

When was a budget passed in calendar year 2007? It was passed on March 29. I would point out that the only thing bipartisan about that budget resolution was the opposition.

Calendar 2008, a bit better, the budget passed on March 13, the middle of the month, about 2 weeks from where we are today. Once again, on that budget, 212 yeas and 207 nays. But the nays were bipartisan. The yeas, of course, were of a single party.

Calendar year 2009, the budget didn't pass until the month of April, and, once again, the only thing bipartisan about the budget that year was its opposition.

Then, finally, I would point out that the following calendar year, 2010, there was no budget submitted.

So, Mr. Speaker, my understanding from the chairman of the Budget Committee is they are actively working on the budget. I wish them Godspeed. I am thankful that I don't have to be in the room while it is being done, but I have every confidence that they will produce a budget document that the House will then consider. But today—today—Mr. Speaker, today's rule provides for consideration of an important fix to the Nation's Medicaid program.

I certainly want to thank Dr. LARRY BUCSHON and Mr. COLLINS of New York—both, of the Energy and Commerce Committee, two important members of the Committee on Energy and Commerce—for their work on this legislation.

Mr. Speaker, I urge my colleagues to vote "yes" on the rule and "yes" on the underlying bill.

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

AN AMENDMENT TO H. RES. 632 OFFERED BY
MR. HASTINGS OF FLORIDA

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

SEC. 2. Immediately upon the adoption of this resolution it shall be in order without intervention of any point of order to consider in the House the resolution (H. Res. 624) Directing the Committee on the Budget to hold a public hearing on the President's fiscal year 2017 budget request with the Director of the Office of Management and Budget as a witness. The resolution shall be considered as read. The previous question shall be considered as ordered on the resolution and preamble to adoption without intervening motion or demand for division of the question except one hour of debate equally divided and controlled by the chair and ranking minority member of the Committee on the Budget.

SEC. 3. Clause 1(c) of rule XIX shall not apply to the consideration of H. Res. 624.

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 previous question was ordered.
The resolution was agreed to.

A motion to reconsider was laid on the table.

□ 1245

RECESS

The SPEAKER pro tempore (Mr. BENISHEK). Pursuant to clause 12(a) of rule I, the Chair declares the House in recess for a period of less than 15 minutes.

Accordingly (at 12 o'clock and 51 minutes p.m.), the House stood in recess.

□ 1301

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. DOLD) at 1 o'clock and 1 minute p.m.

ENSURING REMOVAL OF TERMINATED PROVIDERS FROM MEDICAID AND CHIP ACT

GENERAL LEAVE

Mr. BUCSHON. 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. 3716.

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

There was no objection.

The SPEAKER pro tempore. Pursuant to House Resolution 632 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the state of the Union for the consideration of the bill, H.R. 3716.

The Chair appoints the gentleman from North Carolina (Mr. HOLDING) to preside over the Committee of the Whole.

□ 1302

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the state of the Union for the consideration of the bill (H.R. 3716) to amend title XIX of the Social Security Act to require States to provide to the Secretary of Health and Human Services certain information with respect to provider terminations, and for other purposes, with Mr. HOLDING in the chair.

The Clerk read the title of the bill.

The CHAIR. Pursuant to the rule, the bill is considered read the first time.

The gentleman from Indiana (Mr. BUCSHON) and the gentleman from New York (Mr. TONKO) each will control 30 minutes.

The Chair recognizes the gentleman from Indiana.

Mr. BUCSHON. Mr. Chairman, I yield myself such time as I may consume.

The bipartisan bill before us today improves access to quality healthcare providers for vulnerable Medicaid patients.

Today, State Medicaid programs too often suffer from waste, fraud, and abuse, which can harm beneficiaries and waste taxpayer dollars. At the same time, too many Medicaid patients may have a hard time finding a doctor. Our bill takes an important step forward in addressing both of these issues.

First, H.R. 3716 would ensure healthcare providers that are terminated from Medicaid or from 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 to harm patients across the board. Medicaid beneficiaries are some of the most vulnerable patients, so our bipartisan bill will ensure that they are better protected. This commonsense bill was reported favorably from our Health Subcommittee and from the full Energy and Commerce Committee last year.

The other important aspect of this legislation was authored by CHRIS COLLINS of New York. This provision of the bill requires State Medicaid programs to provide beneficiaries who are served under fee-for-service or primary care case management programs an electronic directory of physicians who are participating in the program.

