women, and 17 states fund these services. This rider effectively prevents low-income women in D.C. from exercising their constitutional right to abortion by depriving them of necessary funds.

Remarkably, this bill could have been even more harmful to the District of Columbia. Three amendments were filed to block D.C. gun safety laws, but they were not made in order. There was no way the Republican leadership could bring these deadly amendments to the floor so soon after Orlando. Representative Thomas Massie filed two amendments. One would have allowed handguns, shotguns and rifles to be carried, openly or concealed, on the streets of the nation's capital. The other would have blocked D.C. from enforcing its enhanced penalties for carrying a gun in schools and other places where children congregate. Representative DAVID SCHWEIKERT filed an amendment that would have allowed people to get a concealed carry permit without demonstrating a "good cause" for needing one.

These amendments presented a threat not only to D.C. residents, but also to the millions who visit the nation's capital and the high-ranking federal officials and foreign dignitaries who travel around the city daily.

Republicans claim to support devolving federal authority to state and local governments. That support should not end at the D.C. border. The Constitution allows, but does not require, Congress to legislate on local D.C. matters. The Rules Committee had a choice to allow me to offer my amendments on the floor to strike the D.C. marijuana and abortion riders, as well as to block the Palmer amendment. In our American democracy in the 21st century, that choice should not have been difficult.

The material previously referred to by Mr. MCGOVERN is as follows:

AN AMENDMENT TO H. RES. 794 OFFERED BY MR. MCGOVERN

At the end of the resolution, add the following new sections:

SEC. 8. Immediately upon adoption of this resolution the Speaker shall, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 1076) to increase public safety by permitting the Attorney General to deny the transfer of a firearm or the issuance of firearms or explosives licenses to a known or suspected dangerous terrorist. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chair and ranking minority member of the Committee on the Judiciary. After general debate the bill shall be considered for amendment under the five-minute rule. All points of order against provisions in the bill are waived. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. If the Committee of the Whole rises and reports that it has come to no resolution on the bill, then on the next legislative day the House shall, immediately after the third daily order of business under clause 1 of rule XIV, resolve into the Committee of the Whole for further consideration of the bill.

SEC. 9. Clause 1(c) of rule XIX shall not apply to the consideration of H.R. 1076.

THE VOTE ON THE PREVIOUS QUESTION: WHAT IT REALLY MEANS

This vote, the vote on whether to order the previous question on a special rule, is not merely a procedural vote. A vote against ordering the previous question is a vote against the Republican majority agenda and a vote to allow the Democratic minority to offer an alternative plan. It is a vote about what the House should be debating.

Mr. Clarence Cannon's Precedents of the House of Representatives (VI, 308–311), describes the vote on the previous question on the rule as "a motion to direct or control the consideration of the subject before the House being made by the Member in charge." To defeat the previous question is to give the opposition a chance to decide the subject before the House. Cannon cites the Speaker's ruling of January 13, 1920, to the effect that "the refusal of the House to sustain the demand for the previous question passes the control of the resolution to the opposition" in order to offer an amendment. On March 15, 1909, a member of the majority party offered a rule resolution. The House defeated the previous question and a member of the opposition rose to a parliamentary inquiry, asking who was entitled to recognition. Speaker Joseph G. Cannon (R–Illinois) said: "The previous question having been refused, the gentleman from New York, Mr. Fitzgerald, who had asked the gentleman to yield to him for an amendment, is entitled to the first recognition."

The Republican majority may say "the vote on the previous question is simply a vote on whether to proceed to an immediate vote on adopting the resolution . . . [and] has no substantive legislative or policy implications whatsoever." But that is not what they have always said. Listen to the Republican Leadership Manual on the Legislative Process in the United States House of Representatives, (6th edition, page 135). Here's how the Republicans describe the previous question vote in their own manual: "Although it is generally not possible to amend the rule because the majority Member controlling the time will not yield for the purpose of offering an amendment, the same result may be achieved by voting down the previous question on the rule . . . When the motion for the previous question is defeated, control of the time passes to the Member who led the opposition to ordering the previous question. That Member, because he then controls the time, may offer an amendment to the rule, or yield for the purpose of amendment."

In Deschler's Procedure in the U.S. House of Representatives, the subchapter titled "Amending Special Rules" states: "a refusal to order the previous question on such a rule [a special rule reported from the Committee on Rules] opens the resolution to amendment and further debate." (Chapter 21, section 21.2) Section 21.3 continues: "Upon rejection of the motion for the previous question on a resolution reported from the Committee on Rules, control shifts to the Member leading the opposition to the previous question, who may offer a proper amendment or motion and who controls the time for debate thereon."

