of the Social Security Act (42 U.S.C. 1395y(b)(5)) is amended by inserting at the end the following new subparagraph:

(5) IN GENERAL.—Beginning January 1, 2017, the amendment made by subsection (a) shall take effect on or after July 1, 2016.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to the date of the enactment of this Act and shall apply retroactively as of January 1, 2016.

SEC. 517. PLAN FOR EXPANDING DATA IN ANNUAL CERT REPORT.

(a) IN GENERAL.—The Secretary of Health and Human Services shall submit to the Committee on Finance of the Senate, and to the Committee on Energy and Commerce of the House of Representatives—

(1) a plan for including, in the annual report of the Comprehensive Error Rate Testing program, data on the percentage and median composite rate for all bidding entities included in the calculation of the median composite rate for each product category, and the median composite rate for all bidding entities included in the calculation of the median composite rate for each product category; and

(b) EFFECTIVE DATE.—The plan required by paragraph (a) shall apply to the fiscal year 2016 and shall apply retroactively as of January 1, 2016.

SEC. 518. REMOVING FUNDS FOR MEDICARE IMPAIRMENT TESTING MODEL FOR RETIREMENT SCHEDULED NON-EMERGENCY AMBULANCE TRANSPORT.

(a) INITIAL EXPANSION.—

(1) IN GENERAL.—The amendment implementing the model described in paragraph (2) proposed to be tested under subsection (b) of section 1115A of the Social Security Act (42 U.S.C. 1395ddd(h)) of Health and Human Services shall revise the testing under subsection (b) of such section to cover, effective

not later than January 1, 2016, States located in medicare administrative contractor (MAC) regions L and 11 (consisting of Delaware, the District of Columbia, Maryland, New Jersey, New York, North Carolina, South Carolina, West Virginia, and Virginia).

(2) MODEL DESCRIBED.—The model described in paragraph (1) is a model of prior authorization for repetitive scheduled non-emergency ambulance transport proposed to be carried out in New Jersey, Pennsylvania, and New York.

(3) FUNDING.—The Secretary shall allocate funds made available under section 1115A(3)(b)(1)(B) of the Social Security Act (42 U.S.C. 1395ddd(3)(b)(1)(B)) to carry out this subsection.

(b) NATIONAL EXPANSION.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new paragraph:

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

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

(3) CLARIFICATION REGARDING BUDGET NEUTRALITY.—Nothing in this paragraph may be construed to preclude the application of section 1115A(b)(3)(B) to models described in such section, including with respect to the model described in subparagraph (A) and expanded beginning January 1, 2017, under such subparagraph.
packages to 0-day global periods. Section 1847 of the Social Security Act (42 U.S.C. 1395w–3).

(2) Rule regarding global surgical packages.—
(a) 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:

"(8) Global surgical packages.—
"(A) Prohibition of implementation of rule regarding global surgical packages.—
"(i) In general.—The Secretary shall not implement the policy established in the final rule published on November 13, 2014 (79 Fed. Reg. 67548 et seq.), that requires the transition of all 10-day and 90-day global surgery information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be reported on claims at the end of the global period, as appropriate. Such information shall be reported on claims at the end of the global period, as appropriate. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be reported on claims at the end of the global period, as appropriate.

(b) Collection of data on services included in global surgical packages.—
With respect to services for which a physician is required to report information in accordance with paragraph (i), the Secretary shall through rulemaking develop a representative sample of physicians, begin-ning not later than January 1, 2017, to report service information to the Secretary. For purposes of carrying out this paragraph (other than clause (iii)), the Secretary shall transfer from the Federal Supplemental Medical Insurance Trust Fund under section 1861(d)(1)(A)(iv) $2,000,000,000 to the Center for Medicare & Medicaid Services Program Management Account for fiscal year 2015. Amounts transferred pursuant to this section shall remain available until expended.

(ii) Reassessment and potential sunset.—Every 4 years, the Secretary shall re-assess the information collected pursuant to clause (i). Based on such a reassessment and by regulation, the Secretary may discontinue the requirement for collection of data under such clause (i). The Secretary determines that the Secretary has adequate information from other sources, such as qualified clinical data registries, surgical logs, billing systems or other practice or facility records, and electronic health records, in order to accurately value global surgical services, and the Secretary determines that the collection of such information is no longer needed to improve the accuracy of valuation of surgical services under the physician fee schedule under this section."

(c) Improving accuracy of pricing for surgical services.—
(Applicability of this section to fiscal years beginning in 2016 and thereafter) Notwithstanding any other provision of law, the Secretary shall, not later than 18 months after the date of enactment of this Act, develop and implement a process to gather, from a representative sample of physicians, begin-ning not later than January 1, 2017, to report service information to the Secretary.

SEC. 523. PAYMENT FOR GLOBAL SURGICAL PACKAGES.


(a) Payments for fiscal years 2014 and 2015.—

(1) Payments required.—Section 101 of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7111) is amended by adding at the end the following new subsection:

"(i) In general.—Section 103(d)(2) of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7111 et seq.), as amended by section 103(d)(2) of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7111) is amended by adding at the end the following new paragraph:

"(iii) Denver denim requirements.—
"(B) EFFECT OF LATE PAYMENT FOR FISCAL YEAR 2014.—The election made by an eligible county under subparagraph (B) of section 207(a) of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7127) for fiscal year 2014 shall be in effect for fiscal years 2014 and 2015.

"(ii) EFFECT OF LATE PAYMENT FOR FISCAL YEAR 2015.—The election made by an eligible county under subparagraph (B) of section 207(a) of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7127) for fiscal year 2015 shall be in effect for fiscal years 2015 and 2016.

"(i) EFFECT OF LATE PAYMENT FOR FISCAL YEAR 2016.—The election made by an eligible county under subparagraph (B) of section 207(a) of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7127) for fiscal year 2016 shall be in effect for fiscal years 2016 and 2017.

"(ii) EFFECT OF LATE PAYMENT FOR FISCAL YEAR 2017.—The election made by an eligible county under subparagraph (B) of section 207(a) of the Secure Rural Schools and Community Self-Determination Act of 2000 (16 U.S.C. 7127) for fiscal year 2017 shall be in effect for fiscal years 2017 and 2018.

SEC. 525. EXCLUSION FROM PAYGO SCORECARDS.

SEC. 526. AUTHORIZATION OF APPROPRIATIONS.

SEC. 527. STATUTORY PAY-AS-YOU-GO SCORECARDS.

SEC. 528. CONGRESSIONAL RECORD — HOUSE OPENING JOINT SESSION.
The SPEAKER pro tempore. The bill shall be debatable for 1 hour, equally divided among and controlled by the chair and ranking minority member of the Committee on Energy and Commerce and the chair and ranking minority member of the Committee on Ways and Means.

The gentleman from Pennsylvania (Mr. PITTS), the gentleman from New Jersey (Mr. PALLONE), the gentleman from Texas (Mr. BRADY), and the gentleman from Michigan (Mr. LEVIN) each will control 15 minutes.

The Chair recognizes the gentleman from Pennsylvania.

Mr. PITTS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include extraneous material on H.R. 2.

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

There was no objection.

The SPEAKER pro tempore. Mr. PITTS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, sponsored by Congressman BURGESS of Texas.

Mr. Speaker, I rise in support of H.R. 2, the bill I just referenced. Four years ago, upon taking leadership of the Energy and Commerce Health Subcommittee, I made it one of my goals to end the patchwork of doc fixes and repeal the sustainable growth rate.

Now, we are here on the floor of the House with a bipartisan policy and a bipartisan set of pay-fours. There are many who thought that this day would never come.

We are replacing the SGR, once and for all, with a system that allows greater freedom for physicians to practice medicine. We do this without threatening access to health care for seniors. Instead of unrealistic price controls, we are instituting a cooperative process to make our healthcare dollars go farther.

We are also replacing a portion of the projected savings with real entitlement reforms, reforms that could reduce spending by $295 billion in the coming decades.

Let’s not make the mistake of saying that this is saving Medicare. The bill makes important reforms that put the program on a better path, but there is much work to do before we achieve that goal.