Research shows that too often Medicaid patients today have a hard time finding a doctor. The Government Accountability Office has previously found that Medicaid patients face particular challenges in accessing certain types of care, such as obtaining specialty care or dental care. Additionally, the GAO has previously reported that 38 States experienced challenges in ensuring enough participating providers.

To help empower Medicaid patients and equip them with better information, this policy would apply requirements similar to those in place for Medicaid managed care plans to fee-for-service and/or primary care case management programs.

Under the bill, States would be required to list on their Web sites a directory of physicians that would include the physician's name, specialty, address, and telephone number. Additionally, for physicians serving as case managers through the PCCM programs, States would be required to include information on whether a physician is accepting new patients as well as to list the physician's cultural and linguistic capabilities.

In a day and age when Medicaid patients can use their phones to search for the nearest gas station or grocery store, it makes good sense to ensure that States are giving patients better information so that they can readily find a doctor near them who accepts Medicaid patients.

Finally, according to the Congressional Budget Office, H.R. 3716 would reduce Federal outlays by \$15 million over a 10-year budget window because the Medicaid program would no longer be paying providers that were terminated for reasons of fraud, integrity, or quality. The CBO does not estimate State-specific savings, but this bill would also save State Medicaid pro-

grams several million dollars over the same timeframe.

Mr. Chairman, this legislation provides commonsense reforms that help protect Medicaid beneficiaries, that improve access to care, and that save Federal and State dollars in the Medicaid program. I urge my colleagues to support H.R. 3716.

I reserve the balance of my time.

Mr. TONKO. Mr. Chairman, I yield myself such time as I may consume.

I am here to express my strong support for the Ensuring Access to Quality Medicaid Providers Act.

In particular, I am pleased that this legislation incorporates the Medicaid Directory of Caregivers Act, also known as the Medicaid DOC Act. This is legislation in which I joined with my colleague and friend from New York, Representative COLLINS, in introducing.

I thank Representative COLLINS for his initiative in this area and for working together on this issue in a collaborative and bipartisan way. I also thank the Energy and Commerce Committee staffs on both sides for providing constructive feedback and for expeditiously moving this bill out of committee.

The impetus behind this bill is simple and straightforward: to make it easier for Medicaid beneficiaries to find and access a doctor.

The underlying legislation would require States that operate a fee-for-service Medicaid program to publish an online provider directory, just like managed care plans and private insurance are already required to do. By creating a one-stop-shop for Medicaid beneficiaries to find information on participating providers, this commonsense legislation will make it easier for individuals and families to access quality health care.

The legislation details the minimum items that must be included in a provider directory, but it also allows States to go beyond those given standards. All consumers deserve to have access to a basic electronic provider directory to find the best physicians for their use.

The second component of the legislation under consideration would provide the CMS with critical tools to keep patients safe, to protect taxpayer dollars, and to protect the integrity of our Medicaid program.

This bipartisan bill, introduced by Representatives BUCSHON, WELCH, and BUTTERFIELD, implements previous OIG recommendations and builds on authorities originally authorized under the ACA. The ACA included a provision that prohibited disqualified providers from Medicare or a one State Medicaid program from simply crossing State lines and receiving payments in another State Medicaid program.

The ACA provision has been hard to implement, however, because States don't have a consistent or a standardized way of knowing when a specific provider has been terminated by Medi-

care or by another State. All 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 legislation 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.

The language would also require all providers in managed care to enroll with State Medicaid agencies so that States know all providers that are participating in the program. This legislation preserves all existing provider appeals processes, and it changes nothing regarding the underlying standard for fraud in this part of the program.

In closing, Mr. Chairman, I urge all Members to support this bipartisan legislation, which makes Medicaid more consumer-friendly and strengthens program integrity.

I reserve the balance of my time.

Mr. BUCSHON. Mr. Chairman, I yield myself such time as I may consume.

This is the type of legislation that we should be passing on the House floor, and I will urge the Senate to pass this legislation later. This is just good government. It corrects some obvious flaws in the Medicaid program that will protect patients and save taxpayers money. I am very pleased that we are able to address this today.

I reserve the balance of my time.

Mr. TONKO. As I earlier mentioned in my comments, one of the key participants in putting this effort together was Representative WELCH from the State of Vermont.

I yield 2 minutes to the gentleman from Vermont (Mr. WELCH), a good friend and a fellow Energy and Commerce Committee member.