Clearly, the vote on the previous question on a rule does have substantive policy implications. It is one of the only available tools for those who oppose the Republican majority's agenda and allows those with alternative views the opportunity to offer an alternative plan.

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

The SPEAKER pro tempore. The question is on ordering the previous question.

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

Mr. MCGOVERN. 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, further proceedings on this question will be postponed.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 30, 2016.

Hon. PAUL D. RYAN,
The Speaker, House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on June 30, 2016 at 3:01 p.m.:

That the Senate relative to the death of Pat Summitt S. Res. 516.

With best wishes, I am,

Sincerely,

KAREN L. HAAS.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

Record votes on postponed questions will be taken later.

PATIENT ACCESS TO DURABLE MEDICAL EQUIPMENT ACT OF 2016

Mr. PITTS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5210) to improve access to durable medical equipment for Medicare beneficiaries under the Medicare program, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5210

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Patient Access to Durable Medical Equipment Act of 2016" or the "PADME Act".

SEC. 2. INCREASING OVERSIGHT OF TERMINATION OF MEDICAID PROVIDERS.

(a) INCREASED OVERSIGHT AND REPORTING.—

(1) STATE REPORTING REQUIREMENTS.—Section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)) is amended—

(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7) the following new paragraph:

''(8) PROVIDER TERMINATIONS.—

''(A) IN GENERAL.—Beginning on July 1, 2018, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider of services or any other person under the State plan (or under a waiver of the plan), the State, not later than 21 business days after the effective date of such termination, submits to the Secretary with respect to any such provider or person, as appropriate—

''(i) the name of such provider or person;

''(ii) the provider type of such provider or person;

''(iii) the specialty of such provider's or person's practice;

''(iv) the date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of such provider or person;

''(v) the reason for the termination;

''(vi) a copy of the notice of termination sent to the provider or person;

''(vii) the date on which such termination is effective, as specified in the notice; and

''(viii) any other information required by the Secretary.

''(B) EFFECTIVE DATE DEFINED.—For purposes of this paragraph, the term 'effective date' means, with respect to a termination described in subparagraph (A), the later of—

''(i) the date on which such termination is effective, as specified in the notice of such termination; or

''(ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.''.

(2) CONTRACT REQUIREMENT FOR MANAGED CARE ENTITIES.—Section 1932(d) of the Social Security Act (42 U.S.C. 1396u–2(d)) is amended by adding at the end the following new paragraph:

''(5) CONTRACT REQUIREMENT FOR MANAGED CARE ENTITIES.—With respect to any contract with a managed care entity under section 1903(m) or 1905(t)(3) (as applicable), no later than July 1, 2018, such contract shall include a provision that providers of services or persons terminated (as described in section 1902(kk)(8)) from participation under this title, title XVIII, or title XXI be terminated from participating under this title as a provider in any network of such entity that serves individuals eligible to receive medical assistance under this title.''.

(3) TERMINATION NOTIFICATION DATABASE.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

''(ll) TERMINATION NOTIFICATION DATABASE.—In the case of a provider of services or any other person whose participation under this title, title XVIII, or title XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 21 business days after the date on which the Secretary terminates such participation under title XVIII or is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111–148).''.

(4) NO FEDERAL FUNDS FOR ITEMS AND SERVICES FURNISHED BY TERMINATED PROVIDERS.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(A) in subsection (i)(2)—

(i) in subparagraph (A), by striking the comma at the end and inserting a semicolon;

(ii) in subparagraph (B), by striking ''or'' at the end; and

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

''(D) beginning not later than July 1, 2018, under the plan by any provider of services or person whose participation in the State plan is terminated (as described in section 1902(kk)(8)) after the date that is 60 days after the date on which such termination is included in the database or other system under section 1902(ll); or''; and

(B) in subsection (m), by inserting after paragraph (2) the following new paragraph:

''(3) No payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity (as defined under section 1932(a)(1)) under the State plan under this title (or under a waiver of the plan) unless the State—

''(A) beginning on July 1, 2018, has a contract with such entity that complies with the requirement specified in section 1932(d)(5); and

''(B) beginning on January 1, 2018, complies with the requirement specified in section 1932(d)(6)(A).''.

(5) DEVELOPMENT OF UNIFORM TERMINOLOGY FOR REASONS FOR PROVIDER TERMINATION.—Not later than July 1, 2017, the Secretary of Health and Human Services shall, in consultation with the heads of State agencies administering State Medicaid plans (or waivers of such plans), issue regulations establishing uniform terminology to be used with respect to specifying reasons under subparagraph (A)(v) of paragraph (8) of section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)), as amended by paragraph (1), for the termination (as described in such paragraph) of the participation of certain providers in the Medicaid program under title XIX of such Act or the Children's Health Insurance Program under title XXI of such Act.