Future generations of Americans have understandable doubts about whether Medicare will be there when they retire. They pay into the program just as my generation did, but the current system of funding the program will not deliver on that promise for them. The extraordinary binary progress represented by the bill before us today is the result of a vision for the future and years of hard work.

That vision was wholeheartedly supported by Speaker BOEHNER, and there are many more to thank: Chairman UPTON, for his persistence in leadership; current Ranking Member PALLONE; and former Ranking Member Waxman for working with us to get a policy that would all agree on; also DR. BURGESS, the primary sponsor of today’s bill and the vice chairman of the Health Subcommittee in the two past Congresses.

I would especially like to thank the dedicated staff that spent countless hours and sacrificed weekends to make this happen: Dr. John O’Shea, Robert Horne, Josh Trent, Clay Alspaugh, Michelle Rosenberg, Heidi Sturrup, and Monica Volente, on my personal staff.

Finally, we should see this bill as a first step toward strengthening and saving Medicare. This can’t be the end of the road.

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

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

Mr. Speaker, I rise today in strong support of H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015.

For more than 10 years, Congress has had to temporarily fix the flawed sustainable growth rate, SGR, nearly 20 times since it was enacted. Well, today is the last time I will have to talk about the broken SGR. The House has come together to fix it once and for all.

This bill is the result of a lot of hard work by the House Energy and Commerce Committee, Ways and Means and Senate Finance Committees and our leadership. Many of our Members have made important contributions to this bill, and I want to thank them all for being so diligent.

This bill not only repeals the SGR, it replaces it with a reformed system that pays providers based on quality and value. It rewards health outcomes. It allows for more focus to their patients, and most importantly, it provides stability and predictability to the Medicare Program for years to come.

This is good for doctors, and it is good for seniors.

This bill also extends critical funding for programs that improve the health and welfare of millions of children, families, and seniors. It makes permanent the qualified individual program which helps low-income seniors pay their Medicare premiums.

It makes permanent the Transitional Medical Assistance program, which allows low-income families to maintain their Medicaid coverage for up to 1 year as they transition from welfare to work.

It includes $8 billion in funding for community health centers, the National Health Service Corps, and teaching health centers. This funding will help serve 28 million patients, and all three, together, strengthen access to primary and preventative health care.

The bill includes a fully funded 2-year extension of CHIP, maintaining all of the improvements in the Affordable Care Act, but this is not just a 2-year extension; it is a robust extension. It keeps the promise made to States by maintaining the 23 percent bump in Federal matching rates and ensures that States in turn will keep their promises to CHIP kids by slowing the maintenance of effort requirements for child enrollment through 2019 untouched.

This bill is not perfect. I wish my Republican colleagues would have agreed to fund CHIP for 4 years. I also remain concerned about the provisions that affect Medicare beneficiaries, but such is the nature of compromise.

Mr. Speaker, I am proud of the work our committees and chairmen of our leaderships. This agreement took courage from both sides, but what we have accomplished is truly significant. It is balanced and a thoughtful product, and I urge Members to support it.

I reserve the balance of my time.

Mr. PITTS. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Mississippi (Mr. HARPER), an outstanding member of the Energy and Commerce Committee and a good advocate on health issues.

Mr. HARPER. Mr. Speaker, the Medicare Access and CHIP Reauthorization Act represents years of bipartisan effort to eliminate the deadly flawed sustainable growth rate, SGR, and implement new payment and delivery models that will promote higher-quality care while reducing costs.

In addition to stabilizing the Medicare Program for our Nation’s seniors, this bill addresses the healthcare needs of children and low-income Americans, while promoting the long-term sustainability of the Medicare Program through significant structural reforms to the Medicare Program.

There is no question that Medicare must be modernized in order to avoid the program’s projected financial shortfalls. Republicans and Democrats have worked together to advance a blueprint to reform our Medicare programs on a sound financial footing for today’s and future retirees.

Now is the time to end this failed policy once and for all and protect access to care for seniors. I urge my colleagues to support this legislation.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GENE GREEN), the ranking member of our House Subcommittee.

Mr. GENE GREEN of Texas. Mr. Speaker, I thank my colleague for yielding to me, and I appreciate his leadership on this issue and many others in our committee.

I rise in support of H.R. 2, the Medicare Access and CHIP Reauthorization Act. As an original cosponsor of this landmark legislation, I urge my colleagues to support the bill.

H.R. 2 will reform the flawed Medicare physician payment system that will reward quality and value over volume, make reforms to slow the growth of healthcare costs, and extend other critical programs, including the Children’s Health Insurance Program and
Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. SCHRADER).

Mr. SCHRADER. Mr. Speaker, I thank the gentleman for yielding.

I am proud to be here today to support real, bipartisan compromise to finally repeal and replace this flawed SGR formula.

I would like to give my congratulations to Congressman BURGESS and, frankly, former Congresswoman Allyson Schwartz also worked very hard for many years to make this thing a reality.

This long-term solution is going to bring stability to Medicare, so seniors will actually be able to continue to see their doctors. Meanwhile, the bill also allows physicians to focus on value and quality of care rather than quantity of care and extends, of course, the vital CHIP program aiding so many children in this country.

Now, though, I would prefer to see this bill completely paid for, like many others in this Chamber, I recognize the nature of compromise means you don't get everything you want, whether you are a House Member or a Senate Member.

I am glad, however, that it has been pointed out that at least part of the cost of this bill is covered by implementing crucial reforms to Medicare that will help improve its solvency for future generations, certainly compared to our current trajectory.

I congratulate my colleagues on the both sides of the aisle for coming together on this agreement. It is long overdue and will greatly improve our system. I hope we vote for this bill.

Mr. PITTS. Mr. Speaker, I am pleased to yield 1 minute to the gentlewoman from Tennessee (Mrs. BLACKBURN), the vice chair of the Energy and Commerce Committee.

Mrs. BLACKBURN. Mr. Speaker, I want to thank Chairman PITTS for the work that he has done on this, as well as the other members of our committee.

I do rise today in support of H.R. 2. I think every one of us have constituents who are Medicare enrollees who tell us the stories and the stress that comes with not being able to see a doctor because they are no longer taking Medicare patients.

What this does is go to the heart of the problem—the SGR, the sustainable growth rate. It was a big part of the problem—the sword of Damocles, if you will—because doctors never knew if they were going to get paid or what they were going to get paid or if it was going to be a double-digit or a single-digit cut. Let's get that off the table and provide some certainty.

H.R. 2 is finally going to eliminate the flawed SGR. It will be replaced with commonsense legislation which will provide healthcare providers with the predictability that is necessary to meet the needs of Medicare enrollees.

In addition, H.R. 2 takes an important step to rein in healthcare spending, incentivizing doctors on quality, as opposed to quantity, getting at part of the problem of our entitlement programs.

I congratulate all involved. I encourage a “yes” vote.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Mr. Speaker, I rise in strong support of H.R. 2.

I have always believed that our physician workforce deserves to be fairly compensated. The flawed SGR formula has failed to do this for over a decade, and it isn’t right that physicians have faced looming Medicare cuts year after year. Therefore, I am pleased that House Democrats and Republicans have come together to craft a fair, bipartisan compromise to this longstanding and expensive problem.

I want to thank Speaker BOEHNER and Leader PELOSI. And while I would have liked to have seen a 4-year extension of CHIP funding, I am upset that unnecessary Hyde language has been attached to much-needed community health center funding, overall, this is a good agreement.

Medicare beneficiaries, their physicians, children, and our entire health care system will benefit from seeing CHIP and health center funding extended, SGR repealed, and quality-based physician reimbursement incentivized.

So I urge my colleagues both here in the House and in the Senate to support this compromise legislation, the Medicare Access and CHIP Reauthorization Act of 2015.

Mr. PITTS. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Tennessee (Mr. ROE), the chairman of the Doctors Caucus, who should be recognized for his tireless efforts to build support for this bill.

Mr. ROE of Tennessee. Mr. Speaker, today I rise in strong support of H.R. 2, which will permanently repeal the flawed SGR formula and replace it with meaningful reform that will ensure seniors’ access to Medicare.