Mr. WELCH. I thank the gentleman from New York.

Mr. Chairman, we are lucky we have Dr. BUCSHON, a good Member, a good friend, and a great Energy and Commerce Committee person, who, with his experience as a physician, is able to give us the benefit of this bill. I thank the gentleman from Indiana for that.

The Medicaid program is an incredibly important program to get health care to poor Americans who need it. The vast majority of our providers use the Medicaid program to provide those services, but some fraudulent providers use that program to rip off taxpayers. It has got to stop.

One of the things that Dr. BUCSHON observed and brought to our attention was that when States are aggressively monitoring for fraud and when they identify a fraudulent provider, they write that person off the rolls so that that provider can't keep ripping off the taxpayers. But that information doesn't get disseminated to other States, so that fraudulent provider simply steps across the State line, sets

up another operation, and starts ripping off taxpayers all over again.

This legislation addresses that rip-off. I am glad it does because we can debate about lots of things, but there is unity here about wanting to make certain that any taxpayer dollar is well spent and that it is not ripped off by a fraudulent provider. This sets up practical mechanisms for States that have identified a fraudulent provider so they may share that information with other States so they don't find themselves digging the same hole.

We have bipartisan support for this. It is a money-saving bill. The CBO estimates that it would save approximately \$28 million over 10 years.

That may sound like small money; but do you want to know something?

That is real money. It is about the money, but it is also about constant vigilance so as to make sure that the programs we design for good intentions work.

The CHAIR. The time of the gentleman has expired.

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

Mr. WELCH. I thank the gentleman.

Mr. Chairman, it is just what we should be doing here so we can look at things that have good intentions, like the Medicaid program, and find where there are holes in it and try to close them so that the program runs better so that taxpayer money is saved and so that the efficiency of government is enhanced.

□ 1315

And that is a mutual responsibility that we have so that people can have confidence that the taxpayer dollars that they are spending, whether it is for Medicaid or the Pentagon or any other program, are spent for the intended purposes and are not wasted.

Mr. BUCSHON. Mr. Chair, I yield myself such time as I may consume.

I thank the gentleman for his comments. It is true that when you find common ground and work together, good things happen, and this is one of those instances.

I think there are a lot of areas in health care. I was a healthcare provider before I was a heart surgeon. I took care of Medicaid and Medicare patients, private insurance patients, and patients that did not have the ability to pay. I think that we need to continue to look for ways to improve our safety net healthcare programs, mainly continue to look for ways to make sure that people have access to health care in the United States regardless of their ability to pay, regardless of their ZIP Code.

That said, we need to make sure that people have access to quality health care, and that is why bills like this are so important. It weeds out providers that are fraudulent and have other quality-related problems.

As a physician—and I will speak for some of my physician friends—this is the type of thing that we all want in

our specialties. We want to make sure that the patients that we serve have access to physicians who are providing quality health care and are not defrauding the system.

I reserve the balance of my time.

Mr. TONKO. Mr. Chair, I will continue to reserve the balance of my time.

Mr. BUCSHON. Mr. Chair, I yield 2 minutes to the gentleman from New York (Mr. COLLINS).

Mr. COLLINS of New York. Mr. Chair, I thank both Congressman BUCSHON and Congressman TONKO for their help on this very important bill that we are debating today. Included in Congressman BUCSHON's bill, H.R. 3716, is a bill that Mr. TONKO and I put together, H.R. 3821, the Medicare Directory of Caregivers, or DOC, Act.

Our thought behind this bill came from the GAO report that identified access to care as one of the key issues facing Medicaid beneficiaries. There is nothing worse than someone saying: "The good news is you have got medical insurance coverage through Medicaid. The bad news is they can't find a physician."

So as a very good, commonsense government idea, what Representative TONKO and I came up with was the thought that we should be publishing on each State's Web site a list of the providers who have seen a Medicaid patient in the last 12 months, the name of the physician, the address, the telephone number, and their specialty, so at least these folks navigating the system to find a doctor have somewhere to go as a starting point: "Here is a doctor that has seen a Medicaid patient in the last 12 months. Let me give them a call." So they are not just lost going through the phonebook, so to speak, or Google.

What our bill would do, it would require that States that operate a fee-for-service or primary care case management program set up an online directory of physicians who have seen these Medicaid patients. We believe that this kind of access to caregivers will keep people out of the emergency rooms. They will have coordinated care by a physician, which is the best and most inexpensive way to treat them.