(6) CONFORMING AMENDMENT.—Section 1902(a)(41) of the Social Security Act (42 U.S.C. 1396a(a)(41)) is amended by striking ''provide that whenever'' and inserting ''provide, in accordance with subsection (kk)(8) (as applicable), that whenever''.

(b) INCREASING AVAILABILITY OF MEDICAID PROVIDER INFORMATION.—

(1) FFS PROVIDER ENROLLMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following new paragraph:

''(78) provide that, not later than January 1, 2017, in the case of a State plan (or a waiver of the plan) that provides medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider;''.

(2) MANAGED CARE PROVIDER ENROLLMENT.—Section 1932(d) of the Social Security Act (42 U.S.C. 1396u–2(d)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

''(6) ENROLLMENT OF PARTICIPATING PROVIDERS.—

''(A) IN GENERAL.—Beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled with the State agency administering the State plan under this title (or waiver of the plan). Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.

''(B) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as requiring a provider described in such subparagraph to provide services to individuals who are not enrolled with a managed care entity under this title.''.

(c) COORDINATION WITH CHIP.—

(1) IN GENERAL.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B), (C), (D), (E), (F), (G), (H), (I), (J), (K), (L), (M), (N), and (O) as subparagraphs (D), (E), (F), (G), (H), (I), (J), (K), (M), (N), (O), (P), (Q), and (R), respectively;

(B) by inserting after subparagraph (A) the following new subparagraphs:

''(B) Section 1902(a)(39) (relating to termination of participation of certain providers).

''(C) Section 1902(a)(78) (relating to enrollment of providers participating in State plans providing medical assistance on a fee-for-service basis).'';

(C) by inserting after subparagraph (K) (as redesignated by subparagraph (A)) the following new subparagraph:

''(L) Section 1903(m)(3) (relating to limitation on payment with respect to managed care).''; and

(D) in subparagraph (P) (as redesignated by subparagraph (A)), by striking ''(a)(2)(C) and (h)'' and inserting ''(a)(2)(C) (relating to Indian enrollment), (d)(5) (relating to contract requirement for managed care entities), (d)(6) (relating to enrollment of providers participating with a managed care entity), and (h) (relating to special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities)''.

(2) EXCLUDING FROM MEDICAID PROVIDERS EXCLUDED FROM CHIP.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)(39)) is amended by striking ''title XVIII or any other State plan under this title'' and inserting ''title XVIII, any other State plan under this title (or waiver of the plan), or any State child health plan under title XXI (or waiver of the plan)''.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act.

(e) OIG REPORT.—Not later than March 31, 2020, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the implementation of the amendments made by this section. Such report shall include the following:

(1) An assessment of the extent to which providers who are included under subsection (ll) of section 1902 of the Social Security Act (42 U.S.C. 1396a) (as added by subsection (a)(3)) in the database or similar system referred to in such subsection are terminated (as described in subsection (kk)(8) of such section, as added by subsection (a)(1)) from participation in all State plans under title XIX of such Act (or waivers of such plans).

(2) Information on the amount of Federal financial participation paid to States under section 1903 of such Act in violation of the

limitation on such payment specified in subsections (i)(2)(D) and (m)(3) of such section, as added by subsection (a)(4) of this section.

(3) An assessment of the extent to which contracts with managed care entities under title XIX of such Act comply with the requirement specified in section 1932(d)(5) of such Act, as added by subsection (a)(2) of this section.

(4) An assessment of the extent to which providers have been enrolled under section 1902(a)(78) or 1932(d)(6)(A) of such Act (42 U.S.C. 1396a(a)(78), 1396u–2(d)(6)(A)) with State agencies administering State plans under title XIX of such Act (or waivers of such plans).

SEC. 3. REQUIRING PUBLICATION OF FEE-FOR-SERVICE PROVIDER DIRECTORY.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (80), by striking ''and'' at the end;

(2) in paragraph (81), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (81) the following new paragraph:

''(82) provide that, not later than January 1, 2017, in the case of a State plan (or waiver of the plan) that provides medical assistance on a fee-for-service basis or through a primary care case-management system described in section 1915(b)(1) (other than a primary care case management entity (as defined by the Secretary)), the State shall publish (and update on at least an annual basis) on the public Website of the State agency administering the State plan, a directory of the physicians described in subsection (mm) and, at State option, other providers described in such subsection that—

''(A) includes—

''(i) with respect to each such physician or provider—

''(I) the name of the physician or provider;

''(II) the specialty of the physician or provider;

''(III) the address at which the physician or provider provides services; and

''(IV) the telephone number of the physician or provider; and

''(ii) with respect to any such physician or provider participating in such a primary care case-management system, information regarding—

''(I) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title; and

''(II) the physician's or provider's cultural and linguistic capabilities, including the languages spoken by the physician or provider or by the skilled medical interpreter providing interpretation services at the physician's or provider's office; and

''(B) may include, at State option, with respect to each such physician or provider—

''(i) the Internet website of such physician or provider; or

''(ii) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title.''.