This agreement is one of the most important things we have accomplished since I have been in Congress, and I couldn’t be prouder of the work done by the House Energy and Commerce and Ways and Means Committees, along with the GOP Doctors Caucus.

I want to give a special thank-you to Speaker JOHN BOEHNER and Leader NANCY PELOSI, without whose leadership this agreement would never have happened.

This bill will ensure Medicare recipients have access to quality care and builds on the work for entitlement reform by making important structural changes to the program. That is an important point. People over the years
have referred to this as the “doc fix,” but it really should be called the “senior fix.” The cuts required by SGR were so severe that, had they been allowed to go into effect, seniors’ access to a Medicare physician almost certainly would have been curtailed.

After 12 years, 17 patches, and $170 billion spent to keep a flawed formula from doing lasting damage to Medicare, we are finally acting in a responsible manner, in a way that should give the American people renewed confidence in Congress’ ability to act on important matters.

I thank all involved.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. PELOSI), our Democratic leader, and I thank her for what she accomplished here today working with the Speaker.

Ms. PELOSI. Mr. Speaker, I thank the gentleman for yielding.

I thank Mr. PALLONE and Mr. LEVIN, our ranking members on the Energy and Commerce Committee and the Ways and Means Committee, for their leadership and cooperation on this issue, as well as Chairman RYAN of the Ways and Means Committee and Chairman UPTON and Ranking Member BILIRAKIS of the Energy and Commerce Committee.

This is a day that we really have to salute our staff. They have worked so hard. It was my honor to work with Speaker Boehner on this important issue. It is time here to do—

do to legislate. We are the legislative branch. We are legislating. We are working together to get the job done for the American people.

From Speaker Boehner's staff, I especially want to thank Charlotte Ivancic, who was extremely knowledgeable about health policy and was smart and fair about all of this. Wendell Primus of my staff was a strong voice for the concerns of seniors and children and their health issues.

Ed Grossman and his team at House Legislative Counsel—for all the ideas that Members churned up, Legislative Counsel had to translate that into what the possibility was for legislative language. They worked 24/7, weekends included.

Megan O'Reilly, Bridget Taylor, and the technical teams at CMS and HHS worked 24/7 for many days.

Holly Harvey and Tom Bradley and the Congressional Budget Office, having to score every change of idea that we may have had.

Again, the staff both at the Ways and Means Committee and the Energy and Commerce Committee on both sides of the aisle, I take the time to recognize them in advance in recognizing them, I really want to recognize the work that is done by staff on all that we do here.

All of these individuals, again, have been working 18-hour days for the past few weeks, and we thank them for their tireless hard work.

This package includes many important victories for low-income seniors, children, and families. There are many reasons to support this bill, four of which I would like to point out:

We are strengthening the quality of care for many older Americans with additional funding for initiatives that help low-income seniors pay their Medicare part B premiums.

We have added almost $750 million for training more urgently needed nurses and physicians.

We have secured the health care of poor children with a 2-year extension of the Children's Health Insurance Program at the same rates set by the Affordable Care Act. Many people wanted more, as did I. That does not diminish the importance of the 2-year extension.

Lastly, we have secured critical funding for community health centers over the next 2 years, expanding a vital investment in underserved communities.

I am proud to rise in support of this historic, bipartisan package. It represents bold, necessary progress for our country. And it is not just about enabling our doctors, which was the original purpose of the bill. It is about how we can increase performance and lower cost; it is about value, not volume of service; it is about quality, not quantity of procedures; and it is about making sure the money rewards the value, not the volume. So I am proud to support it.

At long last, we will replace the broken SGR formula and transition Medicare away from a volume-based system toward one that rewards values, ensures the accuracy of payments, and improves the quality of care.

With this legislation, we give America's seniors confidence that they will be able to see the doctors they need and the doctors they like, liberating them and their families from the shadow of needless, annual crises.

And as a woman, during Women's History Month, I am very proud of what the legislation means to women and their health issues.

So for these and other reasons, I urge my colleagues to vote “aye.”

It was my privilege to work with the Speaker in a bipartisan way on this legislation. I hope it will be a model of things to come.

Mr. PITTS. Mr. Speaker, I join in thanking the minority leader for her role in achieving this bipartisan compromise. It is really historic. I think it is appropriate that this is happening on her birthday, and I join my colleagues in wishing her a happy birthday today.

Mr. Speaker, could I inquire of the time remaining.

The SPEAKER pro tempore. The gentleman from Pennsylvania has 8 minutes remaining. The gentleman from New Jersey has 7 ½ minutes remaining.

Mr. PITTS. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS), another member of the Health Subcommittee.

Mr. BILIRAKIS. Mr. Speaker, I rise today to support H.R. 2, to repeal and replace the SGR.

This bill will replace the SGR with theMerit-Based Incentive Payment System, or MIPS. MIPS means physicians are practicing better medicine to keep their patients healthier. Healthier people utilize less health care, which means a lower cost to the taxpayer.

Nearly 150,000 seniors live in my district. This bill gives them certainty that their doctor will see them. It provides seniors with better care.

H.R. 2 includes a 2-year extension for community health centers and funding, which is very important to my constituents. This bill is pro-senior, pro-doctor, and pro-patient.

This is a historic moment, nearly 20 years in the making. We have a chance to make a huge difference for seniors. The benefits of repealing the SGR are clear. Support this bill.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Ms. CASTOR).

Ms. CASTOR. Mr. Speaker, I thank the gentleman from New Jersey for yielding the time.

Mr. Speaker, I rise in support of this important, bipartisan, landmark bill.

Our parents and grandparents who rely on Medicare and the doctors that take care of them can breathe easier today because of this bill. Medicare will be stronger, and it will be more efficient. We are going to put “modern” into modern medicine by transitioning the Medicare health system into one that focuses on quality rather than quantity.

I would like to thank my colleagues on the Energy and Commerce Committee, Chairman Upton and Ranking Member PALLONE, Mr. PITTS and Mr. GREEN, and Speaker Boehner and Minority Leader PELOSI for also adding into this important package new assurance for children across America, for our community health centers. The State Children’s Health Insurance Program now gets a very significant boost, and for those who take care of so many of our neighbors.

Thanks again to the professional staff, to the great public servants in the Obama administration. I urge a “yes” vote on this important, landmark bill.

Mr. PITTS. Mr. Speaker, I am pleased to yield at this time 1 minute to the gentlelady from North Carolina (Mrs. ELLMERS), another valued member of the Health Subcommittee.

Mrs. ELLMERS. Mr. Speaker, I just want to extend my thanks to all of the members who have worked so hard, both on the Energy and Commerce Committee, but my Democratic colleagues across the aisle, those who we are working with in the Senate.

I just want to say to the American people, don’t look now, but we are actually governing. And this is what the American people want to see.

I have a speech here to read, but I am actually going to go offline and tell you from my heart what this means for our seniors.

This is about certainty. This is about governing. This is about giving solutions to a problem. Yes, it comes with
a price tag. But when we continuously look at things from a one-dimensional perspective on something so important as health care—it is so multidimensional—we can’t stop ourselves from moving forward.

Imagine a day from now where we will look back as if we are not trying to come up with another billion-dollar bandaid to continue the SGR failed formula, when we can actually be looking forward for solutions in health care, continuing our work on 21st century cures, and providing our seniors and every American family in this country how important it is in the work that we are doing.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from North Carolina (Mr. BUTTERFIELD).

Mr. BUTTERFIELD. I thank the gentleman from New Jersey (Mr. PALLONE).

Mr. Speaker, this is a good day for medical providers and for our seniors. This is the day for the House of Representatives. This is bipartisanship at its best.

With the passage of H.R. 2, seniors will no longer have to worry about losing their physicians. Providers will have the certainty to continue to serve their Medicare patients.

But this bill, Mr. Speaker, is about more than fixing Medicare. It also includes a 2-year extension of the CHIP program, which is children’s health insurance for funding for community health centers that is set to expire this fall. Both programs are vital to the low-income vulnerable and rural communities that I represent in North Carolina.