Representative BUCSHON's bill combined with our bill, H.R. 3821, does save \$15 million over the 10-year period, as scored. The bill went through regular order and passed out of the Energy and Commerce subcommittee and full committee by voice vote with no objections.

We are also encouraged to know the White House has signaled that they do support passage of this important access to care legislation.

Again, I thank Chairmen UPTON and PITTS, and Ranking Members PALLONE and GREEN for their support. I encourage my colleagues to vote in favor of this bipartisan legislation.

Mr. TONKO. Mr. Chair, I yield 3 minutes to the gentleman from New Jersey (Mr. PALLONE), the ranking member of

the standing Committee on Energy and Commerce, who has shown great leadership for the Democrats at the Energy and Commerce table. He is very much supportive of this effort here, and we thank him for that.

Mr. PALLONE. Mr. Chair, I am pleased to support H.R. 3716, the Ensuring Access to Quality Medicaid Providers Act. This legislation is the compilation of two bills, H.R. 3821 and H.R. 3716, which are true efforts to improve program integrity in Medicaid in ways that will strengthen the Medicaid program. Both bipartisan bills passed out of the Energy and Commerce Committee through regular order and were favorably reported by voice vote.

Part of the new compiled bill reflects H.R. 3821, the Medicaid DOC Act. This bipartisan initiative, introduced by Representatives COLLINS of New York and TONKO, would require States that participate in fee-for-service Medicaid to publish electronic provider directories. This is critical information for patients so they can more easily find doctors in their area.

Currently, managed care plans in Medicaid are already required to maintain these directories, but there is no such requirement for fee-for-service Medicaid programs. While some States are already providing these directories, not every State does so. This commonsense and consumer-friendly legislation will require that all States provide their Medicaid patients with this information, and it does so quickly, requiring directories to be up and running in less than 1 year.

Now, while the bill includes minimum items that must be included in a provider directory, it also encourages States to go beyond these standards. While I am hopeful that States will take the initiative to provide other information, like whether doctors are taking new patients, the timeline set forth in this legislation is so accelerated, it is important that we build this foundation first before adding additional requirements to States. I look forward to continuing to work on this important issue with my colleagues.

The second part of the bill would provide CMS with critical tools to keep patients safe, protect taxpayer dollars, and protect the integrity of the Medicaid program.

This bipartisan bill, introduced by Representatives BUCSHON, WELCH, and BUTTERFIELD, implements previous OIG recommendations and builds on authorities originally authorized under the Affordable Care Act, which prohibited disqualified providers from Medicare or one State Medicaid program from simply crossing State lines and receiving payments in another State Medicaid program.

But the current 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. Since States are not currently required to report this information or, if it is reported, it is in many

differing formats, it limits the data's usability.

This legislation being considered would require all States to report information on fraudulent providers to the Secretary for inclusion in an existing termination database that is accessible to all States. It also requires the Secretary to develop uniform criteria for States to use when submitting information and ensures those providers in managed care plans are enrolled with the State and also captured in the database.

Finally, the bill preserves and protects all existing provider appeal processes and changes nothing regarding the underlying standard for fraud in this part of the program, an important protection. This is smart policy that stakeholders and the administration agree will improve Federal and State efforts.

I urge Members to support the bill.

Mr. BUCSHON. Mr. Chair, I yield 2 minutes to the gentleman from New Jersey (Mr. LANCE).

Mr. LANCE. Mr. Chair, this is the way Congress should work, in a bipartisan capacity on an issue of importance to better the health of the American Nation.

As is so often true of the House Energy and Commerce Committee, we work in a bipartisan fashion. It is the committee of jurisdiction for so many of the issues that reach this floor, with the support in committee and in subcommittee of both Republicans and Democrats. Legislation coming out of our committee, the Energy and Commerce Committee, is legislation that passes here on the floor, goes over to the other House, and is eventually signed into law by the President of the United States. I am pleased that we are working closely with the other elected branch of government in this area.

I commend Congressman BUCSHON, Dr. BUCSHON, for his legislation that will so improve the issue we are discussing, and I think that Medicaid providers is an important matter for the entire Nation. I also compliment Congressman COLLINS of New York for his involvement on this issue.

With a program as large as Medicaid, it will always be a target for those who engage in fraud, but we can work to limit the impact of those who engage in fraud. The Congressman's bill is a positive step in that direction. It will save millions of dollars and send a message loud and clear that bad actors in one State should not be allowed to participate anywhere.