(b) DIRECTORY PHYSICIAN OR PROVIDER DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 2(a)(3), is further amended by adding at the end the following new subsection:

''(mm) DIRECTORY PHYSICIAN OR PROVIDER DESCRIBED.—A physician or provider described in this subsection is—

''(1) in the case of a physician or provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the physician or provider to individuals eligible to receive medical assistance under the State plan, requires the enrollment of the physician or provider with the State agency, a physician or a provider that—

''(A) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(82); and

''(B) received payment under the State plan in the 12-month period preceding such date; and

''(2) in the case of a physician or provider of a provider type for which the State agency does not require such enrollment, a physician or provider that received payment under the State plan (or waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(82).''.

(c) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—The amendment made by subsection (a) shall not be construed to apply in the case of a State (as defined for purposes of title XIX of the Social Security Act) in which all the individuals enrolled in the State plan under such title (or under a waiver of such plan), other than individuals described in paragraph (2), are enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A))), including prepaid inpatient health plans and prepaid ambulatory health plans (as defined by the Secretary of Health and Human Services).

(2) INDIVIDUALS DESCRIBED.—An individual described in this paragraph is an individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) or an Alaska Native.

(d) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this section, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

SEC. 4. EXTENSION OF THE TRANSITION TO NEW PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall extend the transition period described in clause (i) of section 414.210(g)(9) of title 42, Code of Federal Regulations, from June 30, 2016, to September 30, 2016 (with the full implementation described in clause (ii) of such section applying to items and services furnished with dates of service on or after October 1, 2016).

(b) STUDY AND REPORT.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study that examines the impact of applicable payment adjustments upon—

(i) the number of suppliers of durable medical equipment that, on a date that is not before January 1, 2016, and not later than September 1, 2016, ceased to conduct business as such suppliers; and

(ii) the availability of durable medical equipment, during the period beginning on January 1, 2016, and ending on September 1, 2016, to individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or enrolled under part B of such title.

(B) DEFINITIONS.—For purposes of this subsection, the following definitions apply:

(i) SUPPLIER; DURABLE MEDICAL EQUIPMENT.—The terms ''supplier'' and ''durable medical equipment'' have the meanings given such terms by section 1861 of the Social Security Act (42 U.S.C. 1395x).

(ii) APPLICABLE PAYMENT ADJUSTMENT.—The term ''applicable payment adjustment'' means a payment adjustment described in section 414.210(g) of title 42, Code of Federal Regulations, that is phased in by paragraph (9)(i) of such section. For purposes of the preceding sentence, a payment adjustment that is phased in pursuant to the extension under subsection (a) shall be considered a payment adjustment that is phased in by such paragraph (9)(i).

(2) REPORT.—The Secretary of Health and Human Services shall, not later than September 10, 2016, submit to the Committees on Ways and Means and on Energy and Commerce of the House of Representatives, and to the Committee on Finance of the Senate, a report on the findings of the study conducted under paragraph (1).

SEC. 5. EXCLUSION OF PAYMENTS FROM STATE EUGENICS COMPENSATION PROGRAMS FROM CONSIDERATION IN DETERMINING ELIGIBILITY FOR, OR THE AMOUNT OF, FEDERAL PUBLIC BENEFITS.

(a) IN GENERAL.—Notwithstanding any other provision of law, payments made under a State eugenics compensation program shall not be considered as income or resources in determining eligibility for, or the amount of, any Federal public benefit.

(b) DEFINITIONS.—For purposes of this section:

(1) FEDERAL PUBLIC BENEFIT.—The term ''Federal public benefit'' means—

(A) any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or by appropriated funds of the United States; and

(B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of the United States.

(2) STATE EUGENICS COMPENSATION PROGRAM.—The term ''State eugenics compensation program'' means a program established by State law that is intended to compensate individuals who were sterilized under the authority of the State.

SEC. 6. DEPOSIT OF SAVINGS INTO MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''$0'' and inserting ''$3,000,000''.

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

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

Mr. PITTS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill, including an exchange of letters between the Committee on Energy and Commerce and the Committee on Ways and Means.

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

There was no objection.

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

Mr. Speaker, the bipartisan bill before us accomplishes several important objectives. Since 2003, the durable medical equipment, DME, competitive bidding program has required DME suppliers in certain large, densely populated areas to compete for contracts to serve Medicare beneficiaries in those areas. This market-based competition has saved the Medicare program and beneficiaries billions of dollars in saving and reduced cost sharing.