The CHIP program covers more than 8 million children across the country, including many in my State. It helps provide health coverage to children who are not eligible for Medicaid but cannot afford other insurance.

The community health center program funds 1,300 health centers across the country. Without this extension, the program would expire, and care for 7.4 million patients would be jeopardized.

Supporting this bill is about providing access to care for the most vulnerable Americans. I urge my colleagues in the House and the Senate to vote “yes” on H.R. 2.

Mr. PITTs. Mr. Speaker, I am very pleased at this time to yield 1 minute to the gentleman from Ohio (Mr. BONNER), our Speaker, who deserves a lot of credit in coming up with this bipartisan compromise.

Mr. BOEHNER. I thank my colleague from Pennsylvania for yielding.

Let me say a big thank you to Chairman UPTON, Chairman RYAN, Mr. PALLONE, Mr. LEVIN, and their staffs for all of the work that has gone into this product. Also, I want to thank Wendell Primus with Leader Pelosi’s staff; Charlene MacDonald with Mr. Hoyer’s staff; and, of course, Charlotte Ivanic on my team, all who have worked together to create this product that we have today. Thanks to their hard work and the work of this House, we expect to end the so-called doc fix once and for all.

Many of you know that we have patched this problem 17 times over the last 11 years, and I decided about a year ago that we were going to fix it. In its place, we will deliver for the American people the first real entitlement reform in nearly two decades. I think this is good news for America’s seniors, who will benefit from a more stable and reasonable system for seeing their doctor.

It is good news for hard-working families who will benefit from a stronger Medicare program to help care for their elderly parents. It is good news for the taxpayers who, according to the CBO and a number of other fiscal experts, will save money now and well into the future by getting us out of this process.

Imagine a year from now where we are not trying to come up with another billion-dollar bandaid that will be when we are not trying to come up with another billion-dollar bandaid that will help us move forward.

Mr. Speaker, I am proud of the work we did in a bipartisan way. I want to thank the majority, and I want to thank my colleagues on my side of the aisle for working together and only showing, as the Speaker just said, what we can do when we really do the job that Congress is supposed to do. I urge support of this legislation.

Mr. PITTs. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Texas (Mr. BURGESS), the prime sponsor of the legislation, who deserves a great deal of credit for where we are today.

Mr. BURGESS. Mr. Speaker, I want to thank the chairman of the Subcommittee on Health on Energy and Commerce. Mr. Speaker, I omitted one of the people that should have been thanked earlier this morning from the House Legislative Counsel, Michelle Vanek, who worked so hard on the language that is before us today.

Mr. Speaker, a year ago I came to this floor, we had a similar vote, and I talked about how important it was to send a positive message, because last year it was the key that would get us through the door. Well, guess what, Mr. Speaker. This year, not only will the key get us through the door; we are going to knock the darned door down.

We do need a strong vote today. We saw it evidenced on the rule. I urge all of my colleagues to get behind this legislation. It may not have been everything you want, it may not have been what you would have done if you had done it by yourself, but this is a collaborative body. This is the work of a collaborative body. Now we need to send it over to the world’s greatest deliberative body. Let them deliberate for only a short period of time because our chairman, who has come from the people’s House.

Mr. Speaker, it is time to end the SGR. Let us never speak of this issue again.
Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentleman from Maryland (Mr. HOYER), our Democratic whip.

Mr. HOYER. Mr. Speaker, as an aside, I was inclined to get up and ask that we do it in a different context. With those words, we ought to all be happy today. Whether we are for or against, the Congress is working today as the American people would have the Congress work.

Speaker LEAVITT brought our extraordinary staffs on both sides of the aisle, and Members have come together and dealt with some difficult issues. As the gentleman, Dr. BURGESS indicated—and I have worked with him on SCHIP for a very, very long period of time as I recall—we are making progress. We are not where we all want to be, but we are making progress.

Mr. Speaker, I rise in support of this bill and thank the Democratic leader as well as Speaker BOEHNER, Ranking Members PALLONE and LEVIN, and the chairman of the committee, Mr. PITTS, and others for getting us to where we are today.

This bill will permanently replace the broken Medicare sustainable growth rate formula that, frankly, I have been working to get rid of for almost a decade, if not longer, which has created uncertainty and instability in the Medicare program for over a decade. I am pleased that the parties were able to come together and craft a bipartisan bill that will ensure seniors’ access to their doctors and incentivize high-quality, high-value care.

I am also glad that this bill includes a robust reauthorization of the Children’s Health Insurance Program, known as CHIP, which has been a bipartisan success story. This is an issue. Mr. Speaker, I worked hard on when I was majority leader, and I am glad that the sides were able to come together to craft a bipartisan bill that will ensure our children’s access to their doctors and incentivize high-quality, high-value care.

Another major component of this bipartisan compromise is the $7.2 billion in funding for community health centers. These centers serve some of our most needy citizens. These centers, in my home State of Maryland and throughout our country, provide essential health services for millions of underserved families. That is good for all of us.

This, of course, as I said, is not a perfect bill. No compromise is ever perfect from everybody’s perspective. There are some parts I and other Democrats would have liked to see improved, just as there are some parts my colleagues on the other side of the aisle would change, but this compromise will provide much-needed relief and certainty to seniors, children, and families.

Mr. Speaker, I urge all of my colleagues to support this effort. It will be a good day for the Congress of the United States, and it will be a good day for America. I thank all of whose leadership—Members and staff—who got us to this point for the work that they have done.

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

Mr. PALLONE. Mr. Speaker, I yield myself my time. I want to recognize one gentleman in particular, Ira Burney, a career civil servant who, for more than 30 years, has worked tirelessly on Medicare issues at CMS. There is not one Medicare bill in this time that he has not been a part of. His hard work and technical knowledge have been instrumental in supporting our work here in Congress.

So I want to thank Ira and all those on both sides of the aisle who worked so hard to make this day possible. This is an important and incredibly significant bill, and I urge my colleagues to support it.

I yield back the balance of my time.

Mr. PITTS. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. MCCARTHY), the distinguished majority leader.

Mr. MCCARTHY. I thank the gentleman, and I yield to my friend on the other side of the aisle, Mr. HOYER.

Mr. HOYER. Mr. Speaker, I thank my friend, who has a magic minute that I dearly miss. I forgot to articulate, and I should have articulated, I want to congratulate FRED UPTON.

FRED UPTON is my friend. FRED UPTON is the chairman of the Energy and Commerce Committee. FRED UPTON is one of those Members in this House who represents this institution so well because he is committed to working in a bipartisan fashion. We find ourselves sometimes not able to do that. But I want to say thank you to Mr. UPTON from Michigan for his leadership and his commitment to making sure this institution works as the American people want it to work.

I thank my friend, the majority leader, for today.

Mr. MCCARTHY. Mr. Speaker, I thank the gentleman for his words, and I hope all that are watching today see the American people want it to work.

Mr. UPTON is one of those Members in this Congress, and I think we should all realize it. The bill before us today will, once and for all, repeal and replace the flawed Medicare physician payment system. It will move us away from volume-based care to care based on quality, value, and accountability.

Everyone knows that we need to reform programs like Medicare to save it for the future, but for so long, nothing has been done in this House—that is until today. Today marks the first step that I hope will be many more to save our safety nets from collapse and to ensure it for a future generation. These reforms are permanent, they are bipartisan, and they lay the foundation for a Medicare that lasts.

We wouldn’t be here to make all these big reforms without a lot of hard work. First, I want to thank the Doctors Caucus. There are many times I was in a meeting with frustration wanting to find a solution, and no one who should have on both sides of the aisle who worked so hard to make this day possible. This is an important and incredibly significant bill, and I urge my colleagues to support it.

I yield back the balance of my time.

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

Mr. Speaker, I rise to thank my friend, and I thank the gentleman from Michigan (Mr. UPTON), the chair of the Energy and Commerce, a master of bipartisan compromise who helped build with the Doctors Caucus, they led their own committees.

Today, when this vote is taking place, it is going to be different from others. People aren’t going to sit and watch the sides to wonder whether it gets there and how close does it pass? People are going to watch how big the overall vote is going to be.