Medicaid-managed care plans already provide a network of doctors and nurses to care for patients. The requirement in this bill ensures that patients in fee-for-service Medicaid programs do not have to fend for themselves.

Research has shown that access to doctors can be a problem for Medicaid beneficiaries, so this commonsense step will help ensure beneficiaries are empowered with better information and that this happens across the board.

I thank Dr. BUCSHON and Mr. COLLINS, as well as the Health Subcommittee and its chairman, Chairman PITTS, and the full committee, including, of course, Chairman UPTON and Ranking Member PALLONE. Let's work together to ensure passage of this legislation on the floor of the House today.

Mr. TONKO. Mr. Chair, I reserve the balance of my time.

Mr. BUCSHON. Mr. Chair, I yield 2 minutes to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Chair, I rise today in support of H.R. 3716, the Ensuring Access to Quality Medicaid Providers Act.

A recent report by the HHS inspector general found that more than 1 in every 10 Medicaid providers who were terminated for fraud, integrity, or quality in one State were still participating in another State's Medicaid program.

To ensure that Medicaid patients are receiving their care from a qualified, licensed doctor, H.R. 3716 provides that disqualified providers be reported within 21 days to CMS, and each Medicaid provider must be enrolled with the State Medicaid agency.

H.R. 3716 also provides that State Medicaid programs include an electronic directory of physicians who serve Medicaid patients. Today, many Medicaid patients have a hard time finding a doctor and instead rely on the emergency room. With an established directory, Medicaid patients will be able to know which doctors are available to them and will ultimately get better care.

I encourage my colleagues to support the reforms in H.R. 3716 so we can make sure that Medicaid patients are receiving the care and attention they deserve.

Mr. TONKO. Mr. Chair, again, I just would thank all who have been involved with the effort here—from my perspective, particularly Representative COLLINS, Dr. BUCSHON, Representative WELCH, and others who put together, I think, a good effort here to have a bipartisan, collaborative effort that speaks to sensitivity, speaks to compassion toward the patients, those requiring the access to health care, and certainly has great respect for the taxpayer and the ensuing outcomes.

With that, I would encourage my colleagues to support the legislation.

I yield back the balance of my time.

Mr. BUCSHON. Mr. Chair, I would just like to echo the words of Mr. TONKO. This is good legislation. It improves the Medicaid program. It ensures access to quality providers for our Medicaid recipients in all of our States. Also, it helps our States to determine when people have been kicked off the program as a provider in another State and, therefore, helps them protect the patients in their own States.

I urge all of my colleagues to support this legislation.

I yield back the balance of my time.

Mr. UPTON. Mr. Chair, today we are making a difference for the nation's most vulnerable. Republicans and Democrats working to strengthen Medicaid, and the White House has officially given its seal of approval to these commonsense reforms.

Today is an important day and underscores what we can accomplish when we work together.

Medicaid is an important lifeline for so many in Michigan and across the country. It is estimated the program will expand to cover 83 million people this year—to put that into perspective, that's one in four Americans. Given its rapidly growing size, it is imperative the program is working as it is intended—providing care for folks who need it most.

The Ensuring Access to Quality Medicaid Providers Act we are considering is the product of two bills authored by committee members Dr. LARRY BUCSHON and Rep. CHRIS COLLINS that unanimously cleared both the Health Subcommittee and full committee last fall.

Dr. BUCSHON led the effort to help cut down on fraud by eliminating bad actors. The bipartisan legislation ensures that providers terminated from Medicare or a state Medicaid program for reasons of fraud, integrity, or quality are terminated across the board from all other state Medicaid programs.

With a program as large as Medicaid, it will always be a target for fraudsters, but we can work to limit their impact, and this bill is a positive step that will save millions of dollars and send the message loud and clear that bad actors in one state should not be allowed to participate anywhere, period.

In addition to reducing fraud, we are helping increase access for those most in need. Finding a doctor is often a difficult task, and Mr. COLLINS led this effort to increase access to care beyond the emergency room. If a state is using a fee-for-service or primary case management system to deliver care to Medicaid patients, this bill requires they provide those patients with a directory of physicians.

Medicaid managed care plans already provide a network of doctors and nurses to care for patients. This requirement ensures that patients in fee-for-service Medicaid programs don't have to fend for themselves.