Since 2009, CMS has had the authority to expand the program to additional areas, and in 2014 the agency published a final rule that will expand competitive bidding to all areas of the country. Beginning January 1, 2016, CMS began phasing in new regional reimbursement rates for noncompetitive bid areas using a 50–50 blend of old and new rates. Starting July 1, rates will be based on the new calculations.

To ensure we have a full appreciation of the impact of the phase-in, the bill continues the 50–50 blend payment for an additional 3 months. It also requires HHS to report to Congress on any access issues caused by the blended rate before the full rate change can go into effect.

The bill also improves access to quality healthcare providers for vulnerable Medicaid patients and includes legislation that recently passed the House 406–0.

In this legislation, we again reiterate the House's support to address two important issues that plague Medicaid beneficiaries: first, State Medicaid programs too often suffer from waste, fraud, and abuse; and, second, too many Medicaid patients may have a hard time finding a doctor.

The bill would ensure healthcare providers terminated from Medicare or one State's Medicaid program for reasons of fraud, integrity, or quality are also terminated from other State Medicaid programs. The Office of Inspector General at HHS has previously found that 12 percent of terminated providers were participating in a State Medicaid program after the same provider was terminated from another State Medicaid program. It is critical that fraudulent providers are not allowed to defraud taxpayers or harm patients across the board.

The bill also requires State Medicaid programs to provide beneficiaries served under fee-for-service or primary care case management programs an electronic directory of physicians participating in the program. This important effort will address a critical challenge of Medicaid patients in accessing certain types of care, such as obtaining specialty care or dental care. Medicaid patients would now have better information by simply applying requirements similar to those in place for Medicaid-managed care plans to fee-for-service and/or primary care case management programs.

Finally, the bill includes legislation by Mr. MCHENRY and Mr. BUTTERFIELD that ensures that payments made under a State eugenics compensation program cannot be considered as income in determining eligibility for any Federal public benefit. Simply put, the bill prevents any funds from such a compensation program to be counted as income for purposes of receiving any Federal benefits.

According to the Congressional Budget Office, H.R. 5210, as amended, would be completely offset over the budget window. We will provide more time to understand the impact of DME payment changes on Medicare beneficiaries. We will also enact commonsense reforms that help protect Medicaid beneficiaries, improve access to care, and enact an important clarification for those eligible for certain State compensation programs.

I want to thank Ranking Member PALLONE and his staff as well as the Committee on Ways and Means for their work on this compromise, and I urge my colleagues to support H.R. 5210, as amended.

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

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, June 21, 2016.

The Hon. FRED UPTON,
Chairman, Committee on Energy and Commerce, Washington, DC.

DEAR CHAIRMAN UPTON: I am writing concerning H.R. 5210, the "Patient Access to Durable Medical Equipment Act of 2016," on which the Committee on Ways and Means was granted an additional referral.

In order to allow H.R. 5210 to move expeditiously to the House floor, I agree to waive formal consideration of this bill. The Committee on Ways and Means takes this action with our mutual understanding that by foregoing consideration on H.R. 5210 at this time, we do not waive any jurisdiction over subject matter contained in this or similar legislation, and that our Committee will be appropriately consulted and involved as this bill or similar legislation moves forward. Our Committee also reserves the right to seek appointment of an appropriate number of conferees to any House-Senate conference involving this or similar legislation, and asks that you support any such request.

I would appreciate your response to this letter confirming this understanding, and would request that you include a copy of this letter and your response in the Congressional Record during the floor consideration of this bill. Thank you in advance for your cooperation.

Sincerely,

KEVIN BRADY,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, June 21, 2016.

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

DEAR CHAIRMAN BRADY: Thank you for your letter regarding H.R. 5210, the "Patient Access to Durable Medical Equipment Act of 2016," on which the Committee on Ways and Means was granted an additional referral.

I appreciate your agreeing to waive formal consideration of H.R. 5210 in order to allow the bill to move expeditiously to the House floor.

I agree that by foregoing consideration on H.R. 5210 at this time, the Committee on Ways and Means does not waive any jurisdiction over subject matter contained in this or similar legislation, and that the Committee will be appropriately consulted and involved as this bill or similar legislation moves forward. I also agree that the Committee reserves the right to seek appointment of an appropriate number of conferees to any House-Senate conference involving this or similar legislation, and I will support any such request.

Finally, I will include a copy of your letter and this response in the Congressional Record during the floor consideration of this bill.

Sincerely,

FRED UPTON,
Chairman.

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

I thank my colleague, Mr. PITTS. It is a pleasure to be working with him and with Mr. PALLONE and Mr. UPTON.