After this vote today, we will go back to our districts. We will go back to our districts, hopefully in a different thought and a different time, that yes, we can solve a problem; yes, we can pick a problem that has lasted over a decade, that every Congress before it has kicked it down the road, but no, we found common ground in the ability to come together to solve something that many believed we could not.

We hope the Senate will see the same value. Today is a good day, but today should not be the last day. We should look for the other problems—and there are many—and ways that we can solve them permanently like we will do today.
finally, finally fix Medicare’s broken payment system, protect seniors’ access to care, and, yes, strengthen Medicare and extend the Children’s Health Insurance Program.

For way too long, the so-called SGR has been an anvil over Medicare physicians and the seniors that they care for. It has sparked crisis after crisis for nearly 20 years, forcing this Congress to pass some 17 temporary measures to undo its faulty math and protect seniors’ access to their trusted doctors. Those patches also served as a gravy train, leaving the SGR in the past, and begin to put Medicare on the right track.

This bill is good for seniors and for doctors who treat them. We repeal the flawed SGR formula and replace it with a bipartisan, bicameral agreement on a new system that promotes innovation and higher quality care. It removes the hassle of guessing what so many seniors and physicians face from the cycle of repeated patches.

We also take steps to strengthen Medicare for current and future seniors with structural reforms, which will not only grow our savings today, but the CBO has confirmed those savings will grow over time. And the budget that we passed last night fully accounts for the cost of those permanent reforms.

This package also extends benefits for millions of low-income families and children by extending the Children’s Health Insurance Program for 2 years. This program provides high-quality, affordable coverage for roughly 8 million children and pregnant women and has been an example of sound bipartisan success.

I want to thank the bill’s sponsor, Dr. Burgess, for his leadership on this issue from day one. He came to Congress to solve this problem and, today, we have a bill with his name on it to do just that.

I also commend the great subcommittee chair, Joe Pitts. Four years ago, we embarked together on this effort to end the SGR, and that hard work has brought us to this point.

I want to thank the full committee and the Health Subcommittee ranking members, Mr. Pallone, my good friend, and Mr. Green, for working, again, across the aisle from day one. We weren’t standing here together if we hadn’t started together.

Also, a big thanks to the folks at the House Legislative Counsel, CBO, and the committee staff: Clay Alsaph, Robert Horne, Josh Trent, Paul Edell, and Noelle Clemente.

Finally, I want to thank my friends on the Ways and Means Committee and our leadership on both sides, from John Boehner and Kevin McCarthy to Nancy Pelosi and Steny Hoyer. We are, by this doing, making history.

This is a long time coming. Most of us came to Congress to fight for our Nation’s kids, seniors, and their families. Today’s vote is a defining moment for this Congress and for Medicare.

Those who vote “no” are not only voting against seniors but against the future of the critical safety net. That is why we all need to vote “yes.”

Mr. Pitts, Mr. Speaker, I yield back the balance of my time.
Mr. LEVIN. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. McDermott), who is the ranking member on the Health Subcommittee.

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

Mr. MCDERMOTT. Mr. Speaker, today is, in a sense, an historic event. We are finally putting to rest a problem that has festered around here for as long as I have been here. Every year, as the deadline approach, providers faced draconian cuts, and Congress passed an eleventh-hour fix to delay the implementation of SGR. Doctors, patients, Congress—nobody liked it. Nevertheless, 17 times, we have made temporary fixes. We have spent $174 billion in inadequate ways in dealing with the real problem that SGR was all about, which is cost control.

This is a first step today. We can celebrate, but we have to go on because cost control is still a question, and we paired SGR. I think that we hope that we will make Medicare pay for value rather than for volume. That is not an issue that is for sure. We know that we are trying it.

I thought of Franklin Delano Roosevelt, who once said:

I will try something. If it doesn’t work, I will stop it and try something else.

That is really where we are today, looking at the future of cost control in health care.

The most important thing today, though, is that we have gotten back to regular order. The Republicans put this in 16 years ago. Some of us voted “no” because we knew it wouldn’t work, but we thought that all of our 17 years. Now, we come together to fix it together, and we have to fix things together in this House. Compromise is the essence of what we have here.

For my friends on the other side, just you understand, I have already had a phone call from a group in Washington State who told me they are going to take me off the board if I vote for this.

It isn’t as though this is a nice thing for one side or the other side. It is a compromise, where some people get what they want and where some people don’t get what they want. Some people think it is not enough, and some think it is too much.

That is the essence of compromise, and that is how the Congress has to work. It is what is going to have to work with the ACA, the Affordable Care Act. It is going to have to work on transportation. It is going to have to work on a whole series of issues if we, as a Congress, are going to function on behalf of the American people.

This is a great day. This ought to be a unanimous vote. You never look at all of the things that are in it and at all of the things we have dealt with, it ought to be unanimous. My view is that, when you reach a compromise, that is the kind of thing you can expect because this House ever gets all he wants. Nobody has the right to say: it is my way or the highway.

When we do that, we damage the American people. We have been damaging the healthcare system with these patches, spending all of that money, and not getting what we want. We hope this is the start of a better day for cost control in health care. Everyone should vote for this.

Mr. BRADY of Texas. Mr. Speaker, I am proud to yield 2 minutes to the gentleman from Pennsylvania (Mr. Moxhan), who is a champion in health care and whose district has a large number of seniors.
Mr. MEEHAN. Mr. Speaker, I rise today in strong support of the Medicare Access and CHIP Reauthorization Act of 2015.

This is the product of several years of sustained bipartisan work, and, today, we can finish the job. This is a critically important piece of legislation for seniors because it is going to strengthen and preserve the Medicare Program, and it is going to put an end to the perennial drills that threaten seniors’ access to high-quality care, the care that they deserve.

H.R. 2 is a result of bipartisan compromise. I am sure my friends on both sides of the aisle can agree, as my good friend from Oregon identified, that it isn’t perfect, but I am pleased that they will also extend funding for the Children’s Health Insurance Program.

Just like our seniors, we need to make sure that our kids have access to high-quality, affordable care. We need to continue to support community health centers, which provide quality care for those of lesser means.

Since 2002, Congress has passed 17 patches to avert the SGR’s draconian cuts. But these patches avoid crisis, but they don’t do anything to preserve or improve the Medicare Program for current and future seniors, so I am delighted that, together, we can finally forge a lasting solution.

There isn’t just good for seniors’ care and for our healthcare workforce; it is a sign that partisan differences in Washington can be bridged to address our biggest challenges. I urge my colleagues this is the time to once and for all. Adopt these structural reforms, and help us move forward to strengthen Medicare for today’s seniors and tomorrow’s retirees.

Mr. LEVIN. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PASCRELL), a very vocal member of our committee.

Mr. PASCRELL. I have got to say this to Chairman BRADY and to our leader, Mr. LEVIN: you guys did a great job in keeping us together, and I think this is great. We have got to do all of this work that we will take away are what Dr. BURGESS said about this being a collaborative effort.

Mr. Speaker, if someone came down from Mars today into this Chamber, he would be shocked by the camaraderie. This is great. We have got to do all of this work that we will take away are what Dr. BURGESS said about this being a collaborative effort.

Mr. LEVIN. Mr. Speaker, when he said this was a good day, and he thinks that this will not be the last such day. I sincerely hope that that is the case, that it signals opportunities for us all to go forward.

Mr. Speaker, I rise in strong support of this bipartisan legislation offers a permanent solution to strengthen the Medicare Program that our Nation’s seniors and their doctors rely on. It would repeal the flawed SGR formula that dictates draconian cuts to Medicare reimbursements, and it would do so in a fiscally responsible way that would provide important offset savings. Since 2003, Congress has spent nearly $150 billion in 17 short-term fixes that has staved off these cuts without making the real reforms that are needed, and this cycle has done nothing to address the real problems of our entitlement spending.

I have been a nurse for more than 40 years, as has been said, and I know that you can’t put a bandaid on a problem that needs to be corrected by surgery. The problems impacted and affected by these looming cuts were my patients and my colleagues.