Research has shown that access to doctors can be a problem for Medicaid beneficiaries, so this commonsense step will help ensure beneficiaries are empowered with better information that is more readily available. And that's a good thing.

This bill doesn't solve all our problems, but it is a significant bipartisan step forward. And yesterday, the Office of Management and Budget announced the administration "supports House passage of H.R. 3716 because it improves program integrity for Medicaid and the Children's Health Insurance Program."

We've got Republicans, Democrats, and the White House all in lockstep supporting meaningful, 21st century reforms for Medicaid. This bill shows that it's possible to work together on Medicaid.

I'd like to once again thank Dr. BUCSHON and Mr. COLLINS, as well as Helath Subcommittee Chairman PITTS and full committee Ranking Member PALLONE. Together, we are building upon the committee's proud bipartisan record of success. Let's keep the momentum going to help our most vulnerable folks.

The CHAIR. All time for general debate has expired.

Pursuant to the rule, the bill shall be considered for amendment under the 5-minute rule.

In lieu of the amendment in the nature of a substitute recommended by the Committee on Energy and Commerce, printed in the bill, it shall be in order to consider as an original bill for the purpose of amendment under the 5-minute rule an amendment in the nature of a substitute consisting of the text of Rules Committee Print 114-45. That amendment in the nature of a substitute shall be considered as read.

The text of the amendment in the nature of a substitute is as follows:

H.R. 3716

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 “Ensuring Removal of Terminated Providers from Medicaid and CHIP 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 January 1, 2017, 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, 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 effective date of such termination specified in such 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) REPORTING REQUIREMENTS 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) STATE REPORTING REQUIREMENTS FOR MANAGED CARE ENTITIES.—

“(A) IN GENERAL.—With respect to any contract with a managed care entity under section

1903(m) or 1905(t)(3) (as applicable), beginning on the later of the first day of the first plan year for such managed care entity that begins after the date of the enactment of this paragraph or January 1, 2017, the State shall require that such contract 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.

“(B) NOTIFICATION OF TERMINATION.—For the period beginning on January 1, 2017, and ending on the date on which the enrollment of providers under paragraph (6) is complete for a State, the State shall provide for a system for notifying managed care entities (as defined in subsection (a)(1)) of the termination (as described in section 1902(kk)(8)) of providers of services or persons from participation under this title, title XVIII, or title XXI.”.

(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:

“(II) 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 January 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(II); or”;

(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 the applicable date specified in subparagraph (A) of section 1932(d)(5), has a contract with such entity that complies with the requirement specified in such subparagraph; and

“(B)(i) for the period specified in subparagraph (B) of such section, has a system in effect that meets the requirement specified in such subparagraph; and

“(ii) after such period, complies with section 1932(d)(6).”.

(5) DEVELOPMENT OF UNIFORM TERMINOLOGY FOR REASONS FOR PROVIDER TERMINATION.—Not later than January 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 uni-

form 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 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 and who are enrolled with the entity, the provider is enrolled with the State agency administering the State plan under this title. 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 paragraph (1)) 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 paragraph (1)), by striking “(a)(2)(C) and (h)” and inserting “(a)(2)(C) (relating to Indian enrollment), (d)(5) (relating to reporting requirements 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 any State child health plan under title XXI”.

(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.

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 180 days after the date of the enactment of this paragraph, in the case of a State 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 providers (including, at a minimum, primary and specialty care physicians) described in subsection (mm) that includes—

“(A) with respect to each such provider—
“(i) the name of the provider;
“(ii) the specialty of the provider;
“(iii) the address of the provider; and
“(iv) the telephone number of the provider;
and

“(B) with respect to any such provider participating in such a primary care case-management system, information regarding—

“(i) whether the provider is accepting as new patients individuals who receive medical assistance under this title; and

“(ii) the provider’s cultural and linguistic capabilities, including the languages spoken by the provider or by the skilled medical interpreter providing interpretation services at the provider’s office.”.

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

“(mm) DIRECTORY PROVIDERS DESCRIBED.—A provider described in this subsection is—

“(1) in the case of a provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the provider to individuals eligible to receive medical assistance under the State plan, requires the enrollment of the provider with the State agency, 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 provider of a provider type for which the State agency does not require such enrollment, a provider that received payment under the State 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 in which all the individuals enrolled in the State plan under title XIX of the Social Security Act (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 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 section. 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.