This legislation, as Mr. PITTS indicated, is going to give some relief to communities, particularly rural communities, from the imposition of changes in how charges are made in competitive bidding processes that have a significant potential to make inaccessible durable medical equipment.

I was a cosponsor, but the lead sponsor is here, Dr. PRICE, a good colleague and a really good doctor. Dr. PRICE, Legislator PRICE, came up with a pretty good bill that is going to help Georgia but also help rural Vermont, so I appreciate that.

□ 1745

The bottom line, the DME Competitive Bidding Program was created in 2003. It was aimed at a goal all of us have. It was trying to lower spending on durable medical equipment. It was well-intended, but it has had some serious consequences, especially for rural providers, like in Vermont, and I am sure parts of Georgia and other rural parts of the country.

By the way, when we do something, it can have a good intention, it can even accomplish some of its goals, but I think it always makes sense for us on both sides to step back after there is some history—this went in in 2003—and take a look, kick the tires. What are some of the improvements that we can make so that we get back to the original intention and don't do harm that is unnecessary? And that is what the Price legislation is doing.

In January 2016, the Competitive Bidding Program began its nationwide rollout. That was under the new CMS guidelines. As a result, the rural areas saw significant cuts. It really does jeopardize access to this important equipment for beneficiaries.

The CMS continued its rollout in July with a second round of cuts. It further slashed reimbursement rates for DME across rural America, including Vermont.

In Vermont, we have an excellent equipment provider, Yankee Medical, that is reasonable in its price and incredibly good in its service. It will

bring equipment to people all across rural Vermont. That is such a benefit for folks who can't get out of their homes.

The rural areas do have different challenges than urban areas. It is much more challenging for stakeholders to absorb these cuts. For instance, a small business in rural Vermont in a noncompetitively bid area may not have a large amount of Medicare-related businesses and, therefore, might not be able to afford the prices that a business in a much larger populated area could offer.

So this legislation is going to put on hold for 3 months what these prices will be. It is going to allow time for some adjustment and, hopefully, for us to consider other positive reforms that will be helpful to maintaining access to important healthcare equipment for folks in rural Vermont and rural America.

The bill contains a couple of other provisions, one of which I will speak about. My colleague on the Energy and Commerce Committee, Mr. BUCSHON, was the lead sponsor and I was his cosponsor. As a way to pay for this—and that was cracking down on this Medicare fraud, where there has been a failure administratively—when a provider is found to be fraudulent in one district, that fraud is not then communicated to all other districts or States, so that fraudulent provider tries to just take their operation elsewhere. This is going to require that notification and it is going to shut down that fraud much more quickly, saving money, and then helping us to pay for this.

So this is practical legislation, the result of a compromise by the chairman and ranking member of the Energy and Commerce Committee, Mr. PITTS, and some of my colleagues. Mr. LOEBSACK of Iowa played a very, very active role in this legislation. Of course, Dr. PRICE did as well.

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

Mr. PITTS. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. PRICE), the distinguished Budget Committee chairman.

Mr. TOM PRICE of Georgia. Mr. Speaker, I want to thank the gentleman from Pennsylvania for his work on this and his interest and passion for healthcare issues and the work that we do in this House. I also want to thank the gentleman from Vermont for his kind words and the work he has done on this; and the gentleman from Iowa as well, who has been instrumental in moving this legislation forward.

Mr. Speaker, many Medicare beneficiaries rely on a set of healthcare products and services that are classified as durable medical equipment, or DME. DME is often life-improving or lifesaving; things like blood sugar monitors, canes, crutches, hospital beds, power wheelchairs, and even things like oxygen supplies and tanks. Without access to these items, many Medicare beneficiaries would not be able to survive or would see their quality of life greatly diminished.

In January 2016, Medicare started to slash reimbursement rates for these products and services as part of a nationwide rollout of their Competitive Bidding Program.

Mr. Speaker, I would suggest that this program is neither competitive nor is it a real bidding process. CMS now wants to extend these substandard rates and this substandard program to other areas, as you have heard, including rural regions of our Nation, where these new rates will oftentimes not even cover the cost of the delivery of the item or the service, which means they just won't happen.

In addition, this CMS program has failed to hold bidders to account. It has failed to produce rates that are financially sustainable for those who are trying to provide these service and items to patients.

The National Minority Quality Forum has data that demonstrates this program is driving up costs through avoidable hospital bills and inpatient admissions, increasing out-of-pocket payments by patients, and has led to increased mortality rates. Mr. Speaker, that is more people dying in our Nation because of this program.

In just my home State of Georgia, there has been a 20 percent decrease in the number of DME suppliers between 2013 and 2016. The number of medical equipment supply stores in our State has similarly decreased by nearly 40 percent.