I urge this body to end the SGR crisis once and for all. Adopt these structural reforms, and help us move forward together to strengthen Medicare for today’s seniors and tomorrow’s retirees.

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H.R. 2 fully fund the Children’s Health Insurance Program (CHIP) for two years. CHIP is a partnership between the federal government and the States to provide healthcare coverage for over eight million children. Also, this legislation extends funding for two years to Community Health Centers to avoid draconian cuts to their operations in their communities. Community health centers play a critical role in the delivery of care to our most financially and medically vulnerable populations, and thus play an instrumental role in efforts to achieve health equity. Health centers serve one in seven uninsured, and one in three individuals living below poverty. African Americans, Asians/Hawaiians/Pacific Islanders, American Indians/Alaskan Natives, and persons with multi-racial and ethnic backgrounds account for 36 percent of all health center patients. Approximately 34 percent of health center patients are Hispanic/Latino, and health centers serve one in four racial and ethnic minorities living in poverty.

Community health centers are a local solution to the delivery of primary care—which is precisely how care works best—and services that are tailored to meet local needs, specific to each community. Health centers save the health care system money by keeping patients out of costlier health care settings, coordinating care amongst providers of different health disciplines, and effectively managing chronic conditions. Recent independent research shows that health centers currently save the health care system $24 billion annually in reduced emergency, hospital, and specialty care costs, including an estimated $6 billion annually in reduced federal and Medicaid savings. Despite serving traditionally at-risk populations, community health centers meet or exceed national practice standards for chronic condition treatment and ensure that their patients receive more recommended screening and health promotion services than patients of other providers. Health centers also have a substantial and positive economic impact on their communities. In 2009 alone, health centers across the country generated $20 billion in total economic benefit and produced 189,000 new jobs in the most economically challenged neighborhoods.

H.R. 2 includes the MIECHV home visiting program, which I worked in a bipartisan and bicameral way in Congress to establish a national program that serves approximately 115,000 parents and children. Under this legislation this program will be extended to improve child health, child development, and readiness to learn.

Mr. Speaker, I rise in full support of H.R. 2 and encourage all my colleagues to vote for this bill.

Mr. BRADY of Texas. Mr. Speaker, I yield myself 30 seconds.

I include in the RECORD a list of over 100 healthcare organizations throughout America—and growing—who support the passage of this legislation today. I would like to point out that these represent physicians and healthcare providers who truly want to treat our seniors, to see them when they need to see them, but can’t today because of the way Medicare pays them.

So we start with a fresh start, and I enter into the RECORD this list.

Alliance for Academic Internal Medicine (AAIM); AMDA The Society for Post-Acute and Long-Term Care Medicine American Academy of Allergy, Asthma, and Immunology (AAAAI); American Academy of Dermatology Association; American Academy of Family Physicians; American Academy of Neurology (AAN); American Academy of Ophthalmology; American Academy of Pediatrics; American Action Forum; American Association for the Study of Liver Diseases (AASLD); American Association of Clinical Endocrinologists (AACE); American Association of Neurological Surgeons/Congress of Neurological Surgeons; American Association of Nurse Practitioners (AANP); American College of Orthopedic Surgeons; American College of Allergy, Asthma & Immunology (ACAAI); American College of Cardiology (ACC); American College of Chest Physicians (CHEST); American College of Physicians (ACP); American College of Radiology; American College of Rheumatology (ACR); American College of Surgeons; American Congress of Obstetricians and Gynecologists; American Gastroenterological Association (AGA); American Geriatrics Society (AGS); American Health Care Association; American Hospital Association; American Medical Association; American Medical Society for Sports Medicine (AMSSM); American Osteopathic Association (AOA); American Society for Blood and Marrow Transplantation (ASBMT); American Society for Gastrointestinal Endoscopy (ASGE); American Society for Radiation, Oncology (ASTRO); American Society of Clinical Oncology; American Society of Hematology (ASH); American Society of Nephrology (ASN); American Thoracic Society (ATS); American Tax Reform Association; Department of Family Medicine; Association of Family Medicine Residency Directors; Aurora Health Care; Billings Clinic; Bipartisan Policy Center; California Medical Association; Center for Law and Social Policy (CLASP); College of American Pathologists; Digestive Health Physicians Association; Endocrine Society (ES); Essentia Health; Federation of American Hospitals; Grace Marie Turner for the Galen Institute; Greater New York Hospital Association; Gunderson Health System; HealthCare Association of New York State; Healthcare Leadership Council; Healthcare Quality Coalition; HealthPartners; Healthsouth; Hospital Systems United; Infectious Diseases Society of America (IDSA).

Iowa Medical Society; Let Freedom Ring; Louisiana Rural Health Association; LUGPA; March of Dimes; Marshfield Clinic Health System; Mayo Clinic; McFarland Clinic PC; Medical Group Management Association; Mercy Health; Military Officers Association of America (MOAA); Minnesota Hospital Association; Minnesota Medical Association; National Association of Community Health Centers; Nation of American College of Spine Specialists; National Association of Urban Hospitals; National Coalition on Health Care; National Retail Federation; National Primary Care Research Group; Nova Nordisk.

Oregon Association of Hospitals and Health Systems; PhRMA; Premier Inc.; Peralta Physicians Association; Rural Wisconsin Health Cooperative; Society for Adolescent Health and Medicine (SAHM); Society of Critical Care Medicine (SCCM); Society of General Internal Medicine (SGIM); Society of Teachers of Family Medicine; Tennessee Medical Association; Texas Medical Association; The 60 Plus Association; The American College of Physicians; The Hospital & Healthcare Association of Pennsylvania; The Iowa Clinic; The Society
Physicians from my congressional district in Texas, and others across the country, serve and provide remarkable healthcare to our seniors, children, and low income families.

The 70,000 seniors in my congressional district are entitled to the security that comes from knowing care will be available to them when they need it the most.

The 4.4 million low income families and children in the state of Texas and the 130,000 children in Harris County will benefit from this bill because it provides the resources needed to improve their quality of health. It is important that physicians who are willing to serve our seniors, children, and low income families not have to go broke doing so.

Mr. Speaker, let me briefly list several of the more important aspects of this bill which I wholeheartedly support.

For our seniors, the bill repeals the sustainable growth rate (also known as SGR) formula and phases in a value based payment system for physicians serving Medicare patients for the quality of care they provide.

For our seniors, children and low-income families, the new independent contractors in the bill encourage physicians to move towards alternative payment models such as bundled payment and shared savings which foster alignment of high-quality and cost effective healthcare.

This bill extends the Children's Health Insurance Program, or CHIP, for two years.

Over 928,000 children are in CHIP in Texas, and 130,000 in Harris County, will benefit from this bill.

This bill extends the Maternal, Infant, and Early Childhood Home Visiting Program for two years.

This bill extends funding for 1,300 federally funded community health centers located in all 50 states, the District of Columbia and six U.S. territories, distributed evenly between urban and rural areas, that serve 28 million patients.

A third of those patients are children, and 93 percent of patients served have incomes below 200 percent of the federal poverty line. The vast majority of the 90 million patient visits to community health centers were for primary medical care.

Without the funding, 7.4 million low-income patients—including 4.3 million women provided by this bill would lose access to health care.

This bill extends the Qualifying Individual Program—which subsidizes Medicare premiums for low-income beneficiaries—permanently.

This bill permanently corrects Medicare payments to physicians an provides much-needed certainty and stability to the Medicare program.

Importantly, the bill provides financial incentives to reinforce the country's path toward a health care system that rewards value and performance.

This provides a pathway for providing for our medical providers with the SGR fix; it provides seniors with quality healthcare services so they can go to the doctor they want; and, yes, it provides funding for our children and for our low-income families.

It supports our federally qualified health clinics, and coming from the city of Houston with the Texas Medical Center, there are a lot of doctors. Those doctors serve the poor and they serve seniors, and I want to make sure they are able to do so. The CHIP program will be protected that has been a vital program to provide for those families for our children to be healthy.