The CHAIR. No amendment to the amendment in the nature of a substitute shall be in order except those printed in House Report 114-440. Each such amendment may be offered only in the order printed in the report, by a Member designated in the report, shall be considered read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

□ 1330

AMENDMENT NO. 1 OFFERED BY MR. BUCSHON

The CHAIR. It is now in order to consider amendment No. 1 printed in House Report 114-440.

Mr. BUCSHON. Mr. Chairman, I have an amendment to the desk.

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 1, lines 2 and 3, strike “Ensuring Removal of Terminated Providers from Medicaid and CHIP Act” and insert “Ensuring Access to Quality Medicaid Providers Act”.

Page 1, lines 15 and 16, strike “January 1, 2017” and insert “July 1, 2018”.

Page 3, lines 1 and 2, strike “the effective date of such termination specified in such notice” and insert “the date on which such termination is effective, as specified in the notice”.

Page 3, line 16, strike “REPORTING REQUIREMENTS” and insert “CONTRACT REQUIREMENT”.

Page 3, line 20, strike “STATE REPORTING REQUIREMENTS FOR MANAGED CARE ENTITIES” and insert “CONTRACT REQUIREMENT FOR MANAGED CARE ENTITIES”.

Page 3, line 22, strike “(A)” and all that follows through “With respect” and insert “With respect”.

Page 3, beginning on line 24, strike “applicable), beginning on the later of the first day of the first plan year for such managed care entity that begins after the date of the enactment of this paragraph or January 1, 2017, the State shall require that such contract” and insert “applicable), no later than July 1, 2018, such contract shall”.

Page 4, strike lines 12 through 21.

Page 6, line 1, strike “January 1, 2018” and insert “July 1, 2018”.

Page 6, line 17, strike “the applicable date specified in subparagraph (A) of section 1932(d)(5)” and insert “July 1, 2018”.

Page 6, line 21, strike “(i)”.

Page 6, line 21, strike “for the period specified in subparagraph (B) of such section, has a system in effect that meets” and insert “beginning on January 1, 2018, complies with”.

Page 6, line 23, strike “such subparagraph; and” and all that follows through page 7, line 2 and insert “section 1932(d)(6)(A).”.

Page 7, line 5, strike “January 1, 2017” and insert “July 1, 2017”.

Page 10, line 15, strike “paragraph (1)” and insert “subparagraph (A)”.

Page 10, line 21, strike “paragraph (1)” and insert “subparagraph (A)”.

Page 10, lines 23 and 24, strike “reporting requirements” and insert “contract requirement”.

Page 11, after line 15, insert the following:

(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 (1) 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.

(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 (j)(2)(D) and subsection (m)(3) of such section, as added by subsection (a)(4).

(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).

(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.

Page 12, lines 1 and 2, strike “180 days after the date of the enactment of this paragraph” and insert “January 1, 2017”.

Page 12, line 10, strike “a directory” and all that follows through line 13 and insert the following: “a directory of the physicians described in subsection (mm) and, at State option, other providers described in such subsection that—”

Page 12, after line 13, insert the following: “(A) includes—”.

Page 12, line 14, strike “(A)” and insert “(i)”.

Page 12, line 14, insert “physician or” before “provider”.

Page 12, line 15, strike “(i)” and insert “(I)”.

Page 12, line 15, insert “physician or” before “provider”.

Page 12, line 16, strike “(ii)” and insert “(II)”.

Page 12, line 16, insert “physician or” before “provider”.

Page 12, line 17, strike “(iii)” and insert “(III)”.

Page 12, line 17, strike “of the provider” and insert “at which the physician or provider provides services”.

Page 12, line 18, strike “(iv)” and insert “(IV)”.

Page 12, line 18, insert “physician or” before “provider”.

Page 12, line 20, strike “(B)” and insert “(i)”.

Page 12, line 20, insert “physician or” before “provider”.

Page 12, line 23, strike “(i)” and insert “(I)”.

Page 12, line 23, insert “physician or” before “provider”.

Page 13, line 1, strike “(ii)” and insert “(II)”.

Page 13, line 1, insert “the physician’s” before “provider’s”.

Page 13, line 3, insert “physician or” before “provider”.

Page 13, line 5, strike “provider’s office.” and insert “physician’s or provider’s office; and”.

Page 13, after line 5, insert the following:

“(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.”.

Page 13, line 6, strike “PROVIDERS” and insert “PHYSICIAN OR PROVIDER”.

Page 13, line 10, strike “PROVIDERS” and insert “PHYSICIAN OR PROVIDER”.