The legislation we have before us today, H.R. 5210, would provide a 3-month delay in the cuts, hopefully allowing for work to be done to come up with a real solution.

This legislation represents a bipartisan commitment to ensure that Medicare beneficiaries continue receiving critical care provided through durable medical equipment, particularly those living in the rural areas of our Nation who would be disproportionately harmed by cuts in reimbursements.

Again, this delay will, hopefully, provide policymakers additional time to come up with a consensus on a long-term solution. Every effort must be made to protect access to quality health care for seniors.

I want to thank, again, my colleagues on both sides of the aisle for their work on this issue. I want to, once again, commend Chairman PITTS for his work on this issue.

I urge adoption of the bill.

Mr. PITTS. Mr. Speaker, I urge support for this bipartisan bill, H.R. 5210.

I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I cannot support a delay in the expansion of the competitive bidding program. Competitive bidding for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) has saved the Medicare program billions of dollars. And lowering costs for the Medicare program means lower copayments for Medicare beneficiaries.

Over the years, it has been widely documented by the HHS Office of Inspector General and the Government Accountability Office that Medicare payments for DMEPOS far exceeded reasonable costs. This is why Congress passed legislation requiring competitive bidding for DMEPOS incrementally. Since 2011, CMS has closely monitored all beneficiaries in the competitive bidding areas, and there have been no access concerns. Health outcomes are steady compared to before Medicare began the competitive bidding program. CMS will continue to monitor health outcomes, and until we see any concerns, I do not believe we should stop the progress in saving money for both beneficiaries and the Medicare program.

That said, the Medicaid policies in this legislation were passed by the House in March of this year, 406–0, after consideration by the House Energy and Commerce Committee. The first policy, the Medicaid DOC Act, is an initiative first introduced by Reps. COLLINS and TONKO and would require states that participate in fee-for-service Medicaid to publish electronic provider directories. It's important for patients to know what providers participate in the Medicaid program. States are required to provide electronic directories in managed care, but the same requirement does not exist across the full Medicaid program. The Committee worked throughout the legislative process to streamline this policy with current federal provider directory regulations in Medicaid managed care. The legislation details the minimum items that must be included in a provider directory, but also allows states to go beyond these standards.

The second policy is an initiative first introduced by Reps. BUCSHON, WELCH, and BUTTERFIELD and would provide CMS with critical tools to keep patients safe, protect taxpayer dollars, and protect the integrity of the Medicaid program. The ACA included a provision that prohibited disqualified providers from Medicare or one state Medicaid program from simply crossing state lines and receiving payments in another state Medicaid program. Unfortunately, as drafted, the law has been hard to implement, because states don't have a consistent or standardized way of knowing when a specific provider has been terminated by Medicare or another state. States are not currently required to report this information, and if it is reported, it is in many differing formats, limiting the data's usability. This provision would require all states to report information on fraudulent providers to the Secretary for inclusion in a currently existing termination database that is accessible to all states. The legislation also requires the Secretary to develop uniform criteria for states to use when submitting information. I supported both of these commonsense policies in the past, and I continue to support them today.

Mr. MCDERMOTT. Mr. Speaker, this bill, H.R. 5210, the Patient Access to Durable Medical Equipment Act, delays the implementation of recent changes to durable medical equipment payments.

For the past several years, Medicare has been reforming how we pay for DME, including items like oxygen tanks, walkers, or hospital beds.

In much of the country, CMS uses competitive bidding to determine how much DME costs. But in some communities, primarily in rural areas, CMS pays under the DME fee

schedule. Under this payment system, there is no competitive market to drive prices down.

Nonpartisan, independent experts, including MedPAC and the Government Accountability Office, have warned us that Medicare is overpaying for DME through the fee schedule.

To address this problem, CMS has been phasing in new payments that will reduce DME costs under the fee schedule based on competitive bidding pricing. These lower payments are scheduled to be fully phased in by July.

Getting DME costs under control is critical. Higher prices result in increased Medicare spending and, even more importantly, they force beneficiaries to pay more out of pocket.

At the same time, some DME suppliers and beneficiary groups have expressed concerns that lowering the price for DME too far could hinder beneficiary access to important equipment.

To address this issue, the bill before us provides a compromise that will institute a temporary delay of the lower DME fee schedule payments for three months. This pause will allow us to gather more data on how the new payment rates impact beneficiary access.

That being said, it's not entirely clear that this delay is necessary. CMS has already been carefully monitoring access to DME. Just this month, the agency released data showing that payment cuts have not caused any harm to suppliers or to beneficiaries.

Even as we have significantly reduced spending, suppliers continue to accept the reformed payment rates, and there is no evidence that beneficiary access to high quality DME has been hindered.