Let me agree with my colleague, brother PASCAREL, this is good for America. I am delighted to support this, and we are going to help physician-owned hospitals and look forward to a better day.

Mr. Speaker, I rise in support of H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015,” and the underlying bill.

H.R. 2 repeals and replaces the Medicare Physician Payment System and incentivizes quality care for seniors, children and low income families.

I thank Chairman RYAN and Ranking Member LEVIN for their work in shepherding this legislation, which enjoys bipartisan support to the floor.

I support the bill before us because it protects our seniors, our children, our low income families, and it compensates physicians who provide critically needed health services.

This bipartisan legislation represents a significant achievement because it reforms Medicare's payment system and maintains critical funding for healthcare of millions of seniors, low-income children, and families.

Compensating our medical providers adequately to enable them to continue providing much needed services to our seniors is a moral imperative.

Assuring that our seniors receive quality health services is a moral imperative.

Providing critical healthcare funding for children and low income families is also a moral imperative.

Physicians from my congressional district in Texas, and others across the country, serve and provide remarkable healthcare to our seniors, children, and low income families.

The 70,000 seniors in my congressional district are entitled to the security that comes from knowing care will be available to them when they need it the most.

The 4.4 million low income families and children in the state of Texas and the 130,000 children in Harris County will benefit from this bill because it provides the resources needed to improve their quality of health.

It is important that physicians who are willing to serve our seniors, children, and low income families not have to go broke doing so.

Mr. Speaker, let me briefly list several of the more important aspects of this bill which I wholeheartedly support.

For our seniors, the bill repeals the sustainable growth rate (also known as SGR) formula and phases in a value based payment system for physicians serving Medicare patients for the quality of care they provide.

For our seniors, children and low-income families, the new independent contractors in the bill encourage physicians to move towards alternative payment models such as bundled payment and shared savings which foster alignment of high-quality and cost effective healthcare.

This bill extends the Children's Health Insurance Program, or CHIP, for two years.

Over 928,000 children are in CHIP in Texas, and 130,000 in Harris County, will benefit from this bill.

For our children, “clean” extensions in the bill maintain policies and funding that does not include detrimental policies or cuts.

This funding supports evidence-based programs that have been proven to reduce health care costs, improve school readiness, and increase family self-sufficiency and economic security.

This bill extends the Maternal, Infant, and Early Childhood Home Visiting Program for two years.

This bill extends funding for 1,300 federally funded community health centers located in all 50 states, the District of Columbia and six U.S. territories, distributed evenly between urban and rural areas, that serve 28 million patients.

A third of those patients are children, and 93 percent of patients served have incomes below 200 percent of the federal poverty line. The vast majority of the 90 million patient visits to community health centers were for primary medical care.

Without the funding, 7.4 million low-income patients—including 4.3 million women provided by this bill would lose access to health care.

This bill extends the Qualifying Individual Program—which subsidizes Medicare premiums for low-income beneficiaries—permanently.

This bill permanently corrects Medicare payments to physicians an provides much-needed certainty and stability to the Medicare program.

Importantly, the bill provides financial incentives to reinforce the country's path toward a health care system that rewards value and quality of care.

Mr. Speaker, this bipartisan legislation is a step in the right direction in Medicare payment reform and ensures continued funding that improves the health and welfare of millions of seniors, children, and families.

H.R. 2 is important because it reforms our flawed Medicare physician payment system; incentivizes quality and value for our seniors; and extends coverage for our children and low income families.

For all these reasons, I strongly support this bill and urge my colleagues to likewise.

Mr. BRADY of Texas. Mr. Speaker, I know Mr. LEVIN has additional speaking time, but I will preserve the balance of my time.

Mr. LEVIN. I yield myself the balance of my time.

Mr. Speaker, this is an important moment. As I look back—I have been a decade after a decade of a struggle for health care for all Americans, a real struggle.

Today, we have legislation that covers kids from infancy through seniors, three of their kids, and their grandchildren. I hope we will take these few minutes when we come together and reassert the importance in this country of joining together so that everybody from birth until their last days has the ability to have what is at our fingertips—the ability to have access to health care. I hope that is the significance of this vote. I hope, as a result, it will be a very strong vote, and I think it is a vote for health care for every American.

I yield back the balance of my time.

Mr. BRADY of Texas. I yield myself the balance of my time to close.

Mr. Speaker, there is nothing wrong with being passionate about your ideas and principles, and nowhere is that more evident than in health care. When you can find, though, common ground on those principles that help our seniors, encourage our doctors to treat them, and make the first reforms to really save Medicare for the long term, we ought to do that. That is what this bill does.

But it just isn't a common ground as far as our lawmakers. We have dedicated staff who came together to work out the tough issues for us. On behalf of the Committee on Ways and Means Chairman PAUL RYAN and myself, I would like to thank our staff on the Ways and Means Subcommittee on Health—Matt Hoffmann, Brett Baker, Hall, and my staffer, David Richardson—for their tremendous work.

The Speaker and former Speaker PELOSI also led the effort to find this
Mr. Speaker, I don’t understand why Hyde had to be referenced at all in this bill. Everyone already knows that community health centers are already subject to Hyde restrictions. Including it in this SGR bill is redundant. Unfortu-
nately, it is all too typical of this Tea Party-infused Congress to sow discord rather than accommodation. Adding the Hyde language to the bill only causes heartburn in a bill that could much more easily have satisfied our hunger for bipartisanship.

Ms. BONAMICI. Mr. Speaker, I rise today in support of H.R. 2, the Medi-
care Access and CHIP Reauthorization Act. This legislation is a long overdue remedy to the flawed Medicare physi-
cian payment world, bring more of the Sustainable Growth Rate, or SGR. I look forward to putting an end to the temporary patches that Congress has repeatedly passed in place of a perma-
nent fix.

Replacing the SGR and bringing predict-
dability to Medicare will encourage more providers to enter and remain in the program, which in turn will im-
prove health care access and afford-
ance for seniors. Additionally, H.R. 2 marks an important shift from fee-for-
service payments to a system that re-
wards quality outcomes.

This bill also includes several impor-
tant reauthorizations to crucial pro-
grams, including the Children’s Health Insurance Program, the Qualifying Indi-
dividual program, and the Maternal, Infant, and Early Childhood Home Visiting Program. Although I would have supported a longer authorization of CHIP, which would give us certainty to our states and the children and families they serve through the program, I hope we can work together during the next two years to develop a strong authorization before it expires in two years.

I am also very pleased that this legis-
lation includes an extension of the Se-
cure Rural Schools and Community Self-Determination Act. Hundreds of jurisdictions across Oregon—including timber-dependent counties all across Oregon—rely on this essential funding for their schools, government services, and law enforcement.

Lastly, H.R. 2 provides continued au-
thorization for Community Health Cen-
ters, which provide important services in underserved communities. Although support for community health centers will prevent millions of patients from losing access to primary care, the fund-
ing unfortunately remains subject to the Hyde Amendment—a harmful provision that undermines women’s health. I am deeply troubled with the continuation of this public law.

I am also troubled by the precedent set in this bill where we will begin charging some seniors more for their premiums. Medicare, like Social Secu-

rity, is an earned benefit paid for over a lifetime.

Despite these serious objections, I will support this bipartisan legislation. Congress must preserve access to pri-
mary care for vulnerable individuals
and bring long sought stability to Medicare for our seniors. I urge my colleagues to join me in supporting this comprehensive legislation and permanently fix the SGR.

Mr. BOUSTANY. Mr. Speaker, this week the House had an opportunity to make historic reforms to Medicare, the program that provides coverage to doctors and patients across the country.

I spent 30 years practicing as a heart surgeon, fighting to save lives on the operating table every day. I know firsthand that the cycle of temporary patches and extensions injects tremendous uncertainty into the process, making it much more difficult to run a successful practice.

Last week, I stood with a bipartisan group of Representatives and Senators to introduce the replacement legislation under consideration.

This bill repeals the unworkable SGR, consolidates duplicative programs, and improves transparency for patients and doctors. It is a historic solution to a problem that has plagued doctors and providers for over a decade.

But no solution is one hundred percent perfect.