Page 13, line 10, strike “A” and insert “A physician or”.

Page 13, line 12, insert “physician or” before “provider of”.

Page 13, line 15, insert “physician or” before “provider”.

Page 13, line 17, strike “provider with the State agency, a” and insert “physician or provider with the State agency, a physician or”.

Page 14, line 1, insert “physician or” before “provider of”.

Page 14, line 3, insert “physician or” before “provider”.

Page 14, beginning on line 10, strike “in which all the individuals enrolled in the State plan under title XIX of the Social Security Act” and insert “(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”.

Page 15, line 3, insert “of Health and Human Services” after “Secretary”.

Page 15, line 12, strike “section” and insert “Act”.

The CHAIR. Pursuant to House Resolution 632, the gentleman from Indiana (Mr. BUCSHON) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Indiana.

Mr. BUCSHON. Mr. Chairman, I yield myself such time as I may consume.

This bipartisan amendment makes a few technical changes to the bill.

First, this amendment modifies the short title to better reflect the policies of both sections of the bill.

Second, this amendment updates the effective dates throughout the bill to ensure that States and HHS have the time necessary to correctly implement the provisions.

Next, it includes a requirement that the Office of the Inspector General at

HHS review the implementation of the requirements in this bill regarding terminated providers and report back to Congress on what they find. This is an important feedback loop to ensure appropriate oversight.

Finally, the amendment clarifies that the fee-for-service provider directory is required to include physicians and, at a State’s option, other providers. The amendment also clarifies the information that could be included in the directory.

MODIFICATION TO AMENDMENT NO. 1 OFFERED BY MR. BUCSHON

Mr. BUCSHON. Mr. Chair, I ask unanimous consent to modify the second instruction relating to page 13, line 1, as provided at the desk.

The CHAIR. The Clerk will report the modification.

The Clerk read as follows: Modification to amendment No. 1 offered by Mr. BUCSHON:

Page 13, line 1, insert “physician’s or” before “provider’s”.

The CHAIR. Is there objection to the request of the gentleman from Indiana? There was no objection.

The CHAIR. The amendment is modified.

The Chair recognizes the gentleman from Indiana.

Mr. BUCSHON. Mr. Chairman, I urge my colleagues to support this bipartisan amendment to H.R. 3716.

I yield back the balance of my time.

The CHAIR. Does any Member seek time in opposition to the amendment?

Mr. BUCSHON. Mr. Chairman, I ask unanimous consent to reclaim my time.

The CHAIR. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The CHAIR. The gentleman from Indiana is recognized.

Mr. BUCSHON. Mr. Chairman, I yield to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Mr. Chair, I rise in support of the manager’s amendment.

This amendment provides a new bill name that incorporates the underlying policies from each of its component bills and reflects additional technical changes that have been outlined by the gentleman from Indiana (Mr. BUCSHON), made in consultation with CMS.

This is a very targeted policy that went through extensive review through regular order in the committee. The manager’s amendment reflects the final iteration of that hard work.

I would urge all my colleagues to support this simple refining amendment.

Mr. BUCSHON. Mr. Chairman, I yield back the balance of my time.

The CHAIR. The question is on the amendment, as modified, offered by the gentleman from Indiana (Mr. BUCSHON).

The amendment, as modified, was agreed to.

The CHAIR. It is now in order to consider amendment No. 2 printed in House Report 114-440.

It is now in order to consider amendment No. 3 printed in House Report 114-440.

It is now in order to consider amendment No. 4 printed in House Report 114-440.

The question is on the amendment in the nature of a substitute, as amended.

The amendment was agreed to.

The CHAIR. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. SMITH of Nebraska) having assumed the chair, Mr. HOLDING, Chair of the Committee of the Whole House on the state of the Union, reported that that Committee, having had under consideration the bill (H.R. 3716) to amend title XIX of the Social Security Act to require States to provide to the Secretary of Health and Human Services certain information with respect to provider terminations, and for other purposes, and, pursuant to House Resolution 632, he reported the bill back to the House with an amendment adopted in the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment to the amendment reported from the Committee of the Whole?

If not, the question is on the amendment in the nature of a substitute, as amended.

The amendment was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed 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. BUCSHON. 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.

RECESS

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

Accordingly (at 1 o’clock and 38 minutes p.m.), the House stood in recess.

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. DUNCAN of Tennessee) at 5 o’clock and 15 minutes p.m.