This bill will give us three more months to verify that this is the case. This is only a short-term freeze, and if the evidence continues to show that the new payment rates are working, there will be no reason for us to delay any longer.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Pennsylvania (Mr. PITTS) that the House suspend the rules and pass the bill, H.R. 5210, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

SUPPORTING AMERICA'S INNOVATORS ACT OF 2016

Mr. GARRETT. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4854) to amend the Investment Company Act of 1940 to expand the investor limitation for qualifying venture capital funds under an exemption from the definition of an investment company, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4854

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Supporting America's Innovators Act of 2016''.

SEC. 2. INVESTOR LIMITATION FOR QUALIFYING VENTURE CAPITAL FUNDS.

Section 3(c)(1) of the Investment Company Act of 1940 (15 U.S.C. 80a–3(c)(1)) is amended—

(1) by inserting after ''one hundred persons'' the following: ''(or, with respect to a qualifying venture capital fund, 250 persons)''; and

(2) by adding at the end the following:

''(C) The term 'qualifying venture capital fund' means any venture capital fund (as defined pursuant to section 203(l)(1) of the Investment Advisers Act of 1940 (15 U.S.C. 80b–3(l)(1)) with no more than $10,000,000 in invested capital, as such dollar amount is annually adjusted by the Commission to reflect the change in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. GARRETT) and the gentlewoman from California (Ms. MAXINE WATERS) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. GARRETT. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and include extraneous material on this bill.

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

There was no objection.

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

Mr. Speaker, I rise in support of H.R. 4854, Supporting America's Innovators Act of 2016; and I want to thank the sponsor of the legislation, the gentleman from North Carolina (Mr. MCHENRY).

Mr. Speaker, it is no secret that 7 years after our last recession apparently ended, our economy continues to trudge along at historically weak rates of growth and job creation.

Three points: The most recent jobs report showed that only 38,000 jobs were created during the month of May. That was the worst report since 2010;

New business startups in the country are near a 20-year low;

And, finally, American families and small businesses are finding it extremely difficult to obtain credit in order to expand their businesses or purchase a home.

More than ever, Mr. Speaker, Americans are looking at us, their elected Representatives in Congress, to help get our economy back on track and create opportunities for people that have struggled for too long.

Fortunately, over the last 5 years, the Financial Services Committee has stepped up to the plate and passed a number of bipartisan pieces of legislation. Most notably, in 2012, Congress passed the JOBS Act, which is one of the few bright spots. In April, the Capital Markets and GSE Subcommittee held a hearing to examine the positive impacts that the JOBS Act has had, and to consider further ways that we can work across the aisle to promote job growth. But for just about every measure the JOBS Act has been a resounding success, there is more that Congress can be doing.

So today, Mr. Speaker, the House will consider a couple of measures that will build upon the success of the JOBS Act. The first is this one. This measure is Supporting America's Innovation Act of 2016.

What will the bill do?

First, it would fix what is known as the 99 investor problem. That is, under current securities law, once a venture capital fund gains more than 99 investors, it would have to become registered with the SEC under the Investment Company Act of 1940.

Just in case there is any confusion, registering with the SEC isn't free. It creates a number of costs and regulatory burdens on small venture funds that hinder the ability to deploy vital capital for startup businesses.

What is more, the current investor cap was put in place way back in 1940, at a time when nobody had ever heard of Silicon Valley, and venture capital did not play anywhere near the role it does today.

So while the JOBS Act raised the registration threshold for private companies from 500 to 2,000 investors, it did not concurrently raise the threshold for investors acting as a coordinated group.

As Kevin Laws, COO of AngelList, told our subcommittee back in April:

> With online fundraising and general solicitation becoming more common because of the JOBS Act, companies are bumping up against the limit more frequently. The limit of 99 investors now acts as a brake on the amount of capital that they can raise.

So, Mr. Speaker, in conclusion, the solution envisioned under this legislation is simple. It simply bumps the number from 100 to 250, and it clarifies that registration would not be triggered until the fund crossed a threshold of $10 million invested in a particular company.

This legislation is simple. It is straightforward. It would allow venture capital funds to continue to play the important role they do in our economy without any of the burden having to deal with any unnecessary regulation.

So, once again, I thank the sponsor of the underlying bill, and I urge my colleagues to support it.

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

Ms. MAXINE WATERS of California. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker and Members, this bill, H.R. 4854, is an example of how the two sides can work together. I worked with Mr. MCHENRY on this legislation. It just goes to show that when the opposite side of the aisle is not focused on trying to destroy and undo Dodd-Frank, we can get to doing some credible legislation.

So I am very, very pleased about this legislation. It is another piece of legislation intended to help our Nation's