I believe we must continue working toward full repeal of the unworkable Medicare outpatient therapy cap, something I've introduced legislation to address and will continue to work with my colleagues to make this law.

That's something I'll continue to fight for.

But today, it's time for Congress to do what we are elected to do: come together, find common ground, and pass a solution.

This is the first meaningful opportunity to fix this broken system in years—not let's bypass this moment to do nothing.

I encourage all of my colleagues to support this permanent doc fix.

Mr. LANGEVIN. Mr. Speaker, I rise today in support of the Medicare Access and CHIP Reauthorization Act, which repeals the SGR, places it with a payment system based on quality of care, value and accountability.

Since 2003, Congress has spent nearly $170 billion on short-term patches to temporarily suspend the SGR. This bipartisan, bicameral agreement will finally stabilize payments for medical providers and remove the persistent threat of rate cuts that have jeopardized access to care for our seniors.

Also contained in this legislation is a crucial two-year extension of the Children's Health Insurance Program. Although I would have preferred to see CHIP extended for four years, this measure allows us to take immediate action instead of waiting until the program expires in September, providing certainty to states like Rhode Island that are preparing their budgets for next year, while ensuring that over eight million children continue receiving the health coverage they need at increased funding levels set forth under the Affordable Care Act.

I am also pleased to see the inclusion of over $7 billion for community health centers that provide front line care to millions of families across the country, as well as $620 million for the National Health Service Corps and $120 million for Teaching Health Centers.

Of course, this legislation is not perfect. It includes provisions I do not support, such as reforms to Medigap deductibles for new Medicare beneficiaries beginning in 2020. However, this measure seeks to protect our most vulnerable citizens by permanently extending the Qualifying Individual (OI) program that helps low-income seniors pay their Medicare Part B premiums, and the Transitional Medical Assistance (TMA) program that assists families on Medicaid maintain their coverage for one year as they transition from welfare to work.

Mr. Speaker, this legislation will end the decade-long cycle of annual SGR patches, restore certainty Medicare providers, and extend vital health care programs our constituents depend on. I am pleased that members on both sides of the aisle have come together to address this issue, and I urge my colleagues to support this legislation and provide continued health security for our seniors, children and families.

Mr. FLORES. Mr. Speaker, I rise in support of H.R. 2, the Medicare Access and CHIP Reauthorization Act.

I came to Congress because Washington was in the midst of a culture of excess—excessive spending, excessive regulation and excessive government.

Today, we have the opportunity to repeal and replace Medicare's SGR, an outdated reimbursement system that for over a decade Congress has passed patch after patch to fix the flawed formula while hiding the true state of Medicare.

Mr. Speaker, this legislation will take crucial steps to change spending and improve health care for America.

Today, we are voting to enact policy and reforms that generate savings and finally incentivize quality of care over quantity.

I urge all of my colleagues to support H.R. 2.

Mr. VAN HOLLEN. Mr. Speaker, I rise today in support of H.R. 2, Medicare Access and CHIP Reauthorization Act. This bill is not perfect but on its whole, it extends critical funding to ensure that kids in the Children's Health Insurance Program (CHIP) don't lose access to health insurance and to keep community health centers open to serve hardworking American families. It funds the successful Home Visiting Program, makes permanent a program to assist low-income seniors afford their care premiums, and suspends families on Medicaid who are transitioning to work.

On top of preventing massive cuts to these programs, the legislation replaces a flawed payment system that wasn't working for people in Medicare, their physicians, or taxpay.

In some areas—specifically in extending funding for CHIP for two years—I don't think the bill goes far enough. As a longtime supporter of CHIP, I advocated to extend funding for four years and included a four-year extension in the budget I offered in the House.

House Republicans fought for a four-year extension but was met with resistance from Republicans who have made quite clear that they would rather roll back coverage for kids in CHIP. Despite the two-year compromise, I'm pleased that the legislation funds CHIP at current levels and maintains the safeguards we set in the Affordable Care Act (ACA) to ensure coverage for every eligible child in the nation. Failure to pass this bill and fund CHIP would cause millions of kids to become uninsured or lose access to services, or would cause their parents to face higher out-of-pocket costs.

The bill also includes two years of additional funding for community health centers which provide primary care to families, seniors, people with disabilities, and veterans in Maryland and across the nation. Health centers keep people healthy and working by responding to the unique needs of their communities, create good-paying jobs, and train the next generation of the health care workforce. Without this bill, funding for health centers would be cut by 20 percent and over 7 million Americans could be at risk of losing critical health services. Not funding very cost-effective health providers is irresponsible and unfair to hardworking American families.

It comes as no surprise that my Republican colleagues would have liked to hijack this bill for their arsenal in their unending assault on women's health. If you need any evidence, just look at what Republicans did in the Senate trying to use the human trafficking bill to expand the Hyde amendment to permanent funds and non-taxpayer funds. I applaud the Democratic Senators blocking that Republican anti-choice effort. Let me be clear; this bill does not do that. I worked with Leader PELOSI and the co-chairs of the House Pro-Choice Caucus, of which I am a member, to counter attention with a more humane approach to health care.

As a result, this bill continues the current policy for funding for community health centers. Just like the Hyde language included in annual appropriations bills, the provision is limited to tax payer funds and temporary—terminating when the funding expires in 2017. I strongly share the ongoing concerns of the reproductive health community and I remain deeply committed to protecting a woman's fundamental right to choose her health care.

Finally, the bill repeals and replaces a deeply flawed physician payment system for paying physicians that basically penalizes doctors for participating in Medicare. For more than ten years, doctors have faced the threat of steep rate cuts required by a mindless formula in the law. Congress has repeatedly adopted short-term patches to prevent these cuts from taking effect. This crisis-driven approach to paying physicians makes it difficult for doctors to participate in Medicare, which ultimately is unfair to their patients—the seniors and disabled workers who rely on Medicare for access to the health care services they need. The bill right sizes the Medicare physician payment system that improves quality of care for people with Medicare.

Mr. Speaker, today's bill is not perfect but Congress must move forward with this bipartisan agreement to protect the health of America's families, children and seniors. I urge support of H.R. 2.

Mr. LYNCH. Mr. Speaker, I rise today in support of the Medicare and CHIP Reauthorization Act, H.R. 2.

A bipartisan Energy and Commerce Chairman FRED UPTON and ranking member FRANK PALONE as well as Ways and Means Chairman PAUL RYAN and ranking member SANDER LEVIN for their hard work in putting this bill together.

The sustainable growth rate (SGR) was part of the Balanced Budget Act of 1997 but has proven to be far less than sustainable.

In fact, according to the Congressional Research Service, since 2003 Congress passed 17 laws overriding the SGR-mandated reductions in the Medicare physician fee schedule. This is not a perfect bill but it seems to strike enough compromises that many of us are willing to support a good bill rather than hold out for a perfect one.
I am particularly pleased that the bill includes a two-year extension of the Health Center Fund, which will provide an additional $3.6 billion per year to the nation’s community health centers.

Created under the Affordable Care Act to expand the health centers program and increase access to care, the fund is set to expire after 2015. Should it expire, health centers would be facing a 70% cut in funding which would force devastating reductions and closures at many of the more than 9,000 health centers nationwide.

We simply cannot allow that to happen.

Community health centers are critical to the health care equation, meeting the needs of roughly 23 million people every year. In fact, as we recognize the 50th anniversary of the more than 9,000 health centers nationwide, they are located in every corner of our country and serving all our constituents, Democrat and Republican, young and old, black, white or brown, they are vital to all our communities, and that is why this program has strong bipartisan support.

Whether you supported the Affordable Care Act or think we can do better, I urge my colleagues to join me in supporting this bill.

The SPEAKER pro tempore. The previous question is ordered on the Journal, which the Chair will put to the House for one minute and to read a third time.

The bill was ordered to engross and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BRADY of Texas. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on passage of the bill will be followed by a 5-minute vote on agreeing to the Speaker’s approval of the Journal, if ordered.

The vote was taken by electronic device, and there were—yeas 392, nays 37, not voting 4, as follows:

[Roll No. 114]